

NURSES STORIED EXPERIENCES OF DIRECTION
AND DELEGATION.

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Abstract

Direction and delegation is a professional competency required of all New Zealand nurses and all nurses must attest to understanding direction and delegation on their annual practicing certificate application. However, the literature on how New Zealand nurses managed their direction and delegation interactions was silent. This thesis offers a New Zealand perspective and contributes to the discussion found in the overseas nursing literature about delegation.

The purpose of the study was to explore nurses' perceptions about their everyday direction and delegation experiences using a narrative approach. The role of story in narrative research reflected my own views about the importance of story in nursing. Nurses are responsible for informing others in handovers, progress notes, health information education sessions and inter-disciplinary meetings. This is carried out through a series of different stories depending on the audience which includes patients, nursing and medical colleagues, support staff or whānau and family. The narrative plots made possible by the methodology and methods of narrative research uncovered how nurses made sense of direction and delegation in their workplace.

As the Enrolled and Registered Nurse Agents shared their own storied experiences it was revealed that working *in* a team differs to working *as* a team, and that both are needed; that communicating well and professionally were vital to the success or not of the delegation interaction; and that nurses needed to form a delegation relationship rather than provide a set of instructions. The ability to meet this professional obligation requires skill and knowledge, and more workplace relevant information from nurses in leadership roles to support 'good' direction and delegation interactions.

Taken together the eight major patterns that came into focus, and presented as eight narratives, showed that the main concern for all nurses was to keep the patient safe, and ensure they worked to their Scope of Practice. This narrative research study has provided the unique and individual perspectives related to direction, delegation and accountability relevant to nurses in clinical workplaces, education, leadership and management settings. Significant implications for nursing practice, research, policy design, the theory taught in nursing education programmes, and access to in-service information sessions were identified.

Abbreviations

ANP. - Assistive Nursing Personnel - a workplace employee who is unlicensed and unregulated, and who assists licensed, regulated nurses.

DEU. – Dedicated Education Unit - The DEU model departs from the ‘one-on-one’ approach of traditional preceptor-based models by creating a collaborative teaching and learning environment across the ward. DEUs foster interaction and sharing of knowledge amongst learners and clinical staff, as well as having the practical benefit of reducing the workload on individual practitioners (Ako Aotearoa, National Centre for Tertiary Teaching Excellence)

EEN. – An Endorsed Enrolled nurse – a redundant title that no longer appears on the nursing register in Australia but may still be used unofficially to acknowledge that some Enrolled nurses could administer selected medicines.

HCA. - Health Care Assistant - a term used mainly in New Zealand and sometimes in Australia to describe the unregulated, unregistered support role to Registered Nurses. The Nursing Council of New Zealand (NCNZ) describe a health care assistant as a person employed within a health care, residential or community context who undertakes a component of direct care and who is not regulated by a regulatory authority (Nursing Council of New Zealand, 2011b). The health care assistant can also be referred to as a health care worker, carer, care giver, care assistant or health care support worker.

ICN. - International Council of Nurses - provides international guidance to nurses from member nations who are encouraged to align their policies with those of the ICN international nursing community.

ISBAR. – Identification, Situation, Background, Assessment, Recommendations – a suggested framework to support a structured, standardised communication format between health care professionals (Canterbury District Health Board).

LPN. – Licensed Practical Nurse - a term used in the United States to represent a licensed nurse who has completed a one-year nursing course, and a national licensing exam. LPNs work under the direction of a Registered Nurse.

NCNZ. - Nursing Council of New Zealand - the professional and regulatory body for nursing in New Zealand.

NZNO. - New Zealand Nurses Organisation - the professional and industrial body for nurses, and other workers in the health care sector in New Zealand.

NQN. - Newly Qualified Nurses - a term used in the United States to describe newly qualified nurses (new graduates).

NCA. - Nursing Care Assistant - a term used in the United States to describe an unlicensed assistant to the nursing role.

NAP. - Nursing Assistive Personnel - a term used mainly in the United States to describe a workplace employee who is unlicensed and unregulated who assists licensed, regulated nurses.

NetP. – Nursing Entry to Practice Programme - The vision for the Nursing Entry to Practice (NETP) programme is for New Zealand nursing graduates to be able to enthusiastically commence their careers in New Zealand. This includes being well-supported, safe, skilled and confident in their clinical practice; equipped for further learning and professional development; able to meet the needs of health and disability support service users and employers; and are part of a sustainable base for the New Zealand registered nursing workforce (Ministry of Health, 2006).

NESP. – New Entry to Specialist Practice for new Registered Nurses wishing to work in mental health settings.

PDRP. - Professional development and recognition programmes – a framework containing criteria that enables the nurses' practice and contribution to quality patient care to be recognised and rewarded, to advance professional development, and demonstrate competence with NCNZs competencies.

PSA. - Patient Support Assistant - a term used in the United States to describe a workplace employee who is considered a technical support person to a Registered Nurse.

RGN. - Registered General Nurse - a term used in the United Kingdom to describe a Registered Nurse with a Scope of Practice that enables him or her to work in a general medical or surgical setting.

RPN. - Registered Practical Nurse - a term used in Canada to describe a health care professional who provides nursing care in consultation with a Registered Nurse.

UAP. - Unlicensed assistive personnel – a term used predominantly in the United States to describe a Nurse Aide, care giver, health care worker or assistive personnel.

Glossary of Terms

Accountability - Being answerable for your decisions and actions

Associate nurse - There are three routes to becoming a registered nurse in the United States: a three year diploma program typically administered in hospitals; a 2-3-year associate degree usually offered at community colleges; and the 4-year baccalaureate degree offered at senior colleges and universities. Graduates of all three programs sit for the same licensing examination (American Association of Colleges of Nurses, 2013).

Clinical Nurse Manager – A nurse who manages and reports a budget, leads evidence based clinical care, is responsible for staff development, responding to patient complaints, rostering and business cases (Clarkson, 2009).

Clinical Nurse Specialist - The CNS is described as a leader, a clinical expert, a co-ordinator (Roberts, Floyd, & Thompson, 2011).

Community Nurse – A New Zealand nursing role that developed from the 1938 Nursing Aide role. The Community Nurse name was changed in 1977 to become the Enrolled Nurse.

Delegation – the transfer of responsibility for the performance of an activity from one person to another with the former retaining accountability for the outcome (Nursing Council of New Zealand, 2011b).

Direction - The active process of guiding, monitoring and evaluating aspects of nursing care performed by another. Direction is provided directly when the Registered Nurse is actually present, observes, works with and directs the person; direction is provided indirectly when the Registered Nurse works in the same facility or organisation as the supervised person but does not constantly observe his/her activities. The Registered Nurse must be available for reasonable access, i.e. must be available at all times on the premises or contactable by telephone (in community settings) (Nursing Council of New Zealand, 2011b).

Enrolled Nurse – a nurse in New Zealand who has completed either a 12 or 18 month hospital qualification or a tertiary course of study at NZQA Level 4 or 5, who works under the direction and delegation of a Registered Nurse (Nursing Council of New Zealand, 2014a).

First and second level nurses - a term used mainly in overseas literature but sometimes in New Zealand nursing literature to describe Registered Nurses (first) and Enrolled Nurses (second).

Nursing support personnel - a coverall term for a category of support personnel to New Zealand nurses who do not hold the legal status or the title 'nurse'.

Nursing Aide – a category of nursing support personnel (not legally a nurse) introduced to fill continuing and serious nursing staff shortages in New Zealand in 1938 for patients with chronic illness, and the aged.

Maternity Nurse – a category of nurse introduced in New Zealand, in 1925 to carry out the duties of a midwife under the 'charge' of a registered medical officer.

Obstetric Nurse – a category of nurse introduced to provide better mother and child care in New Zealand. Registration of obstetric nurses was approved in 1904.

Registered Nurse – a nurse in New Zealand who has completed a three year course of study, and is responsible for directing and delegating care to Enrolled Nurses and others (Nursing Council of New Zealand, 2014a).

Supervision – supervision is provided by a Registered Nurse to an Enrolled Nurse who works under the direction of another registered health practitioner. The Registered Nurse provides guidance and feedback on the Enrolled Nurse's practice. This may include monthly face-to-face meetings, discussion of practice issues, discussion of professional development and learning needs, review of work content/nursing activities, or discussion of professional responsibilities (Nursing Council of New Zealand, 2011b).

There can be no doubt that all our knowledge begins with experience. - Immanuel Kant. The Critique of Pure Reason, 1787

Chapter one. Situating the research study and setting the scene

Background to the study

The Enrolled and Registered Nurses' Scope of Practice and their respective competencies make clear that the direction and delegation role is a professional competency required by all New Zealand nurses who are registered with the Nursing Council of New Zealand (NCNZ). With the reintroduction of the Enrolled Nursing Programme in 2002, and a revised and broadened Enrolled Nurse Scope of Practice in 2010, new Enrolled Nurses emerged onto the nursing scene requiring direction and delegation from Registered Nurses. How Enrolled and Registered Nurses made sense of this professional accountability, and the guidance they have access to, is the focus of this narrative inquiry research study. The story of nursing in New Zealand has a past, present and future, and just as any story does, the decision of where to start is arbitrary and is usually shaped by the writer's point of view (Connelly & Clandinin, 1990, p. 9). As the direction and delegation journey in New Zealand has been shaped by its past, an exploration of some of these influences is included here.

The evolution of the supervision, direction and delegation role in New Zealand

As the New Zealand health system responded to international, medical and technological advances, and the social, political and economic changes occurring within New Zealand in the early 20th century, new categories of nursing support personnel and levels of nurse were introduced to meet the increasing demand for "trained" and "untrained" nurses. With the introduction of obstetric, maternity and district nurses, and Nursing Aides, Community and Enrolled Nurses, reference to a nursing supervision role is identified.

While a supervision relationship is not a new requirement for New Zealand nurses, different terms have been used to describe it historically, such as "charged with" "teaching" "instructing" and "supervising". However, the meaning and intent of each of the terms point to some form of supervisory interaction. The term "delegate" is first used in 1938 by Mary Lambie, the Director of the Division of Nursing at that time, who was searching for a new way to maximise the nursing role.

The registered Community Nurse role was set in place in 1965, a precursor to the change in title to Enrolled Nurse in 1977. It is at this point of the exploration of nursing categories and roles, that some nurses in literature credit the development of the term “second level nurse” (Papps & Kilpatrick, 2002, p. 5) as nursing distinguished between two levels of nurse, with the Registered Nurse being the first level nurse, and the Enrolled nurse as the second level nurse. Often the first and second level nursing journey is linked at points along the way, and at times this coming together has produced regulatory changes to the supervision roles and responsibilities of the different levels of ‘nurse’. An exploration of the supervisory role in New Zealand identifies that when a new category of nursing support person, domestic or carer, or a different level of nurse is introduced, one group is “charged with” instruction, teaching or supervising, and the other group receives guidance to complete their duties through being taught, supervised or instructed (Lambie, 1952; MacGregor, 1901; Maclean, 1932).

Between 1938 when the Nurse Aide role was created, through to 1965 when the role changed to a nursing role, rather than a support role to nurses, and into 2010 when the revised New Zealand Qualification Authority (NZQA) Level 5 Diploma in Enrolled Nursing was introduced, a pattern is evident that the supervision requirement, now called direction and delegation, was not supported with specific guidance about how this professional obligation should be carried out. In addition, there has been a significant gap between the closure of hospital based Enrolled Nurse training programmes by 1993, and the re-emergence of the Enrolled Nurse programme in the tertiary education system as a gazetted Level 4 educational programme in 2002. As Bland and Olliver (2002, p. 89) acknowledge nursing has been slow to recognise the skills required for delegation and supervision. There are several “generations” of Registered Nurses who may not have received “formal training” related to the delegation skills needed to work with Enrolled Nurses and others, in undergraduate, graduate, post graduate or employer led courses. The lack of importance placed on this professional competency has resulted in cohorts of nurses who have not had to formally demonstrate their competence in this area, and who may not have been exposed to a delegation relationship (Bland & Olliver, 2002).

Acknowledging the changes to the supervision requirement serves as a backdrop to the development of the direction and delegation role, and provides a context to the changes that this professional obligation has undergone over the decades. A search of the history of the supervision, direction and delegation role contributes to nursing’s understanding of how this professional obligation has been communicated and managed in the past. As a consequence of this exploration, it may be possible to choose which parts of the supervision, direction and

delegation journey nurses wish to revisit and repeat, or reject, if the outcome has not been useful. For those interested in the supervision, direction and delegation journey, a timeline of significant events that shaped the direction and delegation name and role is provided in Appendix A.

While New Zealand's history has shaped the direction and delegation requirement, the delegation role has also been influenced by its association with the International Council of Nurses (ICN). This relationship is explained in the following section.

Policy direction from the International Council of Nurses (ICN)

As a member of the ICN, New Zealand enacts ICN policy directives through the NCNZ and other professional organisations such as the New Zealand Nurses Organisation (NZNO). The major motivation for the guidance, position statements and policy initiatives is the protection of the public. The ICN position statements identify the need for competent nursing leadership and support in order for nurses to be able to practice effectively within their Scope of Practice. They point to the important role nursing leadership has in providing guidance in the form of competencies, evidence and peer support, and policies and procedures, so that nurses are able to function in their nursing role. The relationship between the ICN and New Zealand nursing directly affects the professional requirements of New Zealand Enrolled and Registered Nurses on a number of professional, legal and regulatory levels, and the educational preparation of nurses. The ICN recognises that achieving a balance of skill mix is one of the challenges for management in today's clinical settings (International Council of Nurses, 2008, p. 5). They have developed a nursing care continuum framework document in order to clarify "incremental complexity of the competencies among different levels of nursing across health systems" (International Council of Nurses, 2008, p. 5). This guidance document is clearly reflected in the NCNZ Enrolled and Registered Nurse Competencies and Scopes of Practice (Nursing Council New Zealand, 2007a, 2012a).

New Zealand has adopted the position that the Enrolled Nurse as well as the Registered Nurse is a registered member of the health care team. In these roles they are required to provide evidence of ongoing competence. Continuing competence is defined as: "the ongoing ability of a nurse to integrate and apply knowledge, skills, judgements and personal attributes required to practice safely and ethically in a designated role and setting" (International Council of Nurses, 2013, p. 2). This includes compliance to nursing codes of practice, a commitment to lifelong learning to ensure nurses are able to reflect on, and then change their nursing practice, and understanding the changing health system needs, such as the reintroduction of Enrolled nursing in New Zealand. Continuing competence in relation to

direction and delegation interactions between nurses is a requirement for both Enrolled and Registered Nurses in New Zealand when applying for their competency based annual practicing certificates.

Protecting the title of ‘*nurse*’ ensures that the public are kept safe from others representing themselves as nurses who do not meet the regulatory description of ‘*nurse*.’ In their position paper “Protection of the title *Nurse*”, the ICN identified that the title ‘*nurse*’ should be protected by law and only applied to nurses who are educated, trained and qualified as nurses (International Council of Nurses, 2013). The guidance given on the title of ‘*nurse*’ by the ICN is an important one. This is reflected in the NCNZ’s decision to support an Enrolled Nurse who is a trained and educated nurse, and who has graduated from a nationally regulated and moderated NZQA Level 5 Diploma in Enrolled Nursing programme.

Both the Registered Nurse and the Enrolled Nurse are required to work within a designated Scope of Practice. A Scope of Practice is a broad description of the role associated with the educational preparation and level of the nurse. It is provided as a foundation for establishing standards of nursing practice, nursing education, nursing roles and responsibilities, and is defined within the legislative and regulatory framework of the country in which the nurse works (International Council of Nurses, 2013). The ICN defines a nursing Scope of Practice as a vehicle to describe the knowledge, skills, judgement, professional accountability and responsibilities of the nurse.

New Zealand nursing Scopes of Practice

As a member of the ICN through NZNO, the NCNZ operationalise the ICN internationally agreed policy by providing guidelines for nursing education, administering State Final Examinations and receiving applications for registration (Nursing Council of New Zealand, 2014b). The NCNZ also governs the practice of nurses by setting and monitoring standards of registration. In addition, they audit, monitor and accredit educational institutions who are responsible for providing nursing diploma and degrees programmes, and courses. The NCNZ as the responsible authority for nurses in New Zealand also has a statutory legislative role and works as a body to administer the Health Practitioners Competency Assurance Act (HPCAA) (2003). The HPCAA (2003) requires every New Zealand nurse to have a Scope of Practice in order to articulate the competencies, knowledge, skills and professional accountability required of a nurse.

There are three different nursing Scopes of Practice and associated competencies in New Zealand. The different levels of nurses, the Nurse Practitioner (NP), the Registered Nurse

(RN), and the Enrolled Nurse (EN) are required to provide proof of continuing competence based on the competencies associated with their Scope of Practice. For the Enrolled and Registered Nurse this includes an understanding and competence with the role of directing and delegating, or being directed and delegated to, in order to continue to receive their annual practicing certificate (Nursing Council New Zealand, 2007a, 2012a).

To be registered in the Nurse Practitioner Scope of Practice the Registered Nurse must have completed a minimum of four years' experience in a specific area of practice, completed an approved clinical Master's degree, or overseas equivalent, and pass an assessment against the Nurse Practitioner competencies by an approved panel (Nursing Council New Zealand, 2012c). The Nurse Practitioner Scope of Practice does not mention direction or delegation (Nursing Council New Zealand, 2012c). While the competencies associated with the Nurse Practitioner Scope of Practice might not directly mention direction or delegation, the indicators for the Nurse Practitioner competencies within Domain One point to a leadership, mentoring and coaching role with other colleagues, and the requirement to contribute to positive outcomes for clients and policy development.

To be able to register in the Registered Nurse Scope of Practice the nurse must have completed a Bachelor's degree in nursing or equivalent qualification approved by the Nursing Council of New Zealand and passed an assessment of the competencies required of a Registered Nurse by an approved provider. In addition, the nurse must have passed a national examination for Registered Nurses (Nursing Council New Zealand, 2007a). The Registered Nurse Scope of Practice states that the Registered Nurse must: "delegate to and direct Enrolled Nurses, and nurse assistants" (Nursing Council New Zealand, 2007a, p. 3). Domain One, Competency 1.3 within the competencies for Registered Nurses states that the Registered Nurse must "demonstrate accountability for directing, monitoring and evaluating nursing care that is provided by nursing assistants, Enrolled Nurses and others" (Nursing Council New Zealand, 2007a, p. 11). There are four indicators associated with competency 1.3 that suggest that appropriate decision making and consideration are required when assigning care or delegating activities and providing direction. However, no specific information is provided related to how this should be undertaken.

The Enrolled Nurse Scope of Practice specifically states that: "Enrolled Nurses practice under the direction and delegation of a Registered Nurse, or Nurse Practitioner to deliver nursing care". The Scope of Practice further identifies that: "In acute settings Enrolled Nurses must work in a team with a Registered Nurse who is responsible for directing and delegating nursing interventions". Further, "In some settings Enrolled nurses may work under the

direction and delegation of a registered health care professional” and that Enrolled Nurses are “accountable for their nursing actions” (Nursing Council New Zealand, 2012a, p. 5). Domain one, Competency 1.3, within the competencies for Enrolled Nurses states that the Enrolled Nurse: “Demonstrates understanding of the Enrolled nurse Scope of Practice and the Registered nurse responsibility and accountability for direction and delegation of nursing care” (Nursing Council New Zealand, 2012a, p. 9). There are four indicators associated with the competency. No other information or advice related to how to undertake the direction or delegation role is provided in the Enrolled or Registered Nurse competencies (Nursing Council New Zealand, 2007a, 2012a).

It is important not to overlook that there have been two levels of Enrolled Nurse in New Zealand since 2002. With the introduction of the revised and expanded Scope of Practice in 2010, an Enrolled Nurse is required to complete a Diploma in Enrolled nursing, and an 18 month educational programme at a tertiary school of nursing which is approved and accredited by the NCNZ (Nursing Council of New Zealand, 2014b). There are also Enrolled Nurses who trained prior to 2011 and therefore have been educated to an NZQA Level 4 Enrolled Nurse qualification. Level 4 Enrolled Nurses have conditions placed on their practicing certificate specifying their area of practice and they are not able to take on increased responsibilities in these settings until they complete further education. While all Enrolled Nurses are legally entitled to be called Enrolled Nurse and use the title *nurse* it needs to be acknowledged that some Enrolled Nurses were educationally prepared pre 1993 and although they are highly experienced Enrolled Nurses, and many have transitioned to the Level 5 qualification, not all have done so. This provides for the possibility that there are Enrolled Nurses with 30 years plus experience who have transitioned to the revised and expanded Scope of Practice; Enrolled Nurses who trained prior to 2010 who have not transitioned to the revised and expanded Scope of Practice who will have conditions placed on their practicing certificate; and new and therefore inexperienced Enrolled Nurses post 2010. All three levels of Enrolled Nurses can be employed in one workplace with the title ‘Enrolled Nurse.’ The implications of the three different levels of Enrolled Nurse is that a Registered Nurse responsible for directing and delegating to an Enrolled Nurse will need to assess and understand the differences between these Enrolled Nurses as they apply to the management of nursing care. In addition, the Enrolled Nurse will need to understand their Scope of Practice and associated roles and responsibilities, and be able to communicate this to the Registered Nurses they work alongside.

The guidance afforded by ICN to national nursing agencies about the use of assistive nursing personnel refers to unlicensed health care workers and incorporates a variety of titles and

names. The various titles adopted by member nations are explained in the Abbreviations section provided earlier (p. iii). Health Care Workers (HCWs) as assistive nursing personnel in New Zealand do not have a Scope of Practice and are therefore unregistered, and the title of ‘nurse’ is unable to be used for this group of assistive personnel. Health care assistants are not regulated and do not have a standardised educational programme. Their role is determined by their employer and outlined in their job description. NCNZ’s role in this instance is to provide guidance to Registered Nurses on how to safely direct and monitor unregulated health care assistants (Nursing Council of New Zealand, 2011a) so that they are not inadvertently caught up in task shifting. Task shifting can occur when a group of workers are asked to function beyond the limits of their training or knowledge and skills. Further, any use of assistive nursing personnel requires direct and indirect supervision by a Registered Nurse and it is suggested that the regulation of this group needs to be developed, evaluated and revised by nursing personnel (International Council of Nurses, 2013, p. 3).

Summary of the background to the study

From the discussion above it is clear that the Enrolled and the Registered Nurse Scopes of Practice, and the competencies that accompany their Scope of Practice identifies that direction and delegation is an expected and required role and responsibility for New Zealand nurses. However, as is consistent with the role of a Scope of Practice and competencies the requirement outlined in these nursing documents has been kept brief and broad. While direction and delegation are acknowledged they are not explained or supported in any detail (Nursing Council New Zealand, 2007a, 2012a; Nursing Council of New Zealand, 2011b). This provides a reason and starting point for this research to address two important questions. Firstly, what do New Zealand nurses and those from overseas countries, know and understand about this professional competency? Secondly, how do New Zealand nurses know how to carry out their respective direction and delegation roles and responsibilities?

The research question and aims

My professional and personal interest in the topic of direction and delegation and the research “wondering” (Clandinin, 2013, p. 42) that surrounded thinking about it as a nurse and nursing educator eventually led to the development of my research question, which then determined the aims of the study. The research question that emerged from two years of “wondering” and “puzzling” (Clandinin & Connelly, 2000, p. 124/284) about direction and delegation interactions between nurses and roles of accountability was: *How do Enrolled and Registered Nurses communicate with each other during the direction and delegation interaction?*

The four aims of the research study fell easily from the research question at this point and were captured as a need for me as the narrative inquirer to firstly describe and explore Enrolled and Registered Nurses' understanding of the knowledge, skills and attitudes required during delegation interactions. Secondly, to describe and explore how Enrolled and Registered Nurses' applied this understanding to their everyday direction and delegation communication interactions. Thirdly, to describe and explore the unique and individual direction and delegation perceptions and experiences in which each Enrolled and Registered Nurse had been involved. Fourthly, to explore the direction and delegation support, resources and guidance currently available to nurses, and the support, resources and guidance they believed they needed in order to safely and effectively carry out this professional obligation.

Delegation is defined as the transfer of responsibility for the performance of an activity from one person to another with the former retaining accountability for the outcome (Nursing Council of New Zealand, 2011b).

Direction a term unique to the New Zealand nursing environment is defined as the active process of guiding, monitoring and evaluating aspects of nursing care performed by another. Direction is provided directly when the Registered Nurse is actually present, observes, works with and directs the person. Direction is provided indirectly when the Registered Nurse works in the same facility or organisation as the supervised person but does not constantly observe his/her activities. The Registered Nurse must be available for reasonable access, i.e. must be available at all times on the premises or contactable (Nursing Council of New Zealand, 2011b).

Safe direction and delegation interactions are those interactions between Enrolled and Registered Nurses that enable them to continue to meet the competencies associated with their respective Scope of Practice. Safety also refers to the need for the Enrolled Nurse to work under the direction and delegation of the Registered Nurse, and safely carry out the tasks and skills asked of them. In addition to this, safety refers to the Registered Nurses' ability to delegate the right task, to the right nurse, at the right time. Patients need to be nursed safely, and getting direction and delegation wrong could have negative consequences for them too. Therefore, it is important that the correct nurse is selected to carry out the nursing skill or task for a particular patient.

Effectiveness is defined as the ability to carry out nursing direction and delegation well and in a timely manner. Safety cannot be met without effectiveness, and effectiveness of the direction and delegation interaction cannot be met without safety.

The research puzzle and wonder, and the research question and aims led me to a realisation that a research methodology that could reveal how Enrolled and Registered Nurses' made sense of the direction and delegation interactions they had been involved in, and what direction and delegation meant to them, was required. In addition, the methodology and design would need to explore how nurses had learned about this professional responsibility, the strategies they used to navigate the communication and assessment and leadership interactions required of them, and if they believed the teaching they had received supported their professional obligation to safely and effectively be in a direction or delegation relationship.

Significance – the ‘so what’ and ‘who cares’?

Clandinin is quite clear that the reasons for any research study must be justified. There are three important justifications that were considered by me as the researcher and presented to the research audience. They are the personal, the practice and the social justifications (Clandinin, 2013, p. 65). The personal justification for a narrative inquiry approach involves justifying the content and choice of the inquiry in relation to the researcher's own life experiences. My personal justification for this research study and my interest in the topic is described in: *The role of the researcher in narrative inquiry*, and the *Puzzling and wondering about direction and delegation* in Chapter three of this thesis. Suffice to say, from a teaching and nursing stance I am interested in how direction and delegation relationships and interactions play out in clinical nursing workplaces.

The practice justifications for this research study began to surface when I talked to Enrolled and Registered Nurses in both clinical and teaching settings. Nurses reported feeling confused about how to carry out the direction and delegation role, who was responsible when delegating tasks and where to find information on how to do it. Therefore, a research study that could explore the nurse's understanding of direction, delegation and accountability in clinical settings and how this impacts on the way they communicate and interact with each other will be of significance to Enrolled and Registered Nurses, nurse leaders, managers, educators and employers of nurses.

Social justification for the research study design involves justifying the usefulness of any new knowledge that emerges from the study for the discipline (Clandinin, 2013). The outcome of this research study will be significant to Registered Nurses who are required to direct and delegate tasks and skills, and Enrolled Nurses who are directed and delegated. The study findings will be significant to clinical areas supporting students to learn, clinical areas where

team interactions and direction and delegation takes place, nursing leadership and management involved and responsible for the selection of models of nursing care and skill mix, team leaders responsible for leading teams of nurses and non-regulated staff, and nurse educators responsible for preparing Enrolled and Bachelor of Nursing student nurses for future employment. In addition to this, nurse's perceptions of positive and professional direction and delegation practices and gaining clarity around who is accountable and when, will ensure that the patient's journey is a safe one. Finally, the study will make a significant contribution to how policy is viewed, and the information, guidance and advice nurses need related to this professional competency.

The thesis outline

Chapter one has provided a background and an overview of the history of the term delegation, and the role of the ICN and the NCNZ in shaping the Scope of Practice and competencies for Enrolled and Registered Nurses in New Zealand. Chapter one also included the research question and the aims of the study, and a discussion of the significance of the research.

Chapter two critically reviews the literature from Europe, the United States, Australasia Korea and Iceland where delegation is practised. The literature review includes research studies, non-research based descriptive literature, and the guidance, information and advice about direction, delegation and supervision made available to nurses.

Chapter three explores and examines the methodology for the study, including the social constructionist, and interpretive theoretical perspectives chosen, and the rationale for the narrative inquiry approach.

Chapter four provides a detailed explanation of the methods employed. The discussion includes the design of the study, the sampling methods, inclusion criteria, recruitment, and data collection and analysis. The ethical and rigour considerations are then explored.

Chapter five details the findings of the research study which are presented as *Small stories as shared understandings* for Enrolled Nurses. In addition to the small stories as shared understandings which emerged across the Enrolled nurse Agents' accounts, the unique and individual *Personal and professional stories* are captured as the narrative plots. The narrative plots are reflected in four major patterns and are presented as four separate stories: 'Working together' 'Delegation as a relationship', 'Communicating well' and 'Seeking delegation'.

Chapter six continues the findings and presents the small stories as shared understanding for Registered Nurses and the four stories which capture the narrative plots for each Registered Nurse: 'Working as a team', 'Doing delegation', 'Skills for delegation' and 'Professional communication'.

Chapter seven discusses the findings in relation to what is already known about direction and delegation for New Zealand Enrolled and Registered Nurses, and also identifies new perspectives.

Chapter eight concludes with a discussion of the implications of the findings, the recommendations that emerged from this discussion, and the strengths and limitations of the research study.

We shall not cease from exploration. And the end of all our exploring will be to arrive where we started. And know the place for the first time (T.S. Eliot 1888-1965).

Chapter two. Reviewing the literature

Introduction

This chapter critically reviews the literature that informs this study. It provides a clearer understanding of the skills and attitudes required for successful delegation, and the supports and barriers identified by nurses as they relate to nursing delegation. Section one describes the search methods used for the literature review. Section two reviews the overseas research studies related to nursing delegation, or supervision, as it is known in other countries. The overseas literature identifies different levels of nursing assistive personnel and titles. Some of these levels are “scoped” and some are “un-scoped”. These findings have been included because they contribute to our understanding about what Enrolled and Registered Nurses, and nursing support staff, know and understand about delegation, and how nurses make sense of this professional obligation. Therefore, they add a valuable layer of knowledge, understanding and context about how nurses and others communicate during delegation interactions. The chapter concludes with section three which provides a review of the New Zealand research studies on the Enrolled and Registered Nurse relationship, and the guidance and advice available to New Zealand nurses.

In order to clarify the terms used to describe the different categories and levels of the nursing and the nursing support role, the various titles have been included in the Abbreviations (p. iii) and Glossary of Terms (p. v).

I chose the literature for this review because it situates the experience of nurses who are required to lead, or receive, delegation interactions. Reviewing the research studies and non-research based descriptive literature identified a number of themes which provided clues that the leadership style, how delegation instructions were communicated, how it was taught and the type of nursing model practiced, influenced delegation interactions. This reinforced my conviction that any research study that explored Enrolled and Registered Nurses’ perceptions of direction and delegation interactions needed to include these topics. The selection of this literature was supported when Enrolled and Registered Nurse Agents mentioned key topics during their interviews, namely assessment, communication styles and strategies, the role of leadership, and how nurses had learned about delegation.

The literature review shows that while there have been numerous research studies about delegation, supervision and instructional practices in other countries, there are no New Zealand studies specifically related to researching nursing direction or delegation interactions. The direction and delegation role is a professional obligation for all first and second level nurses in New Zealand, therefore there is a need for relevant and up-to-date research to identify nurses' perceptions of how these occur, how nurses communicated with each other during direction and delegation, how they would like to be communicated with, and how they would prefer to be supported to delegate well.

Searching the literature

The search for literature involved a four stage process and while it might appear linear at this point of chapter presentation, in fact the search for literature never stopped from the time I decided to proceed with a doctoral study, to its completion. In stage one the following key words were used to initiate an Internet search: direction, delegation, supervision, accountability, Enrolled and Registered Nurses, first and second level nurses, Scope of Practice, professional nursing practice, nursing, nursing support, leadership, communication, nursing roles and responsibilities, assessment and skills and knowledge related to delegation. These key words were used again in stage two to initiate a search of CINAHL, JSTOR, Embase, Medline, EBESCOhost, PubMed, ERIC, the Joanna Briggs Institute, and the Cochrane Library available through the two University of Canterbury libraries and the Ara Institute of Canterbury library.¹ No time, date or country restrictions were included. While there are a number of countries globally that use different categories and levels of nurse and nursing support personnel not all of these countries are English speaking. However, this literature review has relied entirely on research studies and reports that have been published in English.

The stage one and two searches gathered a myriad of descriptive non-research articles, policy initiatives, and research studies. In stage three I widened the Internet search to include nursing text book web sites which were included in the search to identify any information, advice or guidance provided to nurses about direction, delegation, accountability or the supervision role.

As there appeared to be no research studies specifically related to nursing direction and delegation in New Zealand, I took a broad approach to literature and included the terms

¹ Formerly known as Christchurch Polytechnic Institute of Technology or CPIT

Nursing Council New Zealand, New Zealand Nurses Organisation, Enrolled Nurse, Registered Nurse, codes and guidelines. This became stage four. Stage four captured three New Zealand research studies related to nurses' perceptions about their respective roles and responsibilities, and one published research report. I read widely and used reference lists, and clues in the body of the texts I had accessed as signposts to harvest other references and topics that I felt as a nurse, researcher and nurse educator would be useful to shed some light on direction and delegation practices. Several regulatory and professional documents emerged. These codes, policies, guidelines and standards provided information related to the two Scopes of Practice, competencies, professional nursing behaviour, nursing ethics, and two guidelines on nursing direction and delegation requirements (Nursing Council New Zealand, 2007a, 2012a, 2012b; Nursing Council of New Zealand, 2011b)

Using peer validation throughout my research study was particularly useful during the four literature gathering stages because in the opening up of discussions with nurse colleagues, articles about direction, delegation or supervision were offered to me as colleagues became aware of my interest in the topic. In one case a nursing colleague provided a box of archival articles, reports and letters about historical direction and supervision decisions. These documents proved extremely helpful to the study as a background account of the changes that had occurred to the term "delegation". Lastly, I contacted some of the researchers of the published literature via email for further information, references or resources, and in two cases clarification of the findings in their research studies.

Descriptive non-research literature available on delegation

The non-research literature on delegation or supervision is extensive. There are over 3,000 non-research based journal articles spanning three decades about nursing delegation which include delegation of tasks from Registered Nurses to other Registered Nurses, and Enrolled Nurses, and also to an unregulated, unlicensed workforce. The articles describe aspects of nursing delegation such as how to teach delegation (Coburn & Sturdevant, 1992; Conger, 1999; Daley, 2013; Davies & Fox-Young, 2002; Parsons & Ward, 2000; Simones et al., 2010) leadership, management of teams and work relationships (Hansten, 2014; Hurley & Hutchinson, 2013; King, 1995; Simones et al., 2010; Weir-Hughes, 2013) benefits and barriers to delegation (Curtis & Nicholl, 2004; Gillen & Graffin, 2010) reducing the risks associated with delegation (Canavan, 1997; Shannon & Kubelka, 2013) the role of communication and assessment (Anthony & Vidal, 2010 ; Harrell, 1995; Quallich, 2005; Trimm, 2003) the Scope of Practice, roles and responsibilities of Enrolled Nurses (Jacob, Barnett, Sellick, & McKenna, 2013) and the tasks, skills and attributes required for safe and

effective delegation (Cipriano, 2010; Hoban, 2003; McInnis & Parsons, 2009; Powell, 2011; Wedyt, 2010). They include nurse authors from Europe, Australia, the Nordic countries and the United States of America. Although many of these articles may not appear useful to New Zealand nurses at first read as they predominantly describe delegation interactions with unlicensed assistive personnel (UAP), and many predate 2010, they offer a context to the discussion on the practice of delegation. It still needs to be acknowledged however, that the history of the second level nurse, the Enrolled Nurse in New Zealand, employment environment, nursing regulations, and grade levels within nursing in New Zealand differs to unlicensed assistive personnel. While the above are a mere snapshot of the plethora of articles available, they have been acknowledged here to illustrate the degree of concern and the interest in delegation practices there has been over many years, and continues to be.

With this in mind I turned my investigation of the literature to the information afforded to nurses in the nursing textbooks in English speaking countries using *delegation, supervision and direction* as key search terms. A search via the Internet of the main nursing textbook publishers' websites provided access to numerous nursing textbooks which include reference to "effective" delegation. Some explanation is briefly given to support the statements made about delegating tasks in these textbooks such as reference to the 'Five Rights of Delegation', the role of policy, using a decision making flow chart to know when to delegate, delegation principles and delegation rules (Alfaro-LeFevre, 2013; Crisp, Taylor, Douglas, & Rebeiro, 2012; Levett-Jones & Bourgeois, 2013; Rebeiro, Jack, & Scully, 2012). Of note is that all the nursing tasks listed in the textbooks from medication administration and enteral tube feeding to venous punctures and peripheral IV dressings to name a mere few, required a three stage assessment before the task could be delegated. This included an assessment of the nurse being delegated to, as well as the patient's health status, and the complexity of the task. How these three assessments should be undertaken was not the focus of the information provided. The main focus of the textbooks reviewed related to providing information about which nursing activities *cannot* be delegated, rather than on *how* to delegate safely and effectively.

The analysis of the non-research based nursing articles and nursing text books provided a background that led to a review of the overseas research literature available about the knowledge, skills and attitude for successful direction or delegation interactions, roles of accountability and the nursing issues, concerns and supports deemed important by nurses.

Research studies on delegation from other countries

This section of the literature review provides a review of the research studies related to delegation practices available from the United States of America, Europe, Australia, Korea and Iceland. The research studies focus on leadership, teaching delegation, the roles and responsibilities of nurses during delegation, the role of team work, communication practices, and the barriers to successful delegation. Only research studies where direction, delegation, supervision and accountability are acknowledged have been included for discussion. They have been chosen because together they provide a thorough and representative picture of the influences on, and implications of, delegation practices for nurses.

The literature search identified 29 primary research studies. Nineteen studies were from the quantitative paradigm. Research studies using quantitative design and methods tested the effectiveness of teaching models, or compared and contrasted Registered Nurse practices with unlicensed assistive personnel (UAP). Ten of the studies were from the qualitative paradigm. Research studies using qualitative design and methods explored nurses' perceptions of their relationships with other nurses and nursing assistive personnel, the influence of organisational culture, and the place and role of the Scope of Practice. The research studies were then ordered into sections based on the problem statement or phenomena of interest. From this grouping of topics I used an adapted critiquing framework (Coughlan, Cronin, & Ryan, 2007; Ryan, Coughlan, & Cronin, 2007) to identify the aim of the study, the participants, the methods and design chosen, and the conclusions drawn. I also included the relevance to New Zealand's nursing direction and delegation environment.

Leadership as a delegation skill

Different types of leadership style, how to assess it, and how to develop and recognise it, are discussed extensively in the nursing literature (Brewer, Tucker, Irving, & Franklin, 2014; Reid, Jones, & O'Brien, 2015; Thistlethwaite, 2015). However, assessment of leadership for the student population is problematic because students working alongside experienced health care professionals will not be in a position to take a leadership role. Thistlethwaite (2015) adds that senior faculty teaching staff also need to be collaborative with their clinical colleagues so that they are kept up to date with changes in curriculum requirements and assessment methods, such as leadership roles. Thistlethwaite (2015, p. 135) includes within the discussion of the leadership role, the importance of being able to "follow" leadership too. This is captured in the term "followership". Followership acknowledges that some team members need to be able to follow team leaders.

Many of the research studies reviewed, explored the skills required for safe, successful delegation interactions, and a leadership role was acknowledged as an important nursing role during delegation. Using a qualitative ethnographic research design McIntosh, Moriarty, Lugton, and Carney (2000) explored how grade levels and skill mix are taken in account during delegation interactions and the delegation practices among district nursing teams in two health boards in Scotland, United Kingdom.

Observation and interviewing were used to identify nurses' perceptions of the skills needed to delegate, the diverse delegation practices and different interpretations of delegation policy in the clinical practice areas between and within the two nursing districts they studied. The researchers found that delegation practices were constantly changing in response to different influences, variations in the responsibilities delegated to different grades of nurses, and that some junior, inexperienced nurses and unqualified nurse auxiliaries were given responsibilities beyond their clinical preparation. They identify the important role that leadership plays during delegation interactions and that the Registered General Nurse (RGN) participants observed inconsistencies in the allocation of tasks to themselves and their Registered Nurse colleagues. They believed this may have been due to the vast differences in the clinical experience of the RGNs employed in the two areas. Enrolled Nurses also reported variations in the responsibilities allocated to them with some Enrolled Nurses enjoying more leeway in the nursing responsibilities asked of them in one of the research settings. In the second nursing area involved in the study however, the Enrolled Nurse believed there was a reduction of their role (McIntosh et al., 2000).

The researchers conclude that delegation practices are evolving and that the policies available on delegation in the two areas under study allowed for a degree of flexibility. This very flexibility though led to various interpretations. In addition, the delegation policies were affected by workforce planning and workload management which resulted in an inconsistent, impromptu and unplanned use of nursing skills across the district nursing teams. They recommend that before there is any further "dilution" of skill mix caused by a reduction of senior nursing positions (grade mix) acknowledgement and valuing of the importance of the leadership and supervisory role of the specialised senior nurses is vital (McIntosh et al., 2000, p. 4). This was viewed as essential given the predicted increase in numbers of nursing auxiliary roles in district nursing settings.

While this study adds to the body of knowledge about delegation practices there are some limitations to the transferability of these findings to New Zealand nursing conditions. For example, there are educational preparation and grade level differences between nurses in the

United Kingdom and nurses in New Zealand. Secondly, the skill mix discussed includes high numbers of “nursing auxiliaries” and only small numbers of Enrolled Nurses. In addition, some of the Enrolled Nurses involved in the study had “specialised” qualifications. These differences are not consistent with the current New Zealand nursing system and environment.

Using a quantitative, descriptive correlational design Yoon, Kim, and Shin (2016) measured Registered Nurses’ confidence to delegate, and their leadership in long term care settings in South Korea. They used two instruments, the Confidence and Intent to Delegate Scale and a Multifactor Leadership Questionnaire to gather the perceptions of 199 Registered Nurses about their delegation practices. They found that the factors that influenced the degree of confidence to delegate included clinical experience both in the unit in which they worked and in nursing generally, experience with delegation, familiarity with the other person’s job description, and the leadership style used. The researchers found that the most statistically significant leadership style required to develop a collaborative culture during delegation communication interactions was a transformative leadership style. The recognition that clinical experience relevant to the area the nurses worked in was necessary in order to delegate confidently, was an important distinction to make. The findings showed that confidence to delegate decreases when staff movement between wards and units occurs, as the nurse is now in unfamiliar territory. This finding in particular coupled with the identification that a transformative leader was able to develop a collaborative culture has implications for New Zealand nurse leaders and managers who are also responsible for moving nurses between nursing workplaces when there is over or under staffing in the workplace.

Registered Nurses are responsible for making a myriad of decisions throughout each shift often in complex ever-changing clinical situations and the leadership they have access to can impact on delegation, and task identification and allocation. Bittner and Gravlin (2009) explored how Registered Nurses in the United States use critical thinking to make numerous clinical decisions and based on the outcome of the decision, nurses then choose which tasks are to be delegated to Unlicensed Assistive Personnel (UAP), and which tasks they need to do themselves. Using a qualitative descriptive design and focus groups the researchers identified a number of barriers that impacted on Registered Nurse to UAP delegation decision making. Firstly, Registered Nurse participants reported that some of the tasks to be delegated were considered routine or they were included in their job description. However, some tasks were more difficult to identify as suitable for the UAP and it was unclear to the Registered Nurse if they should be delegated. Secondly, Registered Nurse participants self-reported that before making a delegation decision they carried out a number of assessments including an

assessment of the patient's condition, an assessment of the UAP's competency level, and experience, and the workload the UAP already had. Registered Nurse participants expected a certain level of assessment knowledge from UAP and an ability to prioritise and report back to the Registered Nurse when they found any patient related concerns. Thirdly, the researchers identified that successful delegation relationships require respect and trust and were dependant on the communication skills of each group of staff. Fourthly, newly licensed Registered Nurse participants were concerned about "role uncertainty," and their lack of confidence about how to, and what to delegate, impacted on their ability to delegate at all. There were examples given in the focus groups related to Registered Nurse to UAP "delegation overload" as Registered Nurses were simply too busy, acuity was high and there were not enough staff. Lastly, the researchers found that many Registered Nurse participants identified a lack of communication as a component of delegation failure. Registered Nurses mentioned that in hindsight they had realised at the end of a shift that the UAP had not understood the tasks allocated to them and the UAP often did not have the background information needed to carry out tasks safely. The researchers report that the lack of communication often led to missed care. They reported feelings of nurse dissatisfaction, burnout and plans to leave the organisation because of these frustrations. Bittner and Gravlin conclude that the concerns related to poor task identification, task allocation and missed care were due to a lack of system support, and without system support in the form of leadership from frontline managers, delegation could never be successful (Bittner & Gravlin, 2009, p. 144).

One year later Gravlin and Bittner (2010) again explored and described the factors that influenced successful delegation interactions between Registered Nurses and nursing assistants in the United States. In this second study they used a quantitative descriptive exploratory design. A MISSCARE survey tool and a delegation questionnaire assessed the perceptions of 568 Registered Nurses and 232 nursing assistants. The researchers found numerous incidents of missed care related to poor delegation interactions, leading to poor patient outcomes. Gravlin and Bittner (2010, p. 329) describe missed care as an error where any aspect of required care is omitted or delayed and there are different types of errors. Missed care occurred due to poor staff utilisation, poor team work and ineffective delegation. Successful delegation was based on the Registered Nurses ability to communicate well, form a relationship, the amount of workload allocated to the nursing assistant, and the attitude, competence and knowledge of the nursing assistant.

Although these two research studies were undertaken in the United States and involved Registered Nurse to UAP delegation interactions, and did not include Enrolled Nurses, the

insights into the factors influencing delegation, such as assessment, leadership, the ability of nurses to form relationships, the role of communication, the need for planning delegation interactions, the need for clear lines of accountability, and the critical thinking skills needed by Registered Nurses, may be relevant to New Zealand Registered Nurses responsible for delegation interactions.

According to a study by Saccomano and Pinto-Zipp (2011) the focus of role development for Registered Nurses in the United States is on clinical knowledge and skills, not on the leadership role required to delegate tasks and lead a team of UAP. Saccomano and Pinto-Zipp (2011) used a quantitative cross sectional survey design and a questionnaire to measure if leadership style, educational preparation and clinical experience influenced the Registered Nurse's confidence levels when delegating patient care tasks in an acute hospital in the United States. The researchers did not find any significant difference in confidence among the 158 registered, associate and diploma prepared nurse respondents when they were grouped by leadership style using the Path-Goal Leadership Questionnaire (PGLQ) and the Confidence and Intent to Delegate Scale (CIDS).

Confidence with delegation interactions however, was found to be linked to the educational preparation and experience level for Registered Nurses. When nurses with a baccalaureate degree were compared with nurses with diplomas or associate degrees, there were some unique differences. The researchers found that baccalaureate prepared nurses were more confident at the beginning of their career but as their clinical experience increased their confidence levels with delegation decreased. Conversely, the less educationally prepared nurses were less confident with delegation at the beginning of their careers but more confident in delegating tasks as their clinical experience increased (Saccomano & Pinto-Zipp, 2011, p. 530).

The researchers conclude that as baccalaureate nurses' clinical experience increases, they gravitate to very acute nursing areas such as critical care environments and their access to delegation opportunities decreases as they are no longer working alongside UAP. The lack of delegation opportunities impacts on confidence levels with the delegation process (Saccomano & Pinto-Zipp, 2011). The researchers point out that the findings from this quantitative study are useful to nurse managers who are charged with developing delegation skills and nurse educators charged with facilitating learning about delegation. As the researchers appropriately suggest the results from their research study may not be generalisable outside the nursing system in the United States. Therefore, before considering implementing these findings within a different nursing system and structure, New Zealand

nurses need access to delegation opportunities, support to identify the influences that impact on their confidence levels to delegate and their ability to lead a team.

The role of education and training

Nurse authors and researchers have expressed concern since 1993 about the lack of educational preparation and clinical experiences offered to prepare Registered Nurses for their delegation role. The Nursing Assessment Decision Grid (NADG) designed by Margaret Conger and used to support delegation decision making, incorporates the key aspects of the nursing task to be allocated and patient problems, so that an informed decision about the most suitable staff member to deliver patient care can be made. This is a reference to the necessity of the Registered Nurse to make an assessment of the staff member being delegated to, and includes assessing the staff member's education, job description, hospital policy, licensing legislation and demonstrated competence prior to making a delegation decision. The Conger (1993) NADG has been used by a number of nurse researchers (Garneau, 2012; Keeling, 1999; Parsons, 1997, 1998, 1999, 2004) to evaluate if structured teaching and learning tools altered nurse delegation knowledge, and decision making skills.

In a quantitative study in 1997 Parsons evaluated a planned educational intervention that could be used to support nurses' decision making during delegation. The rationale and motivation for the study according to Parsons was that the way Registered Nurses' delegate patient care activities will directly affect the quality and safety of that care. The study participants included 87 associate degree nurses, diploma, baccalaureate and masters prepared nurses, staff nurses, charge nurses and head nurses employed in a medical surgical setting in the United States. The nurses were randomly divided into an experimental group and the control group. A vignette was designed and the 46 Registered Nurses within the experimental group received educational support, assessment information and decision making strategies using the Nurse Assessment Decision Grid to problem solve the clinical situation (Conger, 1993; Conger & Artinian, 1997). The control group comprised of 41 Registered Nurses, received a "teaching" session broadly outlining the importance of making sound delegation decisions, and general information about the changing health system in the United States over the previous 20 years.

The participants in the experimental group identified increased knowledge about delegation and increased confidence in delegation decision making after receiving the structured teaching intervention. Nurse participants reported an improved understanding post teaching intervention and were able to identify the relevant Registered Nurse tasks, professionally identify the correct nursing diagnosis and patient problems. This led to an increased ability to

make a rating for task allocation in order to identify if it required direct supervision. The control group did not experience any significant gains in their knowledge or confidence levels during delegation interactions.

Parsons (1997) identifies that half of the Registered Nurse participants in the study had not received any education at any time about delegation. She concluded that increased knowledge relevant to the Registered Nurse delegation role supported and improved delegation decision making, job satisfaction and appropriate and safe patient care. In addition, nursing staff who were informed and knowledgeable about delegation were more able to meet skill mix requirements on a shift by shift basis.

In spite of the limitations Parsons (1997) identifies, this research study holds useful information for New Zealand nurses, nurse leaders, nurse educators and managers. Parsons' research study throws some light on the fact that more is needed in terms of support and training than merely telling nurses they must delegate. Nursing staff development educators may need to consider supporting broad and generic delegation information with workplace specific in-service sessions on delegation decision making for example, as different workplaces have different skill mix, grade level and work requirements which impacts markedly on the delegation information nurses need. Of note for New Zealand's interest in access to delegation training and education, the control group intervention only offered general broad based information on delegation, with the corresponding result that knowledge and confidence did not increase or improve. In the end, Parsons' reference to patient safety shifts the manner in which delegation interactions occur from a nice to know arena, to a vital skill to which all nurses need to be exposed.

The efficacy and role of teaching interventions related to delegation continued to be a focus of research studies in the United States in 2006. A quantitative study by Henderson et al. (2006) evaluated the delegation curriculum content and a newly designed teaching intervention in an associate degree nursing programme in the United States. The participants included 210 associate degree nursing students across the nursing programme. Phase one of the study assessed the delegation skills and knowledge being taught in each nursing course including when it was taught and how it was taught across the three year curriculum. The effectiveness or not of the teaching content and methods was assessed by testing nursing student participants' knowledge of delegation definitions, and the 'Five Rights of Delegation' (National Council of State Boards of Nursing NCSBN, 1995). The researchers used statistical analysis to compare the planned curriculum teaching requirements to student test results for delegation knowledge using a questionnaire. In response to the outcome of phase one, a

second phase of the study introduced a simulation teaching intervention which included the eight steps involved during delegation and making a decision about which tasks can be delegated, and to which team member.

In phase one of the study Henderson et al. (2006) found that the nursing student participants' abilities to define delegation was variable across the three levels of the curriculum, and the teaching content had not been implemented as planned for some students. In phase two of the study the researchers found a significant improvement in learning for Level 3 students after the planned teaching intervention in that they were able to identify the five rights of delegation post intervention.

While the researchers acknowledge the usual limits to generalising quantitative results it must be acknowledged that this research study leads the reader to some useful conclusions. Firstly, 'The Five Rights of Delegation' is a useful and valid teaching tool that can be used to teach the skill of matching the right person to the right task. Secondly, delegation information should be introduced early in the nursing programme and incorporated throughout the curriculum. Henderson's research study is also a timely reminder for New Zealand nurse educators to evaluate, compare and contrast teaching content and curriculum requirements with actual teaching outcomes.

Access to effective educational programmes about delegation is a continuing construct considered important by other researchers. Kaernsted and Bragadottir (2012) designed a quantitative study to explore Icelandic Registered Nurses' attitudes to delegation and their preparedness to delegate effectively using a descriptive correlational study design. Effective delegation is defined as having the knowledge and skills to match the task to be carried out, to the suitable delegate. Kaernsted & Bragadottir link the delegation process to the nursing process which includes assessment, planning, implementing and evaluating. The researchers found that overall Registered Nurse participants' attitudes towards delegation was positive although they noted that "there was room for improvement" (Kaernsted & Bragadottir, 2012, p. 12). Twenty percent of respondents indicated that they would delegate more if they could be sure that the delegated task would be done well, but also felt that some staff they delegated to lacked the commitment to carry out tasks well. The researchers concluded that Nurse participant's with less than five years nursing experience would delegate more if they were more confident about delegating. (Kaernsted & Bragadottir, 2012).

Although the researchers caution readers about generalising the findings of their study to other areas due to the small sample size, a single hospital setting and the self-reporting nature

of the questionnaire, there are enough credible findings and conclusions for New Zealand nurses that makes this well-constructed and honest appraisal of nurses' attitudes worthy of consideration. For example, those recently graduated may well understand the principles of delegation and know the 'rules' surrounding this professional obligation but often feel uncomfortable delegating to more experienced nurses. Secondly, even though the majority of nurses claimed to give praise during feedback to the person being delegated to, a large number of participants only sometimes gave feedback and this could adversely affect the nurses' professional relationships. Thirdly, although believing that feedback is important between nurses, the Registered Nurse participants indicated that they rarely sought feedback on their delegation style. The consequences of this might be that the nurse would not improve their delegation skills. A fourth anomaly identified by the researchers is that while the nurse participants self-report good attitudes and preparedness towards delegation the researchers found that overall there was a lack of trust, mutual respect, teamwork and communication between Registered Nurses, the very skills needed for safe and effective delegation. Conversely, at least 25% of Registered Nurse participants pointed to a lack of commitment and experience by the staff member they were delegating to resulting in them doing the tasks themselves, simply because this was easier and less time consuming.

Josephsen (2013) explored the most effective strategies and methods to teach delegation principles and concepts to nursing students. Her quantitative research study was a professional response to the concerns that had been expressed by students within the nursing school where she was employed as a nurse educator. The students' perception was that although they had completed an online module on "Delegating Effectively" based on the National Council of State Boards of Nursing principles of delegation, (National Council of State Boards of Nursing NCSBN, 1995) they still did not understand delegation (Josephsen, 2013). The purpose of Josephsen's pilot study was to identify if a multi-modal instructional strategy would successfully support the teaching of delegation concepts in an online format for an associate degree of nursing programme in the United States. Josephsen chose four delegation teaching and learning strategies. Twenty-one student nurse participants were asked to rate the four strategies and evaluate which teaching strategy met their learning needs. Teaching strategy one was the NCSBN module currently in use. It contained a video format with role plays of poor delegation practices between nurses resulting in a sentinel event. A post-test accompanied the video. Teaching strategy two was a concept map strategy. A third strategy included for testing was a case study, and the fourth teaching strategy was a group discussion format.

Josephsen concluded that adult learning in an online environment is best supported by multiple instructional strategies to accommodate different learning styles such as case studies, reflective scenarios and problem solving exercises. A multi-modal approach provides opportunities to give advice, model positive delegation interactions, and provide coaching around required delegation behaviours and principles which support the student's ability to learn the role of the delegator (Josephsen, 2013).

Josephsen's research findings provide a platform for other nursing schools to develop their own on-line teaching and learning content and strategies. Using multiple teaching strategies if chosen correctly can support scaffolding of delegation concepts which holds the potential to reinforce knowledge already known from previous teaching sessions, and more importantly develop meaning. These teaching and learning concepts would be valuable to New Zealand Enrolled and Registered Nurses interested in developing delegation *relationships* rather than attempting to follow generic flow charts or generalised rules.

However, while education and training are vital in order to ensure the message about delegation is well supported there appears to be other influences on successful delegation relationships. These include how and when to carry out an assessment of the "delegatee", how to attain and maintain communication skills, and the role of leadership during delegation. Therefore, the literature review now turns attention to the roles and responsibilities of the different nursing levels and categories.

Nursing roles and responsibilities

When two categories and levels of nurse and nursing support personnel work together the roles the Registered Nurse is responsible for can alter. The ICN urge ongoing evaluation of skill mix changes and the potential impact that can occur through task shifting. They suggest that any evaluations need to consider not only cost effectiveness and efficiency when employing assistive nursing personnel, but also patient and health outcomes (International Council of Nurses, 2013).

In a study from the United Kingdom, McLaughlin et al. (2000) used a quantitative researcher developed survey instrument to examine Registered Nurse participants' perceptions of their role in acute health settings where Nursing Care Assistants/Unlicensed Assistive Personnel (NCA/UAP) were also employed (McLaughlin et al., 2000). Staff, ward and 'Sister' level of Registered Nurses across three acute care hospitals in England and Wales indicated there were minimal changes to their Registered Nurse role when working with NCA/UAP. The 18 nursing roles listed using the five-point Likert Scale included delegating responsibility,

leading a team, communication, health teaching, and managing and evaluating nursing care. Overall, the British Registered Nurses in this part of the study were satisfied with the NCA/UAP's ability to carry out delegated tasks and communicate relevant information to the Registered Nurse. In addition, they believed that the employment of NCA/UAP meant that there was more nursing time available to carry out other professional nursing roles.

McLaughlin et al. (2000) then compared these findings to a study that had been carried out in the United States in 1997. The researchers looked for similarities and differences between the British and American Registered Nurses' perceptions of their role when working with NCA/UAP. They also included the Registered Nurse level of satisfaction with NCA/UAP's abilities to perform delegated tasks, communicate relevant information and if the use of an NCA/UAP enabled the Registered Nurses more time to carry out their professional nursing roles. Registered Nurses from the United States identified more profound changes to their role in six of the 18 nursing roles listed in the survey, lower levels of satisfaction working with NCA/UAP and provided more negative observations about NCA/UAP than their United Kingdom counterparts. Additionally, fewer Registered Nurses from the study in the United States believed that working alongside NCA/UAP enabled them to free up their time to perform other nursing tasks.

Although the researchers identify some limitations to their study, in that a convenience sampling strategy was used and only a minority of total Registered Nursing staff responded to the survey in each hospital setting, the researchers provide some significant discussion points about delegation practices for New Zealand nurses. For example, the Registered Nurses from the United Kingdom hospitals recognised that the NCA/UAP benefited from standardised basic training, a well-defined role and worked well in a task orientated environment. Negative comments related to the extra time Registered Nurses needed to delegate and supervise NCA/UAP and that this sometimes detracted from the time needed for the specialised patient nursing care required of a Registered Nurses. Further, staffing levels often did not recognise or adjust for the use of NCA/UAP which altered the skill level and mix on the ward and could result in extra time needed to assess, communicate and decide what to delegate, and to whom. These findings and the conclusions drawn by the researchers are consistent with other research studies that highlight the importance of standardised training, and the close "supervision" of other health care workers as vital to the delegation environment (Barter, McLaughlin, & Thomas, 1997; Neidlinger, Bostrom, Stricker, Hild, & Zhang, 1993).

In an Australian study in 2004 the nature of Enrolled Nurse practice and the processes that Enrolled Nurses use to guide their practice and make decisions are explored (Milson-Hawke & Higgins, 2004). The theory that emerged from this grounded theory methodology provides relevant information related to how Australian Enrolled Nurses in acute hospital settings make sense of their own Scope of Practice, and how their Scope of Practice relates to the Registered Nurse's Scope of Practice.

The main theory that emerged from the Enrolled Nurses interview data was: *'Doing the work without overstepping the mark'*. They were supported by two sub categories *'Doing routine work'* and *'Deciding to do non-routine nursing work'*. The research findings as themes and categories are supported with numerous verbatim examples and quotes from Enrolled Nurse participants which illustrated that the Enrolled Nurses were doing the 'work' of Registered Nurses, and knew they were doing so, sometimes in highly specialised clinical settings. The Enrolled Nurses made judgments about the work they were about to do in order to decide if the 'work' was routine or non-routine and if the task or skill was non-routine, which comprised of non-essential nursing tasks, and more advanced skills and knowledge. The Enrolled Nurse would then need to decide if they were overstepping the mark. Ultimately, the researchers found that the Enrolled Nurses in this study interpret and decide by self-assessment on the tasks and skills they deemed appropriate to their Scope of Practice, and they were observed carrying out nursing tasks beyond their level of educational preparation.

One year later Gibson and Heartfield (2005) used a qualitative design to explore the role and function of Enrolled Nurses in their workplace and their practice experiences in relation to their Enrolled Nurse Scope of Practice. Forty eight Enrolled Nurse participants were interviewed by telephone from across Australia (Gibson & Heartfield, 2005). The researchers identified critical incidents or critical situations described by the Enrolled Nurses in their interviews. Each critical incident was analysed to identify the roles and tasks undertaken by Enrolled Nurses. The findings were then organised thematically.

The critical incidents provided detailed information about the Enrolled Nurse participant's daily practices and their ability to work within their Scope of Practice. The researchers identified frustrations experienced in their work which included variations in application of Scopes of Practice between states, territories, and wards, and units within organisations. In addition to geographical location, organisational policy, management practices and Enrolled and Registered Nurse relationships also influenced how the Enrolled Nurses' Scope of Practice was interpreted and applied. These influences were further compounded by the

perceived similarities between the roles and responsibilities of Enrolled and Registered Nurses.

The findings in the studies by Milson-Hawke and Higgins (2004) and Gibson and Heartfield (2005) are consistent with the findings by Chaboyer et al. (2008). The roles and responsibilities undertaken by Enrolled and Registered Nurses were the subjects of Chaboyer et al. (2008) quantitative descriptive study. One hundred and fourteen Level 1 and 2 Enrolled and Registered Nurse participants were observed on four acute medical wards within two Australian hospitals. The researchers used structured observational methods informed by a work sampling tool which was used to describe and compare activities performed by Enrolled Nurses, and Level 1 and 2 Registered Nurses during a nursing shift.

Chaboyer et al. (2008) found that the roles and responsibilities undertaken by Level 1 Registered Nurses and Enrolled Nurses, were similar and role boundaries between the two levels of nurses were no longer precisely or obviously recognisable. The researchers were surprised by their finding as Enrolled Nurses are not educationally prepared to do initial assessments or admissions. The researchers found that the decision-making process appeared to be based on the Enrolled Nurses' discretion and the Scope of Practice was "open to interpretation" rather than using a clear and concise set of rules (Chaboyer et al., 2008, p. 1279). This is a similar process to the New Zealand nursing system whereby Enrolled Nurses carry out a form of self-assessment and decide if they are trained and competent to carry out the delegated task. This further strengthens the argument that research is needed to identify nurses' understanding of their roles and responsibilities in relation to their Scope of Practice, the nursing delegation competencies, and the guidelines available on direction, delegation and supervision (Nursing Council New Zealand, 2007a, 2012a; Nursing Council of New Zealand, 2011b).

A qualitative phenomenological study undertaken in the United States provides descriptions about the meaning and significance of delegation practices between experienced and novice nurses, and UAP (Standing & Anthony, 2008). The study was motivated by the researchers concern that some Registered Nurses were uncertain about the meaning of delegation and where there is a lack of knowledge about delegation practices, a lack of confidence to delegate and poor patient outcomes can follow. Many of the Registered Nurses were able to recall the definition of delegation as required by the American Nurses Association (American Nurses Association, 1997) but there was also confusion about what constituted a delegation request. This was because some tasks required of UAP were itemised in their job description and this led Registered Nurses to believe that these tasks were not being 'delegated' in the

formal sense of a delegation interaction. These tasks were considered to be a pre-determined and expected role or task. Some nurses described feelings of frustration in that it was unfair that the Registered Nurse was accountable and responsible for the outcome of a task, but the UAP was not. This led to the Registered Nurse spending time “supervising” which really meant checking up that the allocated task had been completed properly, or at all. Many of the Registered Nurses believed that the UAP did not understand the Registered Nurse’s overall role and ultimate responsibility and because of this did not understand the purpose of delegation. The implications surrounding the lack of understanding of the Registered Nurse delegation role were that there was resentment and reluctance to carry out allocated tasks when requested by the Registered Nurses.

These structural themes impacted on the communication style and interpersonal relationships during the delegation process and this affected the success or otherwise of the delegation interaction. The researchers provide some obvious but nevertheless valuable conclusions for the New Zealand context. For example, they point to the need for nurses to have a clear understanding of their delegation roles and responsibilities, to be able to communicate this professional requirement to others they work alongside, understand their responsibility when there is inaction from others, and the need for trust within the delegation relationship. Of note though was that the Registered Nurses in the study only identified their own need to trust the UAP. The UAP’s need to trust the Registered Nurse was not acknowledged. The researchers conclude that future research studies should acknowledge and include both nurse’s and UAP’s perspectives, not just the Registered Nurse perceptions, a subtle but important point for any future research studies. In addition, the requirement for the UAP in this study to answer to a number of Registered Nurses was not found to be conducive to good delegation interactions or building positive relationships. Answering to many Registered Nurses was linked to resentment and communication problems, especially when work areas were busy and acute (Standing & Anthony, 2008).

Standing and Anthony (2008) conclude that nursing education programmes require robust content on communication and interpersonal relationships in team nursing environments. While generalisability of findings is not expected or possible with qualitative research findings there are transferable lessons for New Zealand nurses. At the very least, the findings of this study should be considered because of their potential to influence job satisfaction, nurse retention and patient safety. This section of the review of the literature led to further literature on the role of nurses working together, and the teamwork this involves in order for delegation to be successful.

Working together and the role of team work

Higher education institutions and health care professional accreditation bodies acknowledge team work as a core standard (Thistlethwaite, 2015, p. 135). Although there are no research studies that specifically measure *nursing* teamwork, there are a number of instruments available to assess the effectiveness of team performance related to interprofessional education (IPE), and collaborative practice (Canadian Interprofessional Health Collaborative, 2012; Thistlethwaite, 2015; Valentine, Nembhard, & Edmondson, 2012). There are other instruments available that can be used to assess interprofessional teamwork aspects such as ward rounds and handovers (Thistlethwaite, 2015). Some instruments focus on the skills, knowledge and attitudes team members have towards team work, or how team work performance changes over time (Heinemann, Schmitt, & Farrell, 1999; Valentine et al., 2012). While the definition of interprofessional team work in this context refers to “the levels of cooperation, coordination and collaboration characterising the relationship *between professions* [emphasis added] in delivering patient centered care” (Thistlethwaite, 2015, p. 240) it is a useful definition to apply to different categories and levels of Enrolled and Registered Nurses working within a team.

Other nursing researchers also point to the role that team work plays. Fernandez, Johnson, Tran, and Miranda (2012) in their systematic review for example, determined the best available evidence on the efficacy of the various models of nursing care delivery on patient, nursing and organisational outcomes. The researchers focused on quantitative research studies including randomised and non-randomised controlled studies which compared different models of nursing care such as team nursing, primary nursing and patient allocation. The studies found that wards using a mixture of team nursing and patient allocation models showed significant improvements in quality of patient care, seclusion rates and restraint use in mental health settings. Although there were no significant changes identified for length of hospital stay or patient satisfaction, other studies reviewed relating to the team model of nursing on interprofessional communication reported better relationships with interdisciplinary team members such as physicians when there was a hybrid model of nursing care used. One study identified that team nursing provided a supportive learning environment for nurses. Team nursing appears to be a preferred model of nursing care for inexperienced staff to develop, especially in diverse work environments that employ Enrolled Nurses and Nurse Assistants. Fernandez et al. (2012) note that when there are diverse nursing roles such as Enrolled Nursing and nursing assistants within one workplace then the team nursing model would be an advantage. They conclude that there needs to be more research on the most suitable model of nursing care to support patient, nursing and organisational requirements.

The researchers add that the differing descriptions of the models of care need clarification and standardisation or comparison of models of care will continue to remain difficult.

Bragadottir, Kalisch, Smaradottir, and Jonsdottir (2016) designed and tested the reliability and validity of a tool developed to measure overall team work. The researchers found that the team work measurement tool, based on the Salas, Sims, and Burke (2005) five components of team work, proved to be reliable and valid. According to Salas et al. (2005) there are five components to team work: team leadership, collective orientation, mutual performance monitoring, back up behaviour, and adaptability (Salas et al., 2005, p. 562). A 'team' is defined as: "two or more individuals with specified roles interacting adaptively, interdependently, and dynamically toward a common and valued goal" (Salas et al., 2005, p. 562). Kalisch 2010 (as cited in Bragadottir, Kalisch, Smaradottir 2016, p. 268) explains that a nursing team can be defined as: "a group of nursing staff who work together towards a common goal of patient care in a given hospital acute care setting". Thistlethwaite, (1999, p.241) citing a definition found in Wikipedia provides a definition of team as: "Work done by several associates with each doing a part but all subordinating personal prominence to the efficiency of the whole". The team definition and components identified by Salas et al. (2005), the key skills to measure overall team work (Bragadottir, Kalisch, Smaradottir, et al., 2016) and the instruments used to measure interprofessional team effectiveness (Canadian Interprofessional Health Collaborative, 2012; Valentine et al., 2012) may prove useful when discussing the presence or effectiveness of team work within New Zealand nursing teams currently absent in the New Zealand nursing literature.

A research study from the United States by Kalisch (2011) highlights the issues encountered by Registered Nurses and UAP participants when trying to work as a team and form a delegation relationship. Kalisch used a qualitative study design to identify any barriers that might inhibit effective Registered Nurse to UAP teamwork, and the relationship of teamwork problems to diminished quality and safety of patient care (Kalisch, 2011). She describes the delegation model as UAP supporting the Registered Nurse in their nursing work. The Registered Nurse retains responsibility and accountability for the entire patient care journey while delegating specific tasks to the UAP with UAP in these health care facilities responsible for clinical roles such as bathing, providing ambulation, toileting and patient turning, mouth cares and taking vital signs. In this model the Registered Nurse retains ultimate legal responsibility not only for the delegated tasks but also for any errors made by the team. The 'team' in this study is defined as a Registered Nurse and a UAP.

The findings of this innovative study which were grouped as links made between the problems that arose in teamwork and verbatim statements about how this affected patient care, were significant and sobering. There were seven problem areas with teamwork identified by the focus groups. Lack of role clarity, lack of working together as a team, inability to deal with conflict, not involving the UAP in the decision making, deficient delegation, having more than one boss, and “it’s not my job syndrome” (Kalisch, 2011, p. 19). The researchers conclude that the ability to work in, and as a team, are pivotal skills for nurse to nurse, or nurse to UAP communication interactions. Further, any teamwork issues need to be identified quickly, quantified and presented back to nurses so that they can develop and work towards identifying their own code of practice for teamwork relationships (Kalisch, 2011). The researchers conclude that if unsafe nursing communication practices are ignored, poor decisions will continue to be made within the team which negatively impacts on safe, quality nursing care delivery (Kalisch, 2006, 2011).

These findings related to the role of working together as a team are supported by other nursing research studies (Kalisch, Gosselin, & Choi, 2012; Kalisch & Lee, 2010; Papastavrou, Andreou, Tsangari, Schubert, & De Geest, 2014). Although not specifically related to the delegation role these researchers have found that the level of team work that nurses engage with can influence and impact on patient safety and comfort.

The possible link between the problem areas identified by Kalisch and the implications of these findings for successful communication and teamwork provide a clue that a review of any research studies on communication interactions and team work related to nursing delegation practices in the New Zealand context is important. One obvious difference to these overseas study environments when compared to New Zealand nursing workplaces, is that in New Zealand the roles undertaken by the UAP would be considered as nursing tasks and outside the role or responsibility of an unregulated workforce. However, the rigour of the research study meets the criteria for trustworthiness and transferability to the New Zealand nursing context. Therefore, the usefulness of these findings to Enrolled and Registered Nurses is undeniable as a potential prompt for more qualitative or quantitative research studies about direction and delegation practices in New Zealand.

Communication as a delegation skill

Many researchers from the United States have prefaced their research with the fact that the use of Nursing Assistive Personnel (NAP) is on the increase in acute care settings and this has prompted nurse-researchers to explore the potential and actual issues surrounding delegation. Potter, Deshields, and Kuhrik (2010) point to the need for NAP to work collaboratively under

the direct supervision of the Registered Nurse, and for Registered Nurses to be able to delegate safely and effectively. Safe and effective delegation is possible when there is collaboration and positive conflict management (Potter et al., 2010). In their qualitative descriptive study the term NAP referred to the patient care technicians who received basic training from hospital educators in “nursing skills.” The ten Registered Nurses and six NAP participants based in an acute oncology setting met in small groups to explore Registered Nurses’ and NAPs’ perceptions of their delegation interactions using semi-structured interviews (Potter et al., 2010). They were asked to describe their lived experience, and their perceptions of delegation and in particular what went well and what did not go well. The researchers found that although the National Council of States Boards of Nursing (1995) guidelines were provided as a best practice tool to guide nursing delegation practices in the form of the “Five Rights of Delegation”, they were not always followed by the Registered Nurses in this study. Although there were a few notable exceptions many of the Registered Nurse’s stories about delegation were related to a lack of clear expectations, a lack of limits or clear direction, and this resulted in conflict situations (Potter et al., 2010).

Conflict emerged as a central theme in the study. However, Potter et al. (2010) found that the causes of conflict were different for Registered Nurses than for NAP. Registered Nurses identified three sources of conflict. Firstly, some of the NAP resisted delegation requests from new or young Registered Nurses. These age-related conflicts resulted in poor communication between the young or new Registered Nurse and the NAP, which was linked to lost opportunities for effective communication and delegation. Secondly, work ethics, defined as the values based on hard work and diligence, were another source of conflict. For example, some Registered Nurses perceived that the NAP had a lack of commitment to their role, and a lack of initiating or completing work which resulted in the Registered Nurse taking on more patient care tasks. This resulted in Registered Nurses not delegating, and deciding to do the tasks themselves. Conversely, a poor work ethic was viewed by some of the participant NAP as the Registered Nurse being unwilling to help out. The NAP’s views about work ethics appeared to be based on role conflict and role confusion. For example, it could be seen from the verbatim statements within the interviews that the NAP had very little understanding of the Registered Nurse’s role. The NAP was not able to make links between the Registered Nurses’ responsibilities when the environment became acute or busy, and the Registered Nurses inability to answer bells or take patients to the toilet. Thirdly, the researchers also found that the nurse’s personality could be a cause of conflict that could lead to poor delegation practices. For example, staff who were difficult or uncooperative became known for their way of interacting and this resulted in the nurse or NAP avoiding any communication with the person concerned. One NAP described being apprehensive before coming on duty

wondering who they would be working with. This potential for conflict resulted in a lack of collaboration from the very beginning of shift handover. Registered Nurses completed the tasks that should have been able to be delegated to NAP when there was a conflict situation (Potter et al., 2010).

It is useful to acknowledge here that delegation within the acute oncology unit did not happen at shift handover. Registered Nurses and NAP met after their separate handovers and so any chance of a delegation relationship forming at this stage or understanding each other's workload or role, was lost. After shift handover the Registered Nurses would informally meet up with the NAP but researchers found that delays in this first contact were common. Both Registered Nurses and NAP agreed that this was a barrier to effective communication. The researchers conclude that good communication, working as a team and showing initiative in patient care were needed in order for successful delegation to occur. In addition, they found that information needs to be communicated professionally, respectfully, comprehensively and in a timely manner, and there needs to be an understanding of each other's role in order for effective delegation to occur.

Potter et al. (2010) have provided a unique insight into the perceptions of nurses and NAP working in an acute oncology setting in the United States and are able to clearly identify the attitudes, opinions and beliefs surrounding "good" and "bad" delegation interactions. Further research related to the perceptions about direction and delegation between New Zealand Enrolled and Registered Nurses could extend this basket of knowledge so that any professional concerns such as a lack of communication or lack of team work and potential conflicts can be identified and strategies can be put in place to mitigate them.

The way in which communication occurs between nurses, and nurses and support staff continue to be a topic of interest through into 2011. Huynh, Alderson, Nadon, and Kershaw-Rousseau (2011) designed a study using a survey questionnaire comprised of five questions to gather both quantitative and qualitative information in order to explore the interprofessional collaborative and non-collaborative communication interactions between nurses.

Interprofessional collaboration in this study was defined as communication between Licensed Practical Nurses (LPNs), Registered Nurses and nurse supervisors. The nurse researchers were interested in uncovering the LPN's emotions and perceptions during these interactions (Huynh et al., 2011, p. 3). A questionnaire was administered to 309 LPNs which identified that the majority of LPNs collaborated with Registered Nurses with "only a few" indicating that they collaborated only with "certain nursing staff." This was due to a reluctance to collaborate with new Registered Nurses who they perceived lacked experience. The main driver for interprofessional collaboration between the Registered Nurse and the LPN, was the

LPNs' perception that the Registered Nurse respected their nursing input and assessment. This was closely followed by the Registered Nurses actively seeking nursing input from the LPN and if an active listening style was used in response to the LPN's observations. Further, if and when the LPN reported back to the Registered Nurse was considered an important role that affected the amount and quality of collaboration. Huynh et al. (2011) concluded that when LPNs experienced a compassionate and inclusive leadership style, they worked as a team, there was trust and equitable workloads, successful interactions between Registered Nurses and LPNs followed (Huynh et al., 2011, p. 3). There are potential interests for New Zealand nursing attached to this research study, not only in the findings but in the factors identified that appeared to influence interprofessional collaborations between different categories and levels of nurses and nursing support staff. These influences include nursing leadership, organisational culture, trust and respect and "emotional labour." Emotional labour refers to workers suppressing negative emotions such as frustration and anger, and the expression of unmet emotions such as respect and trust in order to be workplace appropriate and to comply with organisational codes, rules and regulations (Huynh et al., 2011).

The findings of the study by Huynh et al. (2011) are consistent with the research findings two years earlier by other nurse researchers from the United States. Using ethnographic methods and a grounded theory design nurse researchers found the nursing assistant often experienced anger and condescension during their communication interactions, and a lack of mentoring, empathy and respect at times from the Registered Nurse (Rubin, Rengarajan, & Barcikowski, 2009, p. 822). The researchers call for collegial methods of communication to be taught to Registered Nurses and LPNs when delegating. Rubin et al. (2009, p. 830) summarise their findings and associated implications made visible in the surveys, interviews and focus groups, as a recognition of "needing to change the story", and an acknowledgement that some nurses and nursing aides do not get along. There were "convincing stories" of anger and sadness related to some of the judgemental exchanges in which nurses had been involved.

Delegation, negotiation or the nurse deciding to undertake nursing tasks and skills themselves were the subject of Schluter's qualitative Australian research study (Schluter, 2009). Schluter points to a series of social and political influences that have resulted in significant changes to the availability of adequate numbers of licensed nurses, and the effect this has on the skill mix of the health workforce in Australia. The aim of her constructivist, naturalistic study was to identify how medical and surgical nurses within three Queensland hospitals viewed their Scope of Practice and their workload in order to gain an understanding of how nursing work patterns were shifting in the face of changing patient acuity, patient profiles and nursing skill mix (Schluter, 2009, p. 7).

Using the Critical Incident Technique as a method to access the perceptions of 20 Registered and Enrolled Nurse participants Schluter (2009) identified five themes. Taken together the themes illustrate that many of the Registered Nurses understood that the delegation of tasks was necessary in order to achieve realistic workloads and while they understood delegation in principle, they were uncertain about how to do it. Previously, the Registered Nurses on one ward had worked predominantly with Enrolled Nurses and in an interesting and intriguing admission state: “and so had not delegated to others”. Indeed Schluter (2009, p. 120) reports that “delegation from Registered Nurse to EN or EEN was uncommon”. It was only with increasing numbers of HCA being employed that this became a necessity and as the need to delegate became visible, some nurses found they were unclear about the delegation process. The nurses that did delegate found that successful delegation was linked to their knowledge levels about delegation practices. Successful delegation also included an ability to trade tasks between themselves. Knowing how to trade tasks resulted in a successful relationship as nurses adjusted, negotiated and worked together as a team to swap tasks suitable to their Scope of Practice and their knowledge and competence levels. The ability to trade tasks required the valuing of everyone in the team which also included trusting the HCA to do their job competently, and nurses who worked together to design teamwork strategies to manage workload.

Significantly for New Zealand nurses, Schluter (2009) identifies that in the end the ability of a nurse to negotiate during delegation is vital, and this ability is linked to their knowledge levels about the delegation process. In a health system that is ever changing and diversifying in terms of its employment of more cost efficient levels of health care workers, nurses now need to communicate well, negotiate and develop creative ways of working in teams.

Barriers to successful delegation interactions

The barriers to effective delegation and the perceived benefits of delegation, as well as the strategies used by Registered Nurses in leadership roles were the topics selected for a qualitative descriptive research study by Corazzini et al. (2010). Registered Nurses in leadership roles in long term health care settings in the United States included Registered Nurses serving as nursing home administrators, owners, directors and assistant directors of nursing or corporate level consultants (Corazzini et al., 2010).

The Registered Nurse leader participants believed that barriers to effective delegation occurred when there were poor partnerships between Registered Nurse leaders and Nursing Assistants, caused by a lack of inclusion of the Nurse Assistant in the decision making

process. The lack of inclusion resulted in Nurse Assistants not feeling part of the team. The poor partnerships that resulted from this led to Registered Nurse leaders then resisting delegating tasks to others and doing the tasks themselves in order to avoid conflict. Nurse leaders also identified attitudinal barriers such as the Registered Nurse believing that when they delegate they are merely assigning even more workload over to others to carry out, fuelling resentment from the Nursing Assistant. The poor attitudes of Nursing Assistants when asked to do a task also contributed to poor partnerships between them and Registered Nurse leaders. Seniority of experience was viewed as a barrier too in that the Nursing Assistant who had been in their role for many years was reluctant to be delegated to by a new Licensed Practical Nurse (LPN). This was exacerbated by the fact that LPNs were not taught how to delegate in nursing school (Corazzini et al., 2010).

Registered Nurses in leadership roles identified the '*Follow the job description*' approach and the '*Scope of Practice*' approach. In the '*Follow the job description*' approach to delegation, Registered Nurses believed that the job description determined how the care and assistance required from the nursing assistant could and should be delegated. Delegation therefore in this approach meant that the 'rules' and organisational policies were followed. The '*Scope of Practice*' approach however, guided Registered Nurse leaders to firstly identify what was allowable and then assess the confidence and experience of the person being delegated to. The researchers report that this approach led to a degree of uncertainty in how to organise care but in doing so it also encouraged assessment of the resident's quality of care, as a number of assessments were required when this approach was used.

Due to the qualitative constructivist-interpretive nature of the research design and the interstate Scope of Practice and delegation requirements, the researchers expected to see more than one definition of delegation emerge from the 33 semi-structured interviews (Corazzini et al., 2010, p. 18). While this expectation is consistent with this research methodology it should be noted that more than one understanding or definition of delegation could contribute to confusion about the roles and responsibilities of the nurses and health care workers within the delegation interaction.

The researchers provide a comprehensive description of delegation. In this description the Registered Nurse is responsible for the planning of the task to be delegated, supervising and evaluating the performance of the other person during the entire process and then adjusting the nursing care plan accordingly. Highlighting that the Registered Nurse is accountable for planning of the delegation interaction is an important distinction. Making this aspect of the delegation interaction clear may prove useful to New Zealand nurses' description of

accountability. Corazzini et al. (2010) conclude that the purpose of any delegation interaction is to ensure that a professional, safe standard of nursing care reaches the patient. While this is inarguable, it implies that the Nursing Assistant, often a health care worker who has been trained via in-house nurse educators or in-service preparation sessions, is providing *nursing* care at the bedside, a practice that is protected by the title 'nurse' in New Zealand. Overall, this study related to the barriers to delegation, and provides useful information to add to the discussion on definitions of delegation and roles of accountability for both New Zealand student nurses and Enrolled and Registered Nurses, who are required to work within a delegation model.

The delegation issues for Newly Qualified Registered Nurses (NQN) delegating tasks to Health Care Assistants (HCA) became the aim and purpose of a qualitative ethnographic research study by Magnusson et al. (2014). In this study the researchers observed and interviewed 28 newly qualified nurses (NQN), ten HCAs and ten ward managers as participants. The aim of their two phase study funded by the General Nursing Council for England and Wales Trust in the United Kingdom was to investigate the ability of both degree and diploma NQN, to deliver, organise and supervise nursing care and evaluate a delegation tool designed to support the NQN with delegation interactions at the bedside care (Magnusson et al., 2014).

Magnusson et al. (2014) found that the unique culture of each workplace influenced how NQNs integrated and applied the theoretical knowledge that they had gained during their nursing education preparation. In addition, the fast-paced ever-changing workplace also influenced how NQNs transferred to a fully functioning Registered Nurse role. This led researchers to conclude that continuing professional development for both NQNs and HCAs were critical, especially around clarification of role boundaries and communication skills to support NQN and HCA working as a team. Secondly, through observation and interviews the researchers noted a number of approaches the NQN developed to provide safe, quality nursing care and grouped these findings as "delegation in context" (Magnusson et al., 2014, p. 11). The delegation of tasks between NQNs and HCA were influenced by the culture of the ward and how things were done in that workplace and this included if there were well established ward routines and structure. The skill level and experience of the HCAs in the ward also affected the NQN and HCA delegation interactions and both NQNs and Ward Managers reported that experienced HCAs needed minimal delegation instruction. An ability to prioritise care which is based on experience influences what tasks are delegated and what requests are made of other staff (Magnusson et al., 2014).

Although this study was specifically related to Registered Nurse to HCA delegation interactions it is a robust study about the relationship issues, and the supports needed for newly qualified nurses when they are required to delegate to others. The study identifies the skills required to develop a delegation relationship, and the cultural influences that can shape delegation interactions. The findings related to how nurses' approach their communication interactions can be applied to New Zealand's nursing situation and in particular to the employment of new inexperienced Registered Nurses.

So far the literature search has provided a global and overseas perspective about nurses working together with other nurses and nursing support personnel. This review of the overseas research studies has accumulated a valuable pool of possible skills and strategies to support delegation interactions and relationships. The themes that have come into focus from this section of the literature review include nursing leadership, the role of education and training, the role of team work, communication as a skill, the barriers and supports to successful delegation interactions, and nursing workplace issues that may impact on nursing delegation relationships. It seems sensible now to turn to a review of the New Zealand research studies available on delegation interactions. In doing so any unique, different or special aspects to the way delegation is known, understood and experienced in New Zealand can be considered and included in the research design.

New Zealand research studies on direction and delegation

As the search for literature narrows to the New Zealand research studies available on direction, delegation, supervision or accountability between Enrolled and Registered Nurses, it can be seen that only three research studies, and one published report have been found. This is a small number compared to the vast amount of research available of these topics in the overseas literature. The research studies in this more national rather than international section of the literature review have been chosen for inclusion because they acknowledge the delegation or supervision model, or they explore the differences in the Enrolled and Registered Nurses role and responsibilities, educational preparation or perceptions about their nursing work. However, none of these studies specifically explored or tested nursing direction or delegation in New Zealand and are therefore reviewed only briefly.

The aim of Walton's (1989) published report for the National Action Group was to describe the nature and organisation of nursing work in hospital settings in New Zealand and to describe the skills nurses felt were necessary in their work, their perceptions of their nursing work, the workplace rewards and frustrations, and how nurse's work days were organised. The quantitative survey-questionnaire, and qualitative interview format provides a snap shot

of workload allocation and work content of both Enrolled and Registered Nurse's roles during this time frame (Walton, 1989).

The study was divided into 12 sections. For the purpose of this literature review only the findings of sections two, six and twelve will be discussed as these are the sections pertinent to 'delegation' in today's currency. Section two of Walton's (1989) report provides quantitative information on how nurse's workloads are organised and allocated, skill mix and client loads, and *supervision* arrangements. It was noted that Enrolled and Registered Nurses had similar caseloads. Four models of nursing care were defined by the researcher and nurse participants were asked to identify the preferred model in their workplace. The preferred model was 'Patient allocation,' a system whereby the charge nurse allocates a patient to the nurse. Team nursing was ranked second and the primary nursing model followed as third (Walton, 1989). Section six of Walton's report provides quantitative data that indicates that a small percentage of Enrolled Nurses were placed in charge of the ward in an 'Acting up' position. The researcher states this is a high percentage in light of the legal limitations of the Enrolled Nurse registration and Scope of Practice. Section 12 identifies the themes captured from the individual and small group interviews with Enrolled and Registered Nurses. There are a significant number of comments relevant to any study of supervision (delegation today), that point to nurses' confusion and tension about the supervision role, the Enrolled Nurse Scope of Practice, and the roles and responsibilities of an Enrolled Nurse.

The finding that often the Enrolled Nurse would report to the Registered Nurse rather than the Registered Nurse enquiring of an Enrolled Nurse is deserving of mention. In order for a delegation relationship to work and to be able to fulfil the legal requirement to be delegated to, Enrolled Nurses need to be able to work together with a Registered Nurse, not in isolation. Walton acknowledges that although it is a subtle difference, it is an important one in order for a "supervision" relationship to develop. This subtle difference needs further exploration to identify if it is reflected in today's nursing relationships.

Dixon (1996) explores the difference between Enrolled and Registered Nurses' practices and roles using a critical case study design and methodology. A critical case study design was chosen because it afforded an exploration of the historical, social and political contexts that effectively silence the Enrolled Nurse voice. Using critical reflexive discourse and journaling the five Registered Nurse participants who had bridged from the Enrolled Nurse Scope of Practice were asked to compare and contrast their current nursing role to their previous Enrolled Nurse role. Of the two patterns that emerged from the analysis of the data '*Becoming a Registered Nurse*' and '*She was one of us*,' it is the perceptions and verbatim statements

within the pattern: '*Becoming a Registered Nurse*' which have a familiar and believable feel to it even today. The pattern '*Becoming a Registered Nurse*' was composed of a realisation that the Registered Nurse role brought with it a new and increased responsibility, and the realisation that they were now accountable. A second theme within this pattern was that their new Registered Nurse role was accompanied by a changed knowledge base and an underlying rationale for the "why" of the clinical decisions they were now required to make in their new Scope of Practice. A third theme that emerged was that the new Registered Nurse role brought with it increased job satisfaction, greater career flexibility and choice. A fourth theme within this pattern was the "Enrolled Nurse syndrome" which identified tensions between Enrolled and Registered Nurses (Dixon, 1996, p. 196). The term Enrolled Nurse syndrome captured a negativity and feeling of being a "second class (nursing) citizen". These very attitudes, views and beliefs that stem from the way nurses interact with each other can mould the way nurses communicate with their colleagues. It is the admission by one nurse participant that (before she bridged to the Registered Nurse Scope of Practice) she and other Enrolled Nurses often worked outside their Scope of Practice that is worthy of acknowledgment here.

Dixon's (1996) research makes a valuable contribution to the discussion by exploring the taken-for-granted and often repeated mantra in nursing circles that there was no difference between the Registered and Enrolled Nurse practice. Her doctoral thesis provides a comprehensive history and analysis of the Enrolled Nurse role and the numerous iterations that have shaped their careers and nursing journeys. Dixon's (1996) research and the study seven years earlier by Walton (1989) are unique as they are both based on New Zealand nurses' perceptions, they include the Enrolled and Registered Nurse views and beliefs, and they provide an insight into Enrolled Nurse experiences. They have provided an important point of difference to the overseas research studies, directing a spotlight on to the New Zealand Enrolled and Registered Nurse relationship.

Meek (2009) was motivated to critically examine the evolving role of the second level nurse in New Zealand which at the time was a Level 4 Nurse Assistant role, workplace use of Enrolled Nurses and barriers to their employment. She chose a qualitative critical research paradigm for her Masters Research project in order to generate emancipatory knowledge and uncover how socially constructed thinking limits current thinking, and therefore actions related to Enrolled Nurse employment. Significantly for the Enrolled Nurse graduate of today Meek (2009) recommends a true team approach that incorporates the skills and knowledge of three levels of workplace employees, the Registered Nurse, the Enrolled Nurse and a non-regulated care giver. Although Meek's (2009) research project has added a valuable

dimension to the discussion about the possible barriers to employing newly trained Level 4 Nurse Assistants in New Zealand, her research project was undertaken at a point in the second level nurse journey prior to the development of the NZQA Level 5 Diploma in Enrolled Nursing. While a brief history of the journey from supervision to direction and delegation is included in her 'Background' section of the report, there is no further discussion or recommendations related to the direction and delegation role for the Enrolled Nurse of the future. However, her acknowledgement that a more substantial research study that includes interviews with second level nurses is as relevant today as it was then. As Meek (2009) states, hearing the voices of the second level nurses who have worked, adjusted, up-skilled or not, and lived through the numerous changes to their roles and responsibilities in New Zealand is required, and is a timely reminder that the Enrolled Nurse's experiences and stories as well as the Registered Nurse stories need to be heard.

A published research report commissioned by the Nurse Education in the Tertiary Sector (Aotearoa New Zealand) (NETS) group, aimed to identify the learning outcomes suitable to structure nationally standardised and validated simulated clinical learning scenarios for the New Zealand undergraduate nursing curriculum. The focus of the report by Wordsworth, Pool, Hawes, and Holloway (2014) was not related to the Enrolled Nurse role or their educational requirements. However, this report has been included in this section of the literature review because their research results impact on a discussion about the importance placed on teaching delegation principles to Registered Nurses in New Zealand.

The participants within the Wordsworth et al. (2014) report were key nursing leaders involved in nursing regulation, clinical practice and education. They were asked to prioritise, rank and comment on the relevance and importance of the Registered Nurse's competencies from the four domains (Nursing Council New Zealand, 2007a) in a simulated clinical teaching environment. These were then developed into key learning outcomes so that clinical simulation activities could be developed in the future. Significantly, the top fifteen NZNC competencies identified as important enough to develop into learning outcomes for scenario based simulation activities did not include competency 1.3 "Demonstrates accountability for directing, monitoring and evaluating nursing care that is provided by Enrolled Nurses and others" (Nursing Council New Zealand, 2007a). Ranked at number six was: "Understands and practices within their own Scope of Practice" and ranked last was "Effectively communicates with the health care team for example, both verbal and written". The competency related to delegation does not appear to be ranked by the participants, leaders in the nursing profession, as important for clinical simulation activities. In addition, the Enrolled

Nurse role is not included in any way and direction and delegation are unnamed. Therefore, the opportunity to teach this professional obligation was lost.

Apart from the obvious age of the four New Zealand studies discussed here, there is also the issue of timing. The studies reviewed were undertaken prior to the revised and expanded Enrolled Nurse Level 5 Scope of Practice, the change in name from ‘direction and supervision’ to ‘direction and delegation’, and the reintroduction of the Enrolled Nurse training in 2002. However, the studies have been included as they illustrate some of the issues and concerns that have occurred when Enrolled and Registered Nurses work together. During the gathering of these New Zealand studies, other nursing literature directly related to delegation in New Zealand surfaced. These guidance, advice and support materials were therefore incorporated into the next section of this review.

Guidance and advice to New Zealand nurses on direction and delegation

A search of the NCNZ website identifies a number of references to the delegation role. The main guidance document provided by the NCNZ on direction and delegation: *Guideline: Responsibilities for direction and delegation of care to Enrolled Nurses* was updated by NCNZ in 2011 to reflect the change in the Scope of Practice for Enrolled Nurses (Nursing Council of New Zealand, 2011b). It is a much more comprehensive and detailed document than previous documents on delegation (Nursing Council New Zealand, 1999; Nursing Council of New Zealand, 2008). ‘Direction and **supervision**’ as identified in the guidance document from NZNC in 1999 was changed to ‘**direction** and delegation’ (Nursing Council of New Zealand, 2008). Direction and supervision was replaced by ‘direction and delegation’ because supervision meant something different for Registered Nurses employed in New Zealand mental health settings where clinical supervision (professional supervision between peers) is offered to mental health Registered Nurses. Further, supervision in the NCNZ context now referred to nurses who required professional support from a Registered Nurse when working under the direction and delegation of a registered health care practitioner, other than a Registered Nurse (Nursing Council of New Zealand, 2011b). The *Guideline: responsibilities for direction and delegation of care to Enrolled Nurses* (the Guidelines) (Nursing Council of New Zealand, 2011b, pp. 5-10) provide a selection of statements related to accountability. It is unclear from these selections that the Registered Nurse is responsible for the delegation decisions they make, not the practice of Enrolled Nurses (Nursing Council of New Zealand, 2011b, p. 6).

Professional nursing guidance documents

The NCNZ are clear that the Enrolled and Registered Nurse need to acknowledge that their nursing practice and conduct meet the standards of professional, ethical and relevant legislative requirements, and that this is a joint responsibility. A number of professional guidelines and codes are available to New Zealand nurses that contain advice and required behaviours when Enrolled and Registered Nurses interact with each other professionally. *The Guidelines: Professional Boundaries* (Nursing Council New Zealand, 2012b) do not specifically mention direction or delegation. *The Code of Conduct* (Nursing Council of New Zealand, 2012, p. 29) briefly mentions that Registered Nurses must only delegate after ensuring the Enrolled Nurse “has appropriate knowledge and skill”.

The NZNO have provided study days to support nurses with direction and delegation (J. Anderson, personal communication, September 21, 2015). NZNO provides practical support and guidance to Enrolled Nurses through a branch of their web site (New Zealand Nurses Organisation, 2012a). They have produced or contributed to numerous documents, articles, position statements and standards about the Enrolled Nurse role in New Zealand (Cassie, 2010; New Zealand Nurses Organisation, 2000 October, 2011, 2012b). Although overly broad in its meaning and not specifically about the direction or delegation relationship, the nurse to nurse–colleague relationship section of the NZNO *Code of Ethics* provides some guidance on what constitutes an ethical, supportive and positive relationship between nurses. It is a start towards providing nurses with more specific information to support professional and positive communication relationships. The values and ethical principles in this document could be applied to the discussion on direction and delegation relationships (New Zealand Nurses Organisation, 2010/2013, p. 18).

Teaching packages about direction and delegation for nurses in clinical settings

This leads us to a point in the discussion when an examination of the role of the clinical practice areas supporting safe and effective direction and delegation interactions can take place. Internet searches identified a Professional Development Recognition Programme (PDRP) for Canterbury and the West Coast health region (Canterbury District Health Board (CDHB), 2008), a self-directed learning package for students, and Enrolled and Registered Nurses, based on the information contained within the *Guidelines: Responsibilities for direction and delegation of care to Enrolled Nurses*. This is a genuine effort to make direction and delegation information available to Enrolled and Registered Nurses. While it does seek to provide more information around this professional responsibility with some brief “what if” clinical scenarios, it does not elaborate on the communication, leadership, assessment, or knowledge and skills that might be required in different direction or delegation situations.

Policies and procedures in the workplace

The CDHB provides staff with a direction and delegation policy. It contains the principles of delegation and the 'Five Rights of Delegation' as well as a brief and general overview of roles and responsibilities of Enrolled and Registered Nurses in relation to delegation (Canterbury District Health Board, 2013). The information provided in it is a direct reflection of the information provided by the Nursing Council of New Zealand in 'the Guidelines' on direction and delegation (Nursing Council of New Zealand, 2011b). In addition to this there is a CDHB Fluid and Medication policy which clearly identifies the roles and responsibilities of all employed staff in relation to medication administration (Canterbury District Health Board, 2012). The policy however, does not distinguish or explain direction or delegation.

The reliance on merely providing policy about direction, delegation and accountability may prove to be misplaced. In 2007 the Health and Disability Commissioner (HDC) concerned about systems failures which had contributed to a patient death at Wellington Hospital, requested a review of the safety standards within national District Health Boards (DHBs) in response to a patient death known as: *The case of Mr A (05HDC11908)*. Dr Seddon was appointed to review the safety measures that the 21 DHBs had in place to protect vulnerable patients and prevent a similar case occurring in other DHBs. She identified ten possible areas for improvement of their policies, systems and processes. Included in this list is: 'Scope of Practice for Enrolled Nurses.' Seddon found that DHBs pointed out that they had policies about the supervision requirement in place, compliance to the policies however had never been audited by any of the DHBs. She identifies that merely having policy did not mean there was compliance to it and recommended compliance auditing (Seddon, 2007). She also acknowledges that while Scopes of Practice are important to a profession, ongoing training related to the skills and tasks relevant to that role are also important (Seddon, 2007, p. 11).

Summarising the literature

There is no dispute that New Zealand's professional bodies have provided some guidance for New Zealand nurses about the professional accountability to direct and delegate. A number of documents can be cited through the decades in support of this. In order to provide for balance it cannot be ignored that the complexity and diversity of clinical nursing practice areas, and the variety of nursing roles and responsibilities, means that a broad approach to disseminating information about direction or delegation is required. What is worthy of attention though is that a picture starts to emerge of nurses being told to do direction and delegation but with little information about how to do so being made available. Exploring nurses' perceptions toward direction and delegation may throw some light on the Enrolled and Registered Nurses

requirements for safe and effective delegation interactions for future generations of nurses so that whānau and families, as well as the nursing profession, are kept safe.

The twenty-nine research studies selected for a review of the overseas literature are overwhelmingly related to the Registered Nurse and the nursing assistive personnel relationship in the United States. Nine of the research studies included or mentioned either the Enrolled Nurse role or LPN. Four of the studies related to the Australian nursing system, two research studies were related to the nursing system in the United Kingdom, two were from Iceland, and one from Korea.

There are a number of continuing themes that emerged from the review of these overseas research studies that require acknowledgement. The skills and knowledge required to guide nursing colleagues in interpreting delegation policies and guidelines are an important leadership skill. Further to this it appears that educational preparation related to delegation and nursing experience can influence the nurse's ability to lead a team, and that a number of critical thinking skills are required to lead the delegation decision making process, often at the same time and in busy environments. Registered Nurses reported they too needed leadership and guidance when changes were made to the way they were required to carry out their nursing roles. In addition to these aspects of nursing work, policies, procedures and guidelines were often found to be generalised in order to accommodate a number of differing clinical settings, and they are necessarily broad in their application. This can result in too much flexibility leading to boundary blurring, delegation overload and role confusion. In the end any policy, procedure or guideline requires skilled leadership, often associated with senior nurses, to manage the various interpretations.

How, when and why delegation principles are taught feature prominently and at length in the overseas research studies. It appears that multi-modal structured teaching sessions about delegation, commenced early in the nurse's educational programme that include the why, as well as how it is done, are needed to encourage supportive attitudes towards delegation interactions. Some nurse participants indicated that there is a lack of ongoing and continuing training and education about delegation.

Working as a team and working together is often promoted in the overseas nursing literature as an important nursing value. When team nursing fails to function well it can act as a barrier to positive delegation interactions and therefore good patient care. This places team nursing skills such as communication and assessment at the forefront of the delegation discussion. Some nurse participants identified the role of respectful communication, and an ability to

manage conflict, as positive influences on delegation interactions in a team. A lack of working together as a team, not involving the other nurse or nursing support personnel in the decision making, and having more than one boss, were viewed as negative influences. It can be argued that good communication skills are a given for any nurse, so taken-for-granted that it is assumed all nurses are able to communicate well. This is not always an accurate assumption as could be seen by some of the statements from participants in several research studies. The research studies also point to a nurse's ability to collaborate, negotiate and acknowledge different personality styles as personality styles can be both a strength, and a barrier to effective delegation.

The search of the overseas literature also highlighted that it is necessary that all levels and categories within the nursing skill mix in clinical settings understand not only their own roles, responsibilities and Scope of Practice, but also those of the other staff members they are working alongside. Negative comments about working with other levels of assistive personnel related to a lack of confidence or knowledge about delegation, the confusion about what a delegated task was, and the similarity between the Enrolled Nurse and Registered Nurse role. In the end some of these negative experiences led nurses to share that delegation was time consuming especially when they were required to assess firstly what the other staff member or nurse could or could not do, and secondly deciding if the other staff member being delegated to would finish the job to the same standard they wanted to see. Secondary to these beliefs some nurses felt that if you wanted a job done well it was easier and faster to do it yourself. These beliefs and values surrounding delegation were usually shaped by the prevailing culture of the nurse's workplace.

Barriers to effective delegation were identified as poor partnerships between Registered Nurse leaders, nursing or assistive personnel during decision making, nurses and assistive personnel who had been in their role too long and were therefore reluctant to be delegated to, and the perceived poor work ethic of the other staff member in the delegation relationship. Lack of leadership by Registered Nurses and other nurse leaders, failure to assess the other level or category of 'nurse', and unfair communication featured throughout the research studies. These barriers can inadvertently lead to task shifting from one level of nurse to the other, or to the assistive personnel, role expansion, role conflict or missed care.

In the history of the Enrolled Nurse role in New Zealand only three studies and one report have been produced that explore the difference between the Enrolled and Registered Nurses' roles and responsibilities. Although they do not specifically research the direction or delegation relationship, it would be unfair to suggest they failed to research this aspect of

nursing as this was not their aim. They do provide a window on the topics that were of interest to nurses at the time such as nursing workload, nursing roles and responsibilities, teaching and learning content, methods of bridging programmes, and as almost a passing concept, the supervision role between 1989 and 2014.

Although the study by Walton (1989) some 28 years ago was related to a wider exploration of Enrolled and Registered Nurses' perceptions of how their nursing work was organised and allocated, it also managed to access some quantitative information from nurse participants on supervision (Walton, 1989). As such it does offer some insights into supervision as it was then known. She found that in some workplaces Enrolled Nurses supervised both Enrolled and Registered Nurses and were sometimes placed in charge of wards. In addition, there were tensions and some confusion between Registered Nurses and Enrolled Nurses about their respective roles and responsibilities which could negatively affect the supervision role.

The focus of the Wordsworth et al. (2014) report was not about direction and delegation even though direction, delegation and accountability will underscore all nursing management activities in some work areas. Indeed the NZNC competency 1.3 was not considered important enough to be included as a learning outcome for future undergraduate simulation sessions.

A research study by Dixon (1996) explored and analysed Registered Nurses' perceptions of the differences between Enrolled and Registered Nurse roles. She chose Registered Nurses who had bridged from an Enrolled Nurse Scope of Practice because they had worked in both nursing worlds. While Dixon does not specifically set out to research delegation interactions, her research study provides a unique insight into the perceptions that shaped Enrolled and Registered Nurses' beliefs and attitudes about their roles and Scope of Practice in 1996 and because of this inevitably includes some discussion on the supervision relationship.

The barriers to the future employment of Enrolled Nurses and the differences between Enrolled Nurses' evolution and use in New Zealand and Britain were the topics of interest in Meek's 2009 research project. However, Meek's (2009) study does not make any recommendations for delegation practices or Registered Nurse to Enrolled Nurse relationships, as this was not intended as the focus of her research study.

Given the small number and age of the New Zealand research studies available about Enrolled and Registered Nurses' work organisation and work practices, and the lack of research specifically related to direction, delegation and accountability within New Zealand, it

is therefore timely that a research study that explores delegation practices between Enrolled and Registered Nurses is undertaken. Research related to the New Zealand nursing setting is needed so that nurses' perceptions of the direction and delegation experiences they have had, and how their experiences impact on them, their colleagues and patients is a sensible next step given the changes in the Enrolled Scope of Practice post 2010 and the possibility that more Enrolled Nurses will be employed in a variety of nursing areas. A qualitative research study related to New Zealand Enrolled and Registered Nurses' understanding of their own and each other's Scope of Practice may be a valuable contribution to understanding direction and delegation requirements. Specifically, what do nurses know and understand about their Scope of Practice in relation to direction and delegation? What can be directed and delegated? Who is accountable, answerable and responsible, and what are they accountable for? How do New Zealand nurses ensure that delegation is working for them and the patient on the receiving end of nursing's direction and delegation requirements? With these questions in mind, coupled with the literature available, the following two chapters, Chapters three – Methodology, and Chapter four - Methods, provides a plan for the research study: *How do Enrolled and Registered Nurses communicate with each other during the direction and delegation interaction?*

We not only interpret the character of events we may also interpret our interpretations (Kenneth Burke. Permanence and Change. 1954, p xvii).

Chapter three. Methodology

Introduction

This narrative inquiry research study seeks to describe and explore how Enrolled and Registered Nurses' understand and make sense of their professional obligation to delegate to others, or to be delegated to. It seeks to uncover their unique and individual perceptions and personal perspectives of the direction and delegation experiences in which they have been involved, and the impact this has on the way they communicate during direction and delegation. While some indications as to the type of design suitable for this study emerged from the literature review and would fulfil the research purpose described above, a further more mature analysis of the epistemology, ontology, theoretical perspectives and methodology behind the research intention was required. Chapter three outlines the inquiry that led to the methodology underpinning this study. The chapter is divided into seven sections and taken together parts one to seven provide a description of my world view and the beliefs and thinking that influenced this narrative inquiry study. In doing so this chapter makes visible the underlying philosophical stance and the narrative inquiry approach employed to address the research question, aims and purpose.

A world view provides a framework illustrating the epistemological, ontological, theoretical and methodological choices made, and positions the way knowledge is generated, studied, interpreted and understood from within that world view (Crotty, 1998). The detailed description of my world view in this chapter provides a conceptual map and explains the choices I made within the research process. Therefore, part one describes the relationship between epistemology, ontology and theoretical perspectives, and outlines the rationale for the theoretical perspectives behind this narrative inquiry study. This section of the chapter also explains how social constructionism, and a critical theory of interpretation influence the way knowledge, reality and truth are viewed. It also sets the scene for later discussions on the relationship between myself as the narrative inquiry researcher and the participant, and the choice of methodology and methods. An italic emphasis has been placed on either ...ism/ist or ...vism/vist to aid in distinguishing these terms.

The “narrative turn” as a turn away from a positivist worldview is discussed in order to distinguish narrative inquiry from other approaches to research. Narrative inquiry is grounded in a certain way of knowing that is consistent with social constructionism and interpretivism. Part two explores these theoretical perspectives and paradigmatic choices in relation to this study. Part three distinguishes the term *methodology* from *methods* and provides a guideline for the narrative inquiry methodology chosen. Part three also includes the narrative inquiry view of experience, the storied experience and the three common places of temporality, sociality and place. These narrative inquiry views provide a conceptual framework for narrative inquiry. Part four identifies the decision making process for the research design and the rationale for choosing qualitative methods for data collection. Part five examines some of the concerns researchers immersed in other theoretical perspectives have about narrative inquiry as a research methodology and the limitations of a narrative inquiry approach. My “presence” as a researcher is discussed in part six and provides an exploration of the reflexive considerations required for this study into direction and delegation. An important aspect of narrative inquiry research includes an explanation of the professional and personal interest that links the researcher to the research question and aims. Therefore, I share my history and journey with nursing’s professional obligation to be in direction and delegation interactions, in part seven. Part seven acts as a bridge between this methodological chapter, and the Methods chapter, Chapter four.

Part one: Theoretical perspectives and research paradigms

This section of the methodology chapter describes the theoretical perspective behind this research study. A theoretical perspective is a world view and is composed of specific philosophical beliefs and assumptions that guide the research process and choices, and informs the methodology (Crotty, 1998). Crotty identifies though that the terminology used in research studies is often mixed “thrown together in a grab bag style as if they were comparable” when they are not comparable (Crotty, 1998, p. 3). Theoretical perspectives are variously described and defined as a paradigm “a basic belief system or worldview that guides the investigator” (Guba & Lincoln, 1994, p. 105) and Mertens (2005) describes a paradigm as a way of looking at the world. Denzin and Lincoln (2000, p. 19) refer to theoretical perspective as an “interpretive framework” while others describe the ontological and epistemological underpinnings of the research study (Clandinin, 2013; Crotty, 1998). Denzin and Lincoln (2005, p. 183) describe paradigms, as the researcher’s “net” that holds the ontological, epistemological and methodological beliefs of a research study.

The ontological and epistemological underpinnings of a theoretical perspective clearly situate and reflect the researcher's thinking and beliefs about the research process. An ontological and epistemological structure has been used in this chapter to illustrate the possible philosophical choices that researchers need to make, and identify the actual philosophical underpinnings of a narrative inquiry approach that I chose in order to answer the research question.

Ontology (the study of being) provides a world view that guides the research study. Ontology includes questions such as: What kind of being is the human being? What is the nature of reality? Is reality constructed through human relationships or does it reside outside human experience? (Crotty, 1998; Denzin & Lincoln, 2000; Lincoln & Guba, 1985; Mertens, 2005). A critical realist ontology assumes there is an objective reality: "but an imperfectly and probabilistically apprehendable reality" (Mertens, 2005, p. 10). Historical ontology assumes that reality is created and shaped by social, political, cultural, and economic and gender influences within our social structures. A relativist ontology assumes that reality is constructed through the meanings attributed to them and people's understanding of knowledge, events and life through social interaction and experience. I appreciated the philosophy within a relativist ontology and it was this description that helped me to reconcile an ontological perspective to this study's purpose and aims (Guba & Lincoln, 1994, p. 109; Mertens, 2005, p. 11).

Epistemology, described below, provides a focus for the study and asks questions such as how do we know what we know? How can reality be known? What is the relationship between the known and the knower? Does the knower need to be "objective" and is this possible? Does the knower co-construct knowledge with others? (Crotty, 1998, p. 8; Denzin & Lincoln, 2000, p. 19; Denzin & Lincoln, 2005, p. 183; Mertens, 2005, p. 10). Crotty also explains that even though they have their own descriptions and definitions, in reality ontology and epistemology cannot be entirely separated out as they often overlap.

Any researcher takes a particular viewpoint such as a belief in objectivism or subjectivism (Crotty, 1998). Objectivism is defined as the belief that truth and meaning reside within an object and are independent of human subjectivity. An objectivist view of the world leads a researcher to lay claim to being able to remove all contextual reference points and observe and know a phenomenon independent of the human mind. According to an objective researcher it is possible to remove human bias in order to discover knowledge. An objectivist epistemology understands that those being observed and the observer are not changed by the research process. Knowledge creation is through impartial observation and the goal is to

produce natural universal laws of truths used to explain, predict and control (Crotty, 1998, p. 6; Grant & Giddings, 2002, p. 8).

A subjective epistemology on the other hand includes the view that knowledge can only ever be viewed through language, gender, socio economic and cultural influences (Denzin & Lincoln, 2005, p. 21). Knowledge is viewed as being value laden, observations are influenced by the observer or audience, and the observer is also changed in the process. Knowledge is individual and perceptions are dependent on the individual in this situation, and at this time (Crotty, 1998, p. 9). I drew on Crotty's description of a subjective epistemology to gather the unique and individual stories of delegation experiences that included how the Enrolled and Registered Nurses had been shaped by the social and cultural influences in their workplace.

It is the researcher's epistemological and ontological point of view or stance that decides the theoretical perspective most suited for the research study, its associated design and the methodological approach chosen, as each theoretical perspective encompasses a set of beliefs about the world, and about what the world knows (Crotty, 1998, p. 7). *Constructivists* for example, search for individual *meaning making* and assume that knowledge is constructed rather than discovered. *Constructivists* attempt to understand human experience and claim that reality is constructed through the *individual's* view, experiences and perceptions of the event under study as they engage with the world (Crotty, 1998, p. 58; Mertens, 2005, p. 16). *Constructivism* according to Crotty suggests that: "each one's way of making sense of the world is as valid and worthy of respect as any other thereby scotching any hint of a critical spirit" (Crotty, 1998, p. 58).

While *constructivism* focuses our attention on the meaning making of the individual mind Crotty points out that *constructionism* incorporates the "*collective generation and transmission of knowledge*" (Crotty, 1998, p. 58; Mertens, 2005, p. 11) and places an emphasis on the impact and influence of culture. Culture in particular shapes thoughts, feelings, values and views on life. *Social constructionists* view knowledge and the knower as situated in, and already saturated by a history, context, culture, language, experience and understanding. That is, we arrive in a world that already has social meanings attached to every aspect of our lives and we *then* interpret these socially and culturally constructed symbols and meanings. This includes not only our thoughts but also our emotions, beliefs and values. Therefore, "all reality as meaningful reality is socially constructed. There is no exception" (Crotty, 1998, p. 54). There are no claims to discovering 'truth' as this world view is underpinned by a relativist ontology in that there are multiple realities, and a subjective

epistemology and the knower and the participants co-create understandings together in participatory and relational ways.

Given this description and explanation of the relativist ontology and the subjective epistemology of social constructionism it would appear that the theoretical perspective deemed most suitable to address the research question, aims and purpose, and therefore chosen to understand Enrolled and Registered Nurse's experience of direction and delegation, clearly resides in the social *constructionist* world view. A social constructionist perspective would allow for multiple realities and therefore provide opportunities to understand each individual nurses' experiences of delegation, as well as direction, from their unique and differing vantage points. This world view would assist in identifying how nurses made sense of their direction and delegation experiences in an environment that already had social and cultural meaning attached to the delegation role, and the roles and responsibilities of the two nursing Scopes of Practice.

Part two: Theoretical perspectives in narrative inquiry research

This section of the chapter explores the relationship between narrative inquiry research and an interpretive constructionist epistemology and theoretical perspectives. Narrative inquiry researchers understand that people lead socially constructed and storied lives, and naturally construct stories out of life. Therefore, narrative inquiry resides within a social constructionist way of viewing the world (Hunter, 2010, p. 46; Josselson, 2006, p. 4; Phoenix, 2008, p. 67; Riessman & Speedy, 2007, p. 429; Trahar, 2009).

Narrative inquiry research also includes an interpretive world view which is concerned with interpreting and understanding of meaning, and an understanding of human experience (Chase, 2013, p. 62; Clandinin, 2013, p. 13; Clandinin & Connelly, 2000; Clandinin & Rosiek, 2007; Lieblich, Tuval-Mashiach, & Zilber, 1998, p. 10; Pinnegar & Daynes, 2007, p. 3:9; Riessman, 1993, p. 2). The role of the narrative inquiry researcher is to interpret and construct the stories told to them (Connelly & Clandinin, 1990, p. 4) and asks why the story was told this way, for this audience, at this time, and in this place (Riessman, 2008, p. 11). Narrative inquirers make transparent their own personal and professional background and experiences to illustrate the impact this might have on the participants and the research process which is consistent with an interpretive constructionist approach to research (Bold, 2012, p. 13; Pinnegar & Daynes, 2007, p. 7). For some narrative researchers narrative inquiry can take a postmodern stand (Andrews, Squire, & Tamboukou, 2008, p. 9; Bold, 2012, p. 13;

Riessman & Speedy, 2007, p. 429) as truth and certainty are relative, socially constructed and subject to change.

An interpretive theoretical perspective

The interpretive approach emerged from the concerns surrounding a positivist world view and a desire to understand in the full sense of the term. Interpretivism centres on how participants interpret and make sense of a phenomena, event or experience. An interpretive approach views all communities and cultures as having their own ways of knowing and meaning making which have been shaped and influenced, limited or supported by their place in the social, cultural and historical world. In other words we are all only ever products of our time and place. As Crotty explains: an interpretive approach: “Looks for culturally derived and historically situated interpretations of the social life world” (Crotty, 1998, p. 67).

Interpretative researchers have a relativist ontology with a subjective epistemology which is guided by an understanding that there are multiple meanings and socially constructed ways of knowing (Denzin & Lincoln, 2005, p. 5). There is no single truth, but multiple truths because truth is subject to individual interpretation (Denzin & Lincoln, 2000, p. 191). That is, interpretation and understanding are relative to the cultural context, social situation, and experiences of the researcher, participant and the audience as reader of the text. As Polkinghorne (1983, p. 103) points out, who we are and what we think, value and believe to be true is always relative, and the knower, the researcher, cannot stand outside the real world to objectively observe it.

All knowledge is relative to one’s perspective; there is no absolute point of view outside of one’s historical and cultural situation; neither pure sense data nor formal logic can provide an absolute foundation for knowledge, the categories according to which experience is formed, what is considered as reasonable, and so on – all of these are functions of one’s world outlook. One never has access to reality: one can only look through the opaque spectacles of the cognitive apparatus of one’s historically given weltanschauung [world outlook] (Polkinghorne, 1983, p. 103).

In positioning the research within a social constructionist, interpretivist theoretical perspective and methodology, truth, reality, understanding, sense making, meaning making and knowledge should be acknowledged as socially, culturally and individually constructed at this moment, in this place, for this moment in time. The role of the researcher then, can never be objective and value free because the knower can’t stand outside the real world of the known to objectively observe it. Indeed, subjectivity is valued because people’s narratives are based on perspectives and experiences that are personal to them (Riessman, 1993, p. 5). This world

view is consistent with my rationale for choosing a narrative inquiry methodology and methods approach, as narrative inquiry values and acknowledges the role of the environment or place, and the influence of sociality and culture, and timing (Clandinin, 2013).

The “narrative turn” and other theoretical perspectives

A narrative inquirer’s interest in how people make sense of themselves and their experiences in the social sciences was a move away from the traditional positive paradigm in search of a better way to understand how people made sense of their lived experiences. This turn away from positivism is a phenomena known as the “the narrative turn” in which there is a movement or change in thinking about research, either slowly over time or rapidly as the researcher comes to terms with a new research methodology (Clandinin, 2013, p. 10; Pinnegar & Daynes, 2007, p. 7). Narrative *inquiry* as a branch of narrative *research* sits within the wider field of *narratology* (Chase, 2013, p. 56; Connelly & Clandinin, 1990, p. 2). While narrative inquiry research requires the researcher to turn away from positive world views narrative inquiry researchers also acknowledges the value of different theoretical perspectives for their contribution to knowledge. Clandinin (2013) and Clandinin and Rosiek (2007, p. 59) however, are quite clear in their description of the relationship between narrative inquiry with other theoretical perspectives, that there are differences that narrative inquirers must “respectfully examine,” acknowledge and attend to, not ignore. The narrative turn involves four changes *towards* a narrative way of knowing.

Firstly, narrative inquirers have a different way of viewing the researcher and participant relationship. With this turn towards narrative inquiry both the stories told and the people sharing them and interpreting them are visible and narrative is seen as both a relational methodology and a phenomena or aspect of a study for studying experience (Clandinin, 2013, p. 17; Pinnegar & Daynes, 2007, p. 7). For the narrative researcher the interaction between researcher and participant is a *relationship*, and each person leaves the research interaction having learned something or changed in some way. Secondly, there is a move away from the use of numbers, statistics and measuring to describe and depict a phenomena of interest, to the use of words as data, as narrative inquirers embody, comprehend and attempt to portray the influence and outcome of language and experience (Pinnegar & Daynes, 2007, p. 27). Thirdly, the local and specific is valued not the general and universal. In this turn away from a positivist perspective toward a narrative way of knowing the researcher understands the power in a particular experience, in a particular time and place and can build powerful and moving context specific examples. Finally, as a result of the challenge to the assumptions of positivism the turn towards narrative inquiry leads the narrative inquirer to respect and value

different epistemologies or ways of knowing and an understanding that knowledge is only ever “tentative and variable” (Pinnegar & Daynes, 2007, p. 25).

At the risk of oversimplifying the issues, a narrative inquiry methodology provided an opportunity that other theoretical perspectives, methodologies and methods did not offer. Briefly stated, the purpose of the research study was to gain a greater understanding of how nurses make sense of direction and delegation through their personal experiences, their views on how direction and delegation occur in their workplace, how they believed they communicated during delegation interactions and what they understand about this professional accountability. The purpose of the study was not to know how many nurses used direction and delegation or how many had attended education programmes. Nor did I want to reduce their experiences of delegation to themes across multiple cases, quantify, generalise or identify absolute truths (Denzin & Lincoln, 2005), or reduce findings to a common denominator (Chase, 2005, p. 657). This invoked a narrative inquiry methodological approach to describe and explore nurse’s direction and delegation interactions through gathering their stories of experience, which they may have been sharing for the first time. While identifying discursive practices or oppressed group behaviour would be considered relevant to the study if it was relevant to the nurse participant, they were only part of the reasoning and rationale for narrative inquiry, as narrative inquiry is able to look at these influences but also include who, when, where, why and how an experience occurred.

Paradigmatic, logico-scientific knowing and narrative modes of thinking

Narrative inquiry is grounded in a narrative way of knowing (Kramp, 2004, p. 6) and any discussion about contemporary narrative inquiry needs to be prefaced with a brief acknowledgment of the work by Bruner or Polkinghorne, considered to be two of the seminal writers of narrative ways of knowing. Bruner (1985) provides a description of two basic intelligences or cognitive functioning which he named: ‘Paradigmatic knowing’ and ‘Narrative knowing.’ These two ways of knowing define our understanding of how reality, knowledge and experience are viewed and have shaped the way narrative knowing has developed (Kramp, 2004). ‘Paradigmatic knowing’ is grounded in causal explanation and is valued and most observed in the positivist sciences. This way of knowing examines how logic and empirical truth is known and looks for generalisations, and proof. Paradigmatic knowing works to remove or reduce ambiguity and uncertainty (Bruner, 1986; Kramp, 2004, p. 4). ‘Narrative knowing’ on the other hand is valued for its storytelling and its ability to invest experience with meaning. Experiences as shared by the story teller are developed in story form known as re-storying and it is this told story that is particular to the person that is valued

by the researcher, not the gathering of information or facts about it (Bruner, 1986; Kramp, 2004, p. 5). This mode of knowing looks to understand the meaning of experience for that person and includes the valuing of the personal, the specific and particular aspects of the events and experiences as shared by the teller of the story (Bruner, 1986; Kramp, 2004; Polkinghorne, 1995, p. 19). This results in a subjective reality and its merit and worth are in uncovering meaning making.

Planning the research study was not a linear or sequential process and it is only in looking back on my reflective journal and the beginning of my research journey that I realise I was instinctively drawn to Bruner's 'narrative knowing' mode of thinking because of its ability to value each person's contribution. Narrative knowing supported my desire to gather, explore and understand each Enrolled and Registered Nurse's personal and professional experiences through the stories they shared. I immediately recognised that supporting nurses to tell their stories was an extension of the stories nurses tell in patient handovers, interdisciplinary meetings and in written documents such as progress notes and incident reports. Collecting stories that revealed their perceptions about the direction and delegation interactions they had been involved in, and the strategies and techniques they used to 'do' delegation, could be captured *in* their stories and *by* their stories.

Polkinghorne (1988) extended Bruner's way of viewing knowledge, reality, truth and knowing in his classic work about narrative and narrative analysis (Polkinghorne, 1988, 1995). Polkinghorne describes *narrative analysis* as a way of knowing and reasoning, which emplots the experiential data into narrative(s), looking for actions and actors, roles and the *plot*, in order to help the audience or reader understand why and how situations were handled in this way, and why and how participants were motivated to act in the way they did. The plot is an organising theme of a narrative and is constructed by, and reflects the view point of the narrator or person telling the story (Polkinghorne, 1988, p. 10; 1995, p. 16). The teller relays their point of view by placing people, events, situations, experiences, perceptions and relationships, and in doing this provides a meaning or point to their story. Narrative analysis is consistent with Bruner's (1986) narrative knowing or a narrative mode of thought approach.

Conversely, Polkinghorne (1988) second way of knowing, *analysis of narratives* classifies events into categories and identifies themes, metaphors and plot lines and places individual actors into a larger *pattern* based on common elements appearing over and over (Polkinghorne, 1995, p. 12). In this dimension, which is consistent with Bruner's (1986) paradigmatic knowing or a paradigmatic mode of analysis, narrative data is analysed to find

common narrative themes, and uses stories as data either by applying previous theory or logical possibilities *to* the data, or inductively identifying concepts *from* the data.

Taking advice from the work of Kramp (2004) who explains that doing both types of analysis can provide a rich analysis of the participants interview stories I drew on both narrative analysis *and* analysis of narratives to analyse and interpret the nurse participants' field texts. To illustrate, 'narrative analysis' gave me the ability to *emplot* the nurses' stories through the use of a data analysis framework I designed which was informed by the work of Kenneth Burke (Burke, 1945, 1969).

Narrative analysis

Burke's life-long work resulted in his critical method which can be used to study the relationships between what people do and why they do it (Burke, 1945, 1969). Burke's pentad captures the talk about the how, why, when, where and who of experience, as Act, Scene, Agent, Agency and Purpose (Burke, 1969). The *Act* is a motivated and purposeful action that represents our attitudes and when the *Act* is aligned with the *Scene* this made visible *how* the nurse participant performed direction and delegation, and *how* and *why* the nurse acted and spoke. The *Agent* is the Enrolled or Registered Nurse who performs the *Act* and leads to questions around what kind of person carried out the *Act*? By identifying the *Agent* I could clearly see what was important to the nurse and how this impacted on delegation decision making with other staff. The place or *Scene* where the action occurs includes both the physical location and the contextual situation, occasion, event and time, and gives context through asking *where* and *when* this particular delegation or direction *Act* was done, or not done. *Agency* can include a sequence of *Acts* including a principle, technique, idea or the method by which an *Agent* achieves their goals and asks *how* was this *Act* done? The *Agency* uncovers the strategies that nurse *Agents* used to achieve their goal when communicating with other nurses and staff during delegation interactions, and how the role of the organisation they worked within shaped their decision making, problem solving and communication choices during direction and delegation. *Agency* also showed the forces in the nurse *Agent*'s busy workplace. *Purpose* acknowledges why the *Agent* acts and asks why the *Act* was done this way. Sometimes the reasons or *Purpose* that people *Act* are obvious and in the open, at other times the *Agent*'s *Purpose* may be hidden. Reasons may be layered and distracting, for example where an apparent good purpose cloaks an underlying selfish motive (Burke, 1945, 1969). By examining *Purpose* the reasons behind a nurse's direction and delegation actions come into view and the motivation to act or speak can be seen. This was a significant part of uncovering the narrative plot for each nurse *Agent* as it spoke to how and why the nurse did what they did and said what they said. This gave the

nurse Agents' stories context and an ability to see beyond *what* was said and done. *Purpose* made clear *how* each nurse Agent coped with direction and delegation or how they coped with the lack of it. The pentad was aligned with the commonplaces contextual framework (Clandinin, 2013; Clandinin & Connelly, 2000; Connelly & Clandinin, 1990) to incorporate temporality, sociality and place which is discussed in more detail in part three. The evolution of the data analysis framework is discussed in the Methods chapter, Chapter four.

Analysis of narratives

Analysis of narratives gave me the rationale to then craft a narrative script for each nurse based on the outcome of the data analysis framework. The narrative script that resulted highlighted both the shared and similar patterns between and across the nurses' stories, as well as the unique and individual stories within their personal and professional stories. The personal and professional stories led to the identification of the narrative plot. I chose to use the term 'script' as it captured the sense of an actor with lines, dialogue and a part to play, projecting their role to an audience. The term 'script' captured the idea that nurses played a role within the act, scene and plot.

Understanding Bruner's and Polkinghorne's insights into modes of knowing and thinking, and how truth and reality are viewed provided me with the guidance I needed when deciding on narrative data collection, interpretation, analysis and presentation of findings (Bruner, 1985, 1986; Kramp, 2004, p. 17; Polkinghorne, 1995). By using both *narrative analysis* and *analyses of narratives* I was able to identify and present the Enrolled and Registered Nurses' shared understanding about direction and delegation roles and responsibilities, and their individual view points and perspectives about communication, leadership, assessment, models of nursing care and decision making during direction and delegation.

Part three: Methodologies and methods

A methodology is a strategy or theoretical plan linking the choice of methods to the desired outcomes. A methodology informs the research methods and makes clear the philosophical assumptions of the approach taken. Conversely, methods are defined as a set of procedures or tools to systematically collect and analyse data (Crotty, 1998, p. 6). While methods are the concrete activities that act as a recipe to describe the conduct of the research inquiry they still require justification within, and for, the methodological approach taken. The procedure, tools and design are presented in the Chapter four, the Methods chapter. This section of the chapter explains and situates the reason for the choice of a narrative inquiry as a methodology and provides a 'plan of attack' to answer the research question: *How do Enrolled and Registered Nurses communicate with each other during the direction and delegation interaction?*

Narrative inquiry as a methodology

Following on from the possible epistemological, ontological and theoretical perspectives of a research study it was apparent that a narrative inquiry methodology would enable an empathetic understanding of storied experience and experiential knowledge (Clandinin, 2013, p. 9). The logic of narrative inquiry methodology lies in its ability to capture the individual participant's unique story and life experiences.

Narrative research has emerged from and is deeply influenced by the social sciences and humanities (Cortazzi, 1993; Ollerenshaw & Creswell, 2002; Riessman, 2008), an observation which has led Ollerenshaw and Creswell (2002, p. 331) to comment that it is unsurprising that consensus on what constitutes narrative research does not exist and that those seeking to use narrative research must "forge their own construction of the narrative procedure". This is shared by Clandinin and Rosiek (2007) who explain that there is a rich and diverse range of doing narrative inquiry. For Clandinin and Rosiek (2007) not only is it acceptable that some narrative inquiry researchers look for stories of personal identity, of social issues or of experience and some researchers use all three approaches, this diversity of approach adds to narrative inquiry's richness (Clandinin & Rosiek, 2007).

With these narrative inquiry methodological guidelines in mind and informed by the professional advice made available to New Zealand Enrolled and Registered Nurses derived from the literature review, I approached nurses to share their direction and delegation perceptions and experiences, including how communication within delegation interactions *did* happen, and how they felt it *should* happen. I encouraged their perceptions about who they believed was accountable during direction and delegation, and describe the knowledge, skills and attitudes they felt were important in order for safe and effective delegation interactions to occur. This study focuses on stories captured in interviews and reflects an understanding of *how* and *why* the nurses did what they did during direction and delegation.

Since narrative inquiry is not interested in relationships of causality or correlation, it was an eloquent methodology for me to first see, and then connect the patterns within the stories of direction or delegation interactions, to the outcome of the nurses actions over time, from the storyteller's point of view (Clandinin, 2013; Clandinin & Connelly, 2000; Gubrium & Holstein, 2009). The narrative produced through the use of exploratory conversations express the nurses' beliefs, attitudes, emotions, motives and interpretations, and highlights the uniqueness of the person and their lived experience rather than their common properties

across cases. Narrative inquiry as a methodology, and method, fulfilled this brief and enabled an exploration of the research question and aims.

Experience centred narratives and plot

Using a narrative inquiry methodology requires the researcher to proceed only with a particular epistemological and ontological view of experience. Based on Dewey's pragmatic philosophy, the phenomena of experience is viewed as the central and fundamental ontological category for narrative inquirers who ground their research in an ontology of experience (Clandinin, 2013, p. 14; Clandinin & Rosiek, 2007, p. 39; Dewey, 1938).

Experience in narrative inquiry is understood *narratively*, as experience is viewed through the commonplace of time, place and sociality (Clandinin & Huber, 2010). The ability to view experience through the commonplace of time, sociality and place is in part what distinguishes narrative inquiry's interest in experience from other methodologies, such as phenomenology for example. Significantly, time, place, plot and scene work together to create the storied experiences as plot lines. Time especially is viewed as essential to the creation of the plot in narrative inquiry (Clandinin & Huber, 2010).

Narrative inquiry is the study of experience as story and plot (Clandinin & Huber, 2010). A plot connects experiences, events and makes the experiences and events into a story (Polkinghorne, 1988). Narrative inquiry provided a structure for placing people, situations and interactions into a meaningful whole that enabled each of the nurse's storied experiences to be arranged into a narrative plot (Clandinin, 2013; Clandinin & Huber, 2010; Connelly & Clandinin, 1990). Their stories were chronologically sequenced with a beginning, a middle and an end. There is a conflict or struggle, and a time sequence that includes past and present actions, and links to a possible future and sequencing leads to a narrative plot line as is consistent with a narrative inquiry approach (Clandinin & Connelly, 2000; Cortazzi, 1993).

The position taken in this study aligns with Clandinin in that narrative inquiry is not just the story shared, or the narrative produced, or a mechanism to obtain information or represent the experience. Rather, it is a way to understand the Enrolled and Registered Nurses' experience of direction or delegation, and lines of accountability through the plot lines within the stories they constructed for themselves and others as: "experience itself is seen as an embodied narrative life composition" (Clandinin, 2013, p. 38).

The Enrolled and Registered Nurses' understanding of themselves and their colleagues, the impact of direction or delegation on patients, the strategies they use to make sense of delegation as a professional competency, and any barriers they encounter during their

interactions are “embedded and embodied in their experience” (Clandinin, 2013, p. 18). I have therefore inquired in a narrative way, to capture the values, beliefs, reasons and purpose for the actions the nurses did or did not take during direction or delegation interactions. Exerts were threaded through their narrative scripts, as Acts that emerged into Agencies or techniques and strategies that told the ‘why’ as well as the ‘what’ and ‘when’ stories of the nurses’ experiences, that eventually became the narrative plot.

A conceptual framework – temporality, sociality and place

Narrative inquiry requires the researcher to understand and inquire into participants’ experiences in partnership with them, over time, in a place or series of places, and in social action with others. This requires thinking about experience with regard to temporality, sociality and place, and is intended as a conceptual framework for narrative inquiry research studies. As Clandinin points out these three “commonplaces” need to be included simultaneously when exploring participant’s experiences, and in this way experience, time, the social environment and place are linked, contextual and related (Clandinin, 2013, p. 38).

Temporality acknowledges the continuity of the person’s storied experiences that are situated and related in a past, present and future time. Experience is not seen as an unrelated series of events but something that is taken up from the present, shaped by it, and carried forward into future possibilities and experiences, and participants and their experiences and events will always be in transition (Connelly & Clandinin, 2006, p. 479).

I viewed the stories that nurse participants told me as temporal because acknowledging time allowed nurse participants to call on their past and bring what they had learned about themselves, their colleagues, situations and events about direction or delegation into the present and consider them as possible futures. I read the transcripts, looking for an understanding of the experiences of the nurse through interpretation, so that I could retell their stories. Connelly and Clandinin (2006, p. 479) clearly describe temporality as the narrative inquirer’s role in that it is more than merely describing a participant. They reinforce *how* participants have “a certain history” associated with their current beliefs, thoughts and actions that might be responsible for projections in the future. This was true for this study and in this way I have woven temporality into the participant’s initial re-story, the data analysis framework and the nurse’s narrative plots.

Sociality is experience viewed as transactional in that experience is socially constructed as people interact with each other and their social and physical environments (Clandinin & Rosiek, 2007). Narrative inquirers work in the particular, and people’s experiences and their

narratives are understood to be personally and socially produced and situated. Socially produced influences include cultural, social, family and institutional influences, and the environment, in which people are experiencing their lives. By acknowledging and including sociality, each participant's embeddedness of experiences are recognised (Clandinin, 2013, p. 40). Personally produced influences include: "feelings, hopes, desire, aesthetic reactions and moral dispositions" (Clandinin, 2013, p. 40; Clandinin, Pushor, & Murray Orr, 2007, p. 23; Clandinin & Rosiek, 2007, p. 69). Personal conditions are acknowledged as being shaped by family stories and expectations, institutional requirements and beliefs as well as the social and cultural requirements people encounter. The relationship of these social and personal influences and conditions to the nurse participant's experiences, and the researcher too, are explored "inward and outward" and "backward and forward" as described by Clandinin (2013, p. 41). In this manner I encouraged the participant to talk about their feelings, beliefs and perceptions about their "good" and "bad" delegation experiences, their organisational expectations and requirements, and the influence of their personal, social and professional nursing values.

Place includes the setting, environment, milieu, geographical location and the physical makeup of the place, as all events are viewed as "taking place in some place" (Clandinin, 2013, p. 41). For Clandinin the places where people grow up and the places they have lived and worked have shaped them in some way. This study was done with attention to each Enrolled and Registered Nurse's workplace so that differences between workplaces, as well as between community, inpatient, and medical, surgical and mental health nursing workplace settings could be acknowledged.

Defining stories and narratives

I opted to use *stories* as a source of data collection. Stories are "continuously unfolding accounts" (Gubrium & Holstein, 2009, p. 228). On the one hand they are bound by narrative inquiry's responsibility to capture the participant's story as told. At the same time they are also boundary-less as they have a responsibility to follow the social or cultural direction sometimes created by the storyteller, and at other times recognised by the researcher. According to Gubrium and Holstein (2009, p. 229) a story is an "unvarnished account" of a person's experiences, events or situation. A narrative on the other hand is seen as a vehicle to explain, justify, confirm, support "or challenge the status quo." Chase describes the narrative as "retrospective meaning making" and the role of sharing our narratives as a person, the "actor", "performing themselves" (Chase, 2005, p. 657). Chase (2013) succinctly describes the narrative as:

a distinct form of discourse: as meaning making through the shaping or ordering of experience, a way of understanding one's own or others actions, of organising events and objects into a meaningful whole, of connecting and seeing the consequences of actions and events over time. Narrative researchers highlight what we can learn about anything - history and society as well as lived experience – by maintaining a focus on narrated lives (Chase, 2013, p. 56).

Connelly and Clandinin (1990, p. 2) considered to be the architects of narrative inquiry, in distinguishing the *story* from the *narrative* wrote:

People by nature lead storied lives and tell stories of those lives, whereas narrative researchers describe such lives, collect and tell stories and write narratives of experience.

In the end what can be said about *stories* and *narratives* is that stories are told by the person and narratives are interpreted, analysed and created by the researcher. As Gubrium and Holstein (2009, p. 30) put it: “narratives are actively and inventively crafted”.

Narrative inquiry's use of the participant's story and the researcher's narratives allows for an “opening up of the mind” and “opening up of the culture” (Cortazzi, 1993, p. 2) making it an obvious choice as a research method and methodology for studying nurses perceptions of their direction and delegation interactions. Narrative inquiry's use of *stories* and *narratives* allowed me to gain an understanding of the nurses' direction and delegation experiences, the social, cultural and political constraints they experienced, and how their 'history' and workplaces had shaped their understanding of delegation. Stories generated rich data which when re-storied into individual stories and plots, were fundamental to the research aims and objectives. Consequently, this study utilised a narrative inquiry methodology and nurse's stories and narratives to interpret Enrolled and Registered Nurses' understanding of the knowledge, skills and attitudes involved in the direction and delegation communication interactions they had been involved in.

Big and small stories

People live storied lives and make sense of their experiences through the telling of stories, and narrative researchers collect and retell stories and write narratives about the person's storied experiences (Connelly & Clandinin, 1990, p. 3). However, there are different types of stories. Big stories are described as the narrative material gathered in interviews, or for autobiographical narratives of a person's life story or a life determining event (Bamberg, 2006). Big stories allow the researcher distance from the significant events shared by the

teller of the story and an opportunity to reflect on them and account for them, such as disclosure in interviews or therapy sessions (Phoenix, 2008, p. 64).

Chase (2013, p. 63) describes how some researchers avoid the privileged position of big stories in favour of small stories because it is these “conversations” that show what is not said as well as what is said, and more importantly *why* and *how* something may not be said, or is not appropriate to share with this audience, at this time. Small stories are naturally occurring events and situations and are often told in passing (Bamberg, 2004, p. 367; 2006, p. 2) and they can be useful in identifying how the narrative is “performed” and how identity is formed (Phoenix, 2008, p. 65). Small stories are a natural feature of everyday lives and include shared and known events, ordinary conversations as talk about the day’s events and future possibilities (Georgakopolou, 2006, p. 150). Phoenix (2008, p. 65) explains that there are a number of ways that the small story and the wider cultural context can be included. She suggests that focusing on the “*minutiae*” of the communication interaction can unearth cultural contexts as well as how and what is said. In this she is concurring with Squire (2008) who writes that it is useful for narrative researchers to go beyond mere content to understand how participants express themselves, and how they use the required or expected “rules” of the cultural environment to make sense of their experiences. Small stories are referred to as “fleeting moments” by Bochner and Rigg (2014, p. 203) and “slices of experience” by Bamberg and Georgakopoulou (2008, p. 5).

I used narrative inquiry’s interest in small stories as a window into the relationship between the regulatory requirement for nursing, and the guidance and support available to nurses in order for them to provide safe and effective direction and delegation. I adopted small stories as a way to provide a respectful and conversational type of interview format so that nurses felt comfortable to share their ordinary stories. However, it must be acknowledged that in the end small stories adopted me. That is, in the interview I found that nurse participants struggled to tell their whole story from start to finish and they resorted to many small stories. In addition, the nurse participant often started the interview process off with an acknowledgment that they felt they did not have anything of major significance to share with me and certainly “no life changing” disclosures. The decision for me to privilege the small stories was further motivated by a desire for nurses to be able to tell their everyday stories about ordinary delegation communication events and interactions, about events almost forgotten, or stories they had not had an opportunity to tell to anyone else before. I was particularly drawn to the idea that the small story can explore unconscious links between ideas and therefore uncover the reasons why people choose a certain course of action (Holloway & Jefferson, 2000, p.

156; Phoenix, 2008, p. 65). It was this insight that influenced the identification of small stories as shared understandings, and personal and professional stories of experience.

Personal and professional stories

Using a narrative inquiry methodology and methods meant that I needed to attend to both personal and social conditions simultaneously (Clandinin & Huber, 2010; Connelly & Clandinin, 1990). Personal conditions include stories about personal knowledge, events experiences and philosophies (Connelly & Clandinin, 2006, p. 148). They are stories that are developed over time as a reaction to the constraints of culturally appropriate narratives and they diverge from the acceptable canonical story line (Bochner, 1997, p. 418). Connelly and Clandinin (2006) point to the need to include how people react, and why and how they responded to an event, experience or situation in the way they did. By identifying personal stories I also hoped to come across “unanticipated narratives” (Cortazzi & Lixian, 2006) that would lead to an understanding and meaning that I might not otherwise encounter.

Direction and delegation happens in the nurse’s workplace and it requires more than one person to be involved and so the nurse’s stories included their communication interactions with their nursing colleagues and other health care professionals, and sometimes the patients in their care. In the telling of their stories that included the purposeful Act that took place, coupled with the Agency or technique they used to make sense of delegation, and the Purpose behind their decision making, professional stories as well as personal stories emerged. In addition to references to their colleagues and patients there was also reference made to the guidance available to the nurses such as their nursing Scope(s) of Practice, the nursing competencies (Nursing Council New Zealand, 2007a, 2012a) and the guidelines on direction and delegation (Nursing Council of New Zealand, 2011b). This resulted in their stories returning to their clinical practice setting and place of work and these became their professional stories. This connection between personal and professional is consistent with Gidron, Turniansky, Tuval, Mansur, and Barak (2011) who explain that professional understanding develops within, and is shaped by, social and cultural contexts.

Canonical narratives

While I have identified canonical narratives in the discussion chapter, a general explanation of ‘canonical’ is included here. Canonical narratives are stories that provide a socially and culturally acceptable story for people to follow in a culture, a society or community and identify how we ‘should’ behave in different situations (Bruner, 1990, 1991, 2002; Phoenix, 2008, p. 66). They are used to identify “breaches of conventions and expectations” (Bochner, 1997, p. 434). Throughout the interview, the re-storying process and the development of the

narrative scripts I was mindful that stories always occur in a cultural context (Bochner & Rigg, 2014, p. 203). Therefore, I was aware of the influence that the professional expectations of nursing might have on nurse participants' stories about delegation. Canonical stories were an entry point for me to further explore how the nurse participant drew on these canonical and nursing expectations of direction and delegation, to make sense of the professional obligation to be delegated to, or to delegate others, and how they felt delegation communication interactions *should* occur.

I found that the adapted data analysis framework I developed enabled me to follow the advice laid down by Phoenix in her chapter on analysing narrative contexts. Phoenix (2008, p. 65) suggests that it is important to go beyond what people say in their personal narratives and acknowledge how and why the teller of the story draws on the wider culture and the canonical to deviate from the culturally accepted response.

Narrative linkage and patterns

Drawing on the methodological plan that I was developing, and cognisant of the underlying narrative inquiry philosophical stance not to reduce nurse's individual experiences to generalisations, I searched for patterns (Clandinin, 2013, p. 132; Clandinin & Connelly, 2000, p. 143; Patton, 2002). Patterns are described by Patton as descriptive findings, whereas a theme takes a more categorical or topical form (Patton, 2002, p. 453). Gubrium and Holstein (2009, p. 226) describe patterns as "horizons of meaning" which use narrative linkage to connect life experiences contained in people's stories that are combined into places, situations and events that convey meaning (Gubrium & Holstein, 1997, p. 148). The Enrolled and Registered Nurse's stories contained patterns on two different levels. Firstly, when the narrative script was developed it became evident that there were patterns *between and across* nurses' stories which offered rich data information for shared understandings about what nurses knew and understood about direction and delegation. Secondly, there were patterns *within* their individual narrative script that pointed to a unique narrative plot as each nurse made sense of the direction and delegation interactions they had been involved in, in different ways, and coped with the various interpretations of it in different ways. Clandinin and Connelly (2000, p. 143) describe this process as an upward move to identify overarching threads rather than a downward reduction to themes.

While many researchers and authors have been referenced to explain the methodology selected for this research, Clandinin and Connelly as the architects of narrative inquiry have provided the guidance for a narrative inquiry approach and methodology. Researchers who have used a narrative approach and authors who offer advice about narrative research have been included as they have provided valuable information related to using stories, narratives, narrative methods, the role of emplotment, plot and experience, and narrative analysis. Burkes pentad was adapted to incorporate Clandinin and Connelly's commonplaces of time, sociality and place so that the narrative plot of each nurse Agent's stories could be made visible.

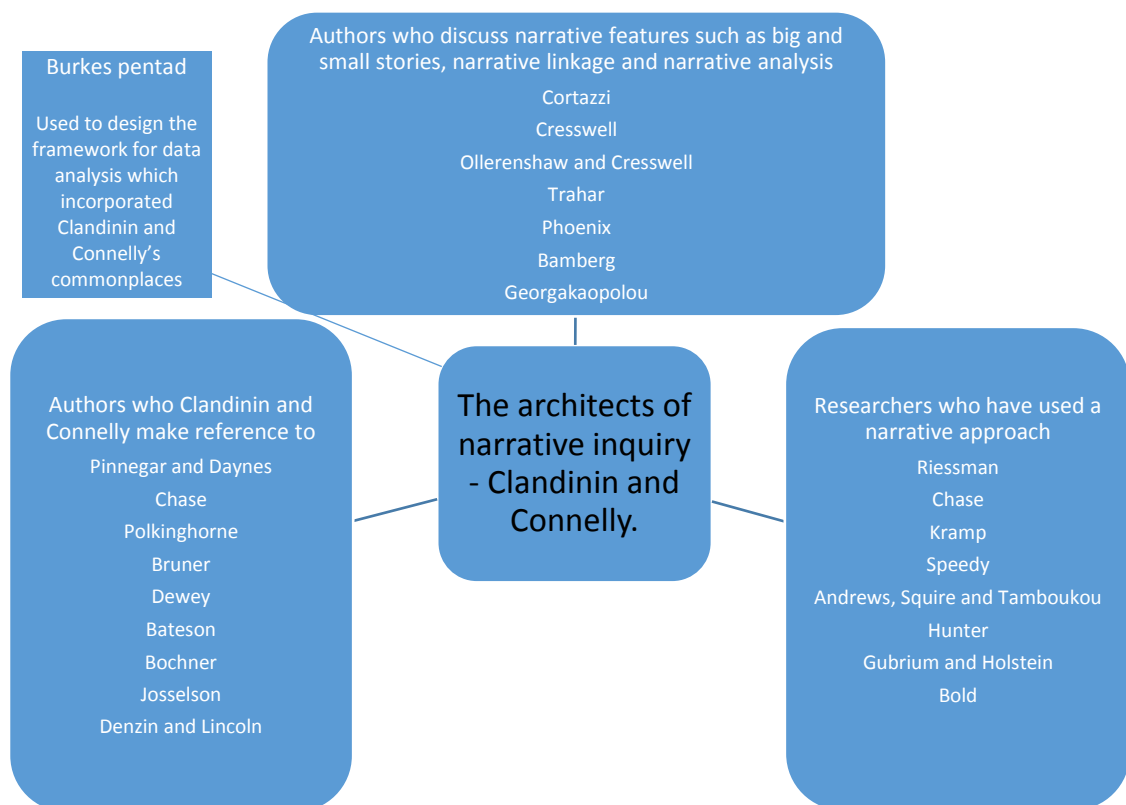


Figure 3.1: The relationship of the architects of narrative inquiry, Clandinin and Connelly, to other researchers and authors related to narrative research and narrative inquiry.

Part four: The rationale for the research design and qualitative methods of data collection

This section of the chapter provides an explanation of the research design choices and the influence of this decision choice on the data collection methods. A descriptive, exploratory design using qualitative methods was chosen because this design reflected the research

question and aims, and the purpose of the study. Descriptive designs are suitable for describing and representing factors, issues or concerns relevant to the research question. Descriptive studies offered nurse participants an opportunity to describe events, situations and experiences in their own words, express themselves and have their voice heard in a focused way (Boeiji, 2010).

An exploratory design is suitable for projects where little knowledge exists, a problem is not well understood, or there are no relevant research studies related to the research question, aim or objectives of the study (Boeiji, 2010). Exploratory designs provide an opportunity to ask the 'why' questions. Exploratory research offered a degree of controlled flexibility in that the data collection could be adjusted to emerging findings (Boeiji, 2010), and adapted when the nurse participant felt they had something of importance to share with the researcher. A qualitative exploratory descriptive design made obvious that a qualitative methods approach was needed. The choice of qualitative research methods meant that I could gather texts and stories that captured the Enrolled and Registered Nurses' different experiences. Qualitative methods enabled the nurse participants' perspectives and their multiple realities (Boeiji, 2010) in relation to the direction and delegation interactions they had been involved in, to be valued.

Qualitative methods gave nurses permission to talk from their own unique point of view and not from within the confines of pre-determined topics that might not have been applicable to their experience, situation and events. The qualitative data collection method I chose was an interview because it was suitable for exploring experiences and developing a richer and deeper understanding of nurses' direction and delegation experiences, perceptions, opinions, feelings and knowledge by including what Miles and Huberman refer to as 'diversity' and 'context' (Miles & Huberman, 1994). I was able to gather information about the "life world" or everyday experiences and events of the participant (Kvale, 1996, p. 149; Patton, 2002, p. 4). As Munhall (2012, p. 428) states the interview format is the most appropriate vehicle for narrative research as richness of information can be developed when the interviews are coupled with historical or archival information.

An interview format was the most suitable format because of the potentially vulnerable position nurse participants may be placing themselves in the interview in that nurses were being asked to share the personal and professional interactions they had had with other nurses, and the delegation relationships in which they had been involved. During discussions with nursing peers and other researchers it was posited that some nurses may have experienced challenging or distressing delegation exchanges and these situations would be more ably captured when the participants felt in control of sharing their stories within the interview

format. Qualitative research affords this opportunity “within well-defined research limits” (Boeiji, 2010, p. 12).

In addition, the exploratory nature of qualitative open ended interview methods produces in-depth insights not previously known about the research question or aims, and gave access to asking nurses what they did and said and felt in real life rather than asking them to comment specifically on the research question and aims (Silverman, 2010, p. 166). This proved to be an accurate assessment of qualitative open ended interviews because I was able to explore what direction and delegation *meant* to the nurse, what they did about it, how it affected them and what they *felt* about it, if that was what was important the nurse Agent. This brought into focus the need for a qualitative open ended in-depth interview method (Patton, 2002, p. 4). In doing this the face to face aspect of an in-depth interview also afforded me an opportunity to respond to nonverbal clues such as laughing, disgust, rolling of eyes, raised eye brows, silences, confusion, inability to answer a question, and what was not said.

A semi-structured open ended in-depth interview with prompt suggestions allowed for a subjective approach to describe and explore people’s perceptions and beliefs, and give meaning to their everyday lived experiences (Schneider, Elliot, Lo Biondo-Wood, & Haber, 1999 p. 140). The interactive relationship between the qualitative narrative researcher and the participant within a semi-structured open ended in-depth interview supports opportunities for meaning to be mutually constructed as is consistent with a constructivist approach (Silverman, 2010). Detailed information about personal and professional situations and events therefore enables rich, thick descriptions to be produced about the complexities of a phenomena.

In the end the choice of a qualitative semi-structured interview with prompt suggestions and a non-directive form of “questioning” (Crotty, 1998, p. 7) as a data collection method was inarguable because it enabled nurse’s knowledge of, and perceptions about direction and delegation to be studied “holistically and contextually” (Schneider et al., 1999 p. 141). The nurse participants were able to describe their delegation interactions and experiences, how they saw themselves in relation to their colleagues in other areas and in relation to the roles and responsibilities within their Scope of Practice, from their own individual point of view. Semi-structured interviews were useful as they enabled me as the researcher to focus on what the participant wanted to say, and explore what was not known or fully understood about their experience, event or situation. Further, open ended discussions allowed for unanticipated responses in conversation.

Narrative interviewing is not a traditional question and answer approach with a questioning interviewer and a “vessel like” respondent (Riessman, 2008, p. 23). The narrative inquiry jointly constructs narrative meaning over time. This is supported by Chase (2005, p. 643) who states that interviews are always conversations and it can never be a neutral tool because the interview method can be influenced by the interviewers race, class and gender. Interviews as conversations require at least two people to be involved in the interaction and it is always a collaboration. Inquirers and participants are co-equals and the outcome of the interview can be an important tool as a vehicle for social change.

The qualitative data collection methods chosen for this study enabled iterative data collection and analysis so that each interview could be written up, reflected on and examined before the next interview took place. Each interview could be explored for questions that did not work or were avoided, and new information that emerged not previously known or imagined. This inductive approach to data collection and analysis is well suited to qualitative methods as it allows for any patterns to emerge from the data within each interview, and are not imposed on the data, and is therefore able to identify multiple realities (Lincoln & Guba, 1985, p. 203).

Part five: Limitations and challenges of a narrative research approach

Despite narrative research’s many supporters it has its detractors too. This section of the chapter discusses the issues and concerns that some researchers and scholars with different world views have about the narrative inquiry methodology. These are presented here in support of a balanced critique. Some readers of narrative research criticise the approach seeing it as no more than “telling stories.” Trahar (2009) discusses the role of re-storying in that the narrative produced and how the participant’s initial story is re-storied by the researcher is vital to the success of the narrative approach (Trahar, 2009, p. 6). She points out that the researcher who presents the person’s story verbatim as an “authentic” representation of the participant’s story, as some opponents of narrative research expect, is doing narrative inquiry and narrative research a disservice. Trahar (2009) identifies a further criticism often levelled at narrative research in that narrative researchers resist a “collective understanding” in favour of privileging the individual participant’s voice. While this is an accurate assessment of a narrative approach it is not viewed as a negative feature within narrative research circles.

Many researchers acknowledge that narrative inquiry is challenging (Andrews et al., 2008; Chase, 2013, p. 21; Clandinin et al., 2007, p. 44). Andrews admits it has no clear starting or

finishing point, there are no clear definitions of the term ‘narrative’ and no clear rules or accounts of how to capture the data or how to analyse it once it has been captured (Andrews et al., 2008). The researcher requires skills in distilling the essence of the person’s story in the face of large amounts of field texts and information. Relaying a story requires the inclusion of specific methodological requirements such as temporality, sociality and place, context, experience and continuity. It is an approach that requires the researcher to clearly and honestly reflect and explain to the audience their own philosophical and political interests in the research phenomena as these interests inevitably influence how the re-story and narrative will be shaped and presented (Clandinin, 2013, p. 21; Clandinin et al., 2007, p. 39). In addition to this the researcher needs to work in a true and actual partnership with the participant and this needs to be re-negotiated at times throughout the research study making it a time consuming research choice. It is this very need for a partnership relationship between the researcher and participant, that is often the subject of further critique (Atkinson, 1997; Riley & Hawe, 2005).

Narrative research has often been critiqued by others outside the narrative field as being “more art than research” (Lieblich et al., 1998, p. 1). Lieblich et al. (1998) suggests that development of a research study needs clear working rules, and a clear identification of the narrative approach, design, and methods, a practical concept supported by (Clandinin, 2013; Clandinin et al., 2007; Riessman, 2008). The critique of narrative research included here makes acceptance of narrative research a challenge for some researchers, especially if they have been immersed in other paradigms.

Part six: A description of the reflexive considerations for the research study

Andrews et al. (2008) describe narrative inquirers as being a crucial part of the research process, and the data collection process especially. The researcher’s presence and location in the research study, and the foot print left in the research journey must be accounted for. For this reason this section of the chapter describes reflexivity and explores the reflexive considerations that needed to be made in order to make the research process, the methodological and methods choices transparent.

Etherington (2004, p. 32) views reflexivity as a form of reflective rigour that requires the researcher to acknowledge how their own experiences, thoughts, feelings, culture, and social and personal history can influence the written and verbal dialogue produced, thereby impacting the research process and the research outcomes. A reflexive researcher opens up the research process and exposes their preconceptions.

A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions (Malterud, 2001, p. 483-484).

The role of the researcher in narrative inquiry

In the end the narrative that is produced will be shaped by the researcher, the teller of the story and the *receiver* of the story, the audience. This occurs when stories are told differently depending on who the audience is. The main role of the narrative inquiry researcher is to negotiate the meaning of the stories created with the participant (Pinnegar & Daynes, 2007, p. 15). This means that the narrative is always a collaboration and therefore it is co-created as a “joint production” between the researcher as “audience” and the participant as “actor.” The potential for both the researcher and the participant to be changed by the process and gain insight into their own lives is created (Chase, 2005; Clandinin, 2013, p. 46; Clandinin et al., 2007, p. 23; Riessman, 2008, p. 31; Salmon & Riessman, 2008, p. 78).

My role as narrative inquirer was not to produce representations of the ‘one truth’, and one reality, but to provide a new way of understanding each of the nurse participant’s delegation milieu. I believe that knowledge, reality and truth came from the participants sharing their everyday experiences through their story telling. Towards this end, throughout the construction and implementation of the research study I treated the gathering of field texts and the interview setting as a relationship between myself and the nurse participant. This also included the ‘others’ who although not present, were nonetheless spoken about or referred to during the interviews. In this I attempted always to emulate the ethical and relational relationship described by Clandinin (2013, p. 197) that can only have been achieved by being in a research relationship rather than a finite transaction. It is an important enough point to mention for a second time that my role as a narrative inquiry researcher was never intended to be objective as I brought with me, as did the nurse participant, a culture, a history and a world view, and this meant that the possibility of questions about objectivity and factuality faded into the backdrop.

Some narrative inquiry researchers choose to include their own voice by narrating the story from the background, and other narrative researchers amplify their own voice by including it as the researcher within the narrative. I believe as Chase (2005) and (Clandinin & Connelly, 2000, p. 122) do, that narrative inquiry emphasises and amplifies the participant’s voice.

Voice refers to *how* the person talked, the social influences and constraints they have experienced, as well as *what* they talked about. Therefore, it was the nurse participant’s

version of self, their reality, experiences and perceptions that I spotlighted and brought to the fore.

In the following section, Part seven, I have included my reflections on how some nurses' I came into contact with struggled to make sense of direction and delegation and the reasons for my interest in delegation. Part seven also includes my interest in narrative inquiry methods as a methodology and the almost 'obviousness' I arrived at that narrative inquiry was the best methodology for this study and why. On a practical level this desire for transparency through reflexivity manifested itself in the following ways. To assist nurse Agents to tell *their* story and ensure that it was captured as intended only one researcher was involved in data collection and analysis, and this prevented any distortion of the interview process (Squire, 2008, p. 50). Further to this I discussed my research decision making processes with my supervisors' each week throughout the six years of this current study which necessitated a justification of my thinking at times, and a rethinking of my choices at other times.

Discussions with my peers made me look at my assumptions and values which proved useful when designing the interview prompts and exploring philosophical concepts around my beliefs in a subjective, social constructionist and interpretive approach to research. Discussion with my supervisors was enhanced by the use of a reflexive journal which reflected the journey I was on and the thinking required of the methodological choices I made. The journal recorded what I (grandly) came to call "epiphanies" at the time, which in reality often turned out to be no such thing, but sometimes were. An example of one of the epiphanies was in viewing my analysis framework as a "prism" that refracted the stories nurses told into experiences, their motivations and how they made sense of the delegation. Finally, the decision making rationale that sometimes shaped and shifted the research data collection methods has been explained in detail.

Part seven: "Puzzling" and "wondering" about direction and delegation

In narrative inquiry studies identification of the researcher's personal and professional interests in the phenomena of study and the social, cultural and political position of the researcher must be made apparent and transparent (Clandinin, 2013). Clandinin (2013, p. 42) refers to this interest as the "puzzling" and "wondering" that occurs before a research study is fully formed or even considered, and in looking back on my research journal, puzzling and wondering were evident throughout this time. Therefore, my interest in nursing direction and delegation is expressly presented here in this section of the methodology chapter.

Part of my role as a clinical lecturer where I work is to educate and inform Enrolled and Bachelor of Nursing students about their Scope of Practice and the

delegation role. My position as clinical and theory lecturer also meant that I was asked to speak to Enrolled and Registered Nurses in acute medical, surgical and mental health clinical work-areas about the new Enrolled Nurse education, their roles and responsibilities, and the Enrolled Nurse Scope of Practice. I found that many of the Registered Nurses I spoke to had never been involved in direction and delegation or worked with an Enrolled Nurse before. I myself had come up through the ranks of nursing in the days when Enrolled Nurse training in New Zealand had stopped. I had worked with experienced Enrolled Nurses in my time who had helped me and worked alongside me. It never occurred to me that I had to 'supervise' their practice and looking back I remember thinking they knew more than me anyway. Some of them had been Enrolled Nurses longer than I had been alive. It hadn't been part of my thinking at the time but I now realise that I had never worked with a new graduate Enrolled Nurse.

Some Registered Nurses shared with me that they did not understand that there were Level 4 and 5 Enrolled Nurses, or what that even meant for them as a Registered Nurse. They were also confused about who was accountable. This was because New Zealand had stopped educating Enrolled Nurses some 20 years earlier and this had resulted in a whole cohort of Registered Nurses in some clinical settings who had never worked with Enrolled Nurses. Some of the Registered Nurses were uncertain about how to work alongside an Enrolled Nurse and most were confused about what an Enrolled Nurse could do and where they were able to work. I had also been a member of that cohort of Registered Nurses in the days when nursing in New Zealand was moving to a Registered Nurse only workforce. Therefore, I had some empathy for Registered Nurses trying to work within a delegation relationship but with no or little experience of it, or guidance about how to do it.

When the Enrolled Nurse students returned from their clinical placements to the class room many of them reported that they had seen and experienced some negative experiences and worrying interactions between nurses. As I continued to talk to Enrolled and Registered Nurses in the clinical settings in my role as clinical lecturer it became apparent that there was some confusion around the direction and delegation role.

I decided to look for articles and nursing literature to see if I could find anything about how to carry out this professional responsibility and how to direct and

delegate in order to support my own class room teaching of delegation, and to support my nursing colleagues in clinical settings. More and more Enrolled Nurses were being educated throughout New Zealand now and this appeared to be putting pressure on nursing staff in some workplaces who were just expected to get on with the delegating tasks. While I found the 'Guideline: Responsibility for direction and delegation of care to an Enrolled Nurse' (NCNZ, 2011) and 'Guideline: Delegation of care by a Registered Nurse to a health care assistant' (NZNC 2011) I could not find or recommend any other literature to help nurses to "do" delegation. It seemed that nurses were told they had to do it, it was stated in their Scope of Practice and competencies, and the Guidelines gave some broad brush strokes information and a definition of direction and delegation but there were no other nursing documents or guidance that specifically provided the information they were asking for. The overseas literature, predominantly from America showed that communication between the Registered Nurse and a second level workforce generally speaking showed some tensions and problems but did this relate to the New Zealand scene?

There were no lists that explained what an Enrolled Nurse could or couldn't do in different workplaces either. While I understood that what they can and can't do will differ from workplace to workplace novices to the study of direction and delegation often asked for a list. As a nursing educator I had knowledge of nursing, nursing direction and delegation and the teaching of it for both Enrolled and Registered Nurses and because of my now growing interest in delegation I understood the frustration for both new and experienced Enrolled and Registered Nurses about the lack of information they needed to make informed decisions around delegation.

I was being asked questions about delegation as a clinical lecturer, and it made me wonder what guidance was available to nurses trying to make delegation work with the newly emerging Enrolled Nurse graduates in busy, rushed, clinical settings. How did they or would they learn to carry out this professional responsibility in practice settings? I knew what Enrolled Nurse students were being taught in my own classes because of my role in teaching them, but how were already graduated Enrolled and Registered Nurses learning the "how to" in clinical areas? How had current practicing Registered Nurses been prepared for "new" Enrolled Nurse students and possible future employment of Enrolled Nurses? And what was actually happening at the coal face between busy nurses charged with making direction and delegation work?

The changes in Enrolled Nurse education, employment opportunities, nursing skill mix in clinical areas, and potentially an increase in Enrolled and Registered Nurse communication interactions around delegation, led me to wonder if this was just merely an expected part of working in a dynamic health system, or a recipe for challenges in nursing relationships, communication styles, and the educational support that nurses needed.

As a nurse, nursing educator (and sometimes consumer of health services) I am vitally interested in the process and outcome of direction and delegation interactions on nursing practice, the nursing profession and patient physical and emotional safety. The ‘wondering’ and ‘puzzling’ that went on for many months as a clinical nursing lecturer led me to this research study. At this point in the journey I also had a growing interest in, and knowledge of, the narrative inquiry process. The more I read about narrative inquiry the more it made sense to me and I could immediately see the usefulness in nurses’ being supported to tell their stories about delegation interactions, given that nurses’ tell stories about patients in handovers and progress notes, in interdisciplinary meetings and to each other at break times, and to patients when supporting health promotion and health education. I believed that by listening to and interpreting nurses stories about direction and delegation the questions they were asking about the roles could be honoured, and given voice. (Reflexive journal, October 2011).

Summary of the methodology

This chapter has provided a set of signposts that describe the thinking and decision making that eventually shaped the research study into nurses’ storied experiences of direction and delegation. Part one to seven reconciled a subjective epistemology with the social constructionist, interpretive theoretical perspective taken, and a narrative inquiry methodology using qualitative methods. The chapter provided a rationale for the use of experience centred narratives as suggested by (Chase, 2013, p. 56; Connelly & Clandinin, 1990, p. 2; 2006, p. 477; Squire, 2008, p. 41). The rationale for a narrative approach to nurses’ stories necessitated a discussion on the narrative turn as the turn *towards* narrative methodologies and away from a positivist stance. In order to support a balanced and transparent decision making process within the research study some of the limitations of narrative inquiry as viewed from other theoretical perspectives have been included in this section. Leading on from the discussion and exploration of the narrative inquiry methodology

in this chapter, the next chapter examines the methods employed in this current research study.

The art of raising challenging questions is easily as important as the art of giving clear answers (Jerome Bruner. The Culture of Education, 1996, p127).

Chapter four. Methods

Introduction

Chapter four describes the methods selected for this research study in relation to nurses' communication interactions during direction and delegation. The goal of the Methods chapter is to provide an explanation of the design of this study and includes a description of the detailed planning that was involved in the sampling methods, inclusion criteria, participant recruitment, data collection and analysis procedures, and the ethical and trustworthiness considerations selected to gather and analyse the data. For clarity a visual representation of the main steps within the research process, from the initial wondering about direction and delegation to the final chapter of the thesis is provided in Appendix B.

Sample size, inclusion criteria and population

Sample size

In order to achieve rich, thick descriptions of participant's experiences the sample size should not be either too large or too small. Large sample sizes in qualitative research result in unwieldy amounts of data (Onwuegbuzie & Leech, 2007) and small sample sizes make informational redundancy whereby no new information is forthcoming, difficult to achieve (Lincoln & Guba, 1985, p. 202). I had originally intended to undertake 30 interviews but the sampling strategies employed and described in this section continued to attract prospective participants after this goal had been reached. This was more so the case for Enrolled Nurses than for Registered Nurses as many of the Enrolled Nurses explained in the interview that they felt they had been given a voice about delegation for the first time. I eventually decided on a sample size of 34 nurse Agents. While it initially appeared to be a large sample size for a research study using qualitative methods, it needed to include two groups of nurses, both Enrolled and Registered Nurses. The final sample size of 36 nurse participants accommodated 17 Registered and 19 Enrolled Nurses. I found that by the 32nd interview I had reached informational redundancy.

Inclusion criteria

The inclusion criteria included all nurses holding a current practicing certificate, who were registered with the NCNZ and who were currently employed as nurses in Canterbury.

Population

For the purposes of this study the terms ‘experienced’ and ‘less experienced’ nurses were used. I defined ‘experience’ as a nurse with five or more years of nursing experience. I avoided using the term ‘new graduate’ when possible because it could potentially identify some of the nurse Agents in such a small sample size and local area. All Enrolled and Registered Nurses employed part time or full time within public and private hospital or community settings from the Canterbury region were eligible to participate in the study.

Sample location

The research study was limited to the Canterbury region as opposed to all Enrolled and Registered Nurses throughout New Zealand. Canterbury was chosen because the past and present employment policies and opportunities for Enrolled Nurses in Canterbury meant that both experienced and less experienced Enrolled and Registered Nurses were represented in the population. As such both Enrolled and Registered Nurses were available as potential participants and as the study was self-funded, travel to South Canterbury, Mid Canterbury and North Canterbury was affordable.

Sampling design

A purposive-purposeful sampling design is appropriate to qualitative narrative research approaches as the researcher selects people who meet the inclusion criteria and who are able to participate in an “information rich way” (Patton, 1990; Schneider et al., 1999 p. 145). Purposive sampling was used to select nurses who came from two District Health Boards and nurses who were employed in community or private agencies including medical, surgical, mental health, rehabilitation, outpatients and older care settings. Purposive sampling can also assist with the discovery of opposing points of view. This ensured that a narrative could be authored that reflected the experienced and less experienced Enrolled and Registered Nurse participant’s journey, their perspectives and perceptions about their direction, delegation and accountability experiences, and the communication interactions they had.

The initial point of contact in accessing nurse participants for the study was a brief information piece about the impending research project published in the New Zealand Nurses Organisation (NZNO) nursing journal: *Kai Tiaki Nursing New Zealand*. The article concluded with a request that asked for Enrolled and Registered Nurse volunteers who lived in the Canterbury region and who were interested in the topic of delegation to contact the researcher. Seventeen nurse participants volunteered to be part of the study in response to the information article. They were predominantly Enrolled Nurses with fewer Registered Nurses

responding. Table 4.1 below presents the text of the Kai Tiaki information article published in March 2013 which outlined the rationale for the study and asked for participants.

Table 4.1 - Information article published in Kai Tiaki Nursing New Zealand

I am doing a research study into how, when and why Enrolled and Registered Nurses (RNs and ENs) direct and delegate in hospital and community settings in Canterbury. The method I am using is narrative inquiry, so nurses can talk to me about their experiences and the interactions they have had with each other, including what worked well and what didn't work so well when communicating within the direction and delegation relationship. I also want to know how nurses learned about direction and delegation, and what other supports nurses would like, or feel they need, to improve their direction and delegation skills.

I work at Christchurch Polytechnic Institute of Technology in the EN and Bachelor of Nursing programmes. I have received ethics approval for the research and would like to start interviewing as soon as possible. If you would like to be part of the study, I will supply the questions before the interview so you know exactly what you will be asked. I would like to interview 15 RNs and 15 ENs from hospital and community settings across a variety of nursing areas in Canterbury. The interview takes approximately one hour.

I believe direction and delegation is an important topic because it supports professional communication between RNs and ENs when carrying out this important professional responsibility; it aids job satisfaction and professional relationships; and ultimately supports patient safety. If you are interested in being part of this study, please contact me on email Margaret.hughes@cpit.ac.nz or phone 03 940 8044 and I will send you an information sheet.

Marg Hughes, senior lecturer, School of Nursing, Christchurch Polytechnic Institute of Technology

(Kai Tiaki Nursing New Zealand, March 2013)

Two sampling strategies, snowballing and opportunist strategies were utilised. Snowballing is a sampling strategy employed when additional information rich participants are required to inform the research problem statement, question and aims and current participants recommend other people who are experiencing the phenomena under study (Patton, 1990, p176). Snowballing occurred when the nurse participants who had responded to the information piece in the NZNO's Kai Tiaki Nursing New Zealand journal and were part of the study, then communicated with other Enrolled and Registered Nurse colleagues about the direction and delegation research study. These newly informed Enrolled and Registered Nurses then contacted me to request to be part of the study.

Opportunistic sampling strategies involve immediate sampling to take advantage of new opportunities after field work has started, during data collection for instance. Opportunistic sampling allows the researcher to take advantage of "whatever unfolds as it unfolds" (Patton, 1990, p. 179). An opportunity to gather more Registered Nurse participants for the study occurred when a Registered Nurse who had been a pilot participant offered to reach out to

other Registered Nurses who met the inclusion criteria. It had become obvious during the data collection stage that more Enrolled Nurses had made contact to be considered for the study as at that stage only seven Registered Nurses had volunteered. The Registered Nurse offered to email other Registered Nurses in her workplace, and an email was sent to them with my details in order for them to make contact with me if they wanted to be part of the study. Eight more Registered Nurses responded to this request.

A second opportunity arose to widen the request for Enrolled Nurse participants when one of the participants suggested I contact the Enrolled Nurse arm of the NZNO and from this opportunity six more Enrolled Nurses responded to an email request for nurse participants. The following table, Table 4.2, provides the information that supported the sampling strategies.

Table 4.2 – Sampling strategies leading to recruitment of Enrolled and Registered Nurses

Sampling strategy and method	Registered Nurses	Enrolled Nurses
Initial response to the information piece about the research in <i>Kai Tiaki Nursing New Zealand</i>	7	10
Snowballing sampling strategy through nurses communication with each other	2	3
Opportunistic sampling strategy through: <ul style="list-style-type: none"> • email from RN pilot participant to other RNs in her work area 	8	-
Opportunistic sampling strategy through: <ul style="list-style-type: none"> • email to EN members of the NZNO 	-	6
Totals:	17	19
36 Enrolled and Registered Nurses in total made contact to be part of study		

While 36 nurses responded to the sampling strategies, two of the Registered Nurses requested that they do the interview together and this was therefore considered as one interview. This was also the case for two Enrolled Nurses who wanted to be interviewed together. Seventeen Registered Nurses and 19 Enrolled Nurses volunteered to be part of the interview process

which resulted in 34 interviews. The age group of the nurses who volunteered to be part of the study ranged between 22 and 64 years of age. One of the nurse Agents was male which is representative of the ratio of male to female nurses and is reflective of the nursing community. One nurse Agent, a Registered Nurse identified as Māori. None of the nurse Agents withdrew from the study. The Enrolled and Registered Nurse Agents are introduced in further detail in Appendix C of the Appendices section as **‘Introducing the nurse Agents’**. Introducing the Agents provides further details about the nurse Agent’s place of work, their nursing environment and experience, and the rationale for the initial re-story.

An inevitable consequence of the regional area chosen for my study was that I knew some of the nurses who volunteered to be nurse participants. Over the course of my nursing career I had taught some of the Enrolled and Registered Nurses, and I had also worked alongside some of the Registered Nurses who volunteered to be part of the study. Being mindful of the damage that unintended bias can cause, coupled with a robust plan for trustworthiness and rigour as discussed at the end of this chapter, ensured I was an audience to their storied experiences of direction and delegation, and my teaching and nursing practices were not part of the research study outcome.

Data collection methods

All nurses who indicated that they would like to participate in the study responded to me by phone or email, if they felt they met the inclusion criteria. I contacted them to arrange for a letter of invitation, an information sheet and a consent form to be sent to them so that they could make an informed decision in their own time, to participate or not (See Appendices D, E and F).

Piloting of the interview schedule

A face to face interview data collection method was chosen because it was suitable for exploring nurse Agents’ perceptions, strategies and intentions, and developing a richer and deeper understanding of their direction and delegation experiences. An interview enables the researcher to gather information about the “life world” or everyday experiences and events of the participant (Kvale, 1996, p. 149). Further, Munhall (2012, p. 428) states that the interview format is the most appropriate vehicle for narrative research as “richness of information” can be developed and augmented further when the interviews are coupled with historical or archival information, and this matched my own research intentions.

The initial concept of narrative inquiry methods rested on the belief that nurses would be able to “tell their story” (Clandinin & Connelly, 2000) about the direction and delegation

interactions in which they had been involved. The research aimed to interpret the meaning nurses ascribed to their everyday communication experiences and their cultural understanding of direction and delegation. Initially an unstructured interview was chosen for this purpose. An open ended interview schedule with one opening question was piloted with four participants, who were representative of the larger group before administering the interview to the others.

The pilot study included two Enrolled Nurses and two Registered Nurses from medical, surgical and mental health clinical settings. The piloting process was useful for testing the length of the interview and whether the opening question worked for the participants. The pilot study illustrated that it was difficult for participants to share their stories unfettered and with a constant flow of ideas. It highlighted the fact that the participant could not tell their “story” like a novel with a beginning, a middle and an end, or in one continuous stream of ideas. That is, their interview included many small stories rather than one big story.

Based on the participants’ experiences during the pilot interviews, the wording in the interview schedule was altered so that the questions were presented as prompt suggestions. This changed the expectation from answering every question to the questions being a support mechanism to guide the participant to tell the stories that mattered to them. The prompts were designed so that the participant could select or ignore them depending on the nurse’s place of work, or personal and professional choice. I took advice from the work of Riessman who recommends that for some people one question at the beginning of an interview works well and they will be able to tell their story, but for other people prompts and further time will help them to recall other facts, emotions, turning points and details (Riessman, 1990). The inclusion of prompt suggestions resulted in a slightly more semi-structured interview approach and enabled me to follow the participant down their chosen path within the conversation. I initially believed that a more structured interview approach would limit the participant’s responses. It transpired that the opposite of this belief was true, and the prompt suggestions seemed to open up the nurse participant’s ability to share a number of smaller everyday stories within their interview.

It did mean though that I had to give up control of the interview as the participant was now “in charge” of the choice of topics for discussion and this did not come easy to me in the beginning. I was concerned that I would not be able to get everything I needed to address the research question and aims. However, each interview became a journey with a different set of experiences and perceptions that I had never envisaged in the beginning which added to the richness of the data. Riessman describes this as the researcher following the participant down

a trail and the need for the research-inquirer to “give up control” (Riessman, 2008, p. 25). The ability to give up control in this way was a salient lesson for me about the narrative researcher’s relationship with a participant. Giving up control of the interview required a sharing of power and a sharing of responsibility between myself as the researcher, and the participant, and it was this that was at the heart of my decision to include prompt suggestions and to empower the participant to select the prompts they wished to discuss. This gave the nurse participant the power to talk to me about what was important to them.

The interview schedule

The concepts found when reviewing the New Zealand and overseas literature in relation to communication interactions between nurses were used to inform the selection of the interview prompts chosen to include in the interview schedule. The literature on delegation points to some possible influences that impact on nurses relationships such as the need for respect, and the type of leadership style used in the workplace (Huynh et al., 2011, p. 10). Teamwork, timely and continuous communication and managing conflict have also been identified as important skills (Potter et al., 2010, p. 157). Coordination, professionalism and problem solving skills are cited by (Dougherty & Larson, 2010, p. 17) as well as collaboration (Apker, Propp, Zabava Ford, & Hofmeister, 2006). Although these perceptions and ideas may differ to current New Zealand nurses’ direction and delegation experiences, they were used to guide the design of the prompt suggestions within the interview schedule.

The opening question in the interview was:

“Can you tell me about your recollections of the direction and delegation interactions you have been involved in?”

The interview schedule provided a selection of prompts as suggestions for nurse participants to choose from, or reject. The interview schedule for both Enrolled and Registered Nurses is provided in Appendix G.

Narrative field texts as data collection

Data collection of field texts in narrative inquiry is always a co-composition. Field texts are collaboratively created, composed or co-composed by participants and inquirers. They are subjective and they are reflective of both the researchers and participant’s experiences (Clandinin, 2013, p. 46; Riessman, 2008, p. 31).

In order to support a collaborative relationship and extend the sharing of power and control during field text collection, I started the interview relationship well before the interview appointment. The interview question with prompt suggestions was sent to the participant after

they consented to be part of the research and prior to the interview. This process contributed to them feeling fully informed. The motivation behind supplying the interview schedule to the nurse Agents was three-fold. Firstly, it was consistent with a narrative inquiry approach for the researcher to be transparent and open in their approach. Secondly, it was anticipated that this step would increase engagement with the interview process because the nurse Agent knew the questions they would be asked before arriving at the interview. Therefore, they had a choice whether to answer, and were comfortable about which topics to share with the researcher. Thirdly, this was done in a spirit of providing a research environment where the nurse Agents felt respected and safe to share their personal and professional beliefs, experiences and perceptions about the direction and delegation interactions they had been a part of.

An unexpected and positive result of sending the interview schedule out to nurse Agents prior to the interview was that many nurses came to the interview prepared with journal entries, notes, examples, certificates, photos or documents from their past. These artefacts became part of the field text data collection process as their inclusion afforded the opportunity for discussion with the nurse Agent on topics that may not have occurred without these visual triggers (Clandinin, 2013; Clandinin & Connelly, 2000, p. 46).

A semi-structured face-to-face interview with prompt suggestions was undertaken as opposed to a survey or focus groups. A semi-structured face-to-face interview with prompts enabled nurse Agents to talk freely about topics of importance to them. Further, it afforded an opportunity for me to observe facial expression, body language, first impressions, and how ideas were shared and expressed. The observation of these non-verbal responses were captured in the field text data collection process and I used my observations to encourage the nurse Agents to provide more information if needed. A face-to-face interview offered the nurse Agent an opportunity to clarify any questions they had about the research process and the interview prompt suggestions which could not be accommodated by a survey. Privacy and confidentiality of the information important to the nurse Agent was supported by a face-to-face interview as opposed to a focus group. The interviews were audio recorded and transcribed and notes were taken throughout the interview. An email follow-up was required after the interview with some of the nurse participants, for clarification of concepts and ideas shared to ensure that the information gathered in the interview reflected what the participant had intended to say. I was the only interviewer involved in the data collection process. One experienced, recommended and referenced transcriber was also employed who signed a confidentiality agreement. While the transcription occurred verbatim, any identifying

references to facilities or names of people were not used in the re-story, the shared understandings, the personal and professional stories of experience, or the narrative plots.

Joint construction of narrative meaning

A narrative interview jointly constructs narrative meaning over time as the two way conversations within the interview can generate detailed accounts and thick descriptions rather than brief answers to general statements (Given, 2008, p. 84; Riessman, 2008, p. 23). Narrative inquiry is variably referred to as a co-construction, joint construction or co-research, as there is a shared understanding that it is an interaction “that stretches to something like conversation” (Squire, 2008, p. 50). Following these principles related to the interview as a conversation and a collaboration, I provided a relaxed two way conversational format that resembled a ‘chat with a purpose’ between two colleagues during the interview, and a respectful, open interview process so that anything of concern and importance to the nurse Agent could be discussed. This was an important part of the interview process because some of the Enrolled Nurses had told me that they were worried about coming forward to share their stories about the direction and delegation interactions they had been involved in.

While I remained in the researcher role I also reflected on how I viewed each story, when a question was *not* answered, a turn of phrase used, or how an idea was expressed or described (Given, 2008). I included questions they asked of me and the emotional environment created in the interview as these were important clues to identifying the nurse Agent’s motivation to act, and therefore the plot of their narrative script. These were captured as notes in the field texts at the time of the interview.

Research location

The interviews took place at a time and place convenient to the nurse Agent, and revolved around the nurse Agents’ shifts and work commitments and availability of transport and convenience for them. Some interviews took place either in the nurse Agent’s home usually in the evening or in the weekend, or in my office. Each interview took approximately one and a half to two hours.

Data analysis

Developing the data analysis framework

The framework I used to analyse the interview field texts was informed by Burke’s pentad (Burke, 1945, 1969) and Clandinin and Connelly’s symbolic three dimensional space (Clandinin, 2013; Clandinin & Connelly, 2000; Connelly & Clandinin, 1990; Creswell, 2006, p. 56). Clandinin (2013); Clandinin and Connelly (2000, p. 50) and Clandinin and

Rosiek (2007) are quite clear that the symbolic, metaphysical three dimensional space defines narrative inquiry methods and methodologies. There is a synergy and consistency between Burke's pentad and Clandinin and Connelly (2000) three dimensional space. For example, Clandinin (2013) and Clandinin and Connelly (2000) asks the narrative inquirer to consider the *Sociality* elements or *interactions* which includes an acknowledgement of people's personal, professional and social conditions including feelings, hopes and desires, and the milieu and environment in which they live and work. The *temporal* elements or *continuity* require the researcher to pay attention to the past, present and future of people's places and events. The *place* or *situation* element requires the inclusion of the places or sequences of places where the situation or event took place. Burke's pentad which includes the element of *Agent* is consistent with Clandinin and Connelly's *Sociality* and the personal and social dimensions of the person's story. Burke's *Scene* and context are consistent with Clandinin and Connelly's *Situation* and place. However, Burke's pentad did not include the past, present and the future or *Temporality* of Clandinin and Connelly's three dimensional space (2000, p. 50) and I adapted my framework to include this important element of narrative inquiry. The Clandinin and Connelly (2000) three dimensional space together with Burke's pentad made my adapted data analysis framework a successful vehicle to explore both the internal conditions such as feelings, moral dispositions, desires and hopes, and the external conditions such as the social, political and local knowledge of nursing. In doing so it enabled me to extract meaning from the nurse Agents' storied experiences of their seemingly everyday direction and delegation interactions.

The adapted data analysis framework presented as Appendix H, transformed each nurse Agents transcript, audio-taped interview and field texts into a narrative script. The narrative script captured the perceptions that each of the nurse Agents had about direction and delegation, how they understood it on a day to day basis, the reasons behind the decisions they made, how they aligned direction or delegation to their Scope of Practice, and their perception of their role and level within the workplace setting.

At this point I stopped using the term "participant" and the nurse was referred to as the 'nurse Agent' as this was consistent with Burke's pentad.

Data analysis plan – part one – data transcription and the Summary Contact Sheet

Each one and a half to two hour interview was audio-taped and then transcribed by the transcriber within a two week time frame as a verbatim account. False starts, "umms" "arrhs" and laughing were left in the interview and tangents were included although this "messy" speech was "cleaned up" when the re-story was created; a process known as "narrative smoothing" (Davy, 2010; Riessman, 2008, p. 54).

Immediately after each interview preliminary field texts were started using a “*Summary Contact Sheet*” as suggested by Silverman (2010, p. 232) and Miles and Huberman (1984, p. 50). The Summary Contact Sheet was used to capture my initial reactions and responses, identify questions that needed clarification, and acknowledge *how* the nurse Agents’ ideas had been shared. I included a draft working title that I felt captured my initial impressions of the interview, and I also included any thoughts about words and phrases used or the way thoughts were expressed that might contribute to the data analysis stage. The Summary Contact Sheet was incorporated into my data analysis framework.

I created a hard copy file for each nurse Agent that included their transcript, the artefacts as notes, photos or certificates they had brought with them to the interview, and the data analysis framework which included aspects of the Contact Summary Sheet. Eventually their re-story and their narrative script were added to this file.

The nurse Agent’s name was left in the initial word-processed transcript so that I was able to distinguish each of the 34 interview transcripts. The names of the nurse Agent, people and places were later altered by me during the re-storying process to protect privacy and maintain confidentiality. Privacy and confidentiality were protected during this time as only the transcriber and I had access to these field texts, and only first names or initials were used. The protection of the nurse Agent’s privacy, confidentiality and interview data is discussed in more detail within the ethics section later in this chapter.

Data analysis plan - Part two - Re-storying the nurse Agent’s stories

The main purpose of part two was to create an initial re-story as a way to capture and retell the nurse Agent’s individual and unique direction or delegation experiences and perceptions. The re-story was given a title that had been discussed with the nurse Agent at the time of the interview, or an interim working title allocated by me during the capture of my thoughts and perceptions in the Contact Summary Sheet.

The re-story that I created was based on the audio-taped interview, the transcript, the artefacts that the nurse Agent brought with them, and the notes captured on the Summary Contact Sheet. Once the re-story and title were selected, it was then sent to the nurse Agent by email for comment. Nurse Agents were encouraged at this stage to comment, change or alter the content of the re-story, or the working title chosen.

The choice of title was an important part of the re-storying process because I wanted to capture the essence of what the nurse Agent was sharing, and in the discussion about the choice of title that followed with the nurse Agent, I uncovered more information about *how* the nurse Agent felt during the interactions and situations they described, which is an important aspect of narrative inquiry. In addition to this it gave me an opportunity to see if I had correctly interpreted what the nurse Agent was saying. For example, when ‘*Alison’s*’ (pseudonym) re-story was returned to her she asked if her re-story title could be changed from: “**Too many chiefs and not enough Indians**” which I had believed reflected her stories to: “**The Lone Wolf**” or “**Wolf without a pack**” because that is how she felt. I thought her choice of title was powerful, and significant as it clearly showed that she felt alone and without support in this workplace. ‘*Milena*’, a Registered Nurse emailed back that she had read the re-story and wondered “if something like “**Delegation in the eyes of a new Graduate Nurse**” would be suitable for her re-story. The re-story titles chosen by the nurse Agents are part of the narrative process and are a narrative conversation in themselves. They have been included in more detail in ‘Introducing the Agents’ in Appendix C.

While member checking is discussed in the trustworthiness section later in this chapter it is timely to include here that I found that facilitating a ‘checking’ of the re-story and working title was vital to the narrative creation process. Firstly, it met my need to gather feedback from the nurse Agent on my initial interpretation of their storied experiences. The checking stage enabled me to confirm the “goodness” and “correctness” of my understanding of their stories, and provide a basis for my later analysis of *Act, Attitude, Agent, Agency, Scene and Purpose* (Burke, 1945, 1969; Creswell, 2006, p. 57). The checking-in stage supported other key aspects of narrative inquiry methods. This included my belief that while I was the ‘custodian’ of the research data created (John Hopkins University, 2015), the nurse Agent owned the information shared with me. Therefore, it was important to me from an ethical view point to return the re-story to them so that the nurse Agent could check and alter my portrayal of what was after all, their stories

Part two was a valuable stage for me because I particularly wanted to encourage the nurse Agent to participate in the creation of their own re-story, and therefore be a “co-creator” (Creswell, 2006, p. 57; Pinnegar & Daynes, 2007) in the narrative process. Encouraging them to change aspects they did not believe reflected their re-story, and creating or changing the title to truly reflect their intended feelings, values and beliefs shared with me in the interview, was a small but significant move to encouraging collaboration and co-creation. Evidence of an open collaborative research relationship can be seen when the feedback, included over, continued after the re-story had been sent back to the nurse Agent. This further supports the

existence of the co-creation relationship I wanted to encourage. Lastly, a major achievement for me as narrative researcher was the ability to ‘give something back’ to the nurse Agent. Crafting a re-story for each nurse Agent enabled me to do just this, in the form of their own personal and professional story about their delegation experiences, and an intended consequence of this step was that it fostered a trusting and open relationship between me as researcher, and the nurse Agent.

The correspondence I entered into during part two included six nurse Agents who made suggestions to the title of their re-story. Eight other nurse Agents commented that they were pleased that their nursing practice had been captured in a story that featured them. Three nurse Agents sent a thank you card to acknowledge that their story had been captured effectively, and two further nurse Agents sent emails for the same reason. One nurse Agent wanted their gender changed to protect their privacy. Another nurse Agent requested a word change in relation to comments that had been included about their relationship with an Enrolled Nurse. Four nurse Agents also sent through questions to me via email after their re-story had been checked to ask me where they could find relevant and up-to-date direction or delegation information. No nurse Agent disagreed with their re-story.

The email or phone contact undertaken post interview also provided an opportunity for nurse Agents to give me their feedback about the interview, or any other unintended concerns they had experienced. During one of the email sessions it transpired that an extremely experienced Enrolled Nurse Agent had retired from her position as she was: “so sick of fighting the system”. This news was not surprising as her inability to work to her “full Scope of Practice” had been evident throughout her interview. *Alison* an inexperienced Enrolled Nurse moved on from her position because her perception was that she could not access the delegation input she needed to keep herself and her patients safe. Another nurse Agent, a Registered Nurse, employed in the community who had graduated less than three year earlier had eventually moved away from Canterbury by the time I had caught up with her by email to find out if I had captured her re-story as she intended to tell it. It was clear from her stories that she had been disenchanted with her employment at the time of the interview and felt unsafe as a Registered Nurse trying to direct and delegate to other staff. She eventually found another job where she could give the patients (and the staff she worked alongside) the care and attention that were evident in her stories, and that she felt were important to her role as a Registered Nurse.

Data analysis plan – part three – Developing the narrative script through act, attitude, agent, scene, agency, and purpose

I wrote in my reflexive journal in October 2013 that when the data analysis framework was applied to the nurse Agent's interview it acted like a prism being turned to meet the light. Much as a prism splinters white light into an array of colours, the framework transformed an array of people, events, situations, perceptions and experiences (Polkinghorne, 1988, p. 19) during direction and delegation interactions and splintered them into the *Act, Attitudes, Agent, Scene, Agency, Purpose*. Without the framework the field texts were a jumble of thoughts, feelings, beliefs, and ideas. As the framework was laid over the field texts the stories the nurse Agent shared as *Acts, Attitudes* and the *Agencies* they employed to 'do' delegation were used to create an individual narrative script. The script uncovered how each nurse Agent understood direction and delegation and highlighted the difference in emphasis on delegation interactions between Enrolled and Registered Nurses, and the social, cultural and political forces that influenced the delegation interactions and relationships with nurses and other staff. When the *Acts* were combined they identified a sequence of techniques, principles and ideas that made up the *Agencies*. The *Agencies* provided a window into, if and when, direction and delegation as it is defined in the New Zealand direction and delegation guidelines (Nursing Council of New Zealand, 2011b) were used in the nurse Agents practice. Together they uncovered stories, examples and scenarios of nurses' communication interactions, leadership and assessment roles, and their decision making during direction or delegation interactions.

The terms 'act' 'scene', and 'plot' were chosen as this is in line with the dramaturgical aspects of Burke's structural analysis framework in that the Agent or actor performs an Act when they are telling and retelling their stories. It is also consistent with narrative inquiry's influences where there is a narrator as storyteller, an audience, a narrative or a story to tell (Riessman, 2008, p. 9) a scene and a plot (Connelly & Clandinin, 1990, p. 8; Polkinghorne, 1988, p. 131).

Data analysis plan – part four – Identifying shared understandings

During the fourth stage of analysis I could see that each nurse Agent shared a number of small stories. That is, their stories were not told in a continuous and uninterrupted stream of related ideas but presented themselves as small everyday stories about what they knew and understood about delegation, how they had learned about direction and delegation 'on-the-job,' or had not learned about direction or delegation at all, or how they could not find any information about direction and delegation in their workplace. I identified a number of patterns *between and across* the nurse Agent's narrative scripts and these small stories became 'Small stories as shared understandings' as they represented similar or shared beliefs,

values and perceptions about direction and delegation practices. Small stories is an umbrella term that includes stories about everyday events, and shared and known events (Bamberg & Georgakopoulou, 2008, p. 5). The ‘Small stories as shared understandings’ are presented in the Findings chapter, Chapter five and Chapter six.

Data analysis plan – part five – Identifying personal and professional stories of experience

The transcribed interviews were re-read to ensure I fully understood what each nurse Agent was saying to me. I listened to each nurse Agent’s audio tape for a second and sometimes third time to identify inflection, how ideas were expressed, how the nurse Agent described events and experiences and how humour and pauses were used. Re-listening to the audio tape was an important step so that I could gain a sense of *how* things were expressed, not just *what* was said. As the nurse Agents told their personal and social stories (Clandinin & Huber, 2010, p. 4; Connelly & Clandinin, 1990, p. 10; Gubrium & Holstein, 2009, p. 41) they linked these stories to their nursing work and these developed into their personal and professional stories of experience. Some of the nurse Agents made reference to how they believed direction and delegation interactions *should* happen and gave reasons as to why they communicated or responded to other nurses and health care professionals in the way they did. This gave me an opportunity to compare and contrast what had happened to them in their workplaces during delegation to what they believed should happen or would like to see happen during direction or delegation.

The data analysis process highlighted the patterns *within* each of the nurse Agent’s narrative script. The *Agencies* each nurse agent employed to make sense of the direction and delegation interactions clearly pointed to the narrative plot for each nurse *Agent*. A plot is a sequencing of actions and events and “grasps together” seemingly jumbled and unrelated ideas. The plot was interpreted from the nurse Agents own language (Kramp, 2004, p. 103/112) and highlights their perspectives and points of view. In relaying their point of view they placed themselves and others in a story (Polkinghorne, 1995, p. 11). I used the plot to amplify each individual nurse Agent’s voice, and I looked beyond the surface level observation and the taken-for-granted of their everyday experiences with direction and delegation. The plot acted as an organising structure for the nurse Agents’ personal and professional stories of experience. I used time and place to provide a setting for the plot as is consistent with narrative inquiry, connecting and situating the nurse Agent’s events and experiences so that they were meaningful (Connelly & Clandinin, 1990; Creswell, 2006, p. 56; Kramp, 2004, p. 103). The personal and professional stories of experience are presented in the Findings chapter, Chapter five and six.

As predicted by Clandinin (2013), Clandinin and Connelly (2000) and Connelly and Clandinin (1990) when the nurse Agents' told their stories they often referred back to past times when they had nursed in other places or when they had trained many years previously, and then returned to present time and experiences (temporality or continuity). The place(s) (situation) where they had worked in the past, and where they worked now often altered the context of their stories as some of the nurse Agents experienced delegation differently in different nursing environments. This was a reflection of the varying professional and social expectations of the nursing culture in a particular workplace setting such as the tasks and skills an Enrolled Nurse was allowed to do in different nursing workplaces (interactions). For example, what any nurse can safely do in different clinical settings such as a surgical or medical ward differs to what they can safely do in a mental health or community setting. In addition to this the tasks and skills a nurse can safely do *within* one seemingly similar surgical or medical ward could also differ between wards. This was consistent with both Burke's pentad and the symbolic three dimensional space (Clandinin, 2013; Clandinin & Connelly, 2000). By acknowledging and highlighting these narrative inquiry elements a bigger story started to unfold about communication styles and preferences, their ability to truly work together, the impact of the nursing model of care chosen, the assessments that needed to be carried out, leadership strategies used, and if the delegation interactions they were involved in felt like a relationship.

A number of small stories about what nurses knew and understood about direction and delegation emerged *between* and *across* nurse Agents scripts. These were collected as 'Small stories as shared understandings'. In addition to the numerous small shared understandings between nurse Agents' scripts, each nurse Agent provided a unique and individual interpretation and perception about their direction or delegation experiences, which were captured in their narrative scripts as personal and professional stories of experience, and these individual stories were represented in the 'narrative plot.' This relationship is presented in Figure 4.1 which is a graphical representation of the relationship between the elements within Burke's adapted pentad, and the shared understandings and narrative plot.

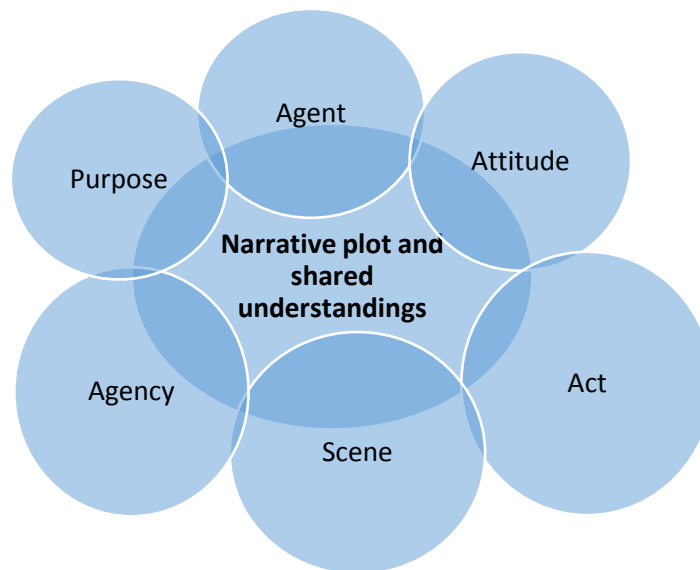


Figure 4.1: The relationship of Act, Attitude, Agent, Scene, Agency and Purpose to the narrative plots.

While narrative and story can be used interchangeably I have used ‘story’ to represent the nurse participant’s stories shared with me in the interview, and ‘narrative’ to denote the narrative plot that developed from the individual narrative scripts. The narrative plots are reflected in eight major patterns: “Working together” “Delegation as a relationship”, “Communicating well”, “Seeking delegation”, “Professional communication”, “Doing delegation and direction”, “Skills for delegation” and “Working as a team” and are presented as eight separate narratives. The relationship of the major patterns, Acts, Scenes, Agencies and the narrative plots that emerged from the nurses personal and professional stories are presented in the Findings chapter, Chapter five and Chapter six.

Summary of the data analysis process

To reiterate, immediately after the interview the Summary Contact Sheet was completed. Once the transcription was finished, I read it and listened to the audio tape two, or in some cases three more times. A re-story was created from these field texts and it was given a working title. The re-story was sent back to the nurse Agent to check if I had captured their ideas, perceptions, experiences, feelings and ideas correctly. The adapted data analysis framework created from Burke’s pentad and the Clandinin (2013) three dimensional space was applied to the field texts to identify the Act, Attitude, Agent, Scene Agency and Purpose. A narrative script was created that identified shared understandings between nurse Agents as well as individual personal and professional stories that uncovered the narrative plot for each nurse Agent. This interpretative process is presented in Figure 4.2.

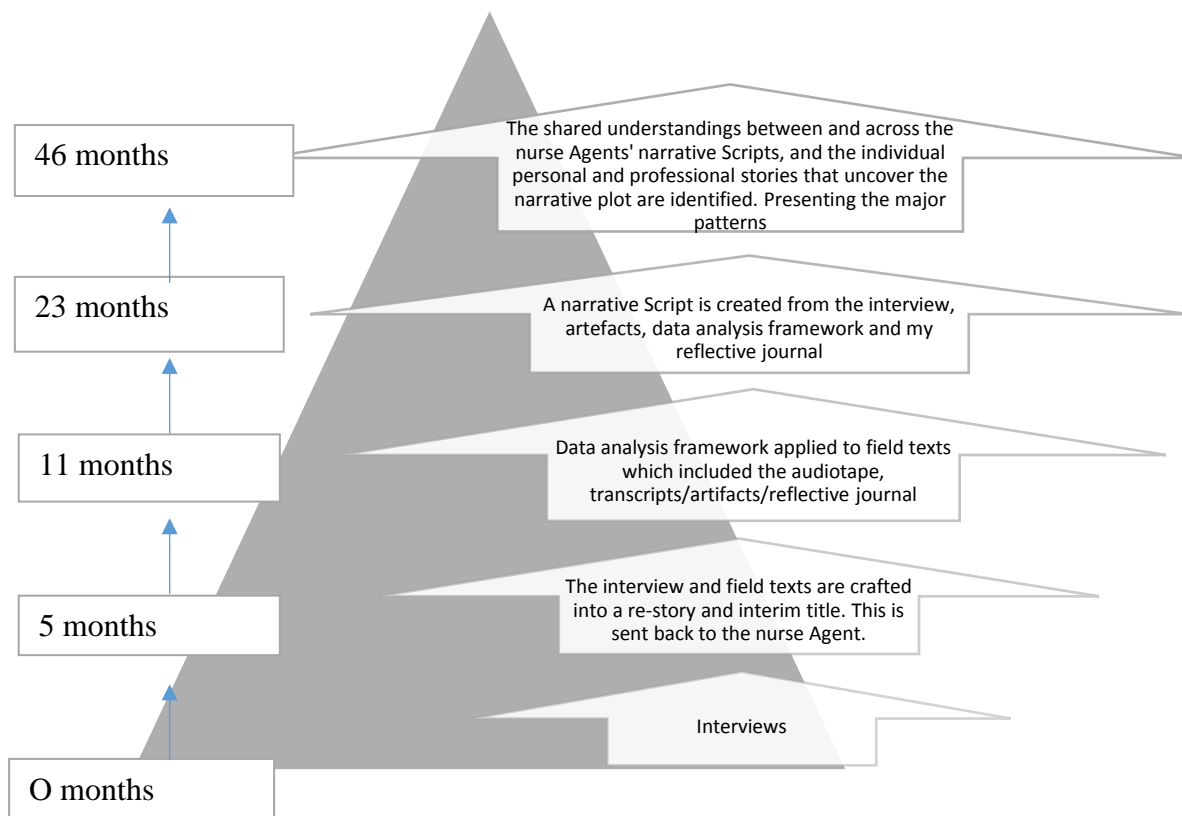


Figure 4.2: The data analysis process

Data quality, rigour and trustworthiness

The value and worth of a qualitative study lies in its ability to establish trustworthiness. In order for the findings and outcome of a narrative research study to be considered by its intended audience, in this case, the profession of nursing, and acknowledged for its: “distinctive contribution to the development of knowledge in a discipline” (Dunleavy, 2003, p. 27) a robust, transparent and methodologically sound set of techniques for establishing rigour is required.

In qualitative research studies, trustworthiness can be evaluated by ensuring there is credibility, transferability, dependability and confirmability. Credibility involves readers having confidence in the truth of the data interpretation and findings. The criteria for credibility can be met through prolonged engagement, peer debriefing and member checks (Lincoln & Guba, 1985, p. 330). Transferability involves showing that the findings have applicability in other contexts and situations and can be supported through the capture of thick, detailed and rich description (Lincoln & Guba, 1985, p. 316). Dependability involves readers having confidence in the truth of the findings. The criteria for dependability can be met through examining how the field texts were collected, kept and the accuracy of them

(Lincoln & Guba, 1985, p. 317). Confirmability involves taking steps to ensure the findings of a study are shaped by the nurse Agents and not influenced by researcher bias, motivations or interests. The criteria for confirmability can be met through examination of the final research report to confirm that the findings, interpretations and conclusions drawn are supported by the nurse Agents' information and reflect their 'voice' (Lincoln & Guba, 1985, p. 318). While the four criteria for trustworthiness have been included in this research study, it became clear from other respected authors acknowledged below that narrative research methods required other criteria to claim rigour and trustworthiness. Fortunately, as Sparkes (2002, p. 211) and Speedy (2008, p. 56) acknowledge such lists are not closed and can be added to, or subtracted from, depending on the inquiry type, stage and process. With this sentiment in mind other criteria relevant to narrative inquiry have been included to support the rigour and trustworthiness of this research study.

Loh (2003) for example is clear that narrative researchers could and should choose from the criteria and techniques for qualitative research as described above, and further suggest verisimilitude and utility as criteria for rigour needed in narrative inquiry studies.

Verisimilitude, is the *quality* of truthfulness for the reader of the text and asks the reader to evaluate if the story rings true. Utility is recognised when the readers can answer: Is the study useful and relevant to the discipline? Can it be used by the research, nursing or teaching community? Or is the study so small, obscure and specialist that it is not useful to the community in any capacity (Loh, 2003, p. 10). Riessman goes further to describe this as so important it is in actual fact the "ultimate test" (Riessman, 2008, p. 193).

Narrative inquirers such as Clandinin and Connelly (2000) and Connelly and Clandinin (1990, p. 7) also acknowledge other characteristics of rigorous, quality narrative studies. They suggest Van Manen's criteria be included when making claims about rigour and trustworthiness and ask narrative researchers to consider and then further develop apparency, verisimilitude and transferability (Van Manen, 1988). They make a plea that narrative researchers do this "thoughtfully." Apparency is defined as the outcome of the research being easy to recognise and easily understood and supports the concept that the reader will be able to make sense of the details provided by the researcher and be able to recognise aspects of the Agents experiences and situation (Rodrigues, 2010, p. 100). Verisimilitude is similar to Loh's description and can be seen when the quality of the writing contains a sense of being real or true to the reader. While transferability enables the reader to make connections between elements of the study and the reader's own experiences (Duke & Mallette, 2004, p. 343). Munhall (2012, p. 436) goes further to add to this that the research process has been a quality process when the reader of the research is moved emotionally by the narrative. In fact she

states that this is critical. Speedy (2008, p. 56) has compiled a comprehensive list for rigour that includes: transparency or how the information has been gathered; trustworthiness which illustrates the truthfulness and credibility of the research findings and outcomes, and how claims of verisimilitude and knowledge have been embedded in multiple criteria that address the lived experience; aesthetic merit which illustrates if the research succeeds aesthetically and identifies if it is satisfying or boring; reflexivity which shows whether the researcher has been able to include a sense of cultural or personal embeddedness; accountability which illustrates how the researcher negotiates their relationship with the Agent; a substantive and enduring contribution which asks does the research contribute to our understanding of social, or cultural life and what it means to be human; and impact and transformation which asks the reader does this resonate with me as a reader? Does it move me to action or affect me emotionally, intellectually, spiritually or politically? Is it able to transgress taken-for-granted assumptions? (Speedy, 2008, p. 57).

Narrative inquiry researchers must be able to support the researcher's contention that analysis and interpretations contribute to new knowledge in a rigorous and quality way (Loh, 2003). I have opted for qualitative research's trustworthiness concepts such as credibility, transferability, confirmability and dependability and I have included narrative inquiry's requirements for rigour which include apparency, verisimilitude and utility. I also took advice from Speedy (2008, p. 57) who suggests that the rigour criteria in her list be used to guide the research process from selection of Agents to data collection and analysis through to the publishing of the research outcomes. I leave it the reader to evaluate if rigour has been met. My aim was to exceed rigour requirements so that my research study would contribute a body of knowledge about direction and delegation, uncover how direction, delegation and accountability were known, understood and carried out in clinical practice by nurses, and make a difference in how this professional obligation was known and understood in the future.

Credibility was achieved through member checking when the nurse Agents' initial stories from the interview were re-storied and sent back to them so that they could alter, change or delete any incorrect assumptions. The nurse Agent was given meaningful opportunities and support to reflect on their re-story contribution with the researcher, so that the accuracy at this beginning stage of interpretation could be checked and were true to their experiences. Changes and comments about the content and title change for the re-story were included in the narrative process by incorporating them into the creation of the narrative script. In addition, the data collection stage was prolonged and occurred over a 19 month period as there were 34 interviews transcripts, re-stories and scripts produced, and their associated

follow up phone and email contacts with nurse Agents. This inevitably led to more than one interaction with each nurse Agent and sometimes up to four as email and phone contact was used to ensure that the nurse Agent felt comfortable with the interview and re-storying outcome, and to gain further consent to proceed. Credibility is also evident as the research study has been written so that it clearly identifies the steps in the research process from my initial research wonderment and puzzling, to the design of the research question, aims and purpose, and through to the methods, methodology, findings, discussion and recommendations. Lastly, peer debriefing with two respected colleagues as uninvolved third parties occurred throughout the research study and provided an opportunity to challenge not only my assumptions about direction and delegation and nursing roles and responsibilities, but also narrative inquiry research concepts.

A confirmability audit supported my intention to show confirmability. It can be seen that data collection and analysis supported the findings, interpretations and recommendations. A personal reflective journey of my “epiphanies”, ideas and observations was kept throughout the research process and used to support weekly communication with my two Supervisors. In addition, I used the reflexive journal to support a reflection of my own thinking during data collection and particularly the analysis stage, and my own involvement and preconceptions as the researcher. By reflecting on the research progress and process I was able to capture the problems I encountered, the outcome of deep thinking, areas where the research ideas changed or altered, and the “ah ha” moments that occurred. Examples of this include the recognition that the data analysis framework acted like a prism splintering interview data into acts, scene and so on. The journal provided evidence of the research journey, or how the research took shape over time. A second weekly email journal to the Supervisors was kept and provided a forum for questions, comments, and noted progress.

Proof of dependability is provided by the completed thesis which provides an audit as data collection and analysis is explained and an audit trail can be clearly seen from the research puzzling, and question design, through to the recommendations. Therefore, accuracy of field texts and how data was collected and the relationship to the major patterns can be assessed by the ‘community’ of nursing. The research supervisors also provided an interrogation of the data collection, analysis and writing of the thesis stages and chapters.

Apparency can be seen in the plain language used throughout the thesis to support easy to understand concepts. I have used “I” statements to make clear when my voice is included. A glossary of terms has been included at the beginning of the thesis on page vi, so that those outside the discipline understand the terms used. I have provided rich thick descriptions so

that the reader can make sense of the details and recognise aspects of the nurse Agents' situation and delegation experiences.

Verisimilitude is acknowledged through member checking, audience validation and peer validation. I believe as a nurse that the findings will ring true and will be believable to nurses. However, this remains to be seen as it is the nursing profession who will decide this. Peer debriefing and the response from guest speaking commitments and conference presentations to nurses was an indicator that nurses will find that the research findings and outcomes 'ring true'. The interview stories, the re-stories, the small stories as shared understandings and the personal and professional stories of experience created provide an emotional connection as Nurse Agents' reasons for acting, emotions, and techniques are described.

The utility or pragmatic use of this study will be judged by the audience as readers. However, the findings, recommendations and conclusions of this study hold the potential to be useful to Enrolled and Registered Nurses, nurse educators, nurse managers and nurse leaders. Lastly, the reader as the audience will be the judge of transferability and it is this audience that will decide if the research findings ring true and can be applied in other nursing areas.

The ethical considerations

Ethics approval HEC Application 2012/171 was sought from the University of Canterbury Human Ethics Approval Committee and granted on December 10th 2012. A further approval application was sought from CPIT Human Ethics Sub-Committee, a committee of the Research and Knowledge Transfer department at CPIT. This was approved by the Department of Nursing and Human Services Research Committee at CPIT in January 2013. The letter of approval from the HEC, University of Canterbury can be found in Appendix I.

While all researchers no matter the design or methodology they select must be mindful of any risks to the people involved in the study, narrative research requires a 'relational quality' to ethical considerations over the life of the study and beyond. Relational ethics mean that the narrative research relationship needs to be negotiated and re-negotiated with Agents at different stages of the research process (Clandinin, 2013, p. 198). Not only when the Agent agrees to be part of the study prior to the start of the study, but during it, as the field texts are captured, and as the interview is co-composed, analysed, and then published. This was necessary in this study because the nurse Agents did not know what would happen with the interview data and this needed to be re-negotiated after the interview.

Clandinin (2013) asks for more than an acknowledgment of ownership, anonymity, confidentiality or informed consent. Relational ethics are respectful and include attitudes of openness, mutual vulnerability, reciprocity and care (Clandinin, 2013, p. 200). Ethics are relational in that the narrative inquiry researcher understands that the research involves many relationships, not just the researcher to Agent relationship. The Agent often refers to, describes and includes the organisations the nurse Agents have worked for, were trained in and other nurses and health care professionals they worked with who are not present at the interview (Clandinin, 2013, p. 198). Relational ethics include inspirational thinking around ethical considerations that include but also go far beyond the qualitative research rigour concepts of credibility, confirmability and dependability (Lugones, 1987). Along similar lines Bateson's thoughts on ethical responsibilities included an acknowledgment that attentiveness, presence and response are also needed to protect Agents, and the people they include and discuss in their stories during their relationship with the researcher (Bateson, 1994; Clandinin, 2013, p. 169).

I included relational ethics in the planning, design, field text collection, analysis and publication stages of this research study. Relational ethics were used to support thoughtfulness and a mutual appreciation for the vulnerability of all those nurse Agents that were involved in the study, and the people they spoke of. The relational ethical considerations are explained in the following section.

Respect, attitudes of openness, mutual vulnerability, reciprocity and care

Clandinin et al. (2007, p. 647) and Clandinin (2013, p. 200); Clandinin and Connelly (2000) suggest that narrative researchers move beyond merely doing no harm to being “empathetic listeners, non-judgmental and suspending their disbelief” as they attend to Agent's stories. Respect was shown through my openness to the nurse Agent's stories. I was respectful of the time they took to share their insights and experiences and respectful of their privacy, safety and confidentiality. I was also respectful of the experienced nurse Agents skill and knowledge and at the same time respectful of new inexperienced nurse Agents' newness to the discipline. This willingness to be open to new ideas was consistent with my own stance that there are many realities, truths and perspectives.

Mutual vulnerability became evident when I recognised that as a researcher I was just as constrained by my discipline as the nurse Agents, and as the author of the final published study I too felt “exposed”. I was concerned that my loyalty to nursing might be questioned, as loyalty is a personal value that is important to me. Therefore, I had empathy with the nurse Agent's vulnerable position within the research study and this led me to re-check their

consent to continue throughout the data collection process, and provide explanations to them about how I was protecting their right to privacy and confidentiality. The relationships I formed with the nurse Agents during the interview were based on truthfulness and trustworthiness. I asked nurse Agents' to share highly personal in-depth thoughts and perceptions about themselves and the people they worked alongside and they trusted me to protect them, as I trusted them to openly and honestly tell me about their experiences, perceptions and beliefs about delegation, direction and accountability.

As Patton (1990, p. 407) states:

Because qualitative methods are highly personal and because naturalistic inquiry takes the researcher into the real world where people live and work, and because in-depth interviewing opens up what is inside people – qualitative inquiry maybe more intrusive and involve greater reactivity than surveys, tests, and other quantitative approaches.

Reciprocity led me to want to give something back to the nurse Agents who had given up their time. I could do this in two ways: the re-story about them and how they dealt with direction and delegation communication interactions within their nursing practice was my 'gift' to them. This was a well-received move born out of respect and as a way to thank the nurse Agent. One nurse Agent commented that they were: "so glad their story had been told as it would have gone unrecorded" if I had not captured it. Another Registered Nurse had not realised she had the "advanced skills" I had identified in her story as she had never thought of her nursing role in this way. An Enrolled Nurse commented "I think it fits the story and you've captured what I was trying to put across. I wouldn't have recognised it was me so no one else should. I'm very happy with it". Secondly, reciprocity was supported when the interviews were over when I was able to give information about direction and delegation to them when they requested it.

Care was taken with the nurse Agent's stories, their self-esteem, their privacy and their trust in me to represent the information they shared with me fairly. It was this that led to the decision to return the re-story crafted after the interview to be able to change or alter aspects about it that they may not have intended to come out, or that led them to feel uncomfortable in any way. Krathwohl (2004, p. 208) talks of "potentially distasteful self-knowledge" that Agents might experience when involved in a qualitative research study. While no nurse Agent contacted me after their interview with these concerns, some nurse Agents felt embarrassed that they did not understand delegation practices, and some nurses indicated that it was not done well in their practice setting. Care was taken to assure them that direction and delegation is a new phenomenon for many nurses in New Zealand, and that direction and delegation

interactions can be supported and learned. However, as a precautionary move there were plans put in place to provide them with contact information about available support services if this was needed for any other reason (Krathwohl, 2004; Teddie & Tashakkori, 2009, p. 199).

Attentiveness, presence and responsiveness

Attentiveness, presence and responsiveness are viewed as important ethical responsibilities and they are required in order to establish trust (Bateson, 1994). In addition to this, when attentiveness, presence and responsiveness are included in the interview, the conversational relationship required to support joint production of the interview information is supported. I showed attentiveness in this study by being attentive to every possible verbal and body language clue, and attending to the way topics were expressed, noting the topics that the nurse Agent chose to discuss and not discuss, as well as what and how a thing was said, or an unusual turn of phrase was used. This enabled me to explore further when I sensed that the nurse Agent was uncomfortable, avoidant or wanting to skim over an issue. This added to the robustness of the information gathered and trust promoted the open sharing of information which added to the robustness of the data collected.

I included an attitude of presence by being ‘fully present’ and being in the moment with them during the interview but also making myself accessible and available after the interview. I showed responsiveness by my “mindfulness” and thoughtfulness about the nurse Agent’s potential vulnerability, their right to confidentiality and to feel safe within the research relationship which was reflected in the way I crafted each interview, re-story and narrative script.

Ownership of data

During the interview I offered to send the word processed transcript back to the nurse Agent as member checking of the transcript affords an opportunity to verify the accuracy of what has been recorded. I intended to include their responses into my re-story as some researchers suggest (Chamberlayne, Rustin, & Wengraf, 2002). However, I felt that checking my interpretation of the nurse Agent’s stories in their re-story and supporting them to be involved with the first stage of my interpretation was more open, honest and respectful of their ownership of their information, than member checking a verbatim transcript.

Riessman (2008, p. 189) is ambivalent about the return of the final narrative to the Agent and I see her point of view in the rationale for non-return of the completed analysis. One of the roles of narrative inquiry is to identify and uncover experiences, motivations, ways of interacting and roles played that may not be obvious, visible or apparent to the nurse Agent at

the time of the telling of their story. Therefore, while the re-story was returned to the nurse Agent for clarification of correctness the finished narrative created at the end of the data analysis process was not returned for comment to them.

Informed consent

The nurse Agents who agreed to be part of the study were given all information about the study, in writing and verbally, and consent was gained from nurse Agents in an *informed* way. The nurse Agent was given an information sheet and consent form. The consent form was attached to a relevant information sheet about the study when they agreed to be part of the research study.

Nurse Agents were given the interview question and prompts prior to the interview which meant they were pre prepared for the format and process of the interview. This informed consent strategy was designed to support transparency, self-determination and autonomy as nurse Agents understood that they could choose the prompts that were relevant to their lived experience and avoid sharing information that would make them feel unsafe or exposed. Informed consent to proceed, given my understanding and interpretation of their interview information, was again re-negotiated when the re-story was sent out by email.

Minimising harm and unintended consequences

The in-depth reflection about possible and potential harm I undertook during the planning and design of the research, and the robust set of ethical considerations as described in this section, led me to believe that the benefits of this research for individual nurses and the profession of nursing will outweigh any risks of harm because the risks have been acknowledged and mitigated.

There were no health and safety, or physical safety issues involved in the research study. Nurse Agents were given a written copy of the researcher's full contact details, the supervisors contact details and the University of Canterbury Ethics Committee details to contact if they had any concerns about any part of the research process.

Confidentiality and privacy

The nurse Agents who agreed to be part of the study and the organisations they worked within had their identities safeguarded and only I as the researcher knew their identity. The nurse Agents were known only by a pseudonym either of their choosing or selected by me, and the names of their organisation, exact locations or the names of colleagues, patient's names and the places they spoke of were altered by me during the re-storying process to become generic names such as "the workplace" or "the organisation".

No identifying or distinguishing features were included in the narrative scripts, the small stories as shared understandings or the narrative plots, and in one case the nurse Agent's gender was altered to protect their privacy and confidentiality as they felt they may be identified. Clandinin (2013, p. 201) describes this as "blurring" and this process was applied in this instance. Their designation as Enrolled or Registered Nurses were used as this was pivotal to the research study. That is, accessing the knowledge and perceptions of both Enrolled and Registered Nurses was necessary to understand their perceptions of their respective direction and delegation interactions.

The information shared was kept private and safe. The hard copy files which included the transcript, Contact Summary sheet, data analysis plan and the re-story were stored in a locked file cabinet and a password protected computer system. Back up data was password protected. The data and information will be stored for seven years and destroyed in a secure manner using the security systems at the Ara Institute of Canterbury² and permission to do so had been obtained.

² Formerly Christchurch Polytechnic Institute of Technology (CPIT)

All the world's a stage, and all the men and women merely players. They have their exits and their entrances; and one man in his time plays many parts (William Shakespeare. Act 2, Scene 7, As you like it)

Chapter five. Findings: small stories as shared understandings and narrative plots for Enrolled Nurses

Introduction

In this chapter I present the findings of the Enrolled Nurse Agent's stories about their delegation experiences. An individual script was created for each Enrolled Nurse Agent that captured the delegation journeys that they had been on, and their perception of "good" and "bad" delegation interactions. The script uncovered two levels of storied experience as both shared understandings emerged in addition to each of the nurse's unique and individual perceptions of their delegation interactions. The patterns that became visible *between* and *across* the Enrolled Nurse Agent's perceptions about how delegation occurred, and what they knew and understood about direction and delegation are presented as: 'Small stories as shared understandings.'

The patterns that appeared *within* each of their unique and individual 'Personal and professional stories of experience' were captured as the narrative plot. The narrative plots reveal an environment where the nurses are shaped by their role and position in the health system as either an experienced or inexperienced Enrolled Nurse, and this influences their professional delegation obligations and expectations. The narrative plots that emerged are reflected in four major patterns: '**Working together**', '**Delegation as a relationship**', '**Communicating well**', '**Seeking delegation**' and are presented as four separate narratives.

Small stories as shared understandings for Enrolled Nurses

Shared understandings included Enrolled Nurse Agent's descriptions about how workload was decided and communicated, and how 'delegation' occurred for them, and presented themselves as '*Delegation or allocation?*' The stories they shared about delegation interactions that had gone well and delegation interactions that had not gone well led to other stories about what the terms 'delegation and direction' meant, and how they knew and understood direction and delegation. These shared understandings are brought together in '*Delegation or direction*'.

All Enrolled Nurse Agents expressed a strong belief that they knew and understood what tasks they were able to do within the Enrolled Nurse Scope of Practice, and that they "worked within their Scope of Practice". However, this shared understanding started to reveal itself as

a pattern of confusion. The Enrolled Nurse Agents believed that many Registered Nurses were confused about what an Enrolled Nurse could and could not do, and this led to other small stories about how an Enrolled Nurse would self-assess what they could do. These small stories were linked to being able to say “no” to a delegated task, and who was accountable and when. The Enrolled Nurse Agents’ perceptions were that what Enrolled Nurses were allowed to do, the way tasks were delegated or allocated, and saying ‘no’ to a delegated task were different in different settings. These perceptions were presented in small stories about the culture of the ward, or the personality of the delegating nurse and were captured as ‘*Working outside the Scope of Practice.*’ The shared understandings illustrated that there were two Scopes of Practice in play here, and threw some light on the real meaning of the phrase ‘working *outside* the Scope of Practice’.

Lastly, how Enrolled Nurses had learned about direction and delegation was a shared understanding for many Enrolled Nurse Agents. Most of the Enrolled Nurses had been shaped by their past understanding of ‘direction and supervision’ many years previously (Nursing Council New Zealand, 1999) or they had ‘learned on-the-job’. This impacted on their expectation of the delegation interaction and their understanding of working under the delegation of a Registered Nurse. These small stories were captured as ‘*Learning about delegation a direction.*’

In this section of the chapter “small stories” told in conversation by Enrolled Nurse Agents, as “tellings of ongoing events” and “shared and known events” (Bamberg & Georgakopoulou, 2008, p. 5) or fleeting moments draw on and contribute to our understanding of the direction and delegation communication interactions between Enrolled and Registered Nurses, and are presented as ‘Small stories as shared understandings’.

Delegation or allocation?

Allocation is defined in the Oxford Dictionary as the act of sharing out, distributing or assigning a job or workload (Oxford Dictionary, 2015). The professional obligation of a Registered Nurse to delegate to an Enrolled Nurse and an Enrolled Nurse to work under the delegation of a Registered Nurse on the other hand involves professional judgment requiring several assessments. It includes an assessment of not only the health status of the patient but also the complexity of the nursing intervention required, the acuteness of the environment, the resources at hand, the clinical support and other health care professionals available at the time, and the level of knowledge, skill and experience of the Enrolled Nurse (Nursing Council of New Zealand, 2011b). Some of the Enrolled Nurse Agents accommodated the requirement to work under the direction and delegation of a Registered Nurse by working to the historical model of delegation they knew and understood from their past as ‘Direction and Supervision’

(Nursing Council New Zealand, 1999) and in the telling of their stories about it, allocation has been recast as delegation.

In response to the opening prompt suggestion in the interview schedule “Can you tell me about your recollections of the direction and delegation interactions you have been involved in?” the Enrolled Nurse Agents described how they were “*allocated*” a patient load to care for at shift handover. The allocation decision was based on either a geographical grouping of patients, an interest the Registered or Enrolled Nurse had in the type of illness or condition the patient had, or they had nursed the person recently. Some of the Enrolled Nurse Agents explained that the allocation of patient load to nurses was decided during the previous shift based on either a formal or informal acuity tool assessment. Throughout all the Enrolled Nurse Agents’ stories, the Enrolled Nurses described how they were allocated a person or a group of people to care for, not aspects of the person’s care ³.

In most of the Enrolled Nurses small stories they described a primary nursing model of care or a geographical model not a team model of nursing care. Trudy’s description of a geographical model is typical of most of the Enrolled Nurses explanation of the model of care in their workplaces.

Trudy: *“You’re allocated to the room not the person. Some of the rooms contain more acutely unwell patients and if you’re allocated to a room you usually stay with that room and those patients for that week”*.

Jody: *“And quite often, how do we call them, the patients we put most work into are in one section and then the other section are those who are getting a little bit better”*.

Lynda: *“Delegation is done by the duty leader, basically the senior nurse who’s on. So if we came on, on a morning shift it’s worked out, the senior nurse works out who’s going to have what patients or what list but they’re very, very open to...we often just work it out amongst ourselves. Like they might say ‘who did you have yesterday?’ if you were on and we try and keep continuity. Whoever was on yesterday tries to have the same patients if they’re still going to be in...There’s a lot of negotiation. And we often say can we have requests today?...Like somebody will say, you know, I love the gynae patients and say can I have the gynae’s, or somebody else wants the orthopaedics or it just depends on what’s in the ward.*

³ The Enrolled and Registered nurse Agent’s in this study came from a variety of nursing workplaces and this resulted in a number of variations on the term “patient” such as client, consumer, resident, or service user. In this research study the term used by the individual Registered or Enrolled Nurse Agent has been used.

But the last say will go down to the senior nurse. But it's, we usually do work it out amongst ourselves".

Lynda describes the important role that working in a 'team' played. A team could be two Enrolled Nurses working together or an Enrolled Nurse and a Registered Nurse working together. The teams were decided by the nurses themselves. *"Yes. But having said that even, at [my workplace] we're very much into team nursing, very much, it's not like we kind of start at one end of the ward and work down, but for patients like first day joint replacements, you can't do that on your own. You've got to have at least two nurses to get them up, so two get them up and one pops them in the shower. So we always do a lot of the bigger cases together".*

Experienced Enrolled Nurses described 'checking in' with the Registered Nurses, or requesting help to administer a medication if or when required. The 'checking in' or running an idea past the Registered Nurse once the allocation process had taken place was a mechanism to ensure that the Enrolled Nurse worked *with* the Registered Nurse. In addition, the 'checking in' component was not formally requested or instructed by the Registered Nurse.

Jody: [Checking in] ... "just happened when you worked with a good buddy... When we go on duty in the morning our patient load is already organised because the afternoon staff do that. You get your patient load, work yourself out with a buddy and then you set about your work and, the way you do it up there, or the way I do it is I keep in contact with the RN and if I have any queries or any concerns I let her know and I get on with my job... And it's usually a choice thing [who you work with]. I mean because you work with the same people all the time you just click in".

The experienced Enrolled Nurses described working autonomously and independently once the allocation of patient load process had occurred at shift handover. Other than the informal 'checking in' process the experienced Enrolled Nurses were responsible for their own patient load, making decisions, organising clinical cares and responding to doctors' rounds. The Enrolled Nurses appeared to be working under the direction and delegation of a Registered Nurse at allocation time but worked independently or semi-autonomously almost as if they were working to an alternative version of the direction and delegation guidelines.

Amy: Amy described a nursing environment where because she was a very senior and experienced Enrolled Nurse, the Registered Nurses would tend to let her work autonomously

and “*get on with things.*” It is often a case of “*you know what you’re doing*” and there were also many times the Registered Nurses would come to her for advice.

Maryanne: Maryanne would be allocated a patient load and she would work alone with her patients until she decided she needed help or input of some kind. She referred to two patients she had nursed recently where she “*told them*” [the Registered Nurses] “*what was happening*” but in reality dealt with any clinical situations herself. Maryanne explains that the Registered Nurses did not complete their own assessments or check on the patient for themselves “*they just trusted me*”.

Barbara: “*Nobody ever says that to me [will you please go and do Mrs. Brown]. No they come around and say how are you going?*”

Karl: “*When I work in this particular clinical area [indicating his current workplace] I still find that often there’s Registered Nurses who I’ll go to and because I know my Scope I have to ask them if I can have a discussion with them, you know, to discuss nursing interventions, like PRN for a client, and they sort of shrug their shoulders and say well of course. You know. Go for it. Not all but there are some Registered Nurses who think it’s unnecessary [to check with them]. But I mean when I’m doing my notes I’ve got to put [write] ‘after consultation with a Registered Nurse’.*”

Dallas: “*No. You’re totally responsible for your own clients...And then if the doctors come in, not very often on an afternoon but in the mornings and especially on a Saturday morning the [nurse in charge] would do the round with the doctors, they would write it down, then they will come up and say “Mary you’ve got Mrs So and So, the surgeon’s been round, you may take the drain out”. Or sometimes we can take them out before but all the doctors have a protocol. But they do not, she does not come in the afternoon and say I want you to do this, this and this and I know that’s how it was way back then but it’s not how it is now. We are totally autonomous, we read the report and we need to check the tests and so on and we’re totally responsible. Anything that’s not done the next time you’re asked why you didn’t do it”.*

For most of the Enrolled Nurses there was concern about taking delegation instruction from the agency or casual nurses or the new inexperienced Registered Nurses as the Enrolled Nurses were often more experienced than the Registered Nurses. Dallas poses an interesting question when she asks: who is safer with a complex or very unwell client, a new graduate Registered Nurse or an experienced Enrolled Nurse? “*No so we try and get it [allocation] right but sometimes you end up being, as I was saying before, with someone who is complex and when you’ve got like a new grad that’s come on well who’s the safer one to do it?*”

Melanie: *“Sometimes it’s quite hard to be working under the delegation of a Registered Nurse when they are very new to your area. And not experienced. You know the new nurses coming in know they’re the RNs and know we’re ENs and we all do as were told. But we’ve got knowledge and we observe what they don’t know, and they don’t, it’s very hard...Enrolled Nurses where I work are more likely to check up on the new or agency or less experienced Registered Nurses rather than the other way around”*.

Delegation or direction

All of the Enrolled Nurses interviewed came prepared to the interview with notes, policy documents, their Scope of Practice, examples and stories that illustrated the points they wanted to make about the delegation interactions they had been involved in. Despite this preparation they found it difficult to describe or distinguish the terms direction *or* delegation. Often the two responsibilities were run together as direction *and* delegation as if they were the same term and many of the Enrolled Nurse Agents used direction and delegation interchangeably. Direct and indirect direction were not mentioned at all. Most of the definitions attempted were based on a layman’s understanding of the terms, especially the direction role.

Katie: Katie had tried to read the *Guidelines: Responsibilities of direction and delegation to an Enrolled Nurse (2011)* because she teaches new nursing staff and students about direction and delegation but had given up half way through because they were overly long. *“To be honest I skimmed through it and thought oh right ok. Too wordy for me”*.

Jody: *“I think that delegation is something that is out of my hands and that it’s done by somebody else. So a delegation on our ward would be the afternoon staff setting up the duty book for the next day that would be delegation. Another delegation would be [the charge nurse] putting certain people to do certain chores on the ward that she likes to get done on a regular basis. Sometimes that works really well and sometimes she says ‘I want you to check the suction and the oxygen things in that room’. Sometimes it’s not done because it’s not firm, it’s not set. I think a delegation is maybe set...Where direction can be discussed...I don’t know. Haven’t really thought about it”*.

Judith: *“They’re not really different are they? Because all we’re doing [in the progress notes] is identifying the RN who is doing the delegation and the direction and the delegation is the delegation of tasks. Direction is the care of the client”*.

Melanie: *“Delegation is when they are delegating the work to me and direction is when they’re directing. Oh yes delegation. Directed is more asking me to do something, delegation is this is your patient or this is your workload”.*

Lynda: *“Delegation I would imagine is what you’re delegated to do so it might be your group of patients or whatever, direction is something you’re directed by somebody to do. Is that right or not?...I should have done more homework”.*

Trudy and Karl, both experienced Enrolled Nurses, had difficulty defining and explaining the two roles and the difference between them. Trudy described direction as *“task orientated”* and goes on to say that it is about instructing others, indicating a lay interpretation of the word.

Karl used the terms direction and delegation interchangeably rather than acknowledging that there was any difference between them. He was also unsure of the meaning of direct and indirect direction. For Karl direction meant being directly told to do something. However, then he could not distinguish this from delegation.

Lynda described asking a Registered Nurse to stand with her if she was unsure about a task but then does not link this to the term direction *“And the other thing I don’t mind how many questions I ask and if I look silly asking the question, I’d rather ask the question if I’m not sure of something than to fire ahead and think ‘I think I can do this’. I’ll just ask or I’ll say to someone can you just come and stand over me while I do this to make sure”.*

Some of the experienced Enrolled Nurses did not believe that delegation or direction was needed in their clinical settings.

Annabelle: *“Yes because you are allocating out the jobs. Yes I think the terminology for the direction and the delegation that for me comes in for me when you’ve got an acutely sick client and when you need something acutely and straight away so you’re saying I need da de da de da (click, click, click of fingers) – go and get. And that is when I look upon that side of it really coming in...I don’t really look upon it in the work we are doing”.*

For Julie direction and delegation also meant that she could delegate to other senior Registered Nurses where she works especially in *“emergency situations,”* a system she called: *‘a request assistance of delegation.’* Julie believed this was a mechanism she could use to be able to delegate to Registered Nurses. *“But there’s a word, a...And as I sort of said in the beginning that if the doctor wants bloods up and he want’s IV fluids up and a bed booked I can quickly ask the triage nurses if I can do something for them whilst they do this because this is urgent and....Yes, and I can book the bed you know and dah, dah, dah, but it is, ‘please*

stop what you're doing, this is more urgent than that', you know, and I can assist you with something else, but 'stop what you're doing and get on with it' pretty much but it's the way in which I get asked by the doctor to do it and the way in which I ask for the RN to do that. But to me it is delegation. Isn't it?"

Some of the Enrolled Nurses believed they played a direction or teaching role themselves when they guided a Registered Nurse's practice or taught them something new.

Annabelle: "We know what we're doing. I could do my job with my eyes closed because I have done it for so long and I know what I'm doing – or I think I know what I'm doing. I was perhaps the first one in [the clinic] to be doing this procedure with the docs. My RN colleagues who are new to the department have had to come in and watch me and how I do it. So I have been teaching them how I do it because there are really no great protocols written yet as it was so new. A lot of nursing is learned by observing. You can't read it out of a book".

Melanie: "But this one RN she asked me could she listen in, and I thought that was actually quite good. And when I work with new RNs, I'll say to them how things work at night. And I said if a phone call comes in from a patient in the community it's really good if you'd let me answer the first few calls, you listen to me and learn how I go about it and then you do the call and I'll listen to you and then once you're doing it similar to what I've been taught I know that you're fine and I won't need to listen in on you anymore...No we rarely have an agency RN...funny enough if there is one on night duty they get the assumed leadership but I direct and delegate them, it's a role reversal".

Judith: "And same with some of the nursing care, a lot of our staff will come and ask me, also we've got this: "what do you think we should do with it?" approach. So in all honesty that part of it is more them [the RN] learning from me but once again that's just because I've been so experienced. Probably more the other way round in all honesty. Yes, because I mean like catheterisation, most of the RNs on the ward have got no idea how to do it".

The distinction between the two different terms direction *or* delegation was only addressed by one of the Enrolled Nurse Agents, Alison, a new inexperienced Enrolled Nurse who distinguished delegation from direction.

Alison: "There's not really a lot of direction though. There is some delegation in my workplace. We're supposed to be working in these pods and it's supposed to be one RN and then maybe

two ENs or two RNs and at the moment we've cut our staff so we're up in the air and people are leaving and coming and going".

Working 'outside' the Enrolled Nurse Scope of Practice

The Enrolled Nurse Scope of Practice is only three paragraphs long (Nursing Council New Zealand, 2012a). It does not itemise what an Enrolled can and cannot do. However, Enrolled Nurses continually referred to "*working outside the Enrolled Nurse Scope of Practice*" as though what they could and could not do was outlined in the Scope of Practice. Other than a Fluid and Medication Policy available in some workplaces or if a 'local policy' had been developed for a specific workplace there is no other 'list' available to guide Enrolled or Registered Nurses in the nursing skills and tasks an Enrolled Nurse is able to do.

For Trudy what she was allowed to do was negotiated. She felt she could do this with some Registered Nurses but not others because of the way they communicated. *No there's no list up. The thing is, I can't make up the plan. I can't take on a patient and decide that they're on two hourly or four hourly obs. that they are immobile or mobile, I have to have an RN direct me as to this patient should be done two hourly, should be confined to bed rest, up only this way, and they should be nil by mouth or they should be only fed this or whatever. And that has to be done with, in conjunction I guess, with an RN. And some of the staff I can do that with. They leave it to me to make the assessment and report back to them and we come up with that in the team...And once that plan is established I can do what I like".*

The experienced Enrolled Nurse's knowledge of what they could and could not do had been shaped by a combination of their past understanding of what they could do, what the workplace culture would allow, and the knowledge that the Registered Nurse had about the Enrolled Nurse role.

Annabelle: *"I've accumulated experience and knowledge over time...I've learned what I can do anecdotally and by word of mouth...I trained in the old days when we were able to give pills, we were in charge of wards and we did the drug rounds. The ENs did all the work. We ran the place. I left my job to have my children and when I returned I found that my job had been amazingly dumbed down. All of a sudden I had to have my Panadol checked but what had I lost in knowledge? Nothing! And what had I lost in level? Everything".*

Katie believed that the culture of the workplace influenced what an Enrolled Nurse could do regardless of their Scope of Practice. Katie used the term, '*scoping down*'. '*Scoping down*' referred to a dumbing down of the Enrolled Nurse's Scope of Practice because the Registered Nurse was anxious about asking the Enrolled Nurse to do something they could not, or should not be doing. *"Yes, there are differences [in what an EN can do] in different places of*

work...And also there's culture I suppose about what ENs are expected to do regardless of Scope. In different workplaces which are usually 'scoped down' not up...yes nurses are frightened of asking an EN to do something they shouldn't be doing".

The Enrolled Nurse Agents were adamant they knew how to say “no” to a delegated task they felt was “*outside their Scope of Practice*”. The ability to decline to do a delegated task they believe is outside their Scope of Practice is an important risk management tool for an Enrolled Nurse. Many of the Enrolled Nurse Agents struggled with some of the Registered Nurses’ responses to their professional concerns. Some of the Enrolled Nurse Agents had adopted a communication style to cope in different situations when they had to decline to do a task.

Dallas: “Sometimes I have been in situations where the charge nurse has rolled her eyes and said in a slightly unpleasant way “Dallas doesn't want to do this...” Or “Dallas doesn't want to look after her client – can we swap around again...?” Although the words don't sound that bad when I say them out loud now it's the way it was said that stopped any negotiation, and the rolling of the eyes doesn't help either”.

Maryanne: “One day I was allocated a very complex patient who had all sorts of drains and tubing attached to her. I did not feel confident to nurse this woman. I really felt like I would be working outside my Scope of Practice by taking this patient and I just didn't feel confident with her. When I tried to tell the [allocating] nurse that I didn't feel confident she said ‘Oh Maryanne she won't always have those drains and things of course you can handle it’. Fortunately another Registered Nurse overheard me and offered to swap patients with me. You often get the busiest caseloads – even today – and I know what I'm comfortable with. I often think to myself if that was my mother or father lying there would I want me [as an EN] looking after them? If I'm not confident with the situation then I say so, and say “no”.

Lynda: “I've certainly got more confident as the years have gone by and being able to stand up for myself and to have the confidence to say if I can't do something or I'm not going to do something...I say I'm sorry it's not in my Scope of Practice”.

Davinia believed she needed to justify saying “no” but sometimes she felt she over justified. *“I think that when I've said ‘no’ in the past I've had to justify myself. Which, I've justified myself further than what it probably needed to be because I think some days it's well, no I need to be delegated to and you know, take it, but these things, and the way that I put it is I'd love to help but I'm really uncomfortable doing that and I've got issues about giving out medications that I haven't signed for. But the RN will go: ‘Oh but you can look at them and then like you know, see what they look like and then just triple check...”*

Elaine: *“I do tell them, the new ones, the new Registered Nurses that come in, I say to them I’m the least experienced of all the nurses here in this hospital. In other words I’m kind of saying to them look I don’t know everything, don’t expect me to know everything and if you want me to do something do find out if I can do it...I mean you know if I feel as though I don’t feel confident enough to do something I will say to her look I don’t feel confident enough to do this but if you have time can I watch so that next time I can do it.”*

On one occasion when Elaine was concerned that she was ‘working outside her Scope of Practice’ she contacted a professional nursing body to discuss her concerns. She was told: *“Well you’d be surprised what happens out there in the community”*. She had not found this response to be a helpful response as a new inexperienced Enrolled Nurse at the time.

Many of the Enrolled Nurse Agents explained that for them ‘working outside the Scope of Practice’ meant doing something they shouldn’t.

Dallas: *“Working outside the Scope of Practice means doing anything you know you shouldn’t do. We get around this by saying something like: “Do you want to come and visit me in Mt Eden next visiting day?”* This served as a humorous warning for the Registered Nurse not to ask again and got the Enrolled Nurse out of the often tricky situation of declining to do a delegated task which then could potentially lead to a conflict situation.

Lynda: *” I mean it sounds dumb by me saying that I don’t know how I know what I can do...well we kind of just know what we’re allowed to do and what we can’t do...Because we, you know, we talk often with the girls at [local hospital] and they say things they’re not allowed to do and we say things we do but they’re not allowed to do. I mean often they’re not even allowed to have drug keys and things like that. The greatest frustration I hear from them is that there are things they’re not allowed to do, which are actually in their Scope of Practice but they’re told they’re not allowed to do it and that is incredibly frustrating for them and it’s demeaning. And undervalues them and that makes you feel not part of the team. You know you can just feel like a skivvy that’s there to clean the sluice room and empty the linen bags...And that’s probably what comes through a lot at the Enrolled Nurse conferences is the sheer frustration that they feel their skills aren’t being utilised”*.

Although a self-assessment process is not mentioned in any of the guidance literature available to New Zealand nurses many of the Enrolled Nurse Agents described a form of self-assessment they carried out in order to identify if they should be doing the task asked of them. The self-assessment was based on their confidence levels. If they did not feel confident doing it or had not been trained to do a task, they would decline to do it. The self-assessment role that they carried out would be invisible to others.

Melanie: *“If I feel confident to do it, it’s OK because the RN might be busy doing something and she might be out on the ward for half an hour with a patient and I feel quite OK about what I’m doing... At night, I always try and put the patient [who has called from the community for advice] on hold for a moment to tell the RN about it, to cover myself. But if there’s no RN in the office, I can’t”.*

Davinia: *“I have a general idea of what I’m allowed to do. [We were taught] at school. Going through like policies and procedures and I always check with a senior RN, I always just, I normally double check and say look is it cool? If you’re comfortable doing it and you’ve seen it done then that should be fine. I personally wouldn’t go and catheterise someone. But I mean I can, if there’s something that needs to be done but if I’m uncomfortable doing it I will let the RN know...And that’s very confusing for everybody, but generally if I feel comfortable doing it [a delegated task] like that I’ve done it a lot I’m more than happy to do it. But there are things that I don’t know about that I wouldn’t do. Like I don’t know if we could put NG feeds down”.*

An Enrolled Nurse self-assessment was accompanied by a degree of trust from the Registered Nurses.

Maryanne: *“And it takes time. You have to build up a relationship of trust as the Registered Nurses get to know you”.*

Trudy: *“Your delegated a task because the Registered Nurse knows you can do it”.*

Judith: *[The RN knew what you could do by] “...dialogue. It would be dialogue. Once again at that beginning of the duty when we’re talking about our clients, I would say, someone has IVABs due and I would say: “they’re due at such and such hours but you will have to get someone from the other end because I’m not allowed to do that...And the RNs they have to trust us. So there is a lot of that and that probably influences a lot of the direction, because I mean I don’t go to my RN every time my client does anything and say Mrs. So and So’s just been to the toilet, she did this or that. I don’t do that...Some of the ENs have been so nullified over the years that they feel that they have to say something to their RN every time their client has done something. They don’t. I say to my RN if I don’t tell you nothing there’s nothing different”.*

Davinia did not refer to trust in this way. Her perception was that the allocation of patient load at shift handover was not consistent and sometimes it was unfair to the Enrolled Nurses. When she had spoken out about it in desperation one day the experienced Enrolled Nurses told her: *“not to rock the boat”... And everybody else’s list was just peachy. I said what is this? Why? This isn’t fair. And they’re like no it’s not very fair. I said why is it that Enrolled*

Nurses always seem to get the heavy end and the Enrolled Nurses were like, well we're all good just shut up, don't rock the boat. I was so angry. I thought how do you expect me to do all this?"

She observed that some of the experienced Enrolled Nurses do not get delegated to in the same way that she did as an inexperienced Enrolled Nurse. *"Some of the [experienced] Enrolled Nurses don't get delegated to because they've been there longer than the Registered Nurses but the Registered Nurses still have the power at the end of the day [to give them heavy workloads] ...I mean which is obviously the way that it all works but I wonder if that's a, you know, 'I'm not going to ask you to do anything [I'm not going to delegate to you] because you'll probably laugh at me but I'll give you the heavy load"*.

The Enrolled Nurses Agents could clearly explain that they were accountable for their own practice. However, they identified that there was confusion about who was responsible for the nursing care delivered.

Trudy: *"And so they don't know that they're not responsible for my decisions but then others take it on board so much because they don't want to be responsible for my decisions so 'you'll do it my way". I don't have any thoughts. I've just got to do it, what I'm told"*.

Eloise and Sally described a situation where there was an avoidance of working with them and a lack of engagement from some Registered Nurses. *"In my area a Registered Nurse is allocated an Enrolled Nurse to work with by attaching an asterisk to their name on the staffing whiteboard for that shift, but some Registered Nurses will often change it to another Registered Nurse's name. They do this because they feel that working with an Enrolled Nurse is unsafe and that they will be responsible and answerable for their [the Enrolled Nurse's] patients as well, if something goes wrong"*.

None of the Enrolled Nurses interviewed had heard of the requirement cited in the delegation literature (Nursing Council of New Zealand, 2011b, p. 6) that involved the patient being told that the nurse caring for them was an *Enrolled Nurse* and this did not happen in their workplaces. All Enrolled Nurse Agents felt this requirement would be insulting to the Enrolled Nurse and it would not support the building of trusting relationships.

Learning about direction and delegation

Many of the experienced Enrolled Nurses' shared stories acknowledged that their access to information and support about the new level and Scope of Practice for Enrolled Nurses stemmed from the preparation of their portfolios when they transitioned to the Level 5 Scope

of Practice post 2011. Other than their portfolios and exemplars and scenarios prepared for the Professional Development Recognition Programme (PDRP) they did not know of any other information sessions available in their workplace related to the roles and responsibilities of Enrolled Nurses or how to do direction and delegation.

Dallas had attended NZNO conferences and study days. *“Yes. And with our study days as well when we run individual ones throughout the country we bring in a speaker. Some think our role has changed and some don’t think anything has changed since we transitioned. Some say no. Some say some do more, some do even less”.*

Katie wanted to see her employer provide more in-service education around Registered Nurses and Enrolled Nurses roles and responsibilities and what an Enrolled Nurse can do in specific nursing areas *“Because a lot of the RNs are suddenly with Enrolled Nurses and they don’t know what to do and they’re quite anxious really...I learnt on-the-job. Oh I probably have been to study days but then again you’ve got to practice what you’re learning and you do your own job. I can’t say there’s been any one particular course that’s sort of stuck in my head anywhere”.*

Dianne believed that PDRP had been extremely useful in identifying information about the Enrolled Nurse role. She described the lack of information about direction and delegation as *“extremely unhelpful for both RNs and ENs...And I feel sorry for the ones that haven’t done their PDRP. Because I was, don’t get me wrong I was s*** scared doing my first one six years ago because I haven’t had to study. I haven’t had to do that for God, probably since after I left, after I did my training. That was it. Because they didn’t really have that much in-service back in the day. But yes, and once I did my PDRP I went back and I was, my boss was probably screaming because his budget would have been blown because I just got probably ninety per cent of the Enrolled Nurses in our ward on to do their PDRP”.*

Jody: *“I think it’s [delegation] has just metamorphosed over the years...And it’s always changing. And when I started, because we were on the ward we were Enrolled Nurses and everybody had a very clear, I think we did in those days, a very clear role. You did this, Registered Nurses did that and there were certain things that we had to do on the ward before you finished in a duty and if you didn’t you were told to because the charge nurse came down and bellowed at you. You knew. But it’s got blurred a little bit sometimes I think on the way and I think you’ve got to be very responsible for your own actions. And I like to think that the systems are set up for an Enrolled Nurse coming out of training to know that that’s what she’s got to do”.*

Maryanne: *“I can’t remember any formal sessions about direction and delegation...You just knew you would be delegated to”*.

Barbara: *“[I learned about delegation] just on the Internet when it came out, I actually went back and did courses in direction and delegation”*. She could not think of any formal teaching sessions in her early days as a Community nurse except that [Community nurse] students were taught to work under the guidance of a Registered Nurse and *“work in together in a positive manner and to ask for help when needed if there was a problem, otherwise you did not need to go to the Registered Nurse”*.

Lynda: *“I learned on-the-job...Well we were talking about this at work the other day too [how do we know what to do during delegation] because I looked at one of the questions and I said to the RN I was working with on Thursday night, I said we had a lot of professional development at [name of workplace]. We both don’t recall that we had anything about delegation though. Maybe a part of a study day or something. So to be honest we don’t know how we know about it”*.

Personal and professional stories about Enrolled Nurses’ direction and delegation experiences

The prompt suggestions within the interview schedule enabled Enrolled Nurse Agents to share their personal feelings, perceptions, hopes and desires, and when these were linked to the social milieu where they worked, professional stories that were individual to them came to light. Personal and professional stories of delegation experiences are *stories* about how Enrolled Nurse Agents made direction and delegation work for them, and their perception of the communication interactions they had been involved in during delegation interactions.

The following tables represent the relationship of the nurse Agent, and the Acts, Scenes and Agencies that arose from the nurse Agent’s stories, and led to the development of the narrative plot for each Enrolled Nurse. The shaded boxes identify inexperienced nurses’ experiences and the unshaded boxes identify experienced nurses’ experiences. A legend is provided at the end of the four tables.

Table 5.1. The relationship of the major patterns, and the Acts, Scene and Agencies that shaped the narrative plot of the Enrolled Nurses' stories of experience

Major pattern: Working together

Agent and script no.	Acts and Scenes	The Agencies	The narrative plot of...
Script no 28 for Dianne	<ul style="list-style-type: none"> ○ Being confident and competent ● Treating people fairly ● Getting along ● Assessing the Enrolled Nurse ● Learning about delegation and direction ● Saying 'no' 	Confident and competent nurses	The narrative plot of being confident and competent: the experienced Enrolled Nurse
Script no 16 for Jody	<ul style="list-style-type: none"> ○ Working as a team ● A partnership approach ● Geographical nursing versus team work ● Knowing about delegation and direction ● Allocation or delegation? ● Being accountable ● A fair workload 	Working as a team	The narrative plot of working as a team: the experienced Enrolled Nurse
Script no 9 for Melanie	<ul style="list-style-type: none"> ○ The blue dot buddy system –seeking leadership ○ Sharing the workload ● The role of culture ● Knowing what and Enrolled Nurse can do ● Working autonomously ● Delegation and direction ● Allocation or delegation? ● Working 'outside' the Scope of Practice 	Leadership	The narrative plot of leadership: the experienced Enrolled Nurse
Script no 20 for Annabelle	<ul style="list-style-type: none"> ○ Team work- working in and as a team ● Learning about delegation ● Allocation, delegation or supervision? ● Delegation or direction? ● Negotiating a fair workload ● Knowing what an Enrolled Nurse can do 	Team work	The narrative plot of team work: the experienced Enrolled Nurse

	<ul style="list-style-type: none"> • Saying no to a delegated task 		
Script no 22 for Maryanne	<ul style="list-style-type: none"> ○ Rebellion - Going higher • Learning about delegation and direction • Allocation or delegation? • Negotiating the workload • The role of assessment • Saying 'no' 	Rebellion	The narrative plot of rebellion: the experienced Enrolled Nurse
Script no 11 for Lynda	<ul style="list-style-type: none"> ○ Valuing nursing leadership ○ Manager-managers and leader-leaders ○ A negotiated partnership • Gaining confidence and saying 'no' • Working 'within' the Scope of Practice • Allocation or delegation? • Fair and equitable workloads Delegation and direction 	Valuing nursing leadership	The narrative plot of leaders or managers: the experienced Enrolled Nurse

Major pattern: Delegation as a relationship

Script no.	Acts and Scenes	The Agencies	The narrative plot of...
Script no 18 for Judith	<ul style="list-style-type: none"> ○ Establishing a relationship ○ Dialogue and trust ● Allocation or delegation? ● The role of local policy and procedure ● Learning about delegation the role of PDRP ● What can and Enrolled Nurse do? ● Working outside the Scope of Practice 	Establishing a delegation relationship	The narrative plot of establishing a relationship: the experienced Enrolled Nurse
Script no 23 for Trudy	<ul style="list-style-type: none"> ○ Being acknowledged ○ Delegation as relationship ● Geographical nursing versus Team nursing versus Primary nursing ● Allocation or delegation? ● Delegation and direction ● Being accountable ● Allocating a fair workload ● Saying 'no' 	Being acknowledged	The narrative plot of being acknowledged: the experienced Enrolled Nurse
Script no 8 for Eloise and Sally	<ul style="list-style-type: none"> ○ Being part of the decision making ○ Being valued ○ Being part of a team ● Advocacy ● Allocation or delegation? ● Delegation and direction ● Being accountable 	Being included in the decision making	The narrative plot of being included in the decision making: the experienced Enrolled Nurses
Script no 10 for Davinia	<ul style="list-style-type: none"> ○ Needing support ○ The inverted hierarchy ● Allocating a fair workload ● Allocation or delegation? ● Autonomous experienced Enrolled Nurses ● Deletion and direction ● Saying 'no' to a delegated task ● Being accountable 	The supportive environment	The narrative plot of support: the inexperienced Enrolled Nurse

Major pattern: Communicating well

Script no.	Acts and Scenes	The Agencies	The narrative plot of...
Script no 24 for Julie	<ul style="list-style-type: none"> ○ Choosing a positive and successful communication style. ○ The role of personality ○ Being a team player and working <i>with</i> the Consultants ● ‘Delegating’ to RNs 	Positive communication, tone and the way people talk to each other	The narrative plot of communicating well: the experienced Enrolled Nurse
Script no 19 for Katie	<ul style="list-style-type: none"> ● Two way discussion - Including the Enrolled Nurse Skills for delegation ● The role of personality ● Scoping down ● Learning about delegation and direction ● Allocation or delegation? 	Supporting two way discussion	The narrative plot of two way discussion: the experienced Enrolled Nurse
Script no 12 for Dallas	<ul style="list-style-type: none"> ○ Assessment and leadership ● Choosing a communication style ● Saying no to a Registered Nurse ● Negotiating workload ● Allocation or delegation? ● Working ‘outside’ the Scope of Practice 	Access to assessment and leadership	The narrative plot of assessment and leadership: the experienced Enrolled Nurse
Script no 17 for Barbara	<ul style="list-style-type: none"> ○ Being welcomed ● Communicating professionally ● EN Self-assessment ● Delegation or allocation? ● What is a team? ● Teaching others and sharing knowledge 	Being welcomed	The narrative plot of being welcomed: the experienced Enrolled Nurse
Script no 7 for Karl	<ul style="list-style-type: none"> ○ Balance - seeing both sides ● An egalitarian approach ● Communication during decision making 	Balance	The narrative plot of balance: the experienced Enrolled Nurse

	<ul style="list-style-type: none">• RN leadership• Regrouping – working in and as a team• Saying “no”• Delegation or direction?• Welcome changes to the Scope of Practice		
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Major pattern: Seeking delegation

Script no.	Acts and Scenes	The Agencies	The narrative plot of...
Script no 27 for Elaine	<ul style="list-style-type: none"> ○ Extracting, triggering and prompting delegation interactions • Communicating professionally • Respect and good and bad manners • Saying 'no' to a Registered Nurse • Knowing the Scope of Practice 	Extracting delegation and direction	The narrative plot of extracting delegation: the inexperienced Enrolled Nurse
Script no 26 for Alison	<ul style="list-style-type: none"> ○ Searching for delegation ○ Saving face ○ Sorting it out herself ○ Working in isolation • Allocation or delegation? • Delegation and direction • Working outside the Scope of Practice 	Requesting and seeking delegation	The narrative plot of seeking delegation and direction: the inexperienced Enrolled Nurse
Script no 14 for Amy	<ul style="list-style-type: none"> ○ Taking responsibility ○ Seeking an allocated R/N buddy ○ Seeking clarification of the EN Scope of Practice ○ Leadership and communication style • Delegation and direction • Geographical nursing versus team nursing • Being accountable • Saying no to a delegated task 	Being responsibility	The narrative plot of taking responsibility: the experienced Enrolled Nurse

Legend

○	Narrative plot
•	Shared meanings
Shaded boxes	Inexperienced nurses
Unshaded boxes	Experienced nurses

Enrolled Nurse Agents' stories about 'Working together'

The findings of the major pattern of 'working together' captures the stories of six experienced Enrolled Nurse Agents who tried to meet the professional obligation to work under the direction and delegation of a Registered Nurse in different ways. The narrative plots gathered together in this major pattern share a belief that working together was important but in order to work within their Enrolled Nurse Scope of Practice they each adopted a different role and a way of interacting, and this was reflected in the way they communicated. In the end the stories show that these experienced Enrolled Nurse Agents had recast 'direction and supervision' to suit their situation and meet the requirements of their Scope of Practice.

For Dianne being confident and competent was important. She herself was confident and competent in her nursing abilities and she expected this of the Registered Nurses with whom she worked. This was not always the case because of the number of new, casual and agency Registered Nurses employed in her specialised nursing area who did not have the nursing knowledge and experience to understand what is involved in the workload. Without specialised nursing knowledge they could not direct or delegate her nursing practice. Dianne's stories point to the finding that as an experienced Enrolled Nurse she was working to a different interpretation of 'working under the delegation of a Registered Nurse' especially when working with new inexperienced Registered Nurses who were not yet confident about delegating to an experienced Enrolled Nurse, or an agency or casual Registered Nurse. This interpretation of the delegation role has been shaped by her past understanding of direction and supervision. For Dianne 'good' delegation included "*getting along*" with the other nurses "*being honest about your abilities*" having a "*good work ethic*" "*understanding what was involved in the workload*" and most importantly being confident and competent. In the end though being experienced and knowledgeable about the nursing area shaped Dianne's ability to work almost independently of the Registered Nurses delegation requests, if any were given. Dianne's stories led to the identification of the narrative plot of being confident and competent.

Jody also expected nurses to work together as a team but was concerned about some of the nurses she worked with who in her opinion were not safe or efficient with their time. This detracted from her willingness to work together with some of the nurses on her ward. In the end though Jody's stories were about the geographical model of nursing care in her workplace which is conducive to an allocation model, not a delegation model, but allowed her some choice in whom she works with. Through her description of working together Jody

created a register of communication skills needed to work together *as* a team. Jody's way of working *as* a team was to expect honest and "*straight up*" positive communication which brought nurses together and included the Registered Nurse "*not lording it over others*" being "*tactful and kind*" when giving feedback, and an ability to "*decode*" or read between the lines of what the Enrolled Nurse was really saying when they were observing and reporting back to the Registered Nurse. Jody believed that Enrolled Nurses needed to be assertive when asking for help with large workloads. A Registered Nurse who took charge of the environment and was confident in their body of knowledge were also important aspects for working together. Although Jody tried to work together with other nurses, *as* a team and in partnership, the geographical model of nursing she was required to work within did not support working *in* a team of different abilities and skill mix. Her description of the geographical nursing model employed in her workplace highlights the impact the nursing model has on working *in* a team and illustrates that these two views of team work have different ways of working together, and outcomes. Jody and her nurse buddy were allocated a patient load and worked separately within their allocated geographical area, and checked in or called for assistance *if* and when needed. While this met Jody's need to feel safe and complete her workloads safely "and on time" it may not be suitable for other new graduate Enrolled Nurses employed in the future as they will not have the many years of experience she has. They will be expecting to be delegated to, and directed. Her stories also highlight the need for a description and definition of 'team' and working *in* a team in acute workplaces, as is required in the Enrolled Nurse Scope of Practice (Nursing Council New Zealand, 2012a). The narrative plot of working *as* a team tells a story about the role Jody had carved out for herself on a busy medical ward, the scene of her stories.

Melanie was also concerned about the lack of nursing knowledge of some of the Registered Nurses she worked with in her current workplace which made her reluctant to work under their delegation. She understood the importance of working together with the Registered Nurse and requested access to a knowledgeable and experienced Registered Nurse who could lead the team and provide sound clinical advice and support. In the process of requesting a "*yellow dotted*" Registered Nurse who could be appointed to provide clinical knowledge and direction and delegation leadership to her and the other nurses, she herself played a leadership role. The request to her charge nurse was based on knowing that she must work under the delegation of a Registered Nurse but there are times when the Registered Nurse in charge of the shift was new or did not have the body of clinical knowledge yet to advise Melanie or the other nurses in this specialised nursing area. In the end though her request for a "*yellow dotted*" Registered Nurse who could lead the shift and provide the clinical advice and *direction* input in the true sense of the nursing term, did not come to fruition, and she and

the other Enrolled Nurses worked without the direction and delegation advise they believed they needed. Although this suited some of the Enrolled Nurses she worked with it did not meet Melanie's needs to work under the direction and delegation of the Registered Nurse. On top of this Melanie often has to advise, direct or delegate to new or casual nurses in a role we named together as "*role reversal*". While some Registered Nurses were appreciative of this advice and her experience in this specialised nursing area, others were not. In one case this had resulted in a Registered Nurse making a complaint to Melanie's manager because she was "*over confident*". At the other extreme a Registered Nurse arrived on duty to explain to Melanie that she could just do whatever she needed to do as she was there to "*babysit*" and "*make it legal*". For Melanie positive communication was the basis of effective leadership, and leadership was needed to support healthy delegation practices. She was a gentle and articulate speaker who believed an Enrolled Nurse should be "*humble*" because "*they are still the RN*" but she asked for two way communication during direction and delegation, being respected as an equal, and tact and diplomacy as she felt that this encouraged nurses to work together. The narrative plot of leadership is built on the stories Melanie shared about the leadership she sought in order to work together with her colleagues, and the patients allocated to her care.

Team work and leadership were important to Annabelle too. Good team work happened when the team shared their knowledge, valued each other's contribution and worked hard. This is reflected in the narrative plot of team work which shows the importance Annabelle places on working *as* a team. Annabelle needed to have pleasant functioning teams that worked hard, team members who were prepared to learn from each other and communication between nurses that was "*clear, succinct and concise*". Annabelle's stories clearly point to the team work she felt nurses needed in order to work together and for Annabelle good team work and the delegation interactions required within the team also pivoted on leadership. Working as a team needed a Registered Nurse who could lead the team, preferably by example, members who were willing to share their knowledge and value each other's input. If the team did not work together in this way then Annabelle would not be able to learn the new skills she required to safely care for her patients, or share her knowledge with other nurses. She described the leadership style she needs using the analogy of a "*figure of eight*". "*A good working team with good leadership is like a figure of eight with RNs and ENs working together, crossing paths, sharing, working as a team, debriefing and explaining and learning from each other*". The strategy she employed to work within her Enrolled Nurse Scope of Practice was to "*work alongside and with*" the other members of the team, not *under* the delegation of the Registered Nurse. In this Annabelle had been shaped by her past experiences

of ‘direction and supervision’, a model from a previous time and place, and this in turn shaped the way she preferred and expected ‘delegation’ to happen in her current nursing role. For these reasons she valued the clinic where she was currently employed as the Enrolled and Registered Nurses worked together, and allocated and decided the workload together. The way Annabelle’s workplace was structured determined how clinics, not individual patients or tasks were allocated by the Registered Nurse charge nurse at the beginning of shift, and how organisational tasks were decided equally by the Enrolled and Registered Nurses together. In the absence of a Registered Nurse to Enrolled Nurse delegation model in place, it could be imagined that the consultant medical personnel were by proxy responsible for the delegation role. However, there was no discussion about the Consultant medical personnel’s delegation role, nor is there any discussion about what Annabelle knew or understood about the supervision role that would be required by the charge Registered Nurse in this nursing model. Annabelle’s stories illustrate the difference between working *as* a team and working *in* a team.

There are similarities and differences to the other Enrolled Nurses’ stories evident in Maryanne’s perception of working together. In the absence of experienced knowledgeable Registered Nurses she could trust who could provide safe direction and delegation advice and support she would go to the other members of the interdisciplinary team that she trusted, not necessarily her appointed Registered Nurse buddy. However, Maryanne’s version of working together took a different turn to the other experienced Enrolled Nurse Agents. This was the plot of rebellion. While she understood that gaining nursing experience took time she had developed a mechanism to keep herself and her patients safe by “*going higher*” until she got the care she needed for her patient. She described several clinical incidents where she would go to the charge nurse or nurse specialist rather than to her allocated Registered Nurse/buddy if she was not confident in the allocated Registered Nurse’s abilities. She did this tactfully and diplomatically “*probably every working day of my life*”. She tried to ensure she did not “*go higher*” in an obvious or hurtful manner as she does not want this to be unpleasant. The end result though was that going to the Registered Nurse for direction or delegation advice and support in this busy and often acute medical workplace, simply because they were a Registered Nurse, was not necessarily the correct course of action in all cases. In this strategy she had modified the delegation requirement to keep her patients safe. Maryanne felt that successful communication during delegation was linked to a nurse’s personality, common courtesy and the way nurses communicated and often Enrolled Nurse felt like “*second class citizens*”. Maryanne’s perception was that Registered Nurses did not want Enrolled Nurses on the ward. She described a typical handover situation where the Registered Nurse repeatedly only addressed the Registered Nurse, even though Maryanne had been caring for this patient.

Another Registered Nurse she had worked with in the past always said to the Enrolled Nurses who came to the ward “*You jump when I say jump, and when I want you to jump*”. Over time and shaped by her past experiences, Maryanne had adapted delegation to suit the kind of nurse she wanted to be. In this her stories and her perception of the events that surrounded the delegation communication interactions with Registered Nurses and other members of the interdisciplinary team, fits the narrative plot of rebellion. Maryanne’s reasoning during these ‘rebellious’ clinical situations was driven by her lack of confidence in her allocated Registered Nurse buddy that prevented her from being able to work together with them, and the compassion she felt for the patients in her care.

Lynda by comparison believed in the nurses she worked alongside. There was low staff turnover and high job satisfaction in her workplace. She attributed this to the good nursing leadership in her workplace which provided flexible, valuing leadership so that the nurses are able work together as a team. For Lynda working together took a slightly different perspective. She described an allocation model of nursing and a very experienced group of Enrolled and Registered Nurses. In the narrative plot of leaders or managers Lynda’s stories show the value she placed on the leadership in the surgical hospital where she was employed. Lynda went on to describe that her workplace had ‘Managers’ and ‘Leaders’, and she could describe the difference between the two and linked this to some of the management personnel in her workplace. Even though some of managers had a nursing background she described them as ‘Manager-managers’ to distinguish them from the clinical nurse leader who was a ‘Leader- manager’. She understood that you needed Manager-managers but was also grateful that they had a Leader-manager who set the scene for the way nurses worked together. Lynda was happy with the communication interactions and the way delegation occurred in her workplace. She cited the nurse leader’s ability to lead which included flexibility, an approachable manner, someone who listens to the staff, helps out in busy periods, and has an open door policy as setting the scene for the way nurses work together. Lynda explained that good leadership required good communication and the way nurses communicate can “*make or break a place*”. Lynda identified the communication skills that Registered Nurses needed: being open and being fair and equal with workload allocation. The skills that an Enrolled Nurse needed included being knowledgeable about the work area and being reflective about their nursing practice. Lynda’s stories showed that leadership style impacted on direction and delegation interactions and true leaders shape the way nurses work together. This led to the narrative plot of leaders and managers.

Enrolled Nurse Agents' stories about 'Delegation as a relationship'

The finding of the major pattern of 'delegation as a relationship' gathers together the stories of one inexperienced and three experienced Enrolled Nurse Agents. At first glance the narrative plots within this major pattern appear to be separate stories but as the plots are revealed they show that Enrolled Nurse Agents believed that delegation interactions are a two way relationship, and this meant being listened to and having their nursing training and education respected. Taken together their stories identify that there are underlying messages about under and over-involvement during delegation interactions that may be detrimental to cultivating the relationship needed to support safe and effective delegation communication interactions between Enrolled and Registered Nurses. In this study all the Enrolled Nurse Agents found that forming a relationship took time, skill and goodwill from both nurses.

Judith's narrative plot of establishing a delegation relationship was told through her perception of the 'good' and 'bad' delegation interactions she had been involved in. She provided a plot that showed that establishing a delegation relationship was built on the way nurses communicate with each other, if an assessment of the Enrolled Nurse and the environment took place, and the leadership style of the Registered Nurse. If there was an absence of "trust" and "dialogue" needed for good communication between nurses, or a lack of assessment and leadership, an under-involvement of direction and delegation interactions was the end result. Conversely, if there was over-communication, over-management or over-leadership, an over-involvement situation could occur. Both of these avoidable situations could be detrimental to her, her colleagues and the clients in her care. She pointed to her story about her patient who was in a great deal of pain. Although Judith was working under the delegation of a Registered Nurse, Judith's patient had waited in pain for over an hour for a decision about the pain relief to be made by a third Registered Nurse who had become unnecessarily over-involved. The third Registered Nurse had incorrect information, had not listened to Judith's assessment and had not assessed the client herself. Judith provided a second story about a Registered Nurse new to the New Zealand nursing system who spent the shift chatting to the patients while Judith completed all the work in this busy medical ward. Judith's perception was that the communication needed for good delegation interactions that allowed a relationship to form between nurses included negotiation, being fair and equitable, trust and dialogue. The stories Judith shared were the first time that the importance of forming a 'delegation relationship' emerged.

In Trudy's narrative plot of being acknowledged she described three delegation interactions that she felt had gone well because there was leadership and a good communication style. As

her stories unfolded it became clear that she would have liked to see more discussion with her Registered Nurse colleagues to plan the workload together and she added that this way of working together seemed rare these days. Mostly the communication between Enrolled and Registered Nurses was “*directive*” in manner and usually involved the Registered Nurse giving orders and instructions. In Trudy’s script she implied that this ‘*directive*’ communication style was the ‘*direction*’ aspect of direction and delegation, as this was her understanding of the term direction. This “*turned nurses off and shut down any discussion*”. Earlier when discussing how unhelpful the Ward Clerk was with her at times she had referred to this as being about “*status*”. As she had a perceived lower ‘status’ as an Enrolled Nurse she felt like “*a second class citizen*” compared to a Registered Nurse as the other staff would only listen to the Registered Nurse and she felt undermined. She wanted the Registered Nurses who would be directing and delegating her nursing practice to have a body of knowledge so that everyone, including the patients and herself, were safe. This resulted in her trying to avoid working with some nurses as she did not trust their knowledge levels and this led to her “*doing her own thing*” and “*just getting on with it*” and forced her into a position of working alone which prevents a relationship forming. Trudy’s stories show that in order for the delegation request or instruction to be heard she needed to have her contribution acknowledged, be part of the discussion, and have her opinion listened to. This made the delegation interaction a relationship as it took two nurses to make it work rather than being made to feel like the “*meat in the sandwich*”. The words and phrases she uses such as “*meat in the sandwich*”, “*status*” and “*second class citizen*” were clues to how she felt about some of the other communications interactions she had been involved in. Even more significantly though when Enrolled Nurses do not work under the direction and delegation of a Registered Nurse, and the Registered Nurse is not directing or delegating to the Enrolled Nurse, both are working outside the Scope of Practice.

In the narrative plot of being included in the decision making Sally and Eloise showed that they wanted to be included in discussions about patient care, and have their nursing assessment skills and experience valued, but felt that they were excluded from this. While some Registered Nurses they worked alongside had been valuing, professional and supportive of the new Enrolled Nurses being employed in the mental health area where they worked, others were not so welcoming and this showed up in patient handovers, and in some of their Enrolled to Registered Nurse delegation interactions. Their experiences as new Enrolled Nurses to mental health were difficult and they were frightened and upset by some of the delegation interactions they had been involved in recently. The stories they share show that they were excluded from the decision making process through a breakdown in communication and this meant that they were unable to form any sort of delegation

relationship with some of the Registered Nurses. For Sally this had resulted in a fatal outcome for one patient that had left her shaken.

Eloise was concerned that her assessment knowledge was not being listened to and that sometimes she would ask for a delegating Registered Nurse when she was in handover report and no one answered. *“How can we work within our Scope of Practice if we don’t have a Registered Nurse to discuss nursing decisions and report our observations to?”* Although Sally describes feeling foolish and undermined it was more important than this and had led to a serious incident in her workplace. Sally and Eloise wanted to be able to contribute to safe nursing care, be accepted as part of the team, not a hindrance to it. They both felt that the communication breakdown could only be improved when Registered Nurses’ understood the Enrolled Nurse Scope of Practice, their roles and responsibilities, and the nursing training and nursing skills they had.

Davina’s narrative plot of support is structured around her perception that there was an *“inverted hierarchy”* in the busy sometimes *“hectic”* medical ward where she had been newly employed. The inverted hierarchy captured the practice that many Registered Nurses could ‘delegate’ any number of tasks, at any time to one Enrolled Nurse on top of the Enrolled Nurse’s allocated workload. The top heavy and unfair inverted hierarchy prevented a direction or delegation relationship from forming. As a new inexperienced Enrolled Nurse Davinia had identified she needed a supportive, non-judgemental delegation *relationship* where questions could be encouraged and answered, there was an empathetic approach from those she worked with, and an understanding from the Registered Nurse delegating the task that after she had self-assessed she could decline to do a ‘delegated’ task if she did not feel confident to carry it out. This was her understanding of direction and delegation based on what she had been taught during her Enrolled Nurse education, and the guidelines available on delegation. She described how a few of the Registered Nurses assessed her abilities and the workload she already had before delegating tasks to her, and one Registered Nurse in particular showed leadership in the way she communicated. When this happened it felt like a *relationship*. However, many of the Registered Nurses did not. There was one Registered Nurse that Davinia really admired and she would often go to her with questions as this Registered Nurse was approachable and non-judgemental. She had exceptional communication skills and could ‘teach,’ answer questions and give Davinia feedback in a supportive way. She found that this nurse was supportive to both patients and her nursing colleagues *“She [the teaching RN] is very empathetic and that’s also important to me. I feel comfortable when this nurse is on duty and I always learn a lot from her. I like her way of being a nurse too. Some of the nurses I work with aren’t empathetic at all, even to the patients and I find this difficult”*. She provided another a story about missed care for one patient and a

story about 'Mrs Watson' which captures the moment she realised that if the nurses are not empathetic with patients how can they be empathetic with each other or with a new inexperienced Enrolled Nurse who is struggling, or even merely asking questions. Together her stories of experience show that to communicate in a supportive way was essential for her as an inexperienced Enrolled Nurse, and led to the narrative plot of support.

Enrolled Nurse Agents' stories about 'Communicating well'

While all the nurse Agents within this study chose to talk about their "good" and "bad" delegation communication experiences, for the five experienced Enrolled Nurse Agents within this major pattern, 'communicating well' was entwined throughout all their stories. The findings of the major pattern of 'Communicating well' points to the communication strategies the nurse Agents used, had seen used, or wanted to see used and in doing so established a link between an understanding of good communication skills, and safe and effective delegation interactions. In this major pattern the *way* a task was communicated was as important as the task being delegated.

For Julie, 'communicating well' meant positive and successful communication from the health care professionals with whom she worked. However, she had not always been on the receiving end of positive communication in the past and it was these concerns that shaped the way she expected people to communicate, and how she preferred to communicate with her colleagues. Julie eloquently described the stress that unpleasant communication interactions can have on a person and she was very clear that in her experience the way people communicate is directly related to their personality. She provided a number of stories in support of this that revealed the narrative plot of communicating well. Julie based her most recent 'communicating well' stories on a charge nurse she currently worked with in the clinic where she was employed, who managed to communicate in such a way as she took the staff "*with her*" rather than telling the nurses what to do. The charge nurse was an example of someone who could deal with the issues that needed to be dealt with even if they were potential conflict situations, with a wonderful delivery and tone that had a softness to it. Julie was adamant this was not just about behaving like a professional in the workplace because you had to, or because it was a requirement of a code or standard, it was about the charge nurse's personality: "*...but she has the most wonderful delivery, she takes a deep breath and she avoids eye contact and you can see that she's really annoyed, but she's got that soft delivery, and you know, if there's a way you'll do it... and then you immediately get on with the request*".

The *way* people communicated in the workplace was very important to Julie and this ability to communicate well supported professional relationships. Not just the way nurses talk to each other but the way they listen too. Together we discussed that if personality does play a part in how professional relationships with colleagues occur in the workplace, this raises questions about the role of nursing's professional Codes, Acts and standards in changing the way nurses' communicate within delegation interactions. There are also implications for information and topics made available to nurses in the workplace. Should sessions on direction and delegation information and professional communication interactions be just as compulsory and available as fire training, falls prevention and ISBAR for example?

In the narrative plot of two way discussion, Katie, an experienced Enrolled Nurse also acknowledged the role of personality, and how this can impact on the nurse's ability to communicate well. However, it became apparent as the stories unfolded that there was some confusion about who should be doing the delegating, and how that should be done. Katie described a recent delegation interaction she had been involved in that was positive because the Registered Nurse had listened to her, and her professional opinion and experience had been respected. On the other hand though she felt it was negative because in her opinion the Registered Nurse should never have been doing assessments of the tasks to be delegated and the team members. Although the Registered Nurse was assessing the skill and experience of the Enrolled Nurses, the 'acuteness' of the consumer, the complexity of the nursing intervention required and the context of care, Katie did not recognise that this is entirely consistent with the Registered Nurse's Scope of Practice, and that it was not the Enrolled Nurse's role. She described challenging the Registered Nurse's decision and "*discussed it*" with her until the Registered Nurse changed her mind. Katie described the delegation skills needed by a Registered Nurse. They needed a body of knowledge about the clinical area, and to be able to explain the rationale for their decisions, provide clear explanations and include a time frame for requests. Katie described the need for two-way negotiation and the inclusion of the Enrolled Nurse's experience and professional opinion in order to support 'communicating well' during delegation. She also described the skills needed by the Enrolled Nurse. This included the need to be aware of their tone of voice, body language and whether eye contact is used when reporting back to the Registered Nurse. Enrolled Nurses need to be able to report back clearly and "*know what they are talking about*". Knowing about ethics, the law, the Enrolled Nurse role and their Scope of Practice, and having good assessment skills are also important. The Enrolled Nurse needs to feel confident that they will be listened to. Katie believed many of the Registered Nurses she worked with did not understand direction and delegation but in this instance the Registered Nurse was trying to delegate according to the descriptions and definitions available to her about direction and delegation, but was prevented

from doing so by Katie. This may be because Katie had learned “*on-the-job*” and in a time when ‘direction and supervision’ were done differently. It might also be attributed to Katie’s extensive experience as an Enrolled Nurse sometimes working with new inexperienced Registered Nurses. In Katie’s story about challenging the Registered Nurse, Katie was in effect working outside her Scope of Practice by not following the delegation of the Registered Nurse, and in doing so was potentially placing the Registered Nurse in a position of working outside her Scope of Practice too. The Registered Nurse was not able to make the best possible decision based on her assessments of the environment for the context of care, and this impacted on her ability to delegate.

For Dallas, communication, assessment and leadership during direction and delegation were linked. Dallas pointed to the impact that the nurse’s personal communication style had on the assessment process and leadership style. Dallas as an experienced Enrolled Nurse knew and understood that the Registered Nurse needed to assess the Enrolled Nurse prior to delegation but it was often the way this was done that was of concern to Dallas. In the relaying of the stories about assessment, communication and leadership that Enrolled and Registered Nurses need it became clear that Dallas herself had advanced assessment, communication and leadership skills. She shared her concerns with the charge nurse about the way nurses communicated at the end of shift and at shift handover and successfully suggested changes to the way this occurs. She described her need to “*protect*” herself and her patients by using a number of assessment skills so that she is not left on the ward with an inexperienced Registered Nurse unfamiliar with this often acute, and busy medical workplace. The ability to make an assessment of the patient, the environment and the skill level of the nurse “*right across the entire shift*” was important in order to keep everyone safe. Her stories also link the ability to assess, to the nurse’s personal communication style and their ability to lead the shift. In order to assess and lead the team Registered Nurses needed to take the time to find what skills the team members have and use those skills within the team. For Dallas the communication interaction felt positive when the Registered Nurse acknowledged the contribution the Enrolled Nurse made when things had genuinely gone well, gave positive feedback to team members, and can say “*thank you*” at the end of shift. Dallas felt that a Registered Nurse who welcomed you when you came on the ward and who knew the Enrolled Nurse’s and the Registered Nurse’s Scope of Practice was an asset to the delegation interaction. Enrolled Nurses had a responsibility within the delegation interaction and also needed to be able to communicate well too. She strongly believed that Enrolled nurses needed to be polite and respectful but they also needed to speak up if they did not feel safe or confident to do the task being asked of them, and they needed to be able to ask for help. Being

assertive but polite was evident throughout all Dallas' stories. Enrolled Nurses needed nursing knowledge to be able to help the Registered Nurse, and they needed to know their own Scope of Practice because they may be the only person on the ward who does know it. The narrative plot of assessment and leadership illustrates Dallas' perception that Registered Nurses need good assessment skills in order to lead a team, and in order to assess and lead, they also need to be able to communicate well.

For Barbara communicating well is embedded in her stories about the communication interactions she has experienced. In the narrative plot of being welcomed Barbara highlighted some concerns around the way Enrolled Nurses were welcomed onto unfamiliar wards.

Barbara's first two stories were from her past but they had had such an effect on her that they were the first stories she offered. They had clearly had an impact on her as she explained that they made her question her own knowledge and abilities. She described a worrying incident where she had been asked to carry out some tasks on an unfamiliar ward where she had been transferred. When she had declined to carry out the tasks the Registered Nurses wrote a formal complaint about her. Her charge nurse at the time, new to her position, and unfamiliar with delegation, had not supported Barbara's right to say 'no' to the delegated tasks. This left her confused and had "*really knocked her confidence*". Barbara adds significantly that she understood that she had a responsibility to say 'no' if she felt that the tasks being asked of her were outside her skill level and confidence but the charge nurse and the Registered Nurses who had written the complaint, did not. It was an avoidable and unpleasant situation that was hard for Barbara to come back from. Barbara's stories showed that Registered Nurses who understood the need for Enrolled Nurses to self-assess, and to say 'no' to a delegated task if they were unsure of it, or did not feel comfortable or safe to carry it out and understood the Enrolled Nurse Scope of Practice were essential. This knowledge was needed even before any type of communication interaction was attempted. When Registered Nurses did not understand this there could be negative consequences for the patient, such as the Enrolled Nurse carrying out unfamiliar and therefore unsafe tasks, or the Registered Nurse not making the required assessments before delegating. Barbara also had positive communication interactions with Registered Nurses and when she talked about her job her whole face lit up. She spoke glowingly of the nursing leadership above her and described the skills she admired in many of the Registered Nurse leaders she had worked with. She listed these without any hesitation. They can teach "*and they have taught me so much.*" They can communicate well with all people, staff and clients. They have a body of knowledge and know how to help other people. They do not put people down. They 'push' you along. They share their knowledge so that we can help the clients. "*We're not just here for ourselves you know. We're here to help others, so anything or anyone who helps me do this is respected by me*". She believed that

Enrolled Nurses needed to be assertive and know *how* and when to say ‘no’ to a delegated task when required so that they did not “*work outside their Scope of Practice*”. Barbara wanted the nurses she works with to communicate well. Enrolled Nurses rely on a self-assessment mechanism to assess if they should accept a delegated task which needs to be understood and respected. Barbara’s stories illustrate the importance she places on nurses respecting each other’s Scope of Practice and the need for good manners such as welcoming new staff to an area. They also illustrate the lack of communication skills of the delegating nurses as well as the lack of knowledge that the Registered Nurses (and the Manager) had around the Enrolled Nurse Scope of Practice. This makes the provision of education about how to communicate within the delegation interaction, how and what to assess and knowledge about the leadership of delegation interactions important if delegation communication interactions are to be safe and successful.

In Karl's narrative plot of balance he shares a number of stories that show his preference for an egalitarian approach during delegation communication interactions. He demonstrated balance throughout all his stories as he tried to see a situation from the other nurse’s point of view. This is reinforced when he acknowledges that any story has a number of sides to it. Karl had seen occasional glimpses of good communication over his many years of Enrolled nursing experience, and he was patient and understanding as to why some nurses are not as good at communicating or leading teams as others. Karl described a recent delegation situation that illustrated the need for Registered Nurses to be able to take the leadership of a situation but on the other hand he also acknowledged the difficulty this posed for new graduate Registered Nurses. Karl was conscious and professionally mindful of his need to work under the delegation of a Registered Nurse and in one of his stories he showed how uncomfortable he was being placed into a position of having to advise the new inexperienced Registered Nurses who did not know how to handle a clinical situation. In a second story he described how a Registered Nurse who used a more authoritarian approach with him, and would not listen to his professional opinion about a patient he had been working with for a whole shift, led to a serious negative outcome for the patient resulting in seclusion, and staff member being hurt. With the Registered Nurse who refused to let him sign the seclusion forms he acknowledged: “*she might be right*” ... “*most of the staff are really good- you’re going to get that aren’t you?*” There was an example of a good direction and delegation experience too. His stories show that he wanted to work with respectful, egalitarian, valuing nurses who were mindful of the way they say things to others. When nurses communicated well, there was leadership and the Scopes of Practice were understood, his workplace could be a better place, not just for him but for the clients as well. Possibly this balanced view of the workplace makes him the type of nurse who can communicate well, that he seeks in others.

Enrolled Nurse Agents' stories about 'Seeking delegation'

The findings in this major pattern 'Seeking delegation' brings together stories from two inexperienced Enrolled Nurse Agents and one experienced Enrolled Nurse Agent about their need to seek, request or search for a direction or delegation interaction with a Registered Nurse. The three Enrolled Nurse Agents in this major pattern know and understand very clearly that they must work under the direction and delegation of the Registered Nurse and although they sought it out they did this in different ways. They all shared a belief that 'getting direction and delegation wrong' places their registration and the safety of the patient in a risk situation. The three Enrolled Nurses in this major pattern illustrated how they worked hard to make sense of the requirement to work under the delegation of the Registered Nurse.

Elaine's narrative plot of extracting delegation revolved around the rationale and methods she used to 'extract' direction and delegation when she needed it. Elaine described herself as a reasonably inexperienced Enrolled Nurse. She had developed the 'extraction' method over time as it was a useful way of meeting her professional obligation to be working under the delegation of a Registered Nurse while running a 25 bed ward. The extraction method was based on a range of communication skills such as "*common courtesy*" "*being collaborative*" and "*being respectful and polite*" that she used to trigger, ask for, or prompt the delegation instructions she needed from the Registered Nurse and provide safe and respectful nursing care to the older age patients in her care. However, she found the way some Registered Nurses communicated with her concerning at times because it challenged her personal view of "*good manners*" and common courtesy. For Elaine triggering a delegation interaction with the Registered Nurse involved asking respectfully and politely for input and advice while being aware that the Registered Nurse had their own busy work commitments too, often in another part of the facility. In addition, she had to communicate her own assessment information to them clearly and accurately, but in a collaborative manner, being mindful of not telling them what to do. She had to negotiate a time to meet while being aware that her patient was sometimes in a situation that required quick attention and she had to do all of this in a timely manner. Elaine made a statement about her "*age*" earlier, and the reason for this became clear by the end of the interview. Elaine felt strongly that it is 'age' that played a very big part in how this "*extraction*" arrangement worked. She was explaining that if she was not as mature ("*older*") and with the life skills she believed she had, she would find this balancing act that involved accessing delegation input, and keeping herself and the patient safe, almost impossible or very difficult at the least. Elaine's way of seeking delegation input in order to ensure she worked within her Scope of Practice had been shaped by her personal values around politeness and respecting your "*elders*" and elders in this situation included the

Registered Nurses who may have been younger than her but had more “*training, experience and knowledge*” than her.

Alison’s narrative plot of seeking delegation shares some similarities to Elaine’s narrative plot in that Alison also “*organises the delegation herself*”. However, for Alison, a new inexperienced Enrolled Nurse, she must continually seek out, search for and initiate direction and delegation interactions with Registered Nurses before she goes out alone into the community to care for the client’s for whom she is responsible. Her main goal at the start of each shift was to find a Registered Nurse willing to delegate or direct to her. While this met with variable success she kept seeking delegation as she knew as a new inexperienced Enrolled Nurse that she needed this input from a Registered Nurse in order to provide quality and safe nursing care. Many of the Registered Nurses she approached were hardworking and helpful but they were not able to help as they had their own patient loads and “*did not know the patients on my list*”. The staff member who compiled the list of patients to visit each day was a non-nursing staff member in a managerial role who did not understand the Enrolled Nurse role. There is no negotiation or assessment prior to allocation and the patient list was emailed to Alison and the other nurses. This model of nurse to patient allocation resulted in being allocated patients unsuitable to Alison’s skill level and experience and did not support Alison to obtain the direction or delegation support she needed. Many of the Registered Nurses she worked with did not know about the Enrolled Nurse role or associated competencies or their Scope of Practice. Also, as she is not working in a team she was constantly having to “*sort it out myself*” and seek delegation input where and when she could, and sometimes that was not at all. Her Enrolled Nurse colleague who trained with her and started at the community placement at the same time as Alison, was responsible for all initial holistic assessments and care plans. Alison used an interesting turn of phrase when she described that she did not know when her Scope “*ran out*”. However, it is clear she knew she needed direction and delegation input and advice; it just was not available when needed. It appears that it was the Registered nursing staff and managers that did not know when her scope ‘ran out.’ She wanted to communicate positively and respectfully and in a way that Registered Nurses could “*save face and feel valued*” even when they gave her conflicting or incorrect advice because she understood they were caught up in a model of nursing that did not allow them to delegate or direct to her or the other Enrolled Nurses. Alison’s stories show she was enmeshed in an allocation model, not a delegation model, exacerbated by working in the community. She wanted to be working under the direction and delegation of a Registered Nurse as she understood that not to do so meant she was working outside her Scope of Practice. She had brought it to her manager’s attention on several occasions. She wanted her patients to receive safe nursing care but found she was constantly sent to patients homes that

required nursing care that she does not feel confident to give. She tried to prevent making errors and mitigate for these risks by searching for, and seeking out, direction and delegation input.

The narrative plot of taking responsibly also showed how Amy had to seek delegation input in order to meet the requirement to work under the delegation of the Registered Nurse. Firstly, she took responsibility for searching and seeking out the Registered Nurse who would be her Registered Nurse buddy for the shift rather than the 'norm' of approaching any Registered Nurse who was available "*at the time*". Organising and identifying her Registered Nurse buddy for the day was important to Amy because there had been two occasions when the medications for her patients had been missed by the Registered Nurse and so she ensured she had a named and appointed Registered Nurse buddy that she could go to. It was significant that Amy took responsibility to organise and arrange this herself rather than a Registered Nurse doing it as part of a leadership role and overall assessment and management of the ward. Secondly, Amy took responsibility for finding out about direction or delegation as there was no information provided in her workplace about it. She had requested in-service about direction and delegation but this did not occur. She had also read the guidelines. Amy felt that the Registered Nurses she worked with did not know that the guidelines were available on the Nursing Council New Zealand web site and even if the guidelines were delivered directly in a hard copy format to every Registered Nurse she worked alongside, she felt that they would not understand about direction and delegation. Although she had found it an invaluable resource and had pinned it up on the nursing notice board, only a few nurses showed any interest in the document. This meant that Registered Nurses continued to expect Amy and some of the other experienced Enrolled Nurses to work autonomously. In a third story, Amy showed how she took responsibility when she was prevented from administering any medications. The *Guidelines: Responsibilities of delegating care to an Enrolled Nurse* (Nursing Council of New Zealand, 2011) and her Scope of Practice and competencies showed her she could do all aspects of patient care including medication administration under the delegation of the Registered Nurse, but in her workplace she was not able to. She had repeatedly questioned this policy and had sought clarification as to why she could no longer administer medications in this workplace, but to date she could not get any answers other than to be told it was "*hospital policy*". Amy believed that the delegation interactions between the Enrolled and Registered Nurses depended on the leadership and communication skills of the Registered Nurse. She added that unfortunately not all Registered Nurses had these skills and there are some Registered Nurses who did not know how to lead a team, or a shift. Amy shared two stories about being treated disrespectfully by a new Registered Nurse, and the lack of understanding about who was accountable and when. Amy's stories confirmed her belief

that some Registered Nurses did not understand the Enrolled Nurse Scope of Practice and accountability, or how to assess, lead or communicate during delegation. She took responsibility for delegation because she did not want mistakes to be made, or nursing care to be missed.

Summarising the Enrolled Nurse Agents' stories

The small stories as shared understandings and the narrative plots for each Enrolled Nurse Agent based on the big and small stories as told by the Enrolled Nurse Agents uncover a variety of ways of ensuring they continued to work within their Scope of Practice by making delegation work for them. The stories show a myriad of strategies and techniques they used to make sense of this professional obligation, and to access delegation interactions from the Registered Nurse, so that they were delegated to.

The Enrolled Nurse Agents' small stories as shared understandings showed a degree of confusion about the direction and delegation role. Firstly, delegation as it is described in the New Zealand nursing literature is not practiced, rather an allocation model at shift handover is used in most nursing workplaces. The confusion is compounded by the continued use of a primary or geographical model of nursing care rather than a team model. Secondly, there was a great deal of confusion about the difference between a direction and a delegation role. When asked about these two different terms, Enrolled Nurse Agents combined the two terms, without distinction, or suggested the role was about giving orders or instructions. Thirdly, although the Enrolled Nurse Agents had a clear understanding of their own Scope of Practice, and understood that they could carry out a form of self-assessment to weigh up if they could accept a delegated task, they were concerned that many Registered Nurses did not understand the Enrolled Nurse role and responsibilities. This often resulted in different interpretations and understandings of what an Enrolled Nurse was allowed to do and this differed from workplace to workplace adding to the confusion. Lastly, there was confusion evident about where to get information from related to the direction and delegation role. Each of the Enrolled Nurse Agents requested access to workplace specific information about direction and delegation that was relevant to their workplace.

Working with each other, keeping the lines of communication open, establishing and maintaining a direction or delegation relationship with a responsible Registered Nurse, and meeting the professional obligation of their Scope of Practice to be delegated to, were shaped by their workplace, how, and if, they had been taught about delegation, and their own delegation history.

While the narrative plots show that each Enrolled Nurse Agent came to the delegation interaction in different ways and for different reasons it was the desire for professional interactions and the safety of the patient that underscored all the Enrolled Nurse Agent's storied experiences. The desire for patient safety and dignity shaped and influenced their individual direction or delegation communication interactions, decisions, strategies, techniques and the choices each Enrolled Nurse Agent made.

Culture and place demand our attention not because our concepts of them are definitive or authoritative, but because they are fragile and fraught with dispute (Jody Berland, Nationalism and Modernist Legacy: Dialogue with Innes, 1997)

Chapter six. Findings: small stories as shared understandings and narrative plots for Registered Nurses

Introduction

Just as some of the stories told by Enrolled Nurses Agents' revealed patterns *between* and *across* their scripts, so too did the Registered Nurses Agent's stories. The small stories about what the Registered Nurse Agents knew and understood about delegation, and how they had learned to carry out this professional responsibility have been gathered together as: 'Small stories as shared understandings'.

The patterns *within* each of the Registered Nurse Agent's personal and professional stories of experience are reflected in their narrative plots. The narrative plots show how Registered Nurse Agents made sense of carrying out their professional delegation role, how they would prefer to work together, and how they communicated during delegation. The narrative plots are captured as four major patterns: '**Professional communication**', '**Doing' delegation and direction**', '**Skills for delegation**' and '**Working as team**', and are presented in Chapter six as four separate stories.

Small stories as shared understandings for Registered Nurses

The shared understandings that emerged between Registered Nurse Agent's narrative scripts show that there was some confusion around who was accountable for the nursing practice delivered in their workplaces. Knowing who was accountable and responsible for the nursing care led to other stories about *how* a Registered Nurse would know what an Enrolled could do, and with this the role of assessment emerged. These small stories are presented as '*Knowing about the Enrolled Nurse role*'. Many of the Registered Nurses stories indicated that they believed there was a lack of information about direction and delegation generally. This perception was in part supported by the Registered Nurse Agent's inability to define, distinguish or explain the two different terms, direction or delegation. Registered Nurse Agents discussed how past relationships and the culture of the workplaces they had worked in had shaped their knowledge of delegation, and therefore their current delegation practices. The Registered Nurse Agent's stories showed that they wanted more information and guidance about the direction and delegation role.

Some of the Registered Nurse Agents identified the role that leadership played in their workplaces. Nursing leadership held the authority to influence the model of nursing care used

which determined whether the nurses worked in teams, or in a geographical or primary model of nursing care, and could also influence access to information about the Enrolled Nurse role and their Scope of Practice, and therefore the direction and delegation role. These small stories were captured as *'Learning about direction and delegation'*.

Knowing about the Enrolled Nurse role

In response to the following prompt suggestion in the interview schedule, the stories that the Registered Nurse Agents shared featured a degree of confusion about who is accountable and responsible for the nursing care delivered by Enrolled Nurses. The prompt suggestion was: *As a Registered Nurse, do you make an assessment of the Enrolled Nurse's skills and knowledge, confidence level and experience before you delegate or direct a task?*

Some of the Registered Nurse Agents believed they were accountable for the Enrolled Nurse practice. Miriam's, Jocelyn's, and Susan's responses were typical of the stories shared. Miriam believed that the Registered Nurse was responsible for the Enrolled Nurse's clinical actions and clinical practice because *"ultimately it falls to you"*.

Jocelyn believed that if things went wrong with the nursing care given by an Enrolled Nurse the Registered Nurse was always responsible and answerable. *"I would be responsible. I'd be supervising her. I mean there'll be an element of, say there's something really stupid and I came along and they'd, you know, turned off the ventilator, I'd be going well that was pretty stupid, you know, there's a certain responsibility that they have over their own actions but I am the delegating person so I'm responsible"*.

Susan: *"If they work outside the Scope of Practice I take the blame"*.

However, Milena's description of accountability went further and acknowledged the Enrolled Nurse's responsibility, and the Registered Nurses responsibility for the overall plan of care. *"I think the way I understood it was that if you ask the EN to do something she's accountable for what she's actually doing, but you're still accountable for like the overall outcome and the wellbeing of the patients. I would say if she's with the patient especially if you're not there it's not something that you can control sort of thing"*.

Sandy's practical explanation of accountability also separated out the Registered Nurses' responsibility from the Enrolled Nurses' role *"...the Registered Nurse being responsible for the level of care the patient has received over the shift from the Enrolled Nurse...You're not accountable for everything on a minute by minute basis. So there's no need to follow the Enrolled Nurse around all the time"*.

Milena's and Sandy's views that accountability is a shared responsibility, that the Registered Nurse is accountable for the overall plan of care and the Enrolled Nurse is responsible for her or his practice were supported by Gail as she shared her perception of who is accountable and when.

Gail: *"Yes [the RN is responsible] to a degree. Yes, to a degree in the sense that I mean that if the EN's patient is unwell and they [EN] do vital signs and if something's not quite right then they have the obligation in my eyes to tell me because in that situation I'm not the responsible one. So then I could guide them if they didn't know what they were doing but then I also need to know what is going on... To a degree the EN should be [accountable]. I mean if someone's blood pressure is in their boots and they don't do anything about it and they don't tell the person in charge. They should be accountable for it at the end of the day, and that's why you have to document things. If you document that you've spoken to them, I do that as an RN"*.

Some of the Registered Nurse Agents made links between understanding accountability and the need to assess the Enrolled Nurse's skills and abilities. Sandy and Miriam showed that an assessment role might take time to set up at the beginning of the shift and that the Registered Nurse also needs to have knowledge of the Enrolled Nurse Scope of Practice.

When Sandy described a positive delegation interaction she had been involved in that had gone well she also developed a recipe for being accountable that included an assessment role. *"[It involves]... taking some time to do a little bit of prep work at the beginning of the shift! That's all really. Finding out what the common goals of the shift were by asking her. I asked her if she had any questions after she read the progress notes, assessing how she read the notes and staying around to help out all contributed to this [positive experience]. After all RNs are meant to have critical thinking skills so this is a time to use them"*.

Miriam: *"I believe that the way Enrolled and Registered Nurses communicate comes back to it being a relationship again because there has to be trust. Because you're delegating you have to be mindful that they have the ability to do it. And so that becomes an assessment and you often can't make that in five minutes or just before you're going to delegate. And that assessment will possibly, to think about my own environment, could possibly occur over time, and we see it too with the students and then we think 'right she can do that, I'll ask her to do something else because I trust her.' Because they [RNs] take the responsibility they hold as a primary nurse very seriously"*.

Gloria and Harry describe what an assessment might look and sound like.

Gloria: *“If they’re unsure then you should question whether you should be delegating it to them at all. So you need to know what their knowledge level is. What they are familiar with is very, very important. If they’re new to the floor I’m not expecting they’ll know a lot. If they’ve been sent to us from another ward I would expect they wouldn’t know a lot. And I have no problem, you know, that I would ask them: ‘So what do you know?’ Because it’s my license on the line”*.

Harry: *“Well you just ask them. Use your verbal and non-verbal skills, and ask...You need to be assessing the whole time, including the Enrolled Nurse, the other staff, the ward and the service user, the allocation of service user to nurse depends on this”*.

The four Registered Nurse Agents featured in the following section show that there was a perception that there was a paucity of information about the Enrolled Nurse role and what the Enrolled Nurses are allowed to do. This was especially confusing when there was a Level 4 Enrolled Nurse⁴ in the workplace who would have a condition placed on their Scope of Practice. Other than the fluid and medication policy, there was no other local policy or guidance in the workplace about what an Enrolled Nurse could or could not do, or the Enrolled Nurse role, and this impacted on what Registered Nurses knew and understood about accountability.

Gloria suggests that a check list would be useful to Registered Nurses so that when she worked alongside Enrolled Nurses she would know what they were able to do, and she wouldn’t be placed in a position of asking the Enrolled Nurse to do tasks they were not capable of, or allowed to do: *“...the [RNs] also need to know what do ENs know, what are they taught? Like our students that come from polytech, what do they know? We need to have a check list of what they know or should know when they come to us”*.

Miriam called for more information about the Diploma of Enrolled Nurse students and graduates and the different levels and Scope of Practice. She describes the added confusion when there was a Level 4 Enrolled Nurse employed in an acute workplace⁵. *“So I mean I must admit I did question having a Level 4 Enrolled Nurse on our very acute ward. I know and I have questioned that more than once until it got to a stage where, just note for the scribe Miriam throwing her hands up in the air in frustration, to illustrate that I said these are the kind of patients that she can care for, you know, but that excludes a few patients such as acutely unwell patients, surgical patients and acute medical patients, and oh my God that’s nearly everyone. And the other comment was well ‘she could just do the obs.’ And I said well*

⁴ A Level Four Enrolled Nurse would have conditions placed on their Scope of Practice to work only with stable and predictable patients but a busy RN buddy would not have immediate access to this information

⁵ A Level 4 EN who had not transitioned to the new Scope of Practice and Level 5 qualification.

actually taking recordings is more than just taking a set of obs. and writing them down, it's about making an assessment, it's about observing, it's about assessing pain, mood, all those things. And then having to come and tell somebody what you think you just saw or what you've recorded so people see that as time wasting...[The RN] needs to make an assessment of that EN and saying do I actually trust her to do that, or no, look I better do it myself! So that EN becomes a bit cumbersome actually. And it's difficult when people feel they can't trust because, in their assessment, they don't trust her, knowing that they're responsible for the practice partly, she is responsible for her own practice but they're responsible for the patient care, it's like what's the point? And people don't want to work alongside her, because they think they are responsible for the outcome of the care when in fact they are responsible for the delegation interaction”.

Jocelyn felt there was little information about the Enrolled Nurse role, the Scope of Practice or direction or delegation in her workplace. She did not know of any policies available to guide practice when working with Enrolled Nurses. She would rely on the Enrolled Nurse knowing what they could and could not do. Her perception of how she would find out what they could do included the idea that this was written somewhere. However it might also require having to go higher. *“I'd say tell me what, like the same as I say to anybody, tell me what you know to be our thing [how we will work together]. And they will say: Oh Jocelyn I've got this piece of paper and it explains everything here. And then I'd be able to read it. Or they'd say I don't know what I can do. And then I'd have to go and ring someone. So either they'll come with that - all I've got to do is ask them for it. Or they've got no idea and then I'll say right if you haven't got any idea, I haven't got an idea, I need to go higher up. So that's going to be the challenge to ensure that that information goes out. There's a bit of work to be done there isn't there?”*

In Hayley's experience she found Enrolled Nurses self-regulated what they did, very well. To Hayley 'working outside the Scope of Practice' only related to Enrolled Nurses not being able to administer some medications and if they administered the 'wrong' medication they would be 'working outside the Scope of Practice'. This information could be found in the organisational policy on fluid and medication management. Other than the one policy on medication administration there was no other documentation on the tasks and skills they could do in her workplace and to her knowledge no new policies on this had been suggested. *“I don't know if they do have [any other documents]. To be fair. No I'm not sure that they do. But some of them, like the IV policy are there. The DHB, and I presume they're nationwide through the DHBs, I don't know. Again it would be different again in the rest homes I'm guessing. Yes, I don't know”.*

Learning about direction and delegation

While some of the Registered Nurse Agents pointed to a lack of information made available to them in their workplaces other Registered Nurses acknowledged the role of their Bachelor of Nursing educational preparation for delegation, or a leader's course they had attended. However, the overall perception was that access to this information was either too brief, was not available to everyone, or did not provide the information they needed about the Enrolled Nurse role, and by association the direction or delegation roles.

In response to two prompt suggestions in the interview schedule Registered Nurse Agents described how they had learned about direction and delegation, the support that was currently available to them and the guidance to which they would like to have access. The prompt suggestions were: *How did you learn about direction and delegation? And: What else do you think needs to be in place for you to learn how to be involved in effective direction and delegation interactions?*

Hayley explains how she had learned about the changes to the Enrolled Nurse Scope of Practice post 2010. *"A lot of it [information] was just through discussion with the ENs. And myself, because I was going through that change in Scope with them as a PDRP assessor. That was our role and I think I had twelve or fifteen ENs to go through the Scope of Practice with and assess them. So it was really just through discussion with them"*.

Hayley believed that the Registered Nurses also had an opportunity to attend these same sessions that were made available to the transitioning Enrolled Nurses at that time. However, they were not required or compulsory for Registered Nurses: *"Mmm, they certainly had the opportunity to go to education sessions. Yes they were put on. Now whether they did... and the ones I went to because I was going to be an assessor, even though it was discussed with us at our PDRP study days, I also went to ones that [another hospital] held. I don't recall any RNs there. It doesn't mean to say that they weren't there because she held several study sessions...I presume that the charge nurses would have gone because it was directly, you know, under their jurisdiction as well. But again I can't just be sure"*.

Gloria had learned about direction and delegation in a two hour lecture in her Bachelor of Nursing education. She had recently attended a leadership course in her workplace and while it was helpful, direction and delegation was only minimally covered. Gloria asked me to consider that Registered Nurses want to know *how* to do direction and delegation: *"Yes. They don't just need to know: 'this is what you do'. 'You go talk, talk, dah, dah, dah. We need to know **how** to do it. Please don't just grumble down somebody's throat and I would express, in fact it would probably be my mantra -we're all in this together"*.

Gloria wanted examples of delegation interactions and to make visible the difference between direction and delegation. *“But this much on direction and delegation? [Holding up two fingers]. They give you a form and they expect you to read it and understand it but I think actually showing us, having a small video with examples of what’s proper delegation and not just for one or two but a few that arose so that we can understand the difference between direction and delegation”.*

Many of the Registered Nurses had learned about delegation “*on-the-job*” and from watching how other nurses communicated during delegation. Barb’s, Susan’s and Bronwyn’s stories are representative of their responses.

Barb had learned about delegation from her past experiences as an Enrolled Nurse before bridging to become a Registered Nurse. She described this as learning “*on-the-job*”. There was no formal training, classes, seminars or study days about delegation in those days you just learned about it from the role models you had on the ward. No one talked about it in the bridging course either. When she became a Registered Nurse though she was just expected to delegate tasks to Enrolled Nurses. *“And then so from there I think I probably learned direction and delegation from experience and also from my past experiences as an Enrolled Nurse. I knew, being an Enrolled Nurse, I knew what the EN could and could not do before they changed the Scope of Practice once again”.*

Even though there has been significant changes to the Enrolled Nurse Scope of Practice since 2010, Susan was not aware of any training or in-service about these changes or how the changes related to direction or delegation provided in her workplace. She had read articles in *Kai Tiaki Nursing New Zealand* and on line to add to her knowledge and understanding of the Enrolled Nurse role. Susan had learned about the ‘how to’ of delegation by watching other nurses. This had shaped how she preferred to interact with Enrolled Nurses and other nurses. *“Just by watching others and thinking well I’m not going to be like that or, I like the way she did that. I’m you know hospital trained and you get sent around different wards and to a stint on each ward and some of the charge nurses I was scared of them and I didn’t want people being scared of me. And some of them were just wonderful and they really listened to me and supported me and did not make me nervous...”*

Bronwyn had learned about direction and delegation through role plays and theory course work during her nursing education and she was eternally grateful for this preparation as it had provided a good basis for her knowledge. However, it was not until she attempted direction and delegation in ‘real life’ that she fully comprehended the communication, leadership and assessment skills needed to make it work. She had developed her more advanced skills “*on-*

the-job” but she had also been shaped by her own (past) beliefs about how this should happen which included treating people fairly and she had developed her own style by trial and error.

Gail learned about delegation in a leadership course she completed as part of her degree as well as her experience of ‘doing delegation’ when she worked overseas. She echoes Bronwyn’s perception that it was not until she graduated and went to work on the wards four months after graduation that she developed the confidence to delegate to others. Gail explains that you could have all the classroom learning and theory available but it was not until you practiced direction and delegation communication that you really learned about it. *“So I mean I had to write essays for that [course] so whether it was through that and a combination of working overseas. But to be honest it wasn’t until my second placement which would have been nearly four months after I started working as a nurse that I actually got the confidence to implement a lot of it”*.

In contrast to these Registered Nurse Agents Harry believed that there was a lot of information around about the Enrolled Nurse Scope of Practice and direction and delegation but you had to attend study days or look up the information on the New Zealand Nurses Organisation (NZNO) and Nursing Council New Zealand (NCNZ) websites and: *“Nurses would be as well prepared as they wanted to be.”* Harry perception was that the uptake of information about roles, responsibilities and delegation by nurses is *“sometimes variable.”* *They [some RNs] don’t know what it says about the EN with the Nursing Council and their revised Scope of Practice. And they’re too ****lazy to go to the computer, turn it on and find it. Even if you put it in front of them they’re too *** lazy to read it”*.

Some of the Registered Nurse Agents referred to the role of ward ‘culture’ in shaping what they knew and understood about their Scope of Practice and how nurses communicated with each other and therefore how delegation occurred. The culture of the various workplaces could be very influential in shaping nursing practice and interactions. Jocelyn’s, Barb’s and Miriam’s stories are indicative of their experiences.

Jocelyn explained that different places you work in have a different sort of response to issues and that is why it is a different ‘culture’ in each of those places *“Yes, and I think the things like the leadership, ‘this is how we do it’ and if the leadership feeds back to people, ‘when you were allocating those patients today you actually gave that new grad a really bad load and I don’t want you to do that again. That would be good but there’s the other type of culture that goes, ‘Who cares?’ ‘Whatever you do, you do’, you know what I mean?”*

Barb started with a description from her past when she worked as an Enrolled Nurse and she had been required to manage some of the IV fluids. As an Enrolled Nurse in those days she

had altered dates, times and flow rates on them. She added that: *“No one really talked about Scope of Practice in those days and as part of the nursing culture on the ward you just did it because everyone else was doing it, no one questioned it really”*.

Miriam described how she came to understand delegation when she was a student by watching other nurses as role models. She had looked to the culture of the workplace to work out how to do delegation. *“I learned about delegation just by looking at other people. You just watch and you learn, to me that was the whole basis of how the nursing culture was. How you learnt as a nurse, you watched, you listened, and you saw how other people did it and you either liked how they did it and you took that mode on or if you didn’t like how they did it you’d ignore it and you’d find somebody, and that was the thing, you’d find a role model or somebody who you liked the way they operated and some of the role models could have been an Enrolled Nurse”*.

A common pattern began to emerge between the Registered Nurse Agents stories in that with the reintroduction of the Enrolled Nurse role and the new level and Scope of Practice there had not been any training or information sessions offered to Registered or Enrolled Nurses specifically about direction and delegation in the workplace. From time to time in-service sessions were offered to Registered Nurses on leadership or communication skills, and delegation might be briefly mentioned in relation to these skills. However, while these courses were open to some Registered Nurses, they were not available to Enrolled Nurses. Registered Nurses had often learned ‘*on-the-job*’ either in past times or they watched what happened in their workplace. Most of the Registered Nurses indicated that they wanted access to information about *how* to do direction and delegation. Given the perceived scarcity of information related to direction and delegation it is not surprising that many of the Registered Nurse Agents were confused about the difference between direction and delegation and struggled to define or distinguish the two different terms.

Hayley described how guidance possibly in the form of ‘teaching’ the Enrolled Nurse a skill such as catheterisation for the first time could be given by the Registered Nurse. However, she did not link this to ‘direct direction’ and did not differentiate the two term, direction and delegation, throughout the interview.

Valerie another experienced Registered Nurse provided her interpretation of direction and delegation and in doing so also identified a teaching aspect to the direction role. *“Delegation is asking her to do it without too much direction as in explaining what to do. Delegation is asking her to do a job that she should feel competent and confident doing. Direction is probably more going through the process with her and teaching her”*.

Jill was unsure of the two terms. She attempted to describe delegation. *“Oh delegation is asking someone if they could do something and delegating work that you’ve got that you can’t do or something. So making it a team effort rather than just yourself. Direction is where...mmm I don’t know, direction. Would that just be where ...?”*

Miriam explained that she looked up the terms direction and delegation before coming to the interview. She was still a bit unclear about the difference between the two terms. One thing that surprised Miriam was that direction and delegation as terms used on the ward were always: *“lumped in together”* when nurses spoke of them. She felt that the differences were not understood by other nurses either.

Gloria described delegation correctly but wasn’t sure about ‘direction’. She took the dictionary or literal meaning of the word rather than the definition in the nursing guidance literature (Nursing Council of New Zealand, 2011b). *“Delegation is being able to delegate that person to the right task to the level of experience that they have. Where direction is I’m asking them to do something that is: this is their task for the day. I think that that’s more, you know, with day to day things. I guess around delegating them to do the person’s laundry or delegating them to do patient care. For me direction is telling them ‘ok I need you to work with Jo over there’ or ‘I need to go do this for me’. The delegation is I’m telling you, you got to do something and then I’m more responsible with that than if you’re just doing the laundry and forget to do that. I’m still responsible but no-one’s going to die over here. I may have it wrong but that’s my explanation of it”.*

Sandy worked with many nurses who did not understand the true meaning of ‘direction’ and fell into the trap of instructing and telling (directing) nurses what to do. Sandy understood that the terms direction and delegation were different. She described *direction* in a quite unique way as: *“the Enrolled Nurse needing extra support to interpret and work out the consequence of an assessment they might have just carried out”.*

This is supported in Bronwyn’s description when she explained that she had also come across this layman’s interpretation of ‘direction’ from the management structure in her workplace. *“To them [management] direction is giving an order”.*

Milena, an inexperienced Registered Nurse and Gail, an experienced Registered Nurse were able to differentiate the two terms.

Milena describes how she understood the difference between direction and delegation and although brief it captured some of the aspects of the two different roles. “...*I think with direction I want to sort of be there when I’m telling the EN could you do that dressing. And you’re there to sort of supervise and with delegation I would say, I would tell them what to do and, to come back and check in with me*”.

Gail was also able to describe both direction and delegation in her own words and although she had provided a definition of direction she also shared with me she had never heard of the term direction before the interview. “*Delegation to me would be you’re telling someone they have to do this thing, this is what you want them to do. Direction is encouraging them to do it and head them towards something...but I haven’t heard of ‘direction’ actually.*”

Jocelyn said that she would have to rely on the Enrolled Nurse telling her about the Enrolled Nurse Scope of Practice and what she or he could or could not do, as she did not know. She had heard of the direction and delegation package and had completed it she thought “*some time ago*”. She was able to describe delegation but was confused about the meaning of direction. She made two observations in that the word ‘direction’ was misleading and did not really signify or give a clue to the meaning. “*Yes, direction and delegation...so delegation is jobs that I can pass over and give to an EN that are suitable for their Scope of Practice. And direction is me saying I would like you to go down there and do this in a specific way. There’s a responsibility on my part of choosing the jobs that I give to people to make sure they fit their Scope*”.

The role of leadership in providing access to information that the nurses felt they needed in order to know about direction and delegation and how to do it was discussed by some of the Registered Nurse Agents. Often the terms ‘management’ and ‘leadership’ were used interchangeably but represented the nurses who had the authority to lead and develop practice and who were responsible for service delivery (Carrier, Gardner, Dunn, & Gardner, 2007). Nursing leadership referred to the group of nurses who could influence access and availability to information about the Enrolled Nurse role and therefore the associated responsibilities surrounding direction and delegation within the Registered Nurse to Enrolled Nurse relationship. Nursing leadership could also influence the nursing model used on the ward. The type of nursing model utilised in the workplace controls whether the nurse worked *in* a team or *as* a team and was influential in shaping how Registered Nurse Agents viewed the introduction of an Enrolled Nurse role, and therefore the delegation role.

Some of the Registered Nurse Agents believed that nursing leadership needed to play a more prominent role with the information Registered Nurses needed in order to work with Enrolled Nurses and through this be able to 'do' direction or delegation well.

Sandy felt that her employer had been remiss in their obligation to provide information to nurses about delegation. She was not aware of any orientation programmes that included direction and delegation or the Enrolled Nurse role, nor any ward level in-service education on it being made available. Sandy was concerned that while Registered Nurses were required to complete generic competencies related to the safety aspects of their role, the competencies required by Nursing Council such as direction and delegation, which are also safety related were not supported by the employer. For many Registered Nurses this could be a problem because direction and delegation was a new role as they had not worked with Enrolled Nurses before. *"The [employer] sets us to do competencies and things like the Five moments of hand washing, 'Smokefree', Falls prevention packs which obviously go to Ministry of Health statistics, restraint minimisation, and ISBAR but that's all about the employer's responsibilities but we're not told, or we're not educated or it doesn't come from Council, the separation between keeping your competencies for your registration and keeping your competencies for employment separate. And I think that that's a real problem for both RNs and ENs....Because as I said you know, if you're on the Council website yes there is information about delegation, you can get pamphlets from Council and all the rest of it. But it is not seen as an employer responsibility"*.

Sandy's perception about a lack of access to information and educational support relevant to a nurse's role such as direction and delegation were further supported in Miriam's stories. In Miriam's workplace the new direction and delegation guidelines (Nursing Council of New Zealand, 2011b) were sent to the nurses as an email attachment along with the newly released Code of Conduct (Nursing Council of New Zealand, 2012). There were no "conversations" about it though. Miriam captures the exceptionally hands-off approach taken by a number of Registered Nurses from nursing leadership or management to the Registered Nurse at the 'coal face' who needs to know and understand about delegation. *"So they [management] would say their responsibilities are over because they've emailed this to every nurse in the country, but I see there would be an expectation that the conversations would occur, that the charge nurse will lead the way, that the conversations would occur in a workplace. But you know in truth a lot of the RNs would say they haven't got time to check their emails or they are disinclined to do so, because it doesn't matter...So whether the leaders feel that the obligation is over when the information's been handed out but how do they check that there's been learning or understanding as a result of that I'm not sure"*.

Jocelyn believed that the one thing that could influence the introduction and acceptance of team nursing was nursing leadership but in her experience it appeared as though there was no leadership in the nursing model used and the Registered Nurses either introduced their own version or interpretation of it, or team nursing just was not done at all. One manager had expressed great interest in team nursing but there did not appear to be any requirements, or insistence from nursing leadership about the introduction of team nursing where Jocelyn was employed “*[Name of manager] he’s very keen on team nursing. We were having a conversation the other day about pool staffing and he was saying he would love to see team nursing go right across. And there’s certainly a way that team nursing would work in our area, like you still need to identify in terms of skill mix that I’m going to take this patient because I’m an experienced RN or that we are going to say well no as a new grad you’re not going to take that patient*”.

Jocelyn recognised that if Enrolled Nurses were going to be employed in her workplace, especially new inexperienced Enrolled Nurses, some wards were going to have to change their model of nursing care and those with strong personalities would have to be convinced. “*However I do think that some of that leadership stuff about like the surgical wards for instance haven’t really been taught what team nursing is and they haven’t had it [team nursing] demanded of them to introduce it. Making ‘Time for Patient Cares*’ (*not the real name) came through and there were elements that were absolutes that had to be done and there was sort of a bit of weight behind those requirements and you had to do these changes and then there were elements where it didn’t come through as strongly that this must be done and ticked off as well. So team nursing was one of the components but it wasn’t sort of sent through to my manager that this is something that must be achieved. Because I don’t think it was a goal for the surgical wards overall. So the team nursing was floated and then with our strong personalities they all went ah, ah, ah, so it never went anywhere*”.

In Jocelyn’s workplace allocation of patient load was decided by the nurses at the beginning of shift. Jocelyn described this nursing practice as “primary nursing”. She described how she had suggested a different way of allocating patients to nurse called ‘pre- allocation’ but it had been rejected by the nurses and the pre-allocation idea was “*shot down in flames*” when she had suggested it in a nursing meeting. She added that some of the Registered Nurses she had worked with would: “*...not give up their observations or other nursing tasks with the patients they were caring for...There was the loan practitioner personality who preferred to work alone, doing all the patient related tasks because she or he knew that they would be done correctly*”.

Personal and professional stories about Registered Nurses' direction and delegation experiences

The prompt suggestions within the interview schedule supported Registered Nurses to discuss their “good” and “bad” delegation experiences, the Agencies or techniques they used to communicate with Enrolled Nurses, and how they met their direction and delegation responsibilities. Their delegation stories were collected as ‘Personal and professional stories of delegation experiences’ and acknowledge the Registered Nurse Agents’ unique and individual experiences with direction and delegation. The following table represents the relationship of the Registered Nurse Agent, and the Acts, Scenes and Agencies that arose from the Registered Nurses’ stories, and led to the development of the narrative plot. The shaded boxes identify inexperienced nurses’ experiences, and the unshaded boxes identify experienced nurses’ experiences. A legend is provided at the end of the four tables.

Table 6.1. The relationship of the major patterns, and the Acts, Scene and Agencies that shaped the narrative plot of the Registered Nurses’ stories of experience

Major pattern: Professional communication

Script no.	Acts and Scenes	The Agencies	The narrative plot of...
Script no 4 for Barb	<ul style="list-style-type: none"> ○ Dealing with confusion –in-service education ○ A myriad of levels- Level 4 and Level 5 Enrolled Nurses – the confusion ○ Confusion with accountability ○ Patients understanding of the different levels of ‘nurse’ ● Learning about delegation and direction ● The role of culture and unwritten rules 	Dealing with confusion	The narrative plot of dealing with confusion: the experienced Registered Nurse
Script no 25 for Hayley	<ul style="list-style-type: none"> ○ Positive professional communication ○ Open communication ○ Leadership and personality ● Working together ● Learning about delegation and direction ● Guidance and support related to delegating tasks 	Professional communication	The narrative plot of professional communication: the experienced Registered Nurse

Script no 32 for Ginny	<ul style="list-style-type: none"> ○ Understanding why we say what we say ○ Respectful and inclusive communication ○ Open communication ○ Role models ○ Gathering information for assessment ● Nursing as a team ● The way things are done - working overseas..... ● The role of leadership 	Understanding why we say what we say	The narrative plot of understanding the other nurse: the experienced Registered Nurse
Script no 33 for Valerie	<ul style="list-style-type: none"> ○ Information seeking and learning by osmosis ○ Knowing what an Enrolled Nurse can do ● Communicating well and being clear ● Managing change ● Learning about delegation and direction ● Working as a group 	Information seeking	The narrative plot of information seeking: the experienced Registered Nurse

Major pattern: ‘Doing’ delegation and direction

Script no.	Acts and Scenes	The Agencies	The narrative plot of...
Script no 3 for Bronwyn	<ul style="list-style-type: none"> ○ Creating lieutenants through teaching and sharing information ○ Conflicting philosophies ○ Confusion about the role of ‘direction’ ○ Providing information about pain management, assessing sleep, comfort cares and monitoring the equipment. ● Checking in with each other ● Learning about delegation <i>and</i> direction 	Sharing information	The narrative plot of sharing knowledge through direction: the inexperienced Registered Nurse
Script no 13 for Ellen and Eleanor	<ul style="list-style-type: none"> ○ Strategies for doing delegation well ○ Working with experienced Enrolled Nurses ○ Checking in at lunchtime ○ The role of personality ○ Reading between the lines – communication ○ Being approachable ● Assessing the Enrolled Nurse ● What can and Enrolled Nurse do? ● Working together and being accountable 	Doing delegation right	The narrative plot of doing delegation and direction right: the experienced Registered Nurse
Script no 21 for Milena	<ul style="list-style-type: none"> ● [Not] Doing delegation? ● Finding out about delegation ● The autonomous EN ● Assessing the EN ● New graduate expectations ● Communication skills ● Learning about delegation ● Delegation or allocation? 	[Not] doing delegation	The narrative plot of [not] doing delegation: the inexperienced Registered Nurse
Script no 29 for Gail	<ul style="list-style-type: none"> ● Good delegation interactions ● Being approachable ● Who’s accountable? ● Working together with a grid ● The role of documentation ● Assessment and communication 	Doing delegation well	The narrative plot of doing delegation well: the experienced Registered Nurse

Major pattern: Skills for delegation

Script no.	Acts and Scenes	The Agencies	The narrative plot of...
Script no 1 for Susan	<ul style="list-style-type: none"> ○ Invisible assessments ○ Leadership skills ○ Communication as relationship ● Working outside the Scope of Practice ● Learning about delegation and direction 	Invisible assessment leadership and communication	The narrative plot of hidden skills: the experienced Registered Nurse
Script no 2 for Miriam	<ul style="list-style-type: none"> ○ The DEU as role model for delegation skills ○ ‘Inherent’ knowledge of delegation and direction ○ Communication as a relationship ● The role of assessment-asking the Enrolled Nurse ● Learning about delegation and direction ● Level 4 and Level 5 Enrolled Nurses 	Role modelling delegation skills	The narrative plot role modelling: the experienced Registered Nurse
Script no 5 for Harry	<ul style="list-style-type: none"> ○ Knowledge, skills and attitudes for working with Enrolled Nurses ○ Working with a regulated workforce ○ Providing information as a leadership role ● Learning about delegation ● The role of culture 	The role of communication, assessment and leadership	The narrative plot of communication, assessment and leadership: the experienced Registered Nurse
Script no 30 for Jill	<ul style="list-style-type: none"> ○ Skilled nurses ○ Open communication ● Learning about delegation and direction ● Delegation or direction? 	The skilled nurse	The narrative plot of the skilled nurse: the experienced Registered Nurse
Script no 31 for Sandy	<ul style="list-style-type: none"> ● Planning the shift together ● Seeking relevant information – the need for assessment ● Finding out what an Enrolled Nurse can do - the need for 	Planning and preparation for delegation	The narrative plot of planning and preparation: the experienced Registered Nurse

	good communication <ul style="list-style-type: none">• Delegation or direction?• Who's accountable?• Learning about delegation and direction		
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Major pattern: Working as a team

Script no.	Acts and Scenes	The Agencies	The narrative plot of...
Script no 6 Janine	<ul style="list-style-type: none"> ○ Working in a team or working as a team. ○ Assessment, communication and leadership of the team ○ Developing local policy. <ul style="list-style-type: none"> ● The role of leadership. ● Looking behind and beyond the behavior' 	Working in teams	The narrative plot of working <i>in</i> and <i>as</i> a team: the experienced Registered Nurse
Script no 15 for Jocelyn	<ul style="list-style-type: none"> ○ Championing team nursing ○ Enrolled Nurses as 'upskilling' – certification ○ Confusion about the Enrolled Nurse role ○ Working with Enrolled Nurses <ul style="list-style-type: none"> ● Accepting and enabling poor communication ● Learning about delegation Allocation not delegation ● The role of leadership ● Unwritten rules 	Team nursing	The narrative plot of team nursing: the experienced Registered Nurse
Script no 34 for Gloria	<ul style="list-style-type: none"> ○ We're all in this together. ○ Working <i>as</i> a team. ○ A supportive environment ○ Successful communication <ul style="list-style-type: none"> ● Defining the terms ● Learning about delegation ● The role of nursing leadership 	Working together	The narrative plot of working together: the less experienced Registered Nurse

Legend

○	Narrative plot
●	Shared meanings
Shaded boxes	Inexperienced nurses
Unshaded boxes	Experienced nurses

Registered Nurse Agents' stories about 'Professional communication'

The finding of the major pattern of 'Professional communication' brings together the stories of four experienced Registered Nurses who wanted to ensure they supported professional and successful delegation interactions through communicating professionally. While the Enrolled Nurse Agents discussed good communication skills and communicating well, the Registered Nurses stories centred on the advanced communication needed between Enrolled and Registered Nurses. In order to meet their understanding of direction and delegation each of the Registered Nurse Agents' developed techniques to ensure that the communication environment was conducive to safe and successful interactions between them and the Enrolled Nurses they worked alongside. How nurses communicated was important for all the Registered Nurse Agents interviewed but for these Registered Nurses it consumed the major portion of the stories in their scripts. Together, the four experienced Registered Nurses were able to provide a 'script' for communication between Enrolled and Registered Nurses if delegation communication interactions were to be successful.

Barb's stories of professional communication in a busy medical ward took on a different perspective from the usual understanding of 'professional communication.' Her stories of the leadership role she played in providing innovative and useful information that her colleagues needed related to the Enrolled Nurse Scope of Practice led to the narrative plot of dealing with confusion. Professional communication for Barb included finding creative and visionary ways to communicate information professionally to the nurses, patients and members of the inter-disciplinary team about the different levels and roles of the nurses in the workplace. She wanted brochures and pamphlets made available to patients that provided an explanation about the different levels and roles of the nursing personnel and health care assistants employed in their workplace, and an explanation about what that meant for the patient. She also suggested making staff photos available on corridor walls and photos of uniforms and the associated regalia that denoted the difference between an Enrolled and Registered Nurse. Her preference extended to having access to uniforms that clearly signaled the difference between an Enrolled and Registered Nurses as these distinctions were not available currently. Barb also wanted quick access for busy nurses and other health professionals to the role relevant, workplace specific information they currently did not have. In Barb's workplace there were Enrolled Nurses with conditions on their practicing certificates.⁶ This caused confusion, not just from Registered Nurses but from some of the Enrolled Nurses themselves, the inter-

⁶ In Barbs workplace there were Enrolled Nurses (Level 4) who had not transitioned to the Level 5 Scope of Practice, experienced Enrolled Nurses who had transitioned to the Level 5 Scope of Practice, and new inexperienced Enrolled Nurses who graduated with a Level 5 Scope of Practice.

disciplinary team members, and patients. Barb envisioned that the techniques she suggested, and the techniques she was able to put into place to communicate with her colleagues would serve to decrease the confusion, the plot of her stories.

Hayley's narrative plot of professional communication differed slightly to the other Registered Nurses in this major pattern. In the narrative plot of professional communication Hayley felt that the way the assessment of patient acuity occurred, and the way staffing skill mix was managed were important aspects of successful delegation interactions. Her stories also illustrate the need for Registered Nurses and Enrolled Nurses to communicate professionally during these assessments. Hayley described how a successful delegation interaction needed to include a Registered Nurse who understood the need for the other nurse to feel part of the team, and have their professional opinion valued and included. The Enrolled Nurse needed to be able to communicate openly, be confident in their own practice and confident to ask questions. Hayley had used the term "*open communication*" several times. She mentioned that sometimes the Enrolled Nurses would contact her in her management role if they felt things had not gone well on the ward. This might be an indication that there was not open communication between Enrolled and Registered Nurses as they were not communicating with each other in a successful way but contacting the manager with their concerns.

She had found that successful delegation interactions also relied on the Registered Nurse's ability to lead the team. She felt that some nurses were great leaders because of their ability to communicate professionally, and others were not. In her management role she had sometimes had to intervene to ensure the delegation task that was being asked of the Enrolled Nurse was fair and the communication has been professional. She added that the leadership skill Registered Nurses' need is not a skill that could necessarily be learned in a course. Hayley felt that the Registered Nurses she worked with had a variable understanding of direction and delegation and there were some nursing staff resistant to change. She had come across one example of a Registered Nurse delegating or allocating overly complex patients that required a lot of nursing intervention, to an Enrolled Nurse. She found the Enrolled Nurse was able to explain to the other nurse in a professional manner why they should not have this complex type of patient in their care but the Registered Nurse had not listened to the Enrolled Nurse. She recalled one other case of disrespectful communication where there had been bullying behaviour between nurses. This was addressed thoroughly, swiftly and professionally by nursing management. There had been incidents of Registered Nurses sitting in offices 'delegating' to Enrolled Nurses who ended up doing the bulk of the work and this was another area where she had to intervene in her management role. However, Hayley's stories related to poor communication during delegation interactions were sporadic and her

perception was that they were more about the nurses' personalities than any systems failure. Hayley noted that personality and the way people *usually* communicate in their everyday lives plays a big part within their professional nursing communication in the workplace. Her stories show that positive, professional nursing communication is shaped by the nurse's personal way of interacting and this influences how the direction and delegation interactions proceed and pan out. This idea became a common pattern throughout the entire interview. She wanted to ensure that the nurses she worked with, and was responsible for in her management role, communicated in a professional way, and this led to the development of the narrative plot of professional communication.

In the narrative plot of understanding the other person Ginny's stories illustrate her perception that when we communicate as nurses we also need to understand "*where the other person was coming from*". She explained that it is important to hear what the other person is saying by really listening, as it's not always *what* people say, it is often *how* they say it and even more importantly *why* they are saying it. Ginny believes that the requirement to communicate in a professional, non-judgemental and polite way can be taught, but these actions also need to be role modelled too when Enrolled and Registered Nurses communicate with each other. Ginny described the need to be aware that for some nurses there may be "*layers of anxiety*" about direction and delegation because Registered Nurses might be anxious about how to do this, and anxious about what the Enrolled Nurse's role and responsibilities were. New inexperienced Enrolled Nurses might be anxious about their new role and skills. It was this anxiety could influence what is said, how it is said because of why it is said. Each nurse within the delegation interaction needs to understand why a Registered Nurse may be anxious about the Enrolled Nurse doing a particular task or skill. For example, if the Registered Nurse believes that they will be legally responsible if things go wrong the Enrolled Nurse needs to know and understand that. The Enrolled Nurse needs to be able to explain their level, and who is accountable and when, and what they can do. Negotiation might be the answer to this and if the Enrolled Nurse does not have the confidence to speak up and explain their Scope of Practice and what they are confident doing, they need to develop it, or the Registered Nurse could become anxious and this might impact on the way they communicated. Ginny felt that Registered Nurses need to understand the clinical environment, and assess the Enrolled Nurse's knowledge and skills before delegating any task. She did not believe this was necessarily a formal 'assessment' but it was about engaging with the Enrolled Nurse and informally chatting about past experience. She described this as "*sussing out*" and it could be done in an enquiring way rather than a formalised assessment type of way. Ginny's past experiences in her training days and working overseas influenced her way of interacting with other nurses and these experiences had shaped her views about communicating with Enrolled

Nurses. Ginny's stories illustrate her perception that there needs to be professional communication between Enrolled and Registered Nurses and this included negotiation, being non-judgemental and being polite so that the other nurse felt listened to and understood. She advised going "*beyond, behind and beneath the words*" that were spoken to really understand what the person was feeling and therefore saying, and why they were saying it, and this led to the identification of the narrative plot of understanding the other person.

The narrative plot of information seeking was told through the stories Valerie shared about her concerns that there was little information available about direction and delegation or professional communication in her workplace. Valerie also spoke of the lack of training about the Enrolled Nurse role. She included in this discussion that any changes to the nursing model, such as introducing a new level of nurse and providing access to relevant information about the Enrolled Nurse role and level needed to be managed, and this she said is the role of nursing leadership. The scene of Valerie's narrative was an outreach medical setting. Valerie felt that the way communication occurred was vital and getting the communication right was an important part of the nursing role but not everyone achieved this. Communication also included the listening component. Just as the other Registered Nurses in this major pattern had been able to do, Valerie provided a script for the professional communication skills Registered Nurses would need so that the Enrolled Nurse felt accepted and valued. Delegation interactions needed to be consultative because the way you ask for something to be done was almost more important than the tasks you were asking the other nurse to do, and the requests made needed to be clearly communicated. Nurses needed to be working as a team and for this Registered Nurses needed empathy and to assess if the Enrolled Nurse felt comfortable being in that particular workplace they were in. Registered Nurses needed to be aware that Enrolled Nurses maybe at a different level but they brought with them valuable life skills and broad experience from other wards. They needed to listen to the Enrolled Nurse and to respect the relationship with them.

Valerie herself communicated collaboratively by sharing her thoughts with her colleagues before making a decision. She found that if information could be shared among the group, decisions could be made *as* a group. Enrolled Nurses needed to ask as many questions as possible and be honest and open to feedback. She added that she believed the patient should not be formally told that the nurse looking after them was an Enrolled Nurse as was required in the Guidelines because patients do not understand about the different levels and this could make patients nervous. Valerie pointed to the role that nursing leadership needed to play in order to support both Enrolled and Registered Nurses to understand the Enrolled Nurse role, and the direction and delegation responsibilities that come with this. And while Registered Nurses would need to be open to change, any change would need to be managed properly. For

example, Registered Nurses needed information to support the changes that would be needed to the nursing model when working with Enrolled Nurses, and in understanding the Enrolled Nurse's new role. Valerie's stories showed that she wanted to have nursing leadership that was effective in providing *accessible* information when changes such as the introduction of the new Enrolled nursing workforce were required rather than learning about important nursing related issues "by osmosis". She felt that knowing what an Enrolled Nurse could and could not do, and about the changes to the newest Enrolled Nurse Scope of Practice were important but she did not know about these changes nor was she sure where she would get this information. While Valerie welcomed working with Enrolled Nurses in the future she was concerned that there is no information or guidance available for Registered Nurses about how to be in a direction and delegation interaction. The technique she used as a professional communicator was a collaborative approach where information is shared as a team. She seeks out information wherever possible in order to understand the Enrolled Nurse's role and new Scope of Practice, which was one of the reasons she had volunteered to be part of the research study. Her stories led to the narrative plot of information seeking.

Registered Nurse Agents' stories about 'Doing direction and delegation'

The finding of the major pattern of 'doing' direction and delegation links together the narrative plots of two experienced and two inexperienced Registered Nurses who described how they met their professional obligation to direct and delegate to Enrolled Nurses and health care assistants (HCAs). 'Doing' direction and delegation represents the requirement to carry it out, and participate in the transaction that is direction and delegation at work. While the Registered Nurse Agents' stories appear as four separate stories there are similarities in the way they attempt to meet the professional obligation to 'do' delegation which brings their stories together. 'Doing' direction and delegation' captures the strategies these four Registered Nurse Agents consciously chose to use in order to meet the direction and delegation requirement of their Scope of Practice, and to keep everyone involved, safe.

Bronwyn, self-identified as a relatively inexperienced Registered Nurse who was responsible for nearly 100 older care residents in a community setting and in this role she was supported by a team of carers. The narrative plot of sharing knowledge through direction illustrates how Bronwyn attempted to do the *direction* aspect of direction and delegation through teaching the carers because they were her "eyes and ears" when she was busy in another part of the facility. Bronwyn understood that she was responsible for the way delegation happened and her perception was that if the carers provide better care, the resident's quality of care also improves. But management did not agree and suggested she take a refresher course on direction and delegation because she was "not forceful enough" and "too familiar" in her

approach with the carers. Bronwyn now believed that management was confused with the nursing terms and thought that ‘directing’ meant merely giving orders or directives. They asked her not to teach the carers as this was “*not her role*”. Management wanted *tasks* to be allocated to the carer who would then do the tasks to the resident, and move on quickly to the next resident. They wanted a “*clean environment and hospital corners*”. This conflicted with Bronwyn’s own philosophy of nursing as she believed that direction and delegation interactions needed to be positive, empathic and kind. She believed that she needed to have faith in people’s abilities, and if she “*created lieutenants*” to carry her ideas forward it would create a better environment for all, workers and residents. As Bronwyn identified as Māori, mana and working in partnership were also important to her. She believed in the Te Whare Tapa Wha model, “*not just for Māori but for everyone*”. This framed her inclusive and holistic way of communicating with residents and carers, and was influential to the way she wanted to be a Registered Nurse in a direction and delegation interaction. But these ideas and ways of communicating were not evident in her workplace or in any of the direction and delegation interactions she witnessed between other Registered Nurses and carers. Bronwyn’s employers did not want this kind of guidance or support given to the carers. Her desire to provide quality nursing care shaped how she insisted on sharing her knowledge and informing the carers about what she was doing and why, what the equipment was for and how certain tasks should be carried out by the carers. This was important to Bronwyn because the residents as well as the carers would benefit because the carers would be able to give informed care and support to the residents. That is, she shared her knowledge through *direction* in the spirit of how she believed it was intended to be used. Bronwyn stories illustrate how she wanted ‘direction’ to be about guiding and teaching the carers and other nurses, not just about giving directions, instructions or allocating tasks at shift handover as had been suggested by management. Sharing knowledge and information with carers provided a tool so that the residents were seen as more than just someone to do tasks to, and led to the development of the narrative plot of sharing information through direction.

The narrative plot of ‘doing’ direction and delegation right reflects the stories Ellen and Eleanor share about the strategies they had in place to ensure delegation worked for everyone. Ellen and Eleanor conceded that at the moment the way they did delegation went well because of their capable and experienced Enrolled Nurses. Their concerns were that it would be a different situation if new inexperienced Enrolled Nurses were employed there. The scene of Ellen and Eleanor’s stories was a rural district nursing service. Ellen and Eleanor had both attended courses on communication which covered learner thinking, adding value, doing things smarter, why things are done the way they are, and collaboration. They had found the courses they attended extremely beneficial. There had been a session on ‘personality typing’

and this had been “*invaluable*”. These sessions covered the “*shadow side of people’s personalities and their motivations*” and how people manage, and what they do under pressure. Ellen acknowledged there were some strong personalities in the team and “*we do have to work around those personalities*”. Eleanor adds that personality sometimes plays a part in how people communicate. Ellen explained that you have to look at, and really examine, if what you think you are doing and saying when you communicate, is what other people are seeing and hearing. Ellen and Eleanor employed a number of strategies for appropriately carrying out delegation. Firstly, the Enrolled Nurses employed in this workplace were experienced and skilled nurses. Secondly, Ellen would increase her own workload at times to accommodate client visits with the Enrolled Nurse when the Enrolled Nurse had concerns. Thirdly, the nurses met informally at lunchtime to discuss any concerns. Another strategy Ellen employed was to be “*in-tune*” and sensitive to what the Enrolled Nurse was saying and have a sense, based on nursing knowledge, that the Enrolled Nurse needed extra support. She explained this as the need for the Registered Nurse to “*read between the lines*” when they were working with Enrolled Nurses. In addition, Ellen was always contactable by cell phone for emergencies and the Enrolled Nurses were encouraged to share their concerns with Ellen. Ellen also ensured that she was approachable and receptive to their questions and this supported the Enrolled Nurses to feel safe to share their concerns. Eleanor explained that observing and assessing the Enrolled Nurse becomes essential so you can assess what they do and do not know, and where they might need extra help and support which is why meeting up in the morning or at lunchtimes was vital. Reading body language and facial expression were part of this ‘assessment’ too.

Eleanor believed she would know what an Enrolled Nurse could and could not do by how they carried out their job. She added that she would sometimes go to the Enrolled Nurse for information around client care too. She explains that the Enrolled Nurses they currently worked with were very skilled with wound care for example. “*One Enrolled Nurse was so skilled in the wound care area, in another life she would probably be a CNS in this specialty*”. In this way Ellen and Eleanor were describing a real partnership, playing to each team member’s strengths. Eleanor made an important point. She and Ellen did not judge nurses based on whether or not they were an Enrolled Nurse or a Registered Nurse, but on their ability to do the job. Ellen added some of the Enrolled Nurses think of themselves as: “*second class citizens*” so “*we stamp that kind of thinking out real quick!*”

The stories shared showed that both nurses wanted to do the right thing, and get direction and delegation right. They were not only practicing delegation and indirect and direct direction correctly, they understood it and could articulate what the Registered Nurse’s responsibilities were, and what the Registered Nurse was accountable for. Ellen and Eleanor clearly described

how they had adapted to the requirement for delegation to Enrolled Nurses and presented these as the techniques they employ in order to achieve this. They wanted to treat the Enrolled Nurses they worked alongside as part of their small team because the Enrolled Nurses they worked with were experienced, competent woman. The techniques they used to lead the team led to the identification of the narrative plot of doing direction and delegation right.

The narrative plot of [not] doing delegation represents the stories Milena shared about her delegation experiences as a new graduate Registered Nurse. While Milena understood that she had a professional obligation to direct and delegate to Enrolled Nurses she did not believe that the Enrolled Nurses on her ward, especially the experienced Enrolled Nurses, would tolerate her delegating tasks to them. Nor would they tolerate being told they needed to be working under the direction and delegation of the Registered Nurse. The scene of Milena's stories was a busy medical ward. Milena's stories showed that she could not imagine how delegation would work and significantly adds, "*if it was expected on her ward*". The fact that Enrolled Nurses and Registered Nurses were not in delegation interactions was just accepted. The charge nurse "*would never really say to the Enrolled Nurses: you're supposed to be delegated to*". It was taken-for-granted that the way direction or delegation did not occur in this workplace was just the way things were done around here "*so why change it as it seems to be working?*" However, Milena acknowledged that when the new inexperienced Enrolled Nurses emerge on the scene to replace retiring experienced Enrolled Nurses they will expect to be delegated to. She felt it might create problems in the workplace if Registered Nurses were suddenly asked to delegate to this cohort because they don't do it now. She did not feel comfortable with the idea of delegating to anyone. Although she felt she would not dare attempt to delegate to an Enrolled Nurse she often had to ask Health Care Assistants (HCA) to help her with a turn or a lift and even this felt uncomfortable to her at times. This was because delegation was [not] done in her workplace. She did not believe any new inexperienced Registered Nurse would be able to do this with any experienced Enrolled Nurse. She felt they had been doing things their own way for such a long time; they would not be able to change now. Milena added that direction and delegation was not discussed at all on the ward. She wanted communication to be polite, professional and pleasant in the workplace and to this end she did not feel confident with any type of conflict situation. She avoided asking the Enrolled Nurses to do anything even though they were pleasant and approachable, and very knowledgeable. She felt they just would not tolerate her delegating to them or questioning their practice in any way. Especially from a new Registered Nurse who clearly had less experience than them. She added that she spent a lot of time monitoring the way she asked for help.

The stories she shared made it clear that she is not ‘doing’ delegation with Enrolled Nurses and shows how ‘delegation’ which was really allocation with the Enrolled Nurses working almost independently post allocation was occurring in her workplace. The techniques Milena used to avoid potential conflict by not asking the Enrolled Nurse to do any tasks, but also finding out as much information about direction and delegation as possible led to the identification of the narrative plot of [not] doing delegation.

The narrative plot of doing delegation well describes how Gail made direction and delegation work for her and the Enrolled Nurse she worked alongside. Gail’s stories showed that as an experienced Registered Nurse she had developed a number of strategies over time to support successful delegation interactions. She felt that if doing delegation was going to be successful there needed to be an assessment of the Enrolled Nurse, good communication between the two nurses, and leadership of the two-person team. These strategies supported the Enrolled Nurse to contribute to the plan for the day and required an assessment of the Enrolled Nurse. Gail discussed how the delegating Registered Nurse would know what the Enrolled Nurse could do and made an important point: *“Well how do we as Registered Nurses know what we can and can’t do? Boils down to, I guess, well how do we know how to do something as an RN? By having your own patients you work out your patient care and you work out what needs to be done and then ...I guess you ask people...”* Gail said she would *ask* the Enrolled Nurse. This aspect of assessment involved the Registered Nurses doing a small “mini” assessment of the Enrolled Nurse, especially if the Registered did not know them well. This included asking the Enrolled Nurse *“even if it’s a little chat”* and observing them in order to get a feel of what they were capable of. Gail described using a grid for task completion and team workload with the patient names down one side and ‘tasks’ across the top. The grid was designed so that the Enrolled and Registered Nurses would put in the relevant nursing tasks together. This was not only a Registered Nurse’s task as the Enrolled Nurse could contribute to planning the nursing care too. The grid was made available as a template and the nurses would tape the grid to the nursing office wall, and the two nurse ‘team’ would return and cross off the tasks as they were completed. The grid helped to prevent mistakes in the form of missed care, delayed medication administration or double ups in care. It also decreased the need for micromanagement by the Registered Nurse. This was an important point as she had found delegating tasks endlessly throughout the day, and an Enrolled Nurse returning each time to *“check in”* with their observations, tedious for both nurses. It also helped to manage time because time was almost ‘automatically managed’ within the plan (grid).

Gail’s stories illustrated that she wanted to provide a safe, supportive environment not just for the patients but for the nurses she worked alongside as well. She had learned that it was

important to teach, help and guide other nurses she worked with and she believed this could only really happen when both nurses were approachable. She assessed the knowledge and abilities of the Enrolled Nurse she was working alongside through questioning and observation in order to protect them from being set up for failure. Gail identified the need to be approachable and she was justifiably proud that other nurses came to her for help and advice. In this she had been shaped by her past as she had worked in both positive and negative workplaces and the approachability of the nursing staff was an important aspect of how well doing delegation worked out. Gail's narrative plot of doing delegation well shows the assessment and communication techniques she had developed over time to support successful delegation interactions with the Enrolled Nurses she worked with. Her stories illustrated the relationship between assessment, communication and the leadership role that Registered Nurses need to play in order to "do delegation" well.

Registered Nurse Agents' stories about 'Skills for delegation'

The finding of the major pattern of 'Skills for delegation' links together the stories of five experienced Registered Nurses who discuss the delegation skills that they believe Enrolled and Registered Nurses need in order to ensure they have safe and effective delegation interactions. The narrative plots included within this major pattern illustrate the delegation skills needed for an assessment of the Enrolled Nurse, the communication skills that meet both Enrolled and Registered Nurses' needs, and the leadership skills needed to bring the communication and assessments together. Although the Registered Nurse Agents in this major pattern share similar ideas about the skills they believe are needed, their approach to finding them, and supporting them differs.

In the narrative plot of hidden skills Susan illustrated that the skills needed for safe and effective direction and delegation are often hidden and taken-for-granted. But they also take time to develop. The assessment, communication and leadership skills Susan described so that direction, and delegation in particular, are done safely are hidden to the casual observer. They appear to come easily to Susan as she has built up her knowledge over many years, and they are linked to her personal values. It was only in the telling of these stories about 'good' and 'bad' delegation that these hidden skills surfaced. For Susan an 'assessment' happened on many levels and was vital to the safety of all involved in the delegation interaction. Firstly, there was an assessment of the Enrolled Nurse's skills and abilities before assigning the patient load. Secondly, there is an assessment of the patient from the patient's progress notes. Thirdly, Susan assessed the level of nurse she would be sending to the patient's home, the nurses' past performance and experience, and she asks the nurse if they feel confident with the tasks being allocated. The assessment process was automatic and none of the assessments

were documented⁷ so the amount of assessment is hidden and almost taken-for-granted. For Susan it was not safe enough for the Enrolled Nurse to self-assess to identify if they were confident to perform a delegated task. Susan believed that a nurse's self-assessment and their "*feeling confident*" was only part of the delegation interaction between Enrolled and Registered Nurses. She believed there also needed to be competencies set by the organisation the nurse works for, which are successfully completed and updated, and captured and monitored by the organisation. It is also about the organisation having rules (local policy) about delegation to follow. Susan's role as coordinator required management skills, but it also required leadership skills. She showed through her stories that often the leadership skills and the communication that good leadership requires were invisible, as two nurses sitting together talking looks like two nurses having a "*bit of a chat.*" But it is a bit of chat with a purpose when you are a leader. The sort of communication skills she used with her patients such as listening also shaped her leadership style with her nursing colleagues. Assessment and leadership required robust communication skills. For Susan communication which included "*common courtesy*" "*good manners*" a "*pleasant and respectful manner*" were important when nurses communicate especially during direction and delegation interactions. This came with experience, and good communication skills were an important part of being able to assess and lead a team. Her stories illustrated that the skills and personal values she brought to her work influenced the delegation interaction. Susan used these assessment, leadership and communication skills everyday but they were taken-for-granted by her, and therefore invisible and hidden to others too. It was not until Susan read her re-story and saw the skills distilled from her interview that she understood the hidden skills she had, because as she said, she "*just got on with it*".

The narrative plot of role modelling are the stories Miriam shared about delegation told through her belief that the skills needed for safe and effective delegation could be role modelled through the use of Dedicated Education Units (DEU) and Nursing Entry to Practice (NetP) programmes. Underneath her stories though was another plot line related to how nurses needed access to information about both direction and delegation, and they needed to be taught it in order to do it. It was not "*inherently*" known or understood by nurses, as management personnel appeared to believe. "*I think nursing management just expects us to know about direction and delegation. They think it's inherent in our work, or there's an expectation that you just know the more junior people are delegated or directed to by the more senior ones*". Miriam explains that there had been a disconnect and: "*a generation or two*" of Registered Nurses not exposed to direction or delegation as nursing made a shift

⁷ Susan explains that firstly there is no place to document these assessments as she believes the patient's notes are not a suitable place for this information, and secondly it is a very busy time of the morning

towards a Registered Nurse-only workforce during that time. Therefore, nurses could not inherently know or understand the knowledge, skill and attitudes required for delegation interactions, or *how* to do it. Expecting nurses to know about it inherently underestimates the need for Registered Nurses to have access to information and education about *how* to do delegation. She felt that with the change in the Enrolled Nurse Scope of Practice a more of a hands on approach by nursing management was required and sending an email attachment to nursing staff with the direction and delegation guidelines attached to it was not going to meet Registered Nurses' needs. No "*conversations*" had been held with the nurses in the wards about the documents sent through via email, just an expectation that the nurse would independently read these, understand them and have the required skills to do direction *and* delegation.

Miriam believed that if delegation interactions between the Enrolled and Registered Nurses were to be successful they required politeness, respect, good manners and kindness. There also needed to be clarity around what the Registered Nurse was asking, what the Enrolled Nurse can or cannot do, and trust. *"And it has to be based on trust. So that would be fundamental wouldn't it? By trust you'd undertake this and you trust me to do it. So it's a two way, oh going down the marriage analogy now are we?"*

The DEU model and the NetP programme were offered up as a successful way to role model the required skills, knowledge and attitudes needed for good delegation interactions, and "*getting the message out there*" and bringing the skills for successful delegation to life. Role modelling safe and effective delegation included showing Enrolled and Registered Nurses that there needed to be communication skills that would lead to "*conversations*" that were supportive of checking in, asking for help, declining to do a task or feeling able to feed back to the Registered Nurse, and these could be role modelled in the resources already in place – the DEU, NetP and NESP programmes.

Harry's narrative plot of assessment, communication and leadership also provided a number of stories about the skills required for safe and effective direction and delegation interactions. However, the back story here was that even before these skills were attempted, the Registered Nurses' needed to know and understand about the Enrolled Nurse Scope of Practice and competencies, and the roles and responsibilities of the Enrolled Nurse workforce. He had found that this was not always the case among his nursing colleagues in the mental health setting where he was employed. Harry's narrative plot differed to the other experienced Registered Nurses in this major pattern, as he believed that there was a lot of information around, but you had to look for it, and engage with it. In the telling of these stories Harry

made two important points. That is, there is a relationship between assessing the Enrolled Nurse knowledge and confidence to do a delegated task, and *how* this is communicated. Secondly, the Registered Nurse is responsible for leading the delegation interaction and how delegation is organised, not the Enrolled Nurse's practice.

Registered Nurses needed to know *how* to delegate, direct and understand what the Enrolled Nurse you are working with, can and cannot do. This required skills in 'assessment'. Harry believed that Registered Nurses also needed communication skills. This included an ability to negotiate and discuss with each other, and be aware that we all have different learning styles. Harry believed that it was important to let people save face. For example: "*I often say 'you've probably done this before, but let me show you this'*". Communication needed to be open, honest, respectful, generous, kind and polite. Registered Nurses needed to be aware not to expect too much of new nurses and students "*as they might not have done the task you are asking of them before*". It was important to "*treat people as you want to be treated*".

Harry's role in supporting Enrolled Nurses, students and new staff was based on his personal value of respecting all people because that was how Harry preferred to be treated. He felt that skills in leadership were needed too. Harry played a leadership role in seeking out information about the Enrolled Nurse responsibilities and providing this information to nursing colleagues. This included providing information about 'local policy' related to the Enrolled Nurse role. That is, organisational policy that had been adapted to suit the specific needs of a unit.

Registered Nurses needed to know that the "*buck stops with them*". However, Harry acknowledged that if the Enrolled Nurse made a mistake that it would be the Registered Nurse who is accountable "*if they have not checked in and the task asked of the Enrolled Nurse is not set up well in the beginning*". This was an important distinction related to safe and effective delegation interactions because it spoke to who was accountable and for what, and the relationship between assessment, communication and accountability. Harry captured that the Registered Nurse is responsible for *how* they delegate, not the Enrolled Nurse's practice.

The narrative plot of the skilled nurse tells a story about Jill's delegation experiences. Her experiences were a mixture of good and bad delegation interactions and woven throughout her stories was a belief that in order for there to be positive experiences of delegation both Enrolled and Registered Nurses needed to have a number of communication and assessment skills. Jill had not worked with new inexperienced Enrolled Nurses before, only with experienced Enrolled Nurses. She felt that Registered Nurses needed skills in finding out what Enrolled Nurses could and could not do. At first she was not sure how she would find

out what an Enrolled Nurse graduate could do and then realised she could ask the Enrolled Nurse herself. She wondered if the nurse manager might be able to tell her and then wondered aloud if there would be [workplace] policies she could access. She felt that many Registered Nurses did not feel they had time for the extra assessing, checking in or double checking associated with working alongside the Enrolled Nurse before allocating tasks. For some Registered Nurses this assessing and “*checking in*” seemed like another extra nursing task and job on top of their already long list of responsibilities, and this made them feel frustrated. “*They feel they have enough on their plate*”. Jill wondered if this may have been why some Registered Nurses were reluctant to work with Enrolled Nurses. Jill explained that new inexperienced Enrolled Nurses need to be skilled in saying “*no*” to a delegated task. She recognised and discussed the implications if Enrolled Nurses did not have the ability to say “*no*” and be listened to and respected when they did. The skilled Enrolled Nurse also needs skills in prioritising and time management.

Jill cited the need for any skilled nurse to use open communication and professionalism. For Registered Nurses it was important to ask for a task to be done in a kind manner. She spoke of kindness on at least three occasions during the interview. She felt strongly that Registered Nurses needed to be polite and not to put the Enrolled Nurse in a difficult position when delegating to them. Here, Jill talked about really listening to the Enrolled Nurse and being flexible and willing to change the plan if necessary, and being considerate. She shared that it was sometime since she had read her Scope of Practice and she had not had cause to read the Enrolled Nurse Scope of Practice. She suggested that perhaps new inexperienced Enrolled Nurses should not be placed in acute nursing areas as they would not have the knowledge and experience yet. This of course is contrary to the current Enrolled Nurse Scope of Practice. However, Jill’s stories represented the experiences she had with extremely experienced Enrolled Nurses with 30 or 40 years’ experience who had accumulated many skills and a lot of knowledge along the way. Therefore, her understanding of delegation had been shaped by her past knowledge of working with experienced Enrolled Nurses. However, she understood that both Enrolled and Registered Nurses would need to have good assessment and communication skills and this led to the identification of the narrative plot of the skilled nurse.

The narrative plot of planning and preparation is told through the stories that Sandy shared about the importance of Registered Nurses being prepared for delegation interactions. This included being prepared and organised by having access to relevant and current information about delegation or direction, understanding the communication and assessment skills required of a delegation interaction, and the need for Enrolled and Registered Nurses to plan

the shift together. Sandy worked hard on setting up the delegation requirements at the beginning of the shift. She had found that ten minutes at the beginning of the shift to get the skill mix right when placing Enrolled and Registered Nurses together could save hours of problems later. Preparation work takes time but it helps build trust. She explained that trust is vital to the success of Enrolled and Registered Nurses delegation interactions. Sandy identified some helpful ‘unwritten rules’ that might be useful for Registered Nurses when setting up direction or delegation for the shift. *“The Registered Nurse who can recognise that it’s busy for the Enrolled Nurse too and they are obviously coming to the Registered Nurse for a reason; the Registered Nurse that gives the Enrolled Nurse some credit for their skills such as taking the patients BP and realises that some Enrolled Nurses have been doing obs. for 20-40 years and they don’t need to be checked up on is going to be able to work well with delegation. Also, Registered Nurses who know the difference between direction and delegation, and ‘instruction’, are going to have more success with the Enrolled Nurse than someone who doesn’t”.*

In a continuation of this story Sandy was able to identify some unwritten rules for Enrolled Nurses when they worked under the delegation of a Registered Nurse. *“Enrolled Nurses need to have good communication skills so that they can tell the Registered Nurse what their level of experience and Scope of Practice is instead of the Registered Nurse having to ask and ‘interview them’ each time you are sort of forced into a ‘quizzing’ mode with them. [Poor delegation interactions] happen when the Enrolled Nurse didn’t really understand the bigger picture of running a ward and the pressure for the RN of being responsible and in charge of the entire shift. When you get an Enrolled Nurse who believes that the Registered Nurse doesn’t have enough direction and delegation knowledge that makes it difficult to be in a delegation interaction too”.*

Sandy’s technique for skilled direction and delegation interactions was to be prepared by having a body of knowledge about the role and responsibilities involved in this professional obligation and to prepare for the shift ahead with the Enrolled Nurse. Preparation and planning included a thorough assessment of the environment, and the Enrolled Nurse, which required tactful communication skills. Her stories showed that skills for delegation include assessment and communication skills, being prepared with knowledge about the delegation role, and planning for the shift ahead which led to the narrative plot of planning and preparation.

Registered Nurse Agents' stories about 'Working as a team'

While the Enrolled Nurse Agents had discussed 'Working together', or not working together in some cases, the findings of the major pattern of 'Working *as* a team' gathers together the stories of two experienced Registered Nurses and one inexperienced Registered Nurse who extended the concept for the need to work together to include the need to work *as* a team. For the three experienced Registered Nurse Agents stories within this major pattern working *as* a team differed to working *in* a team.

The focal point of Janine's narrative plot of working in, and as, a team, was based on her ability to lead the teams of nurses in her workplace. Firstly, there was the team of experienced and inexperienced Enrolled and Registered Nurses gathered together for the entire shift who acted as support for direction and delegation interactions in the general sense as backup personnel. Secondly, there were several teams made up of one Enrolled and one Registered Nurse. While the organisation of teams acknowledged the need for Enrolled Nurses to work *in* a team it was Janine's leadership of the team through a belief in clear and coherent communication and thorough assessments, which provided the point of difference so that the team also worked *as* a team. For Janine, good assessment was supported by good communication because the way that work requirements were communicated, and the way nurses' communicated with each other was vital to the success of teams, and it required someone to take the lead. She described the important role that the assessments she makes prior to delegation played, so that the correct nurse was assigned to a service user. Good communication to support the assessment that successful delegation interactions required included; the tone used, dealing with poor communication between nurses, and role modelling how communication should occur. The team approach Janine fostered in her nursing leadership role so that the two nurse teams worked *as* a team, not just *in* a team, was supported by the nursing leadership above her. Through access to local policy that was relevant to her nursing area she was able to either initiate or use a number of systems that supported safe delegation interactions between Enrolled and Registered Nurses in her workplace.

Jocelyn's narrative plot of team nursing shifted emphasis slightly as she described the way nurses worked 'together,' in her workplace the model of nursing care with which she was required to work, and her desire for a team model of care. While she showed her strong support for team nursing, and in many ways was a champion for it, she also highlighted that the primary model of nursing care was firmly in place and she doubted that she would be able to get her nursing colleagues to change as they "*preferred to work alone*". One of Jocelyn's

managers suggested “*working as a team*” and when this happened you had a “*huddle together*” during the shift to check in with each other and support each other. This story illustrated the degree to which the nurses were actually working independently from each other and not as a team given they had to be advised to communicate with each other and “*check in*” throughout the shift. Jocelyn recognised that if more Enrolled Nurses were to be employed in her workplace the model of nursing care would need to be adjusted as the nurses she worked alongside did not work either *as* a team or *in* a team, and in describing this she identified the important difference between the two roles. She suggested a blend of team and primary nursing and while some cosmetic type changes had been made in a nodding acquaintance to ‘working *as* a team’, actually working together in partnership, side by side with a variety of skill mixes, such as new inexperienced Registered Nurses, Enrolled Nurses, agency nurses as well as HCAs, does not happen at all. She believed there would need to be a huge shift in Registered Nurses’ views about the way they worked on the ward, communicated and allocated patients. Her perception was that some nurses “*may not be as open*” to a second tier of nursing as she was. “*So there would be quite a bit of work to be done if you’re actually having an EN there*”. Jocelyn’s stories were about working together as a team, but some of them were about not working together at all. Taken together the stories identified the narrative plot of team nursing.

Gloria's unique perspective on the major pattern of team work clearly pointed to the communication role required of both Enrolled and Registered Nurses, and the assessment and leadership role required of Registered Nurses if direction or delegation was to be successful. In the narrative plot of working together Gloria’s stories showed that if Enrolled and Registered Nurses were to work together in a positive way they would need time to do so, as safe and effective delegation requires a robust set of assessments and a communication style that supports two-way discussion. The scene of Gloria’s stories was an acute medical surgical in patient setting. Gloria described the type of communication that needed to happen between Enrolled and Registered Nurses in order to successfully interact with each other. “*Registered Nurses also need to be polite and they needed to be sure they were delegating appropriately to the correct level of Enrolled Nurse. As a Registered Nurse you need to be sure that the Enrolled Nurse is capable of doing the task you are asking of them, especially if the Enrolled Nurse is new to the ward. Registered Nurses need to know **how** to delegate and how to get along with other nurses. They need to be specific when delegating and they need to be approachable to the Enrolled Nurse...Registered Nurses need to remember that sometimes new staff and students are scared when they come on the ward*”. Gloria explained that successful communication is honest, kind and gentle. She described the type of communication that Enrolled Nurses needed to successfully interact with Registered Nurses.

Enrolled Nurses need to be accepting of feedback and guidance. Gloria explained that communicating with Enrolled Nurses and giving feedback was shaped by her own beliefs and experiences about taking feedback. Gloria's perception was that some nurses did not take the time to support the Enrolled Nurses in this way and this is evident in her next story. *"To be fair Registered Nurses are very busy and stressed and this might be what is impacting on their willingness to teach others...Sometimes they barely have time to say 'hello' to each other let alone teach a student. They barely have time for handing over their patients to the next Registered Nurse on shift handover let alone "direct" or assess someone's knowledge level"*. This was an important point that Gloria had made. It might transpire that Enrolled and Registered Nurses working together will need more time than has been traditionally acknowledged in order to learn how to be in a direction and delegation relationship. Registered Nurses will also need time to assess the Enrolled Nurse and really communicate with them. Gloria's stories led to the identification of the narrative plot of working together and illustrate that in order to work together a working relationship is needed for direction and delegation interactions and most importantly, this takes time. This would be especially relevant for nurses working with a new inexperienced Enrolled Nurse who would expect to be delegated to, and expect and require direction.

Summarising the Registered Nurse Agents stories

Just as the Enrolled Nurse Agents' stories illustrated a degree of confusion about the delegation role, confusion was also reflected in the Registered Nurse Agents small stories as shared understandings. Registered Nurse Agents were confused about the meaning of the term 'direction', and the accountability role. This resulted in most of the Registered Nurse Agents believing they were accountable for the Enrolled Nurse's practice. Many of the Registered Nurse Agents failed to recognise that they were responsible for the way direction and delegation occurred, the leadership role required for safe and effective direction and delegation, and the assessment roles required of the delegation role.

The major patterns captured by the Registered Nurse Agents narrative plots were similar to the Enrolled Nurse Agent's major patterns. However, the narrative plots illustrated the unique and different way Registered Nurse Agents communicated and interacted in the way they did, carried out their direction and delegation roles and responsibilities, the skills they believed were required and how they worked not in a team, but as a team. Underneath each of the Registered Nurse Agent's stories a more complex narrative emerged that represented the social and cultural environment in which they communicated, allocated work and coordinated nursing care, and uncovered the impact of these interactions on their direction and delegation interactions. The narrative plots also illustrated that just as the Enrolled Nurse Agents had

done, that Registered Nurse Agents were driven by a desire for a professional interaction, and a safe and dignified patient experience. This and their historical experience of previous delegation communication interactions and access or not to information, were woven through the narrative plots.

Registered Nurse Agents called for access to more workplace relevant information and guidance related to this professional responsibility. Nursing leadership was seen as holding the ability to provide a model of nursing care to support different levels, skills and abilities of nurses to work together, and the delegation information and guidance they required, but did not do so. Instead Registered Nurse Agents recognised how the culture of the workplace shaped how Enrolled and Registered Nurses communicated and interacted together.

As I combed through the Enrolled and Registered Nurse Agent's personal and professional stories of experience, a list of communication strategies, skills and preferred communication style during direction and delegation based on the "good" and "bad" direction and delegation interactions they had been involved in came into view. These have been presented as the nurse Agents preferred communication styles and skills to support safe and effective delegation interactions, and are presented in Appendix J.

While the findings in Chapter five and six have identified and explored the who, what, when, where, why and how of the Enrolled and Registered Nurse Agent's storied experiences of direction and delegation it is time to turn to Chapter seven, and the discussion of the findings.

The aim of the study of narrative meaning is to make explicit the operations that produce its particular kind of meaning and to draw out the implications this meaning has for understanding human existence (Donald Polkinghorne, Narrative knowing and the human sciences, 1988, p 6).

Chapter seven. Discussion

Chapter seven discusses the findings of this research in relation to what is already known about nursing direction and delegation. Section one offers a discussion about the small stories as shared understandings under the sub heading: ‘Knowing and understanding direction and delegation – confusion’. Section two moves the discussion to why nurse Agents made the direction and delegation decisions they made, and how the nurses made direction or delegation meaningful to their role in the workplace under the sub heading: ‘Making sense of direction and delegation - the narrative plot.’

Section one: Knowing and understanding direction or delegation - confusion.

While there is no research that has specifically studied the communication interactions between Enrolled and Registered Nurses involved in direction or delegation in New Zealand, there have been some New Zealand studies that explored the differences in nurse responsibilities, educational preparation and perceptions about their nursing work (Dixon, 1996; Meek, 2009; Walton, 1989). In addition to these New Zealand studies, aspects of delegation are discussed in the literature from countries where the delegation role is used, such as Europe, the United States, Australia, Iceland and Korea. The findings from this current research study support a number of findings from the literature reviewed, but also contribute new findings about direction and delegation interactions.

Confusion about the delegation role

In this research, when Enrolled Nurse Agents were asked about how delegation occurred for them, they shared stories about how workload was *allocated* at shift handover and in doing so highlighted the confusion that exists between a delegation model and the allocation of workload model. In addition to the allocation of workload model Enrolled Nurse Agents described either a geographical grouping of patients, a primary model of nursing care, or two nurses working in proximity and calling on each other for help with a patient when needed, not a team of nurses based on skill mix, level, experience or abilities.

While there are no studies that specifically explore the difference between allocation and a direction and delegation model of nursing care, team work when used in combination with an

allocation model, supported interprofessional communication and better relationships with inter-disciplinary team members. This systematic review provided by Fernandez identified that a team model of nursing care provided a supportive learning environment especially where there were new and inexperienced nursing staff, and diverse nursing roles such as Enrolled Nurses and nursing assistants working within one workplace (Fernandez et al., 2012). The researchers make an important point that holds resonance for the New Zealand nursing environment. That is, current models of nursing care used today are based on the notion that nursing is undertaken by a Registered Nurse-only workforce. The ability to access a Registered Nurse-only workforce has changed in many countries and has altered the skill mix and levels of nursing personnel available for staffing purposes

Confusion surrounding the delegation role is evident in the study by Bittner and Gravlin (2009). They found that the nurses responsible for delegation felt that the unlicensed assistive personnel (UAP) they worked alongside should be aware of their responsibility to “report back,” and should not have to be told to report back each time a task was allocated. The nurses describe this lack of checking in as “failure to report ” (Bittner & Gravlin, 2009, p. 144). However, the researchers also found that some Registered Nurses failed to communicate and follow up with the UAP to find out whether they had understood the tasks being delegated to them, if they had followed through on them, or had actually accepted the tasks delegated to them. The Registered Nurse participants acknowledged that in hindsight they had realised at the end of a shift the UAP had not understood the tasks allocated to them and often they did not have the background information needed to carry out tasks safely. The findings also acknowledged that as the UAP worked within a Scope of Practice, the delegating nurse expected a higher level of decision making ability and a degree of critical thinking from the UAP when they accepted, and were carrying out the tasks and skills allocated to them.

In a New Zealand study, Walton (1989, p. 50) found that the lines of communication, and supervision were not well set out for Enrolled or Registered Nurses. Walton concluded that often the Enrolled Nurse would report to the Registered Nurse rather than the Registered Nurse enquiring of an Enrolled Nurse. She acknowledges that although it is a subtle difference, it is an important one in order for a “supervision”⁸ interaction to be supported. In addition, she points out that this led to confusion and tension between the two groups of nurses.

⁸ As the direction and delegation role was historically known. The “supervision” model in today’s language would equate to direction and delegation.

Taking delegation instructions from new, casual or agency Registered Nurses was a shared concern for some of the Enrolled Nurse Agents in this study. Enrolled Nurses felt that new inexperienced Registered Nurses or Registered Nurses new to the area such as agency or casual nurses, did not understand some of the clinical issues within the new workplace they found themselves in. This impacted on their ability to direct or delegate as the Enrolled Nurse who had been employed there for many years felt that they knew more about the clinical area, and the patients, than the new Registered Nurse.

This is in line with the study findings into attitudes to delegation by Kaernsted and Bragadottir (2012, p. 14) who found that inexperienced Registered Nurses may well understand the principles of delegation and know the “rules” surrounding this professional obligation but often felt uncomfortable delegating to older more experienced nurses. Additionally, the Registered Nurses in their study did not seek feedback on their delegation style. The researchers conclude that a lack of self-confidence, or a lack of trust during the delegation process resulted in less collaboration, less team work and because of this, decreased quality of patient care.

While the reluctance to work under the delegation of a Registered Nurse is not new there are a number of new findings in this current research study that support the idea that there is confusion surrounding the delegation role. A striking feature of nearly all of the experienced Enrolled Nurse Agents’ stories in this study is that once the patient-to-nurse workload was allocated at shift handover, they mostly worked alone “checking in” and calling on the Registered Nurse “if required.” Checking in was not formally requested and was related to the nurses need for help with mobility or medication administration. Many of the experienced Enrolled Nurse Agents talked about “being left alone to get on with things” or being “trusted” to do their job as a positive feature of a delegation interaction. Significantly, Enrolled Nurses not working under the delegation of the Registered Nurse, and Registered Nurses not delegating to the Enrolled Nurse, are both ‘working outside their Scope of Practice.’

Another new finding is the Enrolled Nurse Agents’ description of an allocation of patient load model and a geographical and primary model of nursing as the dominant nursing model in their workplaces, not a team nursing model. Patients or groups of patients are allocated at shift handover. The ‘allocation’ model, which is not described or defined in any New Zealand nursing literature does not match the direction or delegation descriptions and definitions provided to New Zealand nurses on delegation, which contributes to confusion about what

delegation means. The version of the delegation model being used had developed over time in each workplace setting and had been recast as direction and delegation.

The confusion between the allocation process and delegation of tasks or skills holds implications for inexperienced Enrolled Nurses who will not have the nursing experience and confidence of experienced Enrolled Nurses, and who will need a closer relationship with the Registered Nurse, and a less “hands-off” approach. This is an important and significant distinction because newly emerging inexperienced Enrolled Nurses as opposed to experienced Enrolled Nurses will expect to have aspects of care delegated to them so that they can “contribute”, “observe” “assist” and “report” back to the Registered Nurse (Nursing Council of New Zealand, 2011b, p. 6). Further, new inexperienced Enrolled Nurses working in ‘acute’ settings will expect to be working within a team of nurses with a designated Registered Nurse who can complement the knowledge and skills of the less experienced or new Enrolled Nurse.

Confusion surrounding the delegation role can be reduced through the adoption of a team model of nursing. A team model of nursing designed to accommodate a safe learning environment and supportive relationships between nurses, will enable new inexperienced Registered Nurses to learn and adjust to, leading the direction and delegation role. A team model of nursing affords an opportunity for different skill mix, experience, and levels of nurse and nursing support personnel to learn from each other. With the introduction of a team model of nursing, a description and definition of what constitutes a team is needed so that role clarification for direction and delegation interactions for both Enrolled and Registered Nurses, and the expectations for Enrolled Nurses around when and what to report, and to whom, can be accommodated. Nurses’ stories indicated that the confusion they experience around the delegation role would be reduced if they had access to information at workplace level about the delegation role, and the Enrolled Nurse Scope of Practice.

Confusion about direction or delegation

Direction and delegation are defined in the New Zealand nursing guidance literature (Nursing Council New Zealand, 2007a, 2012a; Nursing Council of New Zealand, 2011b). They are two different terms with different meanings. The terms are broadly defined so as to be flexible and therefore relevant in a myriad of different nursing workplaces and environments. However, they are not well understood.

In the context of this study nearly all the Enrolled Nurse Agents were confused about the difference between a direction role and a delegation role. They found it difficult to describe or distinguish the terms, and sometimes used the term ‘supervision’ instead. Often the two

different roles were referred to as direction *and* delegation as if they were the same term, and many of the Enrolled Nurse Agents used direction and delegation interchangeably. *Indirect* and *direct* direction were not well understood either. Most of the definitions attempted were based on a layman's understanding of the terms, especially the direction role. This resulted in nurse Agents believing that direction was about giving orders or instructions.

The findings from previous overseas research studies where nursing delegation is practiced describe a degree of confusion about what constitutes a delegation request. In a study by Standing and Anthony (2008, p. 11) while some of the Registered Nurses were able to recall the definition of delegation as required by their professional body there were also examples of their own personal interpretation of delegation. This led to more than one definition of delegation, and therefore more than one practice of delegation.

It is unsurprising that there are no findings related to the confusion about the term 'direction' in the overseas literature. Direction as it is described and defined in the New Zealand guidance literature on direction and delegation (Nursing Council of New Zealand, 2011b) is a term unique to the New Zealand nursing environment.

While there were some findings related to confusion about suitable tasks to delegate, there have been no overseas or New Zealand based research studies to support the following new patterns identified in this study's shared understandings. Firstly, there was a lack of knowledge and differentiation between direction and delegation, and confusion surrounding their purpose, application and intent. Secondly, some experienced Enrolled Nurses felt direction or delegation were not needed in their workplace. Thirdly, some nurses believed that a Registered Nurse could learn from an experienced Enrolled Nurse who may well be the most experienced nurse on duty on that shift. Therefore, these are new findings.

In the absence of the correct understanding and meaning of direction or delegation the void is being filled with various interpretations that are often incorrect and are not consistent with the direction and delegation definitions and descriptions provided by New Zealand's Nursing regulatory body (Nursing Council New Zealand, 2007a, 2012a; Nursing Council of New Zealand, 2011b). This contributes to the confusion surrounding delegation. It may be that the terms were deliberately kept broad so as to be applicable in different nursing environments where direction and delegation occurs. However, these terms may be too flexible to the point of irrelevance.

The confusion with the terms direction and delegation, direct and indirect direction, accountability and supervision can be resolved by providing a range of resources that are supported through a three tiered approach. Firstly, decreasing the ambiguity surrounding the terms through the provision of user friendly descriptions, clarification and differentiation of the terms direction and delegation, and accountability and responsibility, within national guidelines provided by NCNZ. In addition to more robust definitions and descriptions, examples and scenarios of these terms are required.

Secondly, individual workplaces need to augment the generic information contained within national guidelines with workplace relevant, area-specific information related to direction and delegation roles and responsibilities. Workplace relevant area-specific information that clearly identifies how nurses apply the terms in their workplace, what the Scopes of Practice mean for direction and delegation and lines of accountability in their workplace, would serve to decrease confusion.

Thirdly, the availability of a national guidance booklet developed for Enrolled Nurses by the NCNZ specifically to support the Enrolled Nurses direction and delegation role and responsibilities would be useful. A dedicated Enrolled Nurse resource that includes the knowledge, skills and attitudes required for safe direction and delegation would contribute to Enrolled nurses' understanding of this professional competency.

Working outside the Scope of Practice

The Enrolled Nurse Scope of Practice is three paragraphs long. The Scope of Practice and its associated competencies do not itemise or list what an Enrolled Nurse can and cannot do (Nursing Council New Zealand, 2012a; Nursing Council of New Zealand, 2011b). While the Enrolled Nurse Agents in this study were not confused about their own role they sometimes experienced a degree of confusion from the Registered Nurses they worked alongside related to what the Enrolled Nurse was allowed to do. The Enrolled Nurse Agents were quite clear that they were accountable for the nursing practice they delivered. The discussion related to knowing what the Enrolled Nurse could and could not do was framed in their stories as “working outside the Scope of Practice” and their need to make a judgment about their ability to do a task or skill through a self-assessment mechanism.

For the Enrolled Nurse Agents in this research the ability to self-assess was linked to being able to decline to do a task if they did not feel safe or confident to carry it out. Declining a task and being able to say “no” were an important aspect to protecting their Scope of Practice,

by not “working outside the Scope of Practice”. Although they did not use the term ‘self-assessment’ the Enrolled Nurse Agents described a process where they decided if they could undertake the task or skill, if they had been taught it, and if they had the confidence to do it. Some of the Enrolled Nurse Agents believed that Registered Nurses did not always appreciate the Enrolled Nurse’s responsibility to do so.

These findings resonate with the findings of an Australian study by Milson-Hawke and Higgins (2004) who found that the Enrolled Nurses in their study interpret and decide by a self-assessment process on the tasks and skills they deemed appropriate to their Scope of Practice. The Milson-Hawke and Higgins (2004) study uncovered an advanced self-assessment regime whereby the Enrolled Nurse made an assessment whether or not the nursing work they were about to do was routine or non-routine. This helped them to decide if they were ‘*Overstepping the mark or not*’, an occurrence that was so commonplace in this workplace that it became a theme within the researcher’s study findings.

Some of the research studies reviewed warn about *task shifting*. Task shifting is an undesirable and potentially dangerous phenomena where other levels and categories of nursing and nursing support personnel are required to carry out nursing tasks for which they have not been educationally prepared (International Council of Nurses, 2013). As far back as 1989 Walton was investigating how nurses’ workdays were organised, their rewards and frustrations, and the skills New Zealand Enrolled and Registered Nurses felt were necessary in their nursing work. She uncovered a small number of Enrolled Nurses in charge of wards in ‘Acting up’ roles and a high degree of confusion and tension around the supervision (delegation today) role, the Enrolled Nurse Scope of Practice, and the roles and responsibilities associated with the Enrolled Nurse Scope of Practice (Walton, 1989).

In a study by Chaboyer et al. (2008) the researchers found that the delegation decision making process appeared to be based on the Enrolled Nurses discretion, and the Scope of Practice was “open to interpretation” rather than a clear and concise set of rules that guided delegation decision making. The responsibilities undertaken by Registered Nurses who were accountable for direct nursing care, and Enrolled Nurses, were found to be similar, and role boundaries between the two levels of nurses within this Australian study had become blurred and were no longer precisely and obviously recognisable. Role blurring, lack of role boundaries and task shifting between nursing Scopes of Practice can contribute to confusion surrounding delegation communication interactions.

The Enrolled Nurse Agents felt that the way delegation occurred, and *if* it occurred, was linked to the ‘culture’ of each workplace. In the absence of any guidance about the Enrolled Nurse Scope of Practice and what an Enrolled Nurse is allowed to do, the culture influences how the Scope of Practice is interpreted, and this impacts on what an Enrolled Nurse is allowed to do. One of the Enrolled Nurse Agents described how the culture of the ward influenced what was asked of the Enrolled Nurse, regardless of the Enrolled Nurse Scope of Practice. “Local area policy” was a phrase that emerged from the findings of the research. Local area policy captured the idea that relevant rules or policy statements had been developed for a specific workplace, from the generic guidelines from Nursing Council of New Zealand. Access to local area policy supported Enrolled and Registered Nurses to work within their Scope of Practice.

The findings related to the influence of ward culture on direction and delegation interactions support the findings of Magnusson et al. (2014, p. 12) who found that each ward had a unique culture and this influenced how newly qualified Registered Nurses delegated tasks to others. When there were well established routines within the ward, and there were experienced and skilled health care workers the new Registered Nurses felt there was less need, and less opportunity, to delegate, because the health care workers knew and understood what they should be doing. Cultural factors determine who does what work, how and when, and how this is communicated. The influence of ward culture is also supported in an Australian study related to understanding how Enrolled Nurses work within their Scope of Practice (Gibson & Heartfield, 2005). The Enrolled Nurses reported different interpretations of their Scope of Practice and therefore what they were asked to do differed between states, organisations, wards and units.

Nurse researchers in the United States building on the work of Conger (1993) provide evidence that different workplaces require different information, and a one-size-fits-all approach does not meet nurses’ delegation information needs (Parsons, 1997, 1998, 2004; Parsons & Ward, 2000). The researchers summarise in each of these studies that nurses needed more information than merely being told they must delegate to others.

Some of the Enrolled Nurse Agents in this current research study described a reluctance from Registered Nurses to be the delegator. This finding was supported by Kaernsted and Bragadottir (2012) who found that 25% of nurse participants in their study pointed to a lack of commitment and experience by the nursing support staff they worked with resulting in the Registered Nurses doing the tasks themselves rather than delegating to others because this was easier and less time consuming. Conversely, Standing and Anthony (2008) point to the

lack of understanding by the nursing assistive personnel who did not understand the Registered Nurse's overall role and ultimate responsibility, and because of this did not understand the purpose or intent of the delegation role. A lack of understanding of each other's role was also reflected in the Potter et al. (2010) study when they uncovered the effects of role confusion and role conflict on the communication interactions between the Registered Nurses and nursing assistive personnel. The lack of understanding of the Registered Nurse delegation role resulted in resentment and reluctance to carry out allocated tasks when requested by the Registered Nurses.

None of the Enrolled Nurse Agents interviewed had heard of the requirement cited in the New Zealand direction and delegation literature (Nursing Council of New Zealand, 2011b, p. 6) that involved the patient being informed by the Registered Nurse that the nurse caring for them was an Enrolled Nurse. As a consequence this did not happen in their workplaces. There is no research or descriptive literature available related to this requirement. Therefore, this is a new finding on three levels. Firstly, all the nurses who were asked about this requirement felt uncomfortable with the thought that the patient needed to be told that they are being cared for by an Enrolled Nurse. Secondly, that none of the nurses interviewed had heard of this requirement, and thirdly that it did not occur.

The confusion experienced by Registered Nurses related to what Enrolled Nurses could and could not do, could be eliminated through providing information to Registered Nurses in both pre and post-registration nursing educational programmes, as well as at their workplaces, about nursing roles and responsibilities, the levels and Scope of Practice for the Enrolled Nurse, how to meet competency for this professional obligation, and what Enrolled nurses can and cannot do. A four strategy approach could be utilised to provide this information.

Firstly, the information could be provided in Enrolled Nurse, and undergraduate, graduate and post-graduate registered nursing programmes. Secondly, work-based information sessions within the nurses' workplaces that supported dialogue, area-specific information, and different scenarios and exemplars could be provided. Thirdly, the development of 'local area policy' that has been adapted from national guidelines could be made applicable, specific and relevant to the nurses' workplaces. Lastly, Enrolled Nurses indicated that an understanding of the (self) assessment work that Enrolled Nurses undertake before accepting a delegated task, and the professional responsibility they had to decline a delegated task if it was unsafe for them to carry it out would be useful for Registered Nurses to know about. Mitigating against confusion through the provision of robust information around the tasks and skills Enrolled Nurses can do, would prevent role blurring, role overload, role confusion, task shifting and

differing cultural interpretations between workplaces. These four strategic approaches provide an opportunity to decrease the confusion surrounding the meaning of “working outside the Scope of Practice”.

Decreasing confusion - where to find information about direction and delegation

Three new findings emerged from this section of the Enrolled Nurses Agents’ small stories as shared understandings. The Enrolled Nurse Agent’s stories showed there was confusion around where to obtain information about the direction and delegation roles and responsibilities related to their workplace. Most of the experienced Enrolled Nurse Agents had been shaped by their past understandings of ‘direction’ and ‘supervision’, as it had been formerly known in New Zealand (Nursing Council New Zealand, 1999; Nursing Council of New Zealand, 2008). Many of the experienced Enrolled Nurse Agents acknowledged that their access to information and support about the new Enrolled Nurse Scope of Practice stemmed from the preparation required when they transitioned to the new, revised competencies and Scope of Practice post 2010, observing how other Enrolled and Registered Nurses interacted and therefore learning “*on-the-job*”, or when providing evidence to meet PDRP requirements. These three mechanisms filled the gap created by a perception that there was no accessible information or support about direction or delegation in their workplace.

Compounding the confusion around where to find information, even if Enrolled Nurses were to access the two guidelines available related to direction and delegation responsibilities, these were predominantly written for Registered Nurses to help them to understand delegating *to* an Enrolled Nurse. They do not provide specific information on how to be in a delegation relationship, or how to be directed or delegated *to* from an Enrolled Nurse perspective (Nursing Council of New Zealand, 2011a, 2011b).

Lastly, Enrolled Nurse Agents felt that Registered Nurses were confused about the Enrolled Nurse role and this impacted on the Registered Nurse’s direction and delegation decisions. The confusion about the Enrolled Nurse role was exacerbated by a lack of direction and delegation information for both Enrolled and Registered Nurses.

Nurse authors from the United States have expressed concerns about the lack of educational preparation about delegation since 1993 (Conger, 1993). Parsons in her studies using the Conger Nursing Assessment Decision Grid (NADG) model of teaching to evaluate nurse’s decision making during delegation, identifies a number of barriers to the delegation interaction between Registered Nurses and others. This included situations where there was no accepted, standardised baseline of knowledge about delegation, a lack of experience with

delegation interactions, and a lack of education related to nurse delegation (Parsons, 1997, 1998, 1999, 2004). Parsons concluded that increased knowledge and skills relevant to the Registered Nurse role during delegation supported and improved delegation decision making, job satisfaction and appropriate and safe patient care. In addition, nursing staff who are informed and knowledgeable about delegation are more able to meet skill mix requirements on a shift by shift basis (Parsons, 1997, 1998). There is a recognition from other nurse researchers that continuing education is a useful vehicle to teach the skills required when there is a change of nursing model or the professional role required of nurses (Magnusson et al., 2014).

This is consistent with the perceptions of the Enrolled Nurse Agents' stories in this research who overwhelmingly expressed a desire for access to relevant workplace-specific in-service education around Enrolled and Registered Nurse roles and responsibilities.

Of note for this research, despite the perception that there was a lack of information related to both direction and delegation at the time of the interviews, all Enrolled Nurse Agents understood their need to work under the delegation of the Registered Nurse. Within the Enrolled Nurse Agents' stories they acknowledged in detail that they worked under the delegation of the Registered Nurse.

Addressing the lack of specific information to, and for, Enrolled Nurses' direction and delegation interactions could be rectified in three ways. Firstly, by providing work-based guidance and information about the communication strategies and assessment techniques needed for safe and effective direction and delegation. The information provided would include the roles and responsibilities associated with both nursing Scopes of Practice, and the attributes for safe and effective direction and delegation interactions to, and for, Enrolled Nurses.

Secondly, provide access to post registration Enrolled Nurse professional development courses that include learning content and assessment outcomes related to the skills, knowledge and attributes required for direction and delegation interactions.

Thirdly, by providing information about the direction and delegation interaction through the provision of guidance material specifically designed for the Enrolled Nurses' role. Enrolled Nurses' stories indicated that their preference was for information sharing in the form of face to face and interactive sessions with Registered Nurses that incorporate meet and greet, question and answer formats, and feedback opportunities.

Turning now to what Registered Nurse Agents knew and understood about direction and delegation, the discussion about the confusion surrounding ‘Knowing about the Enrolled Nurse Scope of Practice - confusion’ and ‘Decreasing confusion - learning about direction and delegation’ is included in the following section.

Knowing about the Enrolled Nurse Scope of Practice - confusion

There are a number of statements about accountability in the NCNZ guidelines and Scopes of Practice on delegation that on first glance appear to be conflicting (Nursing Council New Zealand, 2012a; Nursing Council of New Zealand, 2011a, 2011b). Although a thorough read of the guidelines and the Scopes of Practice helps to discern the differences in accountability between Enrolled and Registered Nurses, many of the Registered Nurse Agents did not recognise that they were accountable for the leadership of the direction and delegation interaction, and continued to believe they were accountable for the Enrolled Nurse’s practice.

As the findings demonstrate many of the Registered Nurse Agents were confused about accountability. Only two of the Registered Nurse Agents identified that the Enrolled Nurse was responsible for the nursing practice they delivered. Most of the Registered Nurse Agents voiced concerns that ultimately they were responsible for the Enrolled Nurses practice. While some of the Registered Nurse Agent’s extended the idea that they were responsible for the Enrolled Nurses practice, by correctly identifying that the Registered Nurse was responsible for the “overall plan of care” only two of the Registered Nurse Agent’s acknowledged that the Registered Nurse was responsible for the way the delegation process occurred. Two of the Registered Nurse Agents made the link that a number of assessments of the Enrolled Nurses’ level and abilities would be needed at the beginning of the shift. The amount and depth of confusion surrounding who is accountable, and the lack of understanding that the Registered Nurse is accountable for the way they delegate are new and significant findings for New Zealand nurses.

A lack of information and its close relative, misinformation, holds the potential to impact negatively on how accountability is understood and therefore how direction or delegation occurs, or if they occur at all. Confusion about the accountability role could contribute to a reluctance or avoidance of working with an Enrolled Nurse in some workplaces. Avoidance of delegation interactions can lead to Enrolled and Registered Nurses both working outside their Scope of Practice because they are not in a delegation relationship.

Registered Nurses in the Standing and Anthony (2008) research study undertaken in the United States understood, interpreted and carried out delegation in different ways. Some of the Registered Nurses were not comfortable delegating and found the delegation role difficult. The Registered Nurse participants described feelings of frustration and unfairness that the Registered Nurse was accountable and responsible for the outcome of a task, but the unlicensed assistive personnel were not. This interpretation led to the Registered Nurse spending time “supervising” which really meant checking up on the UAP to ensure that the allocated task had been done properly, or at all, rather than on *how* the delegation communication interaction had occurred.

In a study carried out in the United States Kalisch (2011) describes how the Registered Nurses and UAP did not fully understand each other’s or their own roles and responsibilities because of a lack of role clarity. This impacted on how the delegation role was viewed (Kalisch, 2011, p. 20). Kalisch found this was due to a lack of understanding by the UAP of the Registered Nurse’s need to carry out other roles such as documentation. In addition to this there was a lack of Registered Nurse leadership.

Registered Nurse confusion about the Scope of Practice was indicated in other studies. This was framed as ‘being unclear’ (Bittner & Gravlin, 2009), or ‘being unsure’ how to delegate (Schluter, 2009). The study by Bittner and Gravlin (2009, p. 145) found that new Registered Nurses were concerned about a phenomena they named as “role uncertainty,” which captured the inexperienced Registered Nurses’ lack of confidence and confusion about how to, and what to, delegate. Confusion around what tasks to allocate impacted on their ability to delegate at all. Some of the findings also pointed to “delegation overload” when acuity was high and Registered Nurses were simply too busy to delegate as there was a perception that the delegation process takes time.

As evidenced by the findings in this research, the issue of delegation being time consuming was raised by the Registered Nurse Agents. The perception of some Registered Nurse Agents was that the assessments, planning and preparation that needed to be done prior to delegating the best nurse for the best outcome would take time that was not currently available to them on a busy shift. The findings of a study from the United States by McLaughlin et al. (2000) support this finding. There was a shared perception by the Registered Nurses participants that they needed extra time to delegate and supervise and this detracted from patient care time. The Registered Nurse participants in the McLaughlin et al. (2000) study also pointed to the issue of staffing levels in that they were not adjusted for the use of different levels of nursing assistive personnel. This was problematic for nurses because increased use of nursing

assistive personnel altered skill level and skill mix on the ward. This could result in extra time needed to assess, communicate, lead the team and decide what to delegate, and to whom.

The confusion surrounding the different levels of nursing assistants is discussed by Standing and Anthony (2008) who cite a degree of confusion when there are different levels of nursing personnel in one workplace. This made delegation interactions for busy nurses even harder, and longer as they would constantly have to ask and clarify the different roles for the different levels of staff. While the researchers acknowledge the confusion for Registered Nurses, the confusion for patients is not discussed.

Schluter (2009) describes that the need to delegate often caused the Registered Nurse to feel guilt, as they believed they should be able to do all the nursing tasks themselves. The Registered Nurses in Schluter's study understood that delegation of tasks was needed in order to achieve realistic workloads, and they understood delegation in principle, but they were "unsure" about how to go about it. It is of note that previously the Registered Nurses on this ward had worked predominantly with Enrolled Nurses. In an interesting and intriguing admission the researchers capture, "and so [the RNs] had not delegated to others" and that it was "uncommon to delegate to an EN". This illustrates how role uncertainty, task shifting and role confusion about the Enrolled Nurse role and level had impacted on delegation requirements in this workplace.

Sometimes the discussion in the literature surrounding 'doing' delegation is framed around a lack of confidence or a reluctance to carry out the delegation role. Registered Nurses who know and understand their own Scope of Practice, and the Enrolled Nurse Scope of Practice, are essential to support informed direction and delegation interactions. As can be seen in the findings the general confusion surrounding who is accountable, responsible and answerable, and for what, is made visible by the Registered Nurse Agent's stories. The stories show a lack of understanding about direction and delegation and the leadership role they need to play during direction and delegation. When the general confusion about accountability is explored and added to the specific perception that delegation is time consuming, a reluctance to work with Enrolled Nurses because it entails direction and delegation, may be the end result. Confusion and a poor perception of direction and delegation are related to poor delegation practices, and poor delegation practices are linked to poor patient outcomes.

The confusion and lack of understanding around who was accountable and when, and the Registered Nurses' responsibility for the leadership and overall plan of care, could be addressed through robust, clearly written guidelines that avoid conflicting or ambiguous

information. Enrolled Nurse accountability for their own practice, and Registered Nurse accountability for the overall plan of care can be reinforced in in-service presentations, for pre-registration graduate and post graduate nursing programmes, and electronic information on workplace information web sites, within PDRP criteria and linked to workplace performance appraisal systems.

Registered nurse perceptions that delegation took time and was an extra task for them to carry out can be addressed through acknowledging that well executed direction and delegation of tasks do take time and should be factored into workload allocation by nurse leaders and managers. Registered nurses need to be informed about the level of Enrolled nurse and what this means in relation to the time required to delegate tasks, or direct nursing practice. This requires front line leadership and systems support (Bittner & Gravlin, 2009) for the nurses charged with this professional competency.

Decreasing confusion - learning about direction and delegation

Registered Nurse Agents described how they had learned about delegation. Many of the Registered Nurse Agents had learned about delegation from watching others, from a section of a leadership course they had attended, or from their Bachelor of Nursing education. There was an acknowledgment from some Registered Nurse Agents that they had not worked with Enrolled Nurses for many years or decades, or at all. Nearly all of the Registered Nurse Agents called for more information about the Enrolled Nurse Scope of Practice, and a “check list” of tasks and skills that an Enrolled Nurse was allowed to do in their workplace. Of note is that requesting a checklist indicates a lack of understanding of the myriad of places an Enrolled nurse can work across the health services, and the many roles and responsibilities an Enrolled Nurse will play within each of those workplaces.

The findings reveal that most of the Registered Nurse Agents pointed to a lack of readily available, easily accessible information related to working with an Enrolled Nurse. With the added possibility that there could be Level 4 as well as Level 5 Enrolled Nurses employed in the workplace the accessibility of information about how and when to delegate became more significant, and many of the Registered Nurse Agents highlighted the need for up-to-date, relevant, area-specific information related to Enrolled Nurse roles and levels.

Although many of the Registered Nurse Agents in this research attempted to describe the delegation role, the term direction was not understood. In keeping with Enrolled Nurse Agent’s stories nearly all of the Registered Nurse Agents provided a layman’s understanding of ‘direction’ associated with giving instructions or orders. As the term ‘direction and

delegation' is unique to the New Zealand nursing environment there was no overseas research literature to support this finding.

The discussion related to learning about direction and delegation led on to the topic of whose responsibility it was to provide information about this professional obligation.

Overwhelmingly, Registered Nurse Agents felt that this was the role of nursing leadership. This included providing leadership and guidance related to the type of nursing model used in the workplace, or changing to a team model of nursing, and access to 'local area policy' and information specific to their workplace such as working with Enrolled Nurses or the re-introduction of Enrolled Nurses in their workplace. Some of the Registered Nurse Agents went so far as to describe nursing management as "remiss" not to provide information to nurses about direction and delegation. Two of the Registered Nurse Agents made a distinction between being told to do direction and delegation, and being told *how* to do it. Registered Nurse Agents wanted information related to *how* to carry out this professional responsibility. These three findings are new findings for New Zealand nurses.

Much of the research available about teaching delegation principles is related to identifying the best possible method to teach delegation during an undergraduate nursing programme (Conger, 1993; Henderson et al., 2006; Josephsen, 2013) or the communication and interpersonal skills needed during delegation that should be included in teaching content (Standing & Anthony, 2008). There is no New Zealand literature about *how* to teach safe and effective delegation, therefore the call for access to direction and delegation learning opportunities that are inclusive of the nurses' unique workplace is a new finding.

In order to respond to both Enrolled and Registered nurse Agent's requests for more information about delegation decision making, all pre and post-registration nursing educational programmes require a multi-modal approach that includes theory, simulation, OSCE, e-learning opportunities, role plays, case studies, work-based experience and preparation for clinical practice courses. In addition to selecting the correct method and delivery of teaching, evaluation of the teaching methods is essential too. As well as selecting effective methods and evaluating the effectiveness of courses offered, the assessed learning outcomes and resultant delegation teaching content chosen are important components to be considered for information sessions. Teaching and learning content that includes the consequences for Enrolled and Registered nurses when the incorrect nurse is selected for a task or skill, and the consequences for patient safety are required. In addition, the self-assessment and environmental assessment skills nurses need to carry out prior to direction or delegation, the communication techniques and leadership attributes required for safe and

effective direction and delegation have been identified as important components for delegation information courses.

A multi-modal approach for adult on line learning that included multiple strategies to support different learning styles was found to be the most effective vehicle to deliver delegation information to nursing students in an undergraduate nursing programme in the United States (Josephsen, 2013).

It is only natural that nurses will look to their peers and colleagues to know and understand how to 'do' direction and delegation, especially in the absence of accessible and specific information associated with direction and delegation interactions. For this teaching and learning strategy to be successful the direction and delegation interaction being role modelled needs to be safe and effective. Role models in clinical areas within a DEU can provide a supportive and safe environment to learn direction and delegation. Clinical areas that can accommodate increased access to clinical placements so that both pre and post-registration nursing students, and Enrolled nursing students can interact together, and where direction and delegation can be 'practiced' and role modelled in a safe environment will be needed for this to occur. The ability to role model lines of accountability, the communication techniques needed for Registered Nurse to Enrolled Nurse assessments, the leadership role required by Registered Nurses, and the ability to "follow" the Registered Nurse or leader of the team would meet this need.

In addition to a multi-modal approach to teaching strategies and increased access to clinical placements, access to work-based learning opportunities, and work-based refresher courses will reduce the concern nurse Agents expressed, related to a lack of direction and delegation learning opportunities in the workplace. An evaluation of the quality and usefulness of the direction and delegation teaching opportunities, courses and professional development opportunities currently available locally and nationally within nurses' workplaces would be a useful starting point. From this evaluation and review process, provision can be made for a range of communication, leadership and assessment courses that support respectful, inclusive direction and delegation interactions, for all Enrolled and Registered Nurses. The direction and delegation topics Enrolled and Registered nurses' identified as important in their everyday stories of experience can be accommodated in the work-based learning opportunities through dialogue with each other, application to, and reflection on practice. In addition, newly designed work-based courses that are linked to PDRP criteria, and or, performance appraisal systems, provide a relevant rationale and reason for nurses to engage with, and participate in, the newly provided information courses.

Section Two: Making sense of delegation – the major patterns

Enrolled Nurse Agents' stories about 'Working together'

'Working together' tells a story of experienced Enrolled Nurses who needed to be able to work with nurses who were competent and confident about the nursing area to which they had been assigned. Experienced Enrolled Nurse Agents who did not believe the Registered Nurse was confident or competent in providing clinical knowledge, support and leadership also believed that the Registered Nurse could not provide direction or delegation leadership.

Research findings related to working together by Gibson and Heartfield (2005, p. 132) identify that when Australian Enrolled and Registered Nurses worked together over a period of time they were able to establish trust. Working together with someone over a period of time gave the Registered Nurse time to evaluate experience, knowledge and skill base and this led to trust between the nurses. This holds implications for casual, agency and new Registered Nurses who are not able to form trusting relationships because they have not been able to work together over a period of time.

Study findings from Kaernsted and Bragadottir (2012, p. 14) further support this. The researchers found that "younger nurses" and nurses new to a nursing workplace often lacked confidence to delegate because they did not have enough information to be able to trust the other nurse. A lack of confidence and trust impacted negatively on their ability to collaborate with others and this impacted on team work. Many of the young nurses indicated that they would delegate more if they felt confident to delegate.

Kalisch (2011, p. 19) identified a number of themes that impact on the ability of nurses and nursing assistive personnel to work together. In this study the researchers found that when Registered Nurses and UAP did not see themselves *as* a team, the two groups of nursing personnel did not work together. When nurses and assistive personnel did not work together there was deficient delegation that affected the quality and safety of nursing care. These findings fit within the findings of this major pattern in that nurses want access to a model of nursing care that supports their ability to work together.

As the findings show the major pattern of working together also uncovers the Enrolled Nurse Agents' need for access to knowledgeable, flexible nursing leadership. For two of the Enrolled Nurse Agents, access to leadership was essential as this shaped their ability to work together. There are a number of research studies that discuss the role of leadership during

delegation (Bittner & Gravlin, 2009; Corazzini et al., 2010; McIntosh et al., 2000; Saccomano & Pinto-Zipp, 2011). Bittner and Gravlin (2009) found that nurses needed leadership from their managers, and systems and processes in place, in order for delegation to work well. In addition to this study, research findings from Corazzini et al. (2010) identify the clinical nursing leadership required to support positive and successful delegation interactions. The directors of nursing in the Corazzini et al. (2010) study found that having clinical knowledge related to the workplace setting assisted Registered Nurses to be able to delegate because they had, and were seen as having, a body of clinical knowledge. Therefore, this supports the findings within this major pattern that identified the importance of leadership for Enrolled Nurse Agents.

While all the Enrolled Nurse Agents in this major pattern believed that nurses needed to work together each Enrolled Nurse Agent made sense of the need to work under the direction and delegation of the Registered Nurse in different ways. Although experienced Enrolled Nurses *not* working under the delegation of a Registered Nurse is not a new finding, the reasons for it and the strategies Enrolled Nurses use to try and meet this obligation are new findings. Therefore, the narrative plots within the major finding of ‘Working together’ have added a new perspective to current findings about delegation by other nurse researchers and are described below.

Leadership was important to the Enrolled Nurses. They knew and understood that the Enrolled Nurse must “practise under the direction and delegation of a Registered Nurse”, and therefore wanted Registered Nurses to lead the team. The leadership style chosen impacted on delegation interactions. True leaders (“leader-leaders”), shaped the way that Enrolled and Registered Nurses worked together, and good leadership required a positive and inclusive communication style.

Direction, as it is defined in the NCNZ guidelines is not occurring for many Enrolled Nurses because is not well understood, and the Enrolled Nurse is often more experienced than the Registered Nurse. This resulted in some Enrolled Nurses taking on a leadership role, advising, directing and delegating to Registered Nurses new to a clinical area.

Enrolled Nurses’ knowledge and understanding of direction and delegation is predominantly shaped by their past understanding of “direction and supervision”. There was no acknowledgment of the supervisory role required for Enrolled Nurses when working alongside, or being given instruction by other health care professionals, such as medical personnel.

Experienced Enrolled Nurses developed mechanisms to keep themselves and their patients safe, and still “practise under the direction and delegation of the Registered Nurse or Nurse Practitioner” or a health care practitioner. For one experienced Enrolled Nurse this meant “going higher” than her allocated Registered Nurse buddy to get the support she believed she needed for her patient care.

The nursing model of care selected influences the nurse’s ability to work in a team. A geographical, or primary model of nursing care do not support working in a team. There is no description or definition of ‘team’, or why a team approach is important.

A team model of nursing that includes different levels of skill mix and experience would alleviate some of the concerns expressed by Enrolled Nurses within this major pattern.

Appointing a dedicated Registered Nurse for the shift who could act as a knowledge resource person for Enrolled Nurses and others such as newly qualified nurses or health care assistants who must be directed and delegated to, would support their ability to work together. A team model of nursing would also reduce the incidence of many Registered Nurses ‘delegating’ to *one* Enrolled Nurse. In addition, a team model of nursing affords an opportunity for new and inexperienced Registered nurses to be given time and opportunities to come to terms with the new clinical area, their new delegation responsibilities, learn how to lead a team, and support the team members to work together. Therefore, providing a definition of ‘team’ would be a useful addition to the direction and delegation information nurses requested. A definition and description of ‘team’ would need to include an acknowledgment that it included different categories of nurse and nursing support personnel, and levels of experience. Such a definition and description built on the definitions provided by Bragadottir, Kalisch, Smaradottir, et al. (2016) Thistlethwaite (2015) and Salas et al. (2005) is suggested as a starting point.

Registered Nurse Agents’ stories about ‘Working as a team’

The experienced Registered Nurse Agents in this major pattern made the delegation requirement work for them by using their assessment skills and using their leadership role to request, instigate or support a team nursing approach so that nurses worked *as* a team.

Research findings related to working *as* a team found that all the nurses on duty needed to feel part of the team (Corazzini et al., 2010). When the nursing assistant did not feel included in the decision making or valued as a member of the team, this resulted in poor partnerships between Registered Nurses and nursing assistants. Poor partnerships led to Registered Nurses being resistant to delegating tasks to nursing assistants and resulted in Registered Nurses

choosing to work alone and doing the tasks themselves. This impacted on the ability of the nurses and nursing assistants to work *as* a team.

Missed care occurs when the Registered Nurse and the nursing assistive personnel do not work as a team which leads to some nursing cares not being carried out (Kalisch, 2011, p. 18). Specifically, when there was a successful team work approach there was less missed care (Bragadottir, Kalisch, & Tryggvadottir, 2016; Kalisch et al., 2012; Kalisch & Lee, 2010; Papastavrou et al., 2014).

Two of the Registered Nurse Agents within this major pattern spoke of needing extra time to be able to carry out the assessment and leadership roles required in order to support the team approach needed for positive and successful delegation interactions. The perception that delegation takes time is discussed in a study by Standing and Anthony (2008, p. 13). They acknowledge in their findings that the Registered Nurses' perception was that it took longer to find a UAP who would assist, and it was easier and less time consuming to do "just do the job yourself".

The three new findings that emerged from the major pattern of 'Working as a team' adds an extra dimension, depth and different shades of understanding to other nursing research findings from overseas related to team work. To illustrate, a new finding emerged from this major pattern in that all the Registered Nurse Agents agreed that they needed support from nursing leadership to establish teams in order to work *as* a team as well as *in* a team. Further, successful delegation takes time as it requires good assessment, communication and leadership skills. That is, Registered Nurses will need more time than is currently allocated in order to direct and delegate, and to be able to work as a team with Enrolled Nurses.

The new findings also show that "local area policy", or policy designed for a specific workplace was a useful mechanism to tease out and provide work-based relevant rules and guidance related to safe and effective delegation interactions to nurses. Access to the design and implementation of local area policy required nursing leadership support.

Finally, many Registered Nurses prefer a primary model of nursing care and "prefer to work alone". A primary model of nursing care negates a team model of nursing approach, and does not support either working *in* or *as* a team. Some Registered Nurses "may not be as open" to a second level of nurse, as other nurses.

Working as a team can be supported through adjusting the model of nursing care to a team model so that the myriad of assessments, advanced communication and decision making, and the leadership roles required of positive direction and delegation interactions can be accommodated. Nurses need management and leadership support to review and assess the adequacy of the nursing care model they currently use through the measurement of team performance so that the best nursing model of care can be selected that supports the collaboration needed for safe and effective direction and delegation communication interactions (Thistlethwaite, 2015; Valentine et al., 2012).

Providing leadership, carrying out a number of assessments, and advanced communication takes time. This calls for nurses in leadership or management roles to provide a nurse to patient allocation of workload tool that accommodates the nurse's directing and delegating roles and responsibilities. This is because generic levels of management may not be cognisant of the issues surrounding the time needed for safe and effective nursing direction and delegation interactions.

Enrolled Nurse Agents' stories about 'Communicating well'

The Enrolled Nurse Agents within this major pattern told their stories about the need for communication that was inclusive, collegial, collaborative, positive and professional. This was important because *how* the communication occurred was more important than *what* was communicated.

Communication between nurses and nursing aides that is respectful, empathetic and collegial is discussed by Rubin et al. (2009, p. 827). Although the role of personality is not expressly discussed in this research study, many of the nursing aides identified anger, mistrust and ambivalence towards the nurse supervisors, Registered Nurses and LPNs who were responsible for the delegation role. The researchers found that when communication was not collegial, job satisfaction was adversely effected, and staff turnover increased.

The role that personality plays is discussed briefly in the study by Potter et al. (2010, p. 163) who found that both Registered Nurses and NAP identified colleagues who they would approach for help and support, and others they would not. Those nurses who had a poor work ethic, and those with a reputation for being "difficult" were avoided and tasks were not delegated to them.

While these two research studies support some of the findings of this major pattern, they do not acknowledge the four new findings included here. The perception of some of the Enrolled Nurses Agents was that the way people communicated during direction or delegation was not the result of any professional nursing code or standard, but was directly related to the nurse's personality, and the personal communication style they brought with them.

Assessment, communication and leadership are linked. Enrolled Nurses needed good self-assessment and patient assessment skills, and communication skills in order to help the Registered Nurse. Registered Nurses needed good assessment and communication skill in order to lead the team.

The need to welcome the new Enrolled Nurse to the workplace, to feel a welcome part of the team, and an ability for Registered Nurses to share information and knowledge, and to be balanced and fair are also new findings.

The major pattern of communicating well provided detailed information about the communication strategies required for safe and effective direction and delegation interactions. These have contributed to a script of communication strategies (See Appendix J). The strategies include improving the manner in which Enrolled Nurses are welcomed into unfamiliar workplaces, understanding the importance of *how* a request or assessment of the Enrolled Nurse is made, using an egalitarian and balanced approach, and supporting Enrolled Nurses to decline to accept a delegated task. These findings have added a new and different emphasis to previous findings.

The need for a communication style between Enrolled and Registered Nurses' that is inclusive and welcoming can be supported through the appointment of a dedicated Registered Nurse who works within a special interest, consultation role to provide workplace specific information related to the Enrolled and Registered Nurse role as they relate to direction and delegation requirements. Particular attention can then be paid to the way Enrolled Nurse assessments are requested and received, how their responsibility to self-assess is supported and responded to, how workload is delegated, how feedback is offered and understanding each other's role and Scope of Practice. The mandate for this leadership role would be to support the communication strategies and techniques associated with safe and effective direction and delegation interactions required for communicating well.

Additionally, as the direction and delegation role is a professional competency required of all nurses in New Zealand, breaches of safe and effective direction and delegation by Enrolled and Registered Nurses need to be brought to the attention of line management so that

professional development opportunities can be offered. Providing access to refresher courses related to understanding why people communicate in the way they do, is viewed as part of this role and could be linked to PDRP criteria, annual performance appraisal systems as well as professional development opportunities.

Registered Nurse Agents' stories about 'Professional communication'

Nurses in this study called for “in-service” opportunities to be provided about direction and delegation, the Enrolled nurse role and Scope of Practice, and what working alongside an Enrolled Nurses meant for their workplace allocation of tasks and skills.

An American study by Huynh et al. (2011) found that the main influence on the inter-professional collaboration required for delegation to be successful rested on the way the other nurses or Nurse Assistants' assessments of the patients statuses were received and respected. Secondly, the amount of workload delegated to them so that work load was fair and equitable also influenced their perception of delegation interactions with the Registered Nurse. Equitability did not refer to having the same number of patients but to the fair allocation of workload and where feedback on the workload was encouraged and supported. Registered Nurses who used an inclusive and compassionate leadership style and were supported with a team work model of nursing care, were more successful with nurse to nurse delegation interactions because they were seen as being fair in their workload allocation. Huynh et al. (2011, p. 6) point to the level of trust between the Registered Nurse and the nursing assistant as an important factor in fostering the interprofessional collaboration needed for delegation interactions.

Safe and effective delegation interactions are possible when there is collaboration and positive conflict management (Potter et al., 2010) and negotiation (Schluter, 2009). Potter et al. (2010) found that although guidelines were provided as a best practice tool to guide nursing delegation practices in the form of the “Five Rights of Delegation’ they were not always followed by the Registered Nurses. In addition nursing assistive personnel had very little understanding of the Registered Nurses role especially when the Registered Nurse was required to manage patient care and this lack of clear expectations, led to conflict situations. Although these overseas study findings acknowledge the important role of communicating professionally, negotiation and collaboration they do not capture the new findings within this major pattern included below.

There is a significant body of research literature about the need for nurses to have good communication skills. However, the four new findings within the major plot of 'Professional communication' add a different perspective to these findings through the identification of the strategies New Zealand nurses used to communicate professionally.

Firstly, professional communication includes ensuring that all the members of the interdisciplinary team, and the patient, had access to the correct information about the different levels of nursing personnel on the ward. One of the Registered Nurse Agents wanted to provide innovative and creative resources such as posters and brochures about the various Enrolled Nurse roles, responsibilities and levels of nurse working in one area. She wanted to decrease the confusion experienced not just between nurses, but the interdisciplinary team, and significantly, patients too.

Secondly, the way assessment and leadership were carried out very much depended on the ability to communicate professionally, and an ability to understand *why* people communicate in the way they do was part of communicating professionally. Successful delegation interactions require an understanding that *how* and *why* a request is made, is important. Many Registered Nurses believe they are legally responsible for the Enrolled Nurse's practice which can lead to "layers of anxiety". Communication, assessment and leadership that includes going "beyond, behind and beneath" the words spoken, in order to understand "where the other person is coming from" and really listening to other nurse are useful attributes during delegation interactions.

Thirdly, the communication was often driven by the need for information, and how this information was sought, and how it was responded to, became part of the major pattern of 'Professional communication.' Two of the Registered Nurses wanted any nursing related changes within their workplaces such as the reintroduction of the Enrolled Nurse role to be 'managed' by nursing leadership so that nurses did not need to find information by 'osmosis'.

Fourthly, the major pattern of professional communication contributed detailed information about the advanced communication skills and strategies required for safe and effective direction and delegation interactions. These have been gathered together and provided as a script of communication strategies (See Appendix J). The key features of this major pattern included having access to relevant, easy to access information about the different levels and roles and responsibilities of Enrolled Nurses, *listening* well, understanding the anxiety Registered Nurses may have related to the delegation role, being a role model for delegation interactions and the desire for nursing management of the changes that were needed rather

than assuming nurses would know and understand how to 'do' delegation. These strategies would be a useful starting point for the provision of information related to direction and delegation interactions.

While fire training, ISBAR (the communication framework suggested to improve safety when important information is being relayed), and falls prevention in-service sessions were acknowledged as important risk management resources, the lack of easy to access, workplace relevant and up to date direction and delegation information could lead to increased risk to patients too. Therefore, a communication model relevant to direction and delegation interactions that is given the same profile and importance that ISBAR receives, would be a positive addition to the direction and delegation tools required by nurses in order to direct and delegate well.

Enrolled Nurse Agents' stories about 'Delegation as a relationship'

The Enrolled Nurse Agents shared their stories about how they tried to make the professional obligation to work under the delegation of a Registered Nurse work for them. Their stories point to the delegation interaction being a *relationship*.

Gravlin and Bittner (2010, p. 333) found that the relationship that formed between the nursing assistant and the Registered Nurse was a significant influence on successful delegation interactions. Failure to form a relationship was often attributed to poor communication between the nurses within the team and contributed to missed care. The link between poor delegation practices and negative outcomes for patients is a consistent theme throughout many previous nursing research studies. Poor patient outcomes are associated with an inadequate understanding of delegation because incorrect delegation of tasks can lead to missed care and therefore patients being placed in an unsafe situation (Bittner & Gravlin, 2009, p. 333; Gravlin & Bittner, 2010) or documentation of recordings or care carried out that has been "fabricated" (Standing & Anthony, 2008, p. 11).

Standing and Anthony (2008, p. 11) point to the need for mutual respect, recognising good work and giving verbal rewards, and acknowledging the role and importance of the UAP as important factors to support a Registered Nurse to UAP relationship. Poor attitudes of the UAP were cited by nurse participants in the Standing and Anthony (2008) study as impacting negatively on delegation relationships. Relationships needed trust and trust could only be built up over time. In the absence of trust many Registered Nurses did not delegate to other staff because they believed they were ultimately responsible for the care these personnel delivered.

Findings from a study by Kalisch (2011, p. 18) related to Registered Nurse and UAP working relationships point to a number of possible interactions that can negatively impact successful delegation. These include: a lack of role clarity where the UAP does not understand the leadership and clinical role required of the Registered Nurse, a lack of working together as a team as they do not think of themselves as a team, an inability to deal with conflict which results in a lack of dealing with poor care practices leading to unsafe situations for the patient, not engaging the UAP in the decision making and not listening to the UAP when they report back to the Registered Nurse, and a lack of respect and a commanding attitude. Kalisch (2011, p. 19) also identifies the effect that having more than one boss has on the working relationship. She found that having more than one boss can double the UAP workload as the two Registered Nurses appointed are oblivious to the workload being allocated by the other nurse.

While the need for a relationship is not a new finding the narrative plots provided seven new findings such as the purpose or reason for acting, and the techniques or strategies that the Enrolled Nurse Agents used to overcome these delegation barriers.

The Enrolled Nurse Agents within the major finding of ‘Delegation as a relationship’ highlighted that forming a delegation relationship took time, skill and goodwill from both Enrolled and Registered Nurses. When there was an absence of “trust” and “dialogue” needed for good communication between nurses, or a lack of assessment and leadership, this resulted in an under-involvement of direction and delegation interactions. Conversely, if there was over-communication, over-management or over-leadership, an over-involvement situation occurred. Both of these avoidable situations could be detrimental to the nurse and patients.

An “inverted hierarchy” represented one Enrolled Nurse’s perception that many Registered Nurses could “delegate” to one Enrolled Nurse, in addition to the Enrolled Nurses own allocated workload.

The term “direction” was sometimes misinterpreted and explained as “being directive” or “giving an instruction”.

Enrolled Nurses wanted to have their assessment knowledge and nursing skills and experience to be valued, therefore planning the workload together was important in order for a delegation relationship to form.

When Registered Nurses did not understand the Enrolled Nurse Scope of Practice, this resulted in a “communication breakdown”. When there is a communication breakdown a

delegation relationship is unable to form. A communication breakdown between Enrolled and Registered Nurses could have serious and fatal consequences for patient safety, dignity and quality of care.

The ability to self-assess prior to accepting a delegated task was vital to many Enrolled Nurses. A Registered Nurse who understood the Enrolled Nurses' right and responsibility to self-assess, say "no" to a delegated task if required, contributed to the development of a delegation relationship.

It was not recognised that when Enrolled Nurses did not work under the direction or delegation of the Registered Nurse, or the Registered Nurse was prevented from directing or delegating, they were both "working outside their Scope of Practice".

Poor relationships due to poor communication, a top heavy "inverted hierarchy" allocating to one Enrolled Nurse, and under or over-involvement between Enrolled and Registered Nurses interfered with the formation of a delegation relationship. These concerns can be addressed through the provision of guidance and information that encourages nurses to use of positive, valuing and respectful communication interactions, and the Enrolled and Registered Nurse delegation and direction roles and responsibilities that clearly explain the communication, assessment and leadership required in order to form a delegation relationship. In addition, examples of safe and effective and unsafe and ineffective direction can be provided by updating the numerous resources currently available to nurses such as the Code of Conduct, Professional Boundaries, and the standards for nursing (New Zealand Nurses Organisation, 2012b; Nursing Council New Zealand, 2012b; Nursing Council of New Zealand, 2012), and the Code of Ethics (New Zealand Nurses Organisation, 2010/2013), in order to clearly acknowledge the professional behaviour required within a direction and delegation relationship. In particular, working towards the zone of professional behaviour, and avoiding the zone of under or over-involvement (National Council of State Boards of Nursing, 2007) required for direction and delegation communication and leadership interactions.

Enrolled Nurse Agents' stories about 'Seeking delegation'

Seeking delegation was a balancing act in that while the Registered Nurse was busy, there was a degree of urgency for the patients the Enrolled Nurse Agent was caring for too. This required advanced communication strategies such as negotiation, collaboration, allowing the other person to "save face", providing their own assessment information, and polite and respectful communication.

While there is a plethora of nursing research literature that identifies that nurses avoid working with some UAP, and some UAP avoid working with Registered Nurses (Corazzini et al., 2010; Kaernsted & Bragadottir, 2012, p. 14; Kalisch, 2011, p. 19; Potter et al., 2010, p. 162; Standing & Anthony, 2008, p. 13), the finding that Enrolled Nurses had to seek out, search for and organise direction or delegation interactions themselves is a new finding.

The Enrolled Nurse Agents within this major pattern knew and understood the requirement to work under the delegation of the Registered Nurse, and used a technique to trigger, request, or in one case “extract” the delegation communication interactions they needed. This new finding uncovered the lengths some Enrolled Nurses need to go to, in order to meet the requirement to work within their Scope of Practice by organising direction and delegation themselves. While this is time consuming it is required because getting the delegation interaction wrong could result in a risk situation for the patients in their care, and for the nurses who would then be working outside their Scope of Practice

Peeling back the layers of the delegation interaction highlighted two more new findings. Enrolled Nurses’ believed that it was a Registered Nurse’s professional responsibility to understand the Enrolled Nurse Scope of Practice, and what Enrolled Nurses could and could not do. In addition, the Enrolled Nurse emphasised the importance of the Registered Nurse being able to assess, communicate, and lead the delegation interaction.

Placing Enrolled nurses in a position where they had to continually seek out and organise direction or delegation input could be decreased through four strategies. Firstly, ensuring nurses worked within a model of nursing care that enabled them to work with an appointed, named, Registered Nurse so that they could plan and discuss direction and delegation interactions together.

Secondly, ensuring that a new and inexperienced Enrolled nurse has access to an Enrolled Nurse mentor.

Thirdly, appointing a dedicated direction and delegation resource nurse for each workplace to ensure direction and delegation interactions were occurring as required for that workplace.

Fourthly, providing direction and delegation area-specific information and policy relevant to the workplace. These four strategies could be supported with new guidance material specifically designed for the Enrolled Nurses’ role and responsibilities. The guidance material

for Enrolled nurses would include: working together, *in* and *as* a team, direction and delegation as a *relationship*, and communication strategies for communicating well.

Registered Nurse Agents' stories about 'Doing' direction and delegation'

'*Doing*' direction and delegation' illustrates the strategies Registered Nurse Agent's consciously chose in order to meet the professional requirement of direction and delegation, and keep the patients and the their nursing colleagues safe.

Magnusson et al. (2014) identified the role that the organisational context played in influencing nursing practices for newly qualified Registered Nurses (NQN) on the ward. This was demonstrated in the newly qualified nurse's need for time and resources to develop their confidence, their understanding of role boundaries, being able to access knowledge, developing their communication skills and prioritising nursing care. The researchers found that the unique culture of each workplace influenced how newly qualified nurses integrated and applied the theoretical knowledge that they had gained during their undergraduate nursing programme. This led researchers to conclude that continuing professional development for both newly qualified nurse's and health care assistants was vital especially around clarification of role boundaries and communication skills to support nursing delegation.

The finding that managing conflict was a difficult skill for some nurses has been cited by Kalisch (2011, p. 18). In her study nurses and nursing assistants found it difficult to confront each other and give and receive feedback. This eventually resulted in poor quality of care and poor safety outcomes for patients. Failure to manage conflict by avoiding dealing with poor nursing care can have serious consequences for patients in the form of missed care, or ongoing poor care. Kalisch (2011) provides a number of workplace examples and real life scenarios from her research study in support of this.

Errors of omission occur when nursing care is missed or delayed (Gravlin & Bittner, 2010, p. 329). Acknowledging how errors occur helps to situate that the 'error of *not* planning' and not being prepared, speaks to Registered Nurse accountability for how they organise the delegation environment, and the nurse's ability to establish a delegation relationship. While the Enrolled Nurse is responsible for the nursing care they deliver, once they have self-assessed and accepted the delegated task, both nurses are responsible for planning delivery of care. This is a new finding as it is a different way of framing the misunderstandings and confusion surrounding accountability.

The major pattern of ‘Doing’ delegation’ clearly illustrates the Registered Nurse Agents’ perception about the importance of sharing information and knowledge with the nurses and others they worked alongside, and supporting them to contribute to the plan of care. This major pattern has identified five new findings.

One Registered Nurse Agent came into conflict with the management in her workplace as they did not understand the Registered Nurse’s responsibility to share information and direct patient care. It became apparent that management personnel had a layman’s understanding of direction. The Registered Nurse had ‘created lieutenants’ so that they could provide informed, quality, safe and dignified care for older age residents. However, management actively discouraged the Registered Nurse from ‘directing’ the care of the health care assistants. This prevented the Registered Nurse from being able to “guide and monitor” the care they gave.

The ‘plan of care’ was more than just a turn of phrase for one Registered Nurse Agent in particular. This was about the Enrolled and Registered Nurse *planning* out the care *together*. Planning and preparation was required to set up the delegation interaction at the beginning of the shift in order to get the skill mix right. Doing delegation in this way could save “hours of problems”.

For three of the Registered Nurse Agents the assessment and leadership skills and attributes needed for ‘doing’ delegation right was supported by a communication style based on understanding both direction *and* delegation, knowing who was accountable and responsible, how to successfully carry out the assessments needed to keep everyone safe, and valuing the personal strengths of the nurses and others in your team.

Some workplaces did not practice direction or delegation at all. It was taken-for-granted by one new, inexperienced Registered Nurse that direction and delegation between Registered and Enrolled Nurses did not occur in her workplace. She could not imagine how it would work “if it was expected on her ward” and asks: “so why change it as it seems to be working?” She avoided delegating anything to the experienced Enrolled Nurses as her perception was that they would not tolerate her doing so. She avoided this potential conflict by *not* doing delegation.

Using a simple tool, grid or template to identify the tasks required for each patient throughout a shift, supported the Enrolled Nurse and Registered Nurse working together, and enabled the Enrolled Nurse to contribute to planning out, and therefore contributing to nursing care. Using

such a planning tool, coupled with a Registered Nurse's "mini" assessment of the Enrolled Nurse's level of experience and confidence, and good clear communication and leadership of the team prevented missed care, double ups, delayed medication administration and importantly decreased the need for micromanagement of the Enrolled Nurse.

Supporting Enrolled and Registered Nurses to do delegation well can be enhanced through providing a range of professional development opportunities related to direction and delegation so that Enrolled and Registered Nurses learn to plan the shift together. Professional development opportunities in the workplace, and in post-registration nursing courses can be utilised to support the development of a range of tools to encourage the communication techniques required when planning the shift together. In addition, when there is a clearer understanding of how errors of omission or errors of execution manifest in the workplace nurses can be supported to better understand who is accountable and when. As delegation involves a number of assessments of the environment, the context, the task to be delegated, the patient and the nurse (Nursing Council of New Zealand, 2011b), reducing *the allocation of workload model* of patients, and ensuring *the delegation model* of patients is used, can further support nurses to plan the nursing care together.

Registered Nurses stories about 'Skills for delegation'

Skills for delegation have been addressed comprehensively in the descriptive non-research based literature. Anthony and Vidal (2010), Cipriano (2010), Kaernsted and Bragadottir (2012) and Wedyt (2010) identify that the main skills acknowledged as necessary for successful delegation are an ability to assess, 'allocate' appropriately, have trust and a mutual understanding, have clinical knowledge and nursing judgment, know what the other person can and cannot do, manage conflict in a healthy way, clearly communicate requests, lead the team so that the team members work together. Hoban (2003) describes the need for the other nurse or nursing assistant to have skills in being able to reflect on the delegation interaction after completion of the tasks and use this to make improvements to the way delegation occurs next time, and to their own performance. Anthony and Vidal (2010) ask nurses to be "mindful" of the way they delegate and also mindful of what they delegate. That is, being mindful of the context of the delegation situation and the needs of the patient rather than getting a job or task done. These articles provide a useful backdrop to direction and delegation communication interactions. They have been cited here because they identify the skills shared within the major pattern 'Skills for delegation.' This includes the need for clinical skills, managing conflict, establishing trust, leading the team, and 'following' the team leader, and communicating well, and an ability to be mindful of the way delegation occurs.

Recent research findings from a study by Yoon et al. (2016) who explored confidence in delegation, found that confidence with the delegation role was significantly correlated with the amount and length of clinical experience, access to clinical training, and a transformational and transactional leadership style. According to these researchers when effective delegation met effective leadership, staff were able to give good nursing care to the residents in a long-term health setting. Nurses with more than five years of clinical experience were found to have higher levels of confidence with delegation than those with less than five years' experience.

The Registered Nurse Agents within this major pattern shared their perceptions about the skills needed in order to make delegation work. The Registered Nurse Agents acknowledged that many nurses had not worked with Enrolled Nurses before as New Zealand had moved to an "RN only" workforce. Therefore, they needed access to meaningful information about direction and delegation as this professional responsibility was not well known and understood. In the sharing of these stories, six new findings emerged.

The assessment, communication and leadership skills required for safe and effective direction and delegation are often hidden or taken-for-granted.

The skills required for direction and delegation are linked to a nurse's personal communication style. These skills are developed over time, and come with experience.

The DEU model, NetP and New Entry to Specialist Practice (NESP) programmes are considered to be useful vehicles to provide real-world, work-based direction, delegation and accountability learning opportunities through role modelling.

Registered Nurses do not "inherently" know the skills, knowledge and attitudes required for delegation interactions. The perception is that more guidance from nursing management is needed, and a more hands-on approach required to provide information related to working with Enrolled Nurses, and how to "do" direction and delegation.

There is a lack of understanding that the "Registered Nurse maintains overall responsibility for the plan of care" (Nursing Council of New Zealand, 2011), leading the delegation interaction, and how delegation is organised, not the Enrolled Nurse's practice.

Planning and preparation were significant skills required by Registered Nurses in order for successful direction and delegation interactions to occur. While planning and preparation could be time consuming it helped to build trust and could potentially avoid workload problems later. Planning and being prepared included having access to up-to-date and relevant

information related to direction and delegation, understanding the assessment and communication skills required of delegation interactions, and setting up the shift together at the beginning of the shift.

Access to information to support the skills needed for delegation can be improved through the introduction of a number of strategies. Firstly, national guidance material that is inclusive of the skills required for safe and effective direction and delegation interactions is made available. This includes the ability of nurses to work together, recognise delegation as a relationship, and communicate well.

Secondly, national guidance could be supported with access to local area-specific web-based information related to the skills Enrolled and Registered Nurses require for the delegation and direction roles and responsibilities practiced in their workplaces.

Thirdly, Enrolled Nurse educational preparation and post registration courses, and Registered Nurse undergraduate, graduate and post-graduate direction and delegation courses that include the skills necessary for safe and effective direction and delegation interactions would be helpful. These three steps could address the skills Enrolled and Registered Nurses identified as necessary in this major pattern.

Canonical stories

The canonical stories that nurses know and understand direction *and* delegation; their direction and delegation roles and responsibilities; who is accountable and when; that they are ‘doing’ direction and delegation; communicating positively during delegation interactions and are able to find up-to-date, work-based relevant information about direction and delegation are not supported in the small stories as shared understandings, or their personal and professional stories of experience. When the non-research based descriptive literature, and the research and guidance literature is viewed in its entirety, as has been provided in Chapter one and two, some of the reasons for this disconnect become clear, and the confusion surrounding the direction and delegation roles and responsibilities that are barriers to safe and effective delegation interactions come into view. This disconnect is evident throughout the nurse Agents’ storied experiences. Therefore, these canonical stories for nursing in New Zealand cannot be supported.

If the story for direction and delegation communication interactions has not been created yet, this is an opportunity that can be used to develop it. If the story as it has been revealed here is not an entirely positive story then there are opportunities to alter its course. If the story is

currently under development it might be useful to include the issues and concerns raised by the Enrolled and Registered Nurse Agents and summarised in the ‘So what and why should we care?’ section. For the correct and positive direction and delegation story to develop more information is needed for both Enrolled and Registered Nurses involved in, and responsible for, direction and delegation interactions. This includes knowing the roles and responsibilities associated with each of the Scopes of Practice, and knowing the roles and responsibilities associated with the direction and delegation role.

Contributions to the discussion on direction and delegation in New Zealand

The findings that emerged from the narrative inquiry into direction and delegation communication interactions between Enrolled and Registered Nurses in New Zealand reinforced some of the current research findings identified in the review of the literature. In addition to this, a number of new and original findings were revealed.

The Enrolled and Registered Nurse Agent’s ‘Small stories as shared understandings’, and the narrative plots within their ‘Personal and professional stories of experience’ do not meet nursing’s canonical story. The research disputes the canonical story and has made visible that many New Zealand nurses did not understand both the direction and delegation roles and responsibilities, and were not working within a direction or delegation role.

The research enabled the identification of 34 unique and different narrative plots which illustrate how New Zealand Enrolled and Registered Nurses made sense of direction and delegation, communicated during direction or delegation, and attempted to make direction and delegation relevant to their workplace, so that they could work to their Scope of Practice.

There are three further pragmatic and original contributions to the direction and delegation discussion that have evolved from this research study. Firstly, Appendix A provides a history and time line of the delegation role in New Zealand. Secondly, a table of preferred communication skills, strategies and techniques is provided as a Script for required communication interactions during direction and delegation, in Appendix J. Thirdly, a definition of ‘team’ relevant to the New Zealand nursing setting is provided in the recommendations section.

It ought to be remembered that there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things. Because the innovator has for enemies all those who have done well under the old conditions, and lukewarm defenders in those who may do well under the new (Niccolo Machiavelli 1469-1527).

Chapter eight. Conclusion

This chapter discusses the implications of the findings for nurses in the workplace, nurses in leadership roles and nurse educators. The recommendations for nurses charged with the delegation role, which includes graduate and post-graduate Enrolled and Registered Nurses, and nurse leaders in positions of influence and authority are also provided in this chapter. The chapter concludes with a reflection on the strengths and weaknesses of the research design.

Implications - So what and why should we care?

Nurses in the workplace

The literature related to nursing delegation from Europe, the United States, the Nordic countries, Australia and Korea identifies many barriers to successful delegation interactions. Of note is that the term “direction and delegation” is used only in New Zealand. As would be expected this term is not discussed in the overseas literature. My research showed that one of the main barriers to safe and effective delegation interactions is that many of the Registered Nurse Agents were confused about the Enrolled Nurse Scope of Practice, what Enrolled Nurses could, and could not do, and this impacted on their understanding of their direction *and* delegation roles and responsibilities. The implications of this are two-fold. Registered Nurses need access to national guidelines that provide clear information related to how to assess the Enrolled Nurse’s skill and ability in order to either delegate or direct tasks. In addition to clear national guidelines Registered Nurses need access to workplace relevant area-specific information about what an Enrolled Nurse can and cannot do in their workplace.

My research supports the view that accountability is not well understood. A lack of understanding about the Enrolled Nurse Scope of Practice and the associated roles and responsibilities, contributes to the confusion about who is accountable, and when. The implications of this are that if Registered Nurses continue to believe they are accountable for the nursing care delivered by the Enrolled Nurse they may become increasingly resentful about the perceived extra workload. This could lead to avoidance of the delegation role altogether. Any avoidance or reluctance to engage with the Enrolled Nurse or with the professional responsibility to direct or delegate when Enrolled and Registered Nurses are required to work together could lead to either an under or over-involvement situation between

them. That is, if Enrolled and Registered Nurses are avoidant of each other or they are working in isolation this could be an example of under-involvement. Conversely, if the Registered Nurse undervalues the Enrolled Nurse's abilities, and over-leads and over-manages the interaction through giving excessively detailed instruction, this can lead to over-involvement.

Registered Nurses are required to direct and delegate to Enrolled Nurses, and Enrolled Nurses are required to work under the direction and delegation of the Registered Nurse. Therefore, Enrolled and Registered Nurses who are not engaged in direction or delegation communication interactions in their clinical settings are 'working outside their Scope of Practice.' More importantly, my research provided examples where failure to delegate the correct tasks or skills led to decreased patient dignity and safety.

Both Enrolled and Registered Nurse Agents reported a lack of accessible and workplace relevant information about the Enrolled Nurse Scope of Practice and how to do delegation. They voiced their concerns about the implications of this for the workplace where they were employed, and both direction and delegation as a professional obligation. When there is a lack of information, or misinformation about the Enrolled Nurse Scope of Practice there is also a lack of understanding about the Enrolled Nurse's right and responsibility to self-assess, and if necessary to say "no" to a delegated task. This places Enrolled Nurses in an unsafe position, if they decline to carry out the tasks asked of them after they have self-assessed, but do not feel confident to accept the delegated task.

The personal and professional stories showed that a lack of assessment and leadership in conjunction with unsatisfactory communication within the delegation interaction can have serious implications for both nurses and patients. When there is inadequate information about direction and delegation roles and responsibilities there will be an incomplete grasp of the assessment skills needed for safe and effective delegation interactions. This can result in two different outcomes. Firstly, any potential risk situations related to delegating patients to the correct skill level of nurse fail to be assessed or evaluated. Secondly, this results in the Enrolled Nurse being placed in an unsafe position because they are now working outside their level of confidence and ability. A lack of information about direction and delegation can result in nurses failing to recognise that there is a leadership role required by Registered Nurses who need to lead a team, and this could result in unsafe or ineffective direction or delegation interactions, or no direction or delegation occurring at all. A lack of knowing and understanding about delegation interactions and poor communication are related, as positive and professional communication interactions during direction and delegation relies on

knowing and understanding both of these roles. Furthermore, such deficiencies in access to information can lead to poor staff retention and increased staff turnover.

The research study shows that when direction or delegation cannot be clearly articulated or differentiated there will be a degree of confusion about the meaning and application of delegation, and especially the direction role. The implications when the direction role is not understood can lead to a lack of learning, teaching and facilitating opportunities, guidance and support, most notably for inexperienced Enrolled Nurses.

Finally, in order to gain the competency-based Annual Practicing Certificate (APC) all New Zealand Enrolled and Registered Nurses must indicate that they meet the competencies including Competency 1.3 (Nursing Council New Zealand, 2007a, 2012a). When nurses self-assess and agree that they meet this competency they are acknowledging that they know and understand both direction and delegation, and the associated roles and responsibilities of this professional obligation. The implications of indicating that they meet this competency when the research study points to a degree of confusion about how to do direction and delegation, the difference between the terms, and what an Enrolled Nurse can do is indicative of a disconnect between what is required, and what is understood by nurses. In addition, while nurses are audited by NCNZ to assess their ability to meet this competency, agreeing that they meet the direction and delegation competency in the APC application if they do not understand it, becomes an ethical dilemma.

Nurse leadership

The findings in this research also point to some models of nursing care acting as a barrier to positive direction and delegation interactions. Nurse Agents in the workplace need a model of nursing care that supports both direction *and* delegation interactions. The continued use of a primary model of nursing care and a geographical model of nursing do not meet this remit. A lack of information from nurses in leadership and management roles about direction, delegation and accountability results in a failure to adopt the team model of nursing care. The team model of nursing is necessary to support a mix of nursing skills, levels, experience and knowledge. While a degree of flexibility in interpretation and application of direction and delegation, and the role of Enrolled Nurses is expected due to the differences in place, situation and environment, the nursing profession need some consistency in application.

In the face of confusion about how to delegate, and a lack of information from nurse leaders, nurses turn to “how it’s done around here” or “how we have always done it”. If such direction and delegation interactions have been positive and role modelled correctly then a continuation

of such practices will be acceptable. However, this becomes problematic if the direction and delegation environment is not robust or satisfactory for all the nurses involved. This is especially true for new and inexperienced Enrolled and Registered Nurses emerging into the employment scene who are trying to learn how to navigate the communication, assessment and leadership skills required for positive and successful direction and delegation interactions. The implications for nurse leaders are that the model of nursing care needs to be changed to a team model of nursing and this requires a transformative leadership style and change management initiatives.

Nurses who are charged with the direction and delegation role also need access to workplace relevant guidance and information about direction and delegation roles and responsibilities in the form of on-the-job training and in-service sessions, refresher courses, a buddy system for new and inexperienced Registered Nurses required to lead, or Enrolled Nurses required to follow the team leader. Finally, a mechanism within PDRP assessment criteria that enhances direction and delegation communication, assessment and leadership between Enrolled and Registered Nurses, such as encouraging nurses to seek and give feedback to each other about their direction and delegation interactions and experiences will require nurse leadership support.

The findings of this research point to the confusion surrounding the direction and delegation role. The confusion has implications for nurse leaders who need to review the direction and delegation information available to Enrolled and Registered Nurses such as induction and orientation programmes, and compare this to the information nurses indicate they need. In addition to this, any review needs to include accessibility to information when nurses need to make numerous direction and delegation decisions every day, in busy workplaces.

One of the most significant implications of this research is that if confusion with the meaning of the two terms, and the responsibilities required of the delegation role are allowed to continue, this can result in avoidance of direction and delegation interactions, poor collegial relationships, low job satisfaction and poor retention of nurses. The implications of this are that when avoidance or poor collegial relationships develop, this needs to be brought to the attention of Clinical Nurse Managers who can incorporate this into 'no blame' performance appraisal systems with a view to providing professional development opportunities related to safe and effective direction and delegation.

The perception of Registered Nurse Agents who believe that this professional obligation is time consuming is a potential barrier to effective direction and delegation interactions. This is

compounded by Registered Nurse Agents who believe that the obligation to direct and delegate, places their registration in jeopardy because they are accountable for the Enrolled Nurse's practice. Therefore, Registered Nurses need guidance from within four specific areas. Firstly, national guidance material that removes ambiguity from the accountability role. Secondly, in area-specific information and policy relevant to the nurses' workplace. Thirdly, by nurses in positions of influence and authority, such as Clinical Nurse Specialists, Clinical Nurse Educators, and Clinical Nurse Managers who can advocate for the introduction of a patient-to-nurse workload allocation system that acknowledges and incorporates the time required to direct and delegate safely and effectively. Fourthly, an evaluation and assessment of the nursing model of care currently in use in each workplace.

In the absence of any local area policy that is specific to the workplace where the Enrolled or Registered Nurse is employed, confusion persists. It is important to heed the criticism and warning provided in Seddon's review of patient safety across DHBs in New Zealand (Seddon, 2007). Seddon (2007) notes that the responses by DHBs to her request for patient safety initiatives, acknowledged that they had nursing supervision policies in place. However, she found that there was no compliance auditing of the supervision guidance, nor any assessment of their effectiveness. While concurring that having policy does not necessarily ensure its use, the findings of this research can be used to inform future discussion on the need for a review of 'local area' or workplace relevant policy. The need for local area policy initiatives that are specific enough to be workplace relevant, and at the same time flexible enough to acknowledge the myriad of places where an Enrolled Nurse can be employed will be a challenge that nurse leaders in clinical settings such as Clinical Nurse Specialists and Managers, responsible for quality initiatives and policy or procedure will need to meet and manage. The implications of this are that nurse leaders in clinical settings at all levels will need to provide guidance in order to negotiate the tension between the need for workplace relevant policy, and flexible policy. Such nursing leadership will need to be manifested at a national regulatory level, a national nursing organisation level, as well as at the nursing clinical workplace leadership, and management level.

The shared small stories and narrative plots within the nurse Agent's personal and professional stories all point to the role that communication plays between nurses and the way nurses communicate with each other. Sometimes this was linked to the nurse's personality and at other times it was explained in terms of the culture of the workplace. This is indicative of the need for more information and guidance from nursing leadership around communication style, and expectations surrounding communicating professionally in order to support positive delegation communication interactions in the workplace. In doing so, this

encourages a view of delegation interactions as a *relationship* between Enrolled and Registered Nurses, not merely an obligation to be met.

With respect to nurse educators the implications of the research findings point to finding meaningful ways to teach direction *and* delegation requirements that meet the knowledge, skills, attitudes and attributes required by nurses to provide safe direction, as well as delegation interactions. This includes developing new resources in some clinical areas that meet this need and making clear in the teaching of direction and delegation, who is accountable, responsible and answerable, and the communication, assessment and leadership skills required for effective direction and delegation. In addition to these skills, promoting direction and delegation as a *relationship* between Registered and Enrolled Nurses that requires time, respect, trust and an inclusive approach to decision making is also required.

The guidance literature currently available from NCNZ as New Zealand's regulatory nurse leaders also needs review and critical appraisal. While definitions for delegation, direction and accountability are provided in the guidance literature from NCNZ, Enrolled and Registered nurse Agents in this research could not differentiate or describe direction. The guidance material provided requires a definition of 'team', and information related to *how* to do delegation. The implications for NCNZ are that new guidelines are needed to replace generic information and rewritten to include working *as a team*, as well as *in a team*, direction and delegation as a *relationship*, the *skills* needed for direction and delegation and *professional communication*. Based on this research study it appears that Enrolled Nurses would benefit from having access to their own national guidelines, so that their roles and responsibilities within the delegation and direction relationship can be clearly articulated.

Recommendations - So what now?

The 'Implications - So what and who cares' for practice, leadership and education have been identified. This leads naturally to the 'Recommendations - So what now?' As Riessman (1993, p. 70) points out "our ultimate goal as social scientists is to *learn* about the substance, make theoretical claims through method and *learn* the general from the particular" [emphasis added]. With this in mind, the shared understandings and personal and professional stories nurse Agents 'told', viewed through time, place and sociality (Clandinin, 2013), enable some evidence based recommendations to be drawn from the discussion and implications.

Recommendations for the nurses in the workplace

The type of nursing model used in the workplace can shape and influence the way direction or delegation occurs. Nurses in this study described working within either a geographical or a

primary model of nursing care. Team nursing has been identified in the Enrolled Nurse Scope of Practice as the model of nursing care required for Enrolled Nurses in acute settings (Nursing Council New Zealand, 2012a). A team model of nursing supports the *delegation of patients* rather than an *allocation of patient load*. *Delegation of patients* is based on the level, confidence and experience of the nurse being delegated to, the complexity of the tasks or skill or patient condition being delegated, the skill mix, the supports and resources available in the environment and the acuteness or otherwise of the environment where nursing work takes place.

Therefore, it is recommended that a team nursing model is selected by nurse leaders, and practiced by nurses in the workplace. A team nursing model is required in order to support different skill mix, and direction and delegation interactions.

The study findings raise the need for a Resource Nurse to be appointed for each workplace area who can provide both big picture (national) and area-specific (workplace level) information and advice around direction and delegation responsibilities. This role could alleviate the confusion and misinformation related to who is accountable and when, so that Registered Nurses understand that they are not accountable for the Enrolled Nurse Agent's nursing practice.

It is recommended that nurses proficient at understanding the potential issues and concerns during direction and delegation interactions, and lines of accountability can be selected to provide buddying and mentoring to new inexperienced Enrolled and Registered nurses. Such information should be disseminated to staff new to an area, agency or casual nurses, nurses who need direction or delegation advice and support, health care assistants, and other members of interdisciplinary teams. Recommending a dedicated role such as this will ensure both continuity of information, and workplace relevance.

Recommendations for nursing leadership

The main value and worth of a planning tool is in its ability to support nurses to work as a team, manage the potential risks associated with missed care, address the perception that direction and delegation is time consuming, support the Enrolled Nurses responsibility to self-assess and decline to do a task if it is outside their skill set and ability, and to decrease the possibility of doubling up on tasks. Moreover, it may go some way to stopping the practice of many Registered Nurses delegating a number of tasks to one Enrolled Nurse. An example of a grid that meets this brief is provided in Appendix K.

It is recommended that a tool that supports both the Enrolled and Registered Nurse's contribution to planning nursing care is developed and trialled by clinical nurse leadership with a view to introducing it where Enrolled and Registered Nurses work together.

A range of other nursing delegation e-tools are suggested. For example, providing a direction and delegation communication tool similar to ISBAR⁹ and given the same prominence and access as ISBAR, is also recommended.

The nurse Agent's small stories as shared understandings and the narrative plots demonstrated a need for "dialogue" around direction and delegation. Nurse Agents suggested fora that enabled opportunities to talk to, and with, the 'other' nurse, and provide direction and delegation examples, and feedback on delegation interactions for discussion. Clinical nursing leadership, clinical nurse educators and nursing management are positioned to support such fora, and to review the content, quality and access to work-based direction and delegation information currently provided to nurses.

Therefore, it is recommended that work-based information sessions that are inclusive and interactive and are deemed to be as important as the compulsory fire training, falls prevention in-service training sessions required of nurses are introduced. Such information will need to include: the meaning and definition of both terms direction *and* delegation; a precise and role relevant definition and explanation of what each nurse is accountable, responsible and answerable for; self-assessment as an Enrolled Nurse's role and right; the assessment and leadership responsibilities for Registered Nurses; "followership" responsibilities for Enrolled Nurses; and the communication style and model of nursing care required by both groups of nurses to support successful delegation interactions. The information content can be adapted for inclusion in, in-service sessions, induction and orientation programmes, and as work-based refresher courses.

Further, it is recommended that there is a review of the quality and usefulness of the direction and delegation learning opportunities and professional development opportunities available to both Enrolled and Registered Nurses within their nursing workplaces. Depending on the outcome of the review, a range of resources commissioned by clinical nursing leadership, is recommended to support nurses to access direction, delegation and accountability information.

⁹ Identify, Situation, Background, Assessment and Recommendation (ISBAR) is a mnemonic created to improve safety in the transfer of critical information during communication between health care professionals

Given that it is the regulatory level of nursing leadership who are responsible for the nursing Scopes of Practice, competencies and nursing standards, it is nursing leadership at this level who are responsible for reviewing and strengthening the national direction and delegation resources required by nurses in workplace settings.

It is recommended that nursing leadership at the regulatory level review and update the national guidance material available to nurses (Nursing Council of New Zealand, 2011b). Guidance material that distinguishes and differentiates the terms direction and delegation, and clarifies accountability is required.

Definitions and descriptions of nursing models of care, to distinguish allocation, geographical and primary models of nursing care from a team model of nursing, and the impact of these models on direction and delegation interactions and relationships are recommended. These changes could go some way to decreasing the confusion with the direction and delegation roles and responsibilities, and reducing the ambiguity about accountability identified in the research.

It is further recommended that Enrolled Nurse guidelines are developed that are relevant to the Enrolled Nurse's delegation responsibilities, and include explanations of their assessment, self-assessment, accountability and communication roles.

Teamwork problems need to be identified quickly and brought to the nurse's attention so that they can work towards improving team work relationships. If unsafe practices are ignored they continue, and this can impact on safe nursing care.

It is therefore recommended that in acute settings where Enrolled Nurses are employed, Enrolled and Registered Nurses are given advice and support related to working *in* a team, not just *as* a team, and a clear definition and description of 'team'. Building on the definitions provided by Bragadottir, Kalisch, and Tryggvadottir (2016); Salas et al. (2005), a definition of 'team' relevant to nurses in New Zealand workplace settings is recommended. One such example is included here: *A team consists of four or more nurses and nursing support personnel. A team is comprised of different categories of nurse (Enrolled or Registered Nurses) and different levels of experience. Nurses provide leadership through inclusive communication in order to support a direction or delegation relationship. Team members work together as a team, as well as in a team, to meet the needs of the patient, the team members and the workplace.*

It is further recommend that the effectiveness of team performance is measured so that any lack of team collaboration and cooperation can be assessed and rectified (Thistlethwaite, 2015; Valentine et al., 2012).

Nurses in the workplace also need a range to tools to fairly and accurately assess workload that adjusts and accommodates for the directing and delegating nurse's roles and responsibilities for nurses when nurse to patient workload is being delegated.

Having access to the reasons that errors occur provides context to how direction and delegation interactions evolve, and supports nurses to better understand the role of accountability during direction and delegation

Therefore, it is recommended that nurses are given information related to errors of omission (missed care), errors of planning and errors of execution. It is recommended that these definitions and explanations are developed and introduced by the regulatory level of nursing leadership, and included in updated guidance material.

Innovative resources such as a road show related to the direction and delegation role can provide prominence, denote importance, as well as provide information. A road show along similar presentation lines that supported the national introduction of the Code of Conduct in 2012 (Nursing Council of New Zealand, 2012) is recommended.

A series of DVDs and web based information related to direction and delegation interactions affords an opportunity to replace, update or introduce new material, link direction, delegation and accountability to PDRP requirements and performance appraisal systems. DVDs and web based information can be viewed individually or in seminars, workshops or in in-service sessions. A series of electronic resources can be used to support the "dialogue" and "role plays" requested by nurse Agents. In addition, the "welcoming" content for Enrolled Nurses being moved to unfamiliar workplaces that some of the Enrolled nurse Agents requested can be accommodated. This would follow a similar format to the NZNO DVD 'Changing Attitudes,' designed to provide six scenarios that explore unsafe nursing views and attitudes and provide strategies on how to confront unacceptable behaviour.

It is therefore recommended that a series of DVDs and web based information that illustrate and reflect the topics nurses want to know in relation to direction, delegation and accountability are developed. This might include but is not limited to content related to working as a team, working together, communicating well, professional communication, ‘doing’ delegation, delegation as a relationship, and skills for delegation.

While it is suggested in the current NCNZ guidelines that patients are informed they are being cared for by an Enrolled Nurse, none of the nurse Agents interviewed were aware of its existence. Added to this, most patients who enter health care facilities would not be aware of the delegation requirement, the difference between an Enrolled or Registered Nurse, or how this might impact on their health care. This requirement needs clarification and explanation, and a rationale for its continued use.

If this requirement is considered vital to patient dignity, safety or quality of care, it is recommended that information that aids in distinguishing the Enrolled and Registered Nurse level and role is commissioned by clinical nursing leadership and produced in consultation with nurse educators, and professional bodies such as the NZNO. The identification of different roles and responsibilities between Enrolled and Registered Nurses could be provided in a brochure format, photos of staff and their designation information on corridor walls. This information would be useful to patients, as well as casual, agency and new nursing staff, and members of the interdisciplinary team who may be responsible for delegation instructions. These suggested visual resources, would include information related to the role of the Enrolled Nurse, and what this means for patient care.

It is recommended that the continuum of professional behaviour provided in the ‘Professional behaviour booklet’ (Nursing Council New Zealand, 2012b, p. 4) to illustrate the type of relationship needed in order to foster therapeutic relationships between nurse and patient, is adapted to illustrate the type of direction and delegation interactions required to support safe and effective direction and delegation interactions¹⁰. The model would be useful to identify the need to avoid under-involvement and over-involvement between Enrolled and Registered Nurses so that a professional level of involvement or “zone of professional delegation behaviour” is reached.

¹⁰ With permission from the original authors

Recommendations for education

It is recommended that there is a review of the quality and successful application or not of the direction and delegation teaching content available to students within pre-registration Bachelor of Nursing and Enrolled Nurse student education programmes by nurse educators who deliver and assess nursing programmes. Material that builds on theory presentation of direction and delegation and then progresses to simulated activities that are inclusive of the assessment, communication and leadership skills required to support safe and effective direction or delegation relationships are areas suggested for the review.

It is recommended that both Enrolled and Bachelor of Nursing students, experience simulation sessions related to direction and delegation together, so that a relationship is initiated during this initial contact time. While this may impact on the way nursing programmes are co-ordinated due to room and resource availability, it is recommended as an important teaching tool for direction and delegation interactions between the Registered and Enrolled nurse. Delegation information introduced early in the nursing programme and incorporated throughout the curriculum has been found to be beneficial (Henderson et al., 2006).

It is recommended that there is a review of the availability and quality of direction and delegation professional development opportunities available to post registration Enrolled and Registered nurses. Depending on the outcome of this review, courses should be made available that are inclusive of the assessment, communication and leadership techniques and strategies required for safe and effective direction and delegation interactions and relationships.

Communication courses that are inclusive of different communication styles, strategies and techniques, and the skills needed in relation to the professional behaviour required to support direction and delegation relationships are suggested. This includes an increased and strengthened emphasis on respect, giving and receiving feedback, nurses seeking feedback on their own delegation style, building trust and valuing of the 'other' nurse, and conflict management skills in order to support positive and professional direction and delegation interactions.

It is therefore recommended that there is a review of the communication courses offered in the Bachelor of Nursing and Enrolled Nurse student educational programmes so that the delegation relationship is specifically acknowledged.

The use of Dedicated Education Units (DEU) is an invaluable resource to ‘practice’ delegation interactions together, and be immersed in them. This will require support from the clinical workplace so that access to clinical placements can occur at the same time for Enrolled and Bachelor of Nursing students. While the pressure of clinical placements and clinical teaching resources is acknowledged, the DEU provides a safe environment for nurses to work together, and to role model a ‘culture of reflection’ on the way direction and delegation is carried out, including the way any ‘errors’ in planning, or errors in executing direction or delegation interactions are received and responded to.

It is therefore recommended that Enrolled and Bachelor of Nursing students are placed together in DEUs for clinical placement experience.

Recommendation for policy

The study findings suggest a need to review the policy available to busy nurses in the workplace. More ‘local area policy’ development relevant to the specific workplace where Enrolled Nurses are employed would reduce negative and incorrect perspectives about accountability, and reduce confusion around the Enrolled Nurse role, and the Enrolled and Registered Nurse responsibilities within the delegation relationship. While there is a need to remain flexible and acknowledge the myriad of workplaces where an Enrolled Nurse may be employed, easy to access workplace relevant local policy is required.

It is recommended that a review of the delegation and direction policies available to Enrolled and Registered Nurses is undertaken. In addition to this review an audit of the compliance to the policies on delegation is initiated.

Reflections on the strengths and weaknesses of the research design

Narrative inquiry methods and methodology provided a prism that refracted the nurse Agent’s stories so that the meaning conveyed in the small stories as shared understandings and the narrative plot within their personal and professional stories of experience were revealed. Narrative inquiry provided a mechanism to see how the Enrolled and Registered Nurse Agents were influenced by their social and cultural settings and uncovered the implications of the choices they made. Although this thesis clearly answers the research question and contributes to the gap in knowledge and understanding surrounding direction and delegation communication interaction practices between Enrolled and Registered Nurses, there are both strengths and limitations to the study.

Using narrative inquiry provided an insight into the nurse Agents' knowledge and understanding of direction and delegation and at the same time enabled a deeper exploration of each nurse Agent's different perspectives about direction and delegation, making the choice of narrative inquiry methods and methodology a significant strength of the study. Using an interview format provided a two way 'chat with a purpose' that opened up the reasons the nurse acted, the techniques and strategies they employed to make sure they worked within their Scope of Practice, and the communication style and knowledge, skills and attitudes used during direction and delegation. Using this knowledge to improve direction and delegation relationships may contribute to retaining nurses in the health system at a time when there is a global shortage of nurses.

The pilot interviews were a strength of the study as this step showed that not all nurse Agents were able to tell their 'good' and 'bad' direction or delegation stories from beginning to end. The pilot study enabled me to respond to this unforeseen situation with an adjustment of the interview schedule that enabled nurse Agents to choose from an array of suggested prompts rather than expect a question-and-answer format that corralled the topics for discussion. Adjusting the interview schedule to be framed by prompt suggestions rather than a question and answer format strengthened the research design on three levels. Firstly, this alteration was consistent with the concept that the nurse Agent owned the information they shared and could therefore choose what they shared. Secondly, it supported the nurse Agent to share the information that was important to them when they recalled their direction or delegation interactions. Thirdly, the nurse Agents were not put under pressure to 'come up with a story'.

The design of the study included a number of strengths that contributed to the richness of the information generated. According to the nurse Agents' comments post interview having access to the interview schedule prior to the interview reduced potential anxiety as some of the Enrolled Nurses expressed a concern in speaking out about their experiences. Having access to the interview schedule prior to the interview also resulted in many of the nurses coming to the interview prepared with photos, certificates, policies and written notes and this contributed to the depth of the field texts gathered. Creating a re-story that captured and reflected what the nurse Agents' intended to say and were comfortable sharing was also a strength of the research design as it provided a 'checking in' and 'checking up' process. The re-story provided an opportunity to value and respect the nurse Agents' interest, time, contribution, and in some cases their bravery in coming forward to share their stories. The creation of the re-story also acted as a member check process which contributed to the strength of the research design.

The re-story and follow-up email contact provided an opportunity for nurse Agents to reflect on what had been shared in the interview and gave them time to add to the narrative under design, retract or correct the information shared which not only met the relational and on-going ethics required of narrative inquiry, but exceeded these ethical requirements. The added step of encouraging nurse Agents to suggest a title for their re-story, or to alter the title suggested in the interview contributed to the joint and co-construction aspect of narrative inquiry. While not everyone wanted to change or suggest a title, these steps strengthened the research design by encouraging ownership of the information, supporting two way communication, and the partnership approach I was trying to foster throughout the research process.

The reflective journal was a strength in that I had time to reflect on what had happened in the interviews and the re-storying process, and captured my emerging understanding of direction and delegation interactions, and my own thoughts about my performance as a narrative researcher, nurse and teacher. The reflective journal allowed me to question myself, my assumptions and my own motives. By questioning myself I was able to take questions to my supervisors, and to my nursing peers who also acted as supportive questioners. This opened me, and my nursing history and teaching experiences, up to self-inspection as well.

The audit trail is a strength of the study as it makes clear how the analysis decisions were made, and why. The audit trail as 'Mapping the major patterns', 'Introducing the nurse Agents', the shared findings between and across nurse Agents' stories, and their individual narrative plots, documented the evolution from each nurse Agent's interview to eight separate narratives at the end. The findings chapter illustrates how these stories have emerged from, and are based on, the nurse Agents beliefs, values, words and perceptions.

While rigor is an expected requirement for any research study the care taken with the rigor within this research and explained in detail in the Methods chapter, Chapter four, is a strength of the research. However, it will be the nurse-reader who will determine if the quality of truthfulness, apperency, impact and transformation, aesthetic merit, and the trustworthiness of the findings have been met.

There is a tendency to refer to the Enrolled Nurse as a homogenous group without acknowledgement of the vast experience some Enrolled Nurses have, while other Enrolled Nurses are new to their role. This lack of acknowledgement that there are experienced and inexperienced Enrolled Nurses results in inexperienced Enrolled Nurses being expected to work in the same way as experienced Enrolled Nurses who prefer to work almost

autonomously post allocation. This denies the reality that new inexperienced Enrolled Nurses are only forming their knowledge and skills and do not yet have the knowledge and skills to work autonomously, or their right to the direction role within 'direction and delegation'. Therefore, a strength of the study has been in its ability to distinguish between experienced and inexperienced Enrolled Nurses, and the impact this has on the direction and delegation relationship.

While the narrative inquiry approach was well suited to the research question, purpose and aims it must be recognised that there were limitations too. Qualitative research is not ever meant to provide cause and effect relationships, test theory or generalise to larger populations. As such the findings from this study are not generalisable. Rather, the ability of narrative inquiry to value each nurse's story enabled each nurse Agent to tell their individual and unique direction and delegation story for the first time.

Gathering personal stories of experience that include the social and cultural influences in their workplaces, by people who have been shaped by their past, and shaped by the place where the acts occurred is part of narrative inquiry. In order to remain true to the methodology retrospective recall was not only required, but valued. Giving each nurse Agent a voice, and honouring their big and small stories were important to me. This resulted in a large sample size for a qualitative study, and while this added depth to the findings, the paradox was that enlisting more nurse Agents did not transfer to a diverse range of Nurse Agent. Future narrative inquiry research projects should work towards ensuring a more diverse gender and ethnicity participation.

The major patterns generated by this study could be used as a basis to inform a larger quantitative study using survey methods to test this study's findings, and investigate nurses' satisfaction levels with the direction and delegation relationships they are involved with. In keeping with a quantitative approach a pre and post-test design that investigates changes in direction and delegation knowledge and understanding after the introduction of new direction and delegation training programmes is suggested for consideration. Along similar lines a cross-sectional research design that compares the perceptions, concerns and views of nurses about the delegation role from all levels of nursing within the health system, including clinical nurse leadership, and management, nurse educators and nurses within different clinical practice settings would provide a useful snap shot in time, and provide an evidence base for further policy and practice development.

There is merit for a qualitative research study using an ethnographic approach and participant observational methods where the researcher as participant becomes immersed in the culture at handover times and when nurse to patient workload is being allocated. This holds the potential for a different perspective and could contribute to further understanding of how direction and delegation communication interactions and practices occur between Enrolled and Registered Nurses.

Lastly, while there is no evidence to suggest that nurse Agents were prevented from sharing their personal and truthful opinions with me as the researcher because of my position as nurse educator and nurse, it should not be ruled out. Being aware from the initial design stage of this as a possibility led to the introduction of a number of steps that would mitigate this potential concern. These steps have been well documented in the rigour section of the Methods chapter, chapter four, and involved the respectful, valuing and collaborative approach I adopted before, during and after the interview. Supplying the interview schedule prior to the interview, and encouraging the nurse Agent to select what they wanted to discuss and to critique what had been written in their re-story are also examples of the steps put in place. The end result of these steps was that nurse Agents shared whatever was important to them, as I followed them down a path they chose to talk about.

My concluding reflections as the narrative inquiry researcher

This study arose out of my puzzling and wondering about the professional obligation that is direction and delegation. As a nursing educator I am responsible for designing teaching sessions that teach direction, delegation and accountability to both Enrolled and Bachelor of Nursing students. As a Registered Nurse I am responsible for meeting the competency associated with my Scope of Practice, competency *1.3 Demonstrates accountability for directing and monitoring and evaluating nursing care that is provided by Enrolled Nurses and others*. It was through these two roles that I developed an interest in how direction and delegation was understood and practiced. Although I was aware that there were concerns from some nurses about the new Enrolled Nurse role I was unprepared for some of the sad, moving and worrying stories that nurses shared with me in their interviews. Some of the stories I heard made me weep and some made me laugh, some shocked me and some made me proud to be a nurse. But underneath all the nurse Agents stories it was clear that every nurse wanted the patient to be safe, and they wanted their interactions with other nurses to be professional.

When I first floated the idea of doing a study about delegation I wanted to throw some light on what the terms really meant for nurses “at the coal face”. As the research study unfolded it

led me to question what else I did not know about direction and delegation. As one door after another opened on topics I had not recognised as important to the delegation role, I wondered how busy nurses could find out about how to 'do' delegation in the face of a lack of information or support. While nurses' desire for patient safety and positive interactions with other nurses was their starting point in their interviews, it is a good place to make the exit point too. That is, there is good will out there in 'nursing land' despite some of the barriers encountered, and a willingness, even I would say, a thirst to learn about how to do delegation well. What is needed now is access to the information, guidance, support and advice they need to make their direction and delegation relationships safe and effective.

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Appendix A

Timeline of the evolution of a nursing supervision, direction and delegation role in New Zealand

Rational for the time line

This time line is provided to illustrate the changes that occurred to nursing supervision, direction and delegation roles and responsibilities over the preceding years since 1901. The time line shows that despite changes to its name, a supervision relationship has been a requirement for New Zealand nurses, and nursing support personnel throughout nursing's history.

1901: Registration for nurses (first in the world) was introduced with the passing of the Nurses Registration Act 1901. The Act specified that nurses needed to be 23 years of age to be registered and payment of a fee was required. State examinations were introduced soon after this date. The main aim of the Act was to protect the public from untrained woman purporting to be a 'nurse' (Maclean, 1932).

1901: Any discussion about a supervisory role is couched in terms of a training role and the employment of "trained nurses" as opposed to "untrained nurses". As trained nurses replaced untrained women: "Ward sisters" were encouraged "not to do the work herself, but to *teach* [emphasis added] others how to do it" (MacGregor, 1901, p. 3).

1904: Three years after the Nurses Registration Act 1901, registration for women practicing obstetrics was approved by the New Zealand Government (Lambie, 1952, p. 7). These changes resulted in registration of obstetric nurses, access to better Obstetric Nurse training, and improved mother and child care.

There was opposition from many medical men as well as the general public who did not realise the significance of the new legislation which was passed in 1904. This Act immediately brought under *supervision* [emphasis added] the work of obstetric nurses and necessitated the appointment of additional Nurse Inspectors (Lambie, 1952, p. 7).

1907: Psychiatric nurses were registered under the Department of Mental Hospitals.

1910: Dr Valintine, who had succeeded Dr MacGregor as Inspector General of Hospitals, in his description of the services required, advocated for a role for district nurses in the community to support the work being carried out by institutional and charitable aid services. The District Nurse role would include: “faithfully to follow the Doctor’s orders” and “to acquaint the doctor of the daily condition, pulse, temp etc of each patient” and “to be local *supervisors* [emphasis added] of untrained midwives” and ensure their “kit was kept clean”, and advising mothers on sanitation and baby feeding, and attending emergency maternity cases (New Zealand Government, 1974, p. 36). This is a second reference to a form of *supervision* between nurses that was expected to become part of the practice of nursing.

1911: The Department of Health administered a “native nursing service” to control disease and infant mortality in the Māori population. District nurses for Māori were established. This service is considered to be a precursor to the public health system. The trained nurse though had a great deal of *autonomy and responsibility* due to geographical isolation as many worked in remote areas without access to doctors (McKillop, 1998; Te Ara - the Encyclopedia of New Zealand).

1912: New Zealand nursing was accepted into the International Council of Nurses (ICN) at the International Congress of Nurses held in Cologne, Germany.

1914-1919: World War One - active military service for some nurses. Nursing leadership becomes increasingly concerned about attracting and recruiting nurses and world events exacerbated the nursing shortage. The staffing difficulties within hospitals naturally reflected the loss of man power in the general population. The influenza epidemic in 1918 and the devastation to families during World War One (Lambie, 1952, p. 12), a high entry age to nursing training programmes of 21 years old, low wages and an apprenticeship model of training, resulted in a shortage of nursing recruits. Nursing shortages were again reported in the Department of Health Annual Reports a number of times through into 1920 (French, 2001, p. 29).

1917: School nurses were appointed to assist with, and support medical personnel *instructions*, and check on treatments ordered by Doctors.

1918: Influenza epidemic occurs.

1920: The Nurses Registration Amendment Act 1920 reduced the age of registration for nurses to 22 years of age.

1925/30: A third reference to a supervisory role is made at this time. The Nurses and Midwives Registration Act 1925 and its amendments in 1930 opened the door for the first time to a second category of nursing support. The second category of nursing support—the Maternity Nurse—was required to work under *supervision*. The Registered Maternity Nurse, was considered at the time to be a ‘nurse’ but was more accurately a nursing support role for the care for pregnant women. The Registered Maternity Nurse had 12 months training and would attend maternity cases only under the *supervision* of a medical practitioner, and therefore assumed less overall responsibility. MacLean (1932, p. 268) described their reporting lines as being under the “*charge* [emphasis added] of a registered medical practitioner”. However the Act uses the term *supervision*.

1938/39: Nurses were asked to delegate tasks to domestic staff, and this new turn of events was motivated by a desire to utilise hospital staff differently in order to maximise the nursing role. The term *delegate* is being used for the first time. As a result of the changes brought by the Social Security Act, such as shorter working hours and higher pay, more nurses were needed to fill rosters. Inevitably higher pay meant that hospital boards trying to contain costs were reluctant to spend money on employing more trained nurses. The resultant change in skill mix necessitated a different way of utilising nursing staff. Miss Lambie, suggests that nurses, *delegate* to domestic staff.

While it is necessary that young nurses should have some grounding in personal hygiene and good housekeeping many duties assigned to them could be *delegated* [emphasis added] to the domestic staff. Though all hospitals in this country employ domestic staff to a much greater extent than formerly, there are still duties assigned to nurses, even in their second year which could not be termed as educational value (New Zealand Department of Health, 1939, p. 70).

1938: It was not until 1938 that a new nursing support role, the Nursing Aide, was created. This was made possible by an amendment to the Nurses and Midwives Registration Act 1925 and the introduction of a reduced training time for nurses combined with lobbying by hospital boards for training schools in smaller geographical areas (French, 2001, p. 29). It was envisaged that the Nursing Aide category of nursing support would be able to fill the continuing and serious nursing staff shortages in hospital and sanatoria and attract staff that could be supported to care for people who had chronic conditions such as tuberculosis, or those in the aged care area (Dickson, 1994, p. 4; Lambie, 1952, p. 24; Papps & Kilpatrick, 2002, p. 5). It is important to note that they did not have the legal status of nurses, as they were not a Registered Nurse aide, rather they were registered Nursing Aides. Therefore, it

would not be accurate to refer to this group of workers as second level nurses, as the title nurse had a protected status (Papps & Kilpatrick, 2002). The two-year training period for Nursing Aides would concentrate on domestic duties in year one and nursing tasks in year two. There would be a preliminary state examination at the end, and when qualified the graduate would work under the *supervision* of a doctor or nurse. They were required to have a practising certificate and the Nursing Aide's name would be placed on a register (Lambie, 1952, p. 24; New Zealand Department of Health, 1939, p. 71). In her nursing report to the Department of Health Miss Lambie details the supervision role and the support the Nursing Aide should receive.

Thirdly, there should be adequate *supervision* [emphasis added] by the registered staff who should realise what *supervision* [emphasis added] means – to assist in the development of the individual – not to inspect the individuals work (New Zealand Department of Health, 1939, p. 71).

1939: The Nurses and Midwives Registration Amendment Act 1939 was passed and this allowed for the two year training of Nursing Aides, instituted annual practicing certificates, and accepted male students.

1939 -1945: Nursing resources were strained due to shortages in “man power” during World War Two as troops left for overseas and women filled some of these jobs. Married woman returned to nursing roles and this led to a more part time labour market (O'Connor, 2010).

1944: Psychiatric hospitals came under the jurisdiction of the Department of Health, and psychiatric nurses were registered by the Nurses and Midwives Board from 1947. The administration of psychiatric hospitals was transferred to hospital boards in 1976.

1945: Registration of the two year male nurse programme commenced.

1947: Concerns related to attracting and retaining nurses that had been identified and reported by Miss Lambie in 1939 were again being reported by Mr Ritchie in his role as Deputy Director-General of Health in 1947. In Mr Ritchie's report to Mrs Mabel Howard, the Minister of Health, he cites an increase in birth rate placing higher demand on hospital beds, a “wastage” of nurses due to marriage to returning service men, and the high number of nurses wishing to travel overseas (New Zealand Department of Health, 1947, p. 22).

Mr. Ritchie concerned about the nursing staffing shortages, suggests that nursing salaries, hours and conditions should improve. He advocates for employing married Registered Nurses “over busy periods” as part-time employees, and minimally trained domestic staff members to carry out what appears to be nursing roles. He acknowledges a lack of clerical and domestic

staff, which resulted in Registered Nurses having to carry out many non-nursing tasks. Mr. Ritchie ends this section of his report with a plea for what appears to be a third category of nursing support:

If only it were possible to obtain more workers with a little *instruction* [emphasis added] they might be given a wider range of duties which in turn might make their work more attractive and would certainly assist the nursing staff to a much greater degree. There is no reason why they should not be taught to assist convalescent patients, feed helpless patients and many other simple duties (New Zealand Department of Health, 1947, p. 25) .

1957: Nursing Aide courses were amended to become 18 months long.

1961: Registration of the three year psychopaedic nursing programmes commenced in psychopaedic hospitals which were responsible to the Department of Health.

1962 -1972: Four major investigations and their corresponding reports were written about New Zealand nursing education. They included: *The Reid Report 1965*, *The Department of Health report 1969*, *The Carpenter Report 1971* and *The Department of Education 1972 report*. Each of these reports supported the transfer of nursing education from the control of the Department of Health to the Department of Education.

1965: An amendment to the Nurses and Midwives Act 1965 established a new register for Community Nurses. The registered Nursing Aides registration ceased in 1965, and the names of these hospital employees were transferred to a new register as Community Nurses (New Zealand Department of Health, 1966, p. 73). The Hospital Board administered the Community Nurse training programmes, which were delivered over 18 months. It prepared nurses to be able to provide a practical level of support to patients and other health staff and included “basic nursing services” “under the *supervision* [emphasis added] of a Registered Nurse or doctor” to “perform specific nursing tasks relating to patient care that require considerable less use of judgement” (Department of Health, 1969, p. 64; Papps & Kilpatrick, 2002, p. 5).

1967: Endorsement nursing programmes leading to certification in some specialties were made available to Community Nurses. By 1970, forty endorsement programmes for Community Nurses were offered and certificates were awarded by the Nurses and Midwives Board (Dickson, 1994, p. 4).

1971: The Nurses Act 1971 led to the establishment of the Nursing Council of New Zealand and replaced the Nurses and Midwives Registration Board (French, 2001, p. 104).

1973: Second level nurse training continues in hospital schools of nursing settings.

1977: The Nurses Act 1977 (the Act) provided for *direction and supervision* of Enrolled Nurses, registered Obstetric Nurses and general nurses in regard to obstetric nursing. It did not define *delegation or supervision*.

The Nurses Act 1977 stated that: (all) nurses were “fully responsible and accountable for their actions” (New Zealand Government, 1977). The Act further stipulated that the title “nurse” refers to both Registered and Enrolled Nurses.

The Act removed the name Community Nurse and the names of the successful candidates were entered onto a *roll*, not a register, as Enrolled Nurses (Dickson, 1994, p. 4; O'Connor, 2010). The name was changed to Enrolled Nurse at this time because there was a perception from within the profession that the title Community Nurse did not reflect the role of the second level nurse, and Community Nurses if they could be retained in the health system worked in hospital settings, not the community. The new title of Enrolled Nurse was believed to be less confusing. The newly named Enrolled nurse would be “Free to practice and excel within the scope of her practical competence and theoretical knowledge” (O'Connor, 2010, p. 179).

1983: The 1983 amendment to the Nurse Act 1977, Section 53A, reaffirmed that Enrolled Nurses were required to work under the “*direction and supervision*” of a medical doctor, or Registered Nurse except in an emergency. Indeed it stated that the failure of the Enrolled Nurse to follow the direction and supervision of Registered Nursing and medical staff would result in a fine of \$1,000 (New Zealand Government, 1983). The Nurses Amendment Act 1983 did not define or describe *direction or supervision*.

1988: The terms *direction and supervision* identified in the Section 53A amendment to the Act in 1983, continue to be used. However, what was not made clear was what *direction or supervision* meant for nurses working with this professional and legal requirement. Keene (1988, p. 23) states:

Ever since Enrolled nurses appeared on the scene officially in January 1978 there has been uncertainty within the profession itself about the role that these ‘second level’ nurses play in practice. The NZNA Policy Statement on Maternal and Infant Nursing expressed the point in 1981: “a general sense of confusion has developed as the

enrolled nurse can see no clear definition of the parameters of this role practically”. It is probably fair to say registered nurses were equally unclear about the enrolled nurse’s role (Keene (1988, p. 23).

In 1988, building on the work of the International Council of Nurses (ICN), an ad hoc committee was established by the New Zealand Nurses Association (NZNA) National Executive to examine the regulation of nursing in New Zealand in relation to changing health needs, health care services and nursing perspectives. The draft document produced was intended for discussion and feedback from their members. The ad hoc committee identified a degree of confusion around the first and second level of nursing roles (New Zealand Nurses Association, 1988, p. 12) .

The current position in New Zealand with regard to the levels of nursing practice is the existence of two categories of qualified nursing staff, the registered nurse and the enrolled nurse – both entitled by statute to use the title “nurse”, with the enrolled nurse working under the *direction and supervision* [emphasis added] of the registered nurse.

Unqualified staff in New Zealand include hospital aides, psychiatric assistants, and hospital nursing orderlies. These personnel are employed to work under the *supervision* [emphasis added] of a registered nurse in much the same way as an enrolled nurse.

The lack of precise meaning of “working under the *direction and supervision* [emphasis added] of the registered nurse” leads to a variety of interpretations in practice. The implications of a lack of a clear definition relating to the scope and function of the registered nurse creates confusion for the consumer, the health service workforce planner and indeed nurses themselves (New Zealand Nurses Association, 1988, p. 12).

1989: One hundred and twenty two Enrolled and Registered Nurses wrote a letter to the New Zealand Nurses’ Journal to share their concerns about the proposal to remove the Enrolled Nurse and replace qualified, trained Enrolled Nurses with a nursing auxiliary who would be trained in the “art and science” of nursing over only 12 weeks (Anonymous, 1989, p. 5). The writers make the following point:

The present enrolled nurse system where the *supervision is indirect direction* [emphasis added] for basic nursing or *direct direction* [emphasis added] for situations requiring complex nursing judgement and skills, works fairly well. Will the nursing

auxiliary be able to judge when this *supervision* [emphasis added] needs to be direct or indirect? (Anonymous, 1989, p. 5).

1990: The 1990s were a turbulent time for many Enrolled Nurses as discussions about their role and usefulness in the health care system continued (New Zealand Nurses Association, 1991, p. 3; New Zealand Nurses Organisation, 1994, p. 3). There were calls for a clear definition of *direction and supervision* (New Zealand Nurses Association, 1990, p. 4).

1992: Bachelor of nursing degree programme for registration as a Registered Nurse were introduced.

1993: All Enrolled Nurse training programmes provided by hospital schools of nursing ceased. No new Enrolled Nurse applicants were entered onto the roll of Enrolled Nurses after 1996 (Bland & Olliver, 2002, p. 87). There was a desire by nursing management within hospital and community settings and some Area Health Boards to replace Enrolled Nurses with the cheaper unregulated Health Care Assistants (HCAs), and this became the norm in many places throughout New Zealand over the following years until 1998.

1998/1999: The terms *direction and supervision* continue to be used with the Nursing Council of New Zealand's inclusion of definitions related to *direction and supervision* in the *Competencies for Entry to the Register of Nurses*, and the *Competencies for Entry to the Register of Midwives* (Nursing Council of New Zealand, 1998, 1999). Enrolled nurses were required to work under the *direction and supervision* of the Registered nurse.

1999: The College of Nurses Aotearoa (NZ) Inc., Nurse Educators in the Tertiary Sector (NETS) and Nurse Executives of New Zealand (NENZ) provided a discussion paper which included principles and guidelines related to the *supervision of, and delegation to, an unregulated assistant from a Registered Nurse or Midwife*. The College of Nurses preference was for a health care *assistant* rather than a second level *nurse*. *Delegation and supervision* are defined in the definitions section of the booklet (College of Nurses Aotearoa (NZ) Inc, 1999).

The College of Nurses wrote:

Although many RNs have been responsible for delegating aspects of nursing care in a variety of settings for many years (e.g., long-term care/rest homes) and to a variety of people (e.g., enrolled nurses, less experienced colleagues and family members), there has been little formal training in this area in the undergraduate programme; in post-

graduate courses/programmes or by employers (College of Nurses Aotearoa (NZ) Inc, 1999, p. 5).

They added that Registered Nurses would need to be competent with specific skills to ensure safe and effective delegation. These skills included:

Documentation, comprehensive assessment, delegation and supervision, facilitation of team effectiveness, conflict resolution and problem solving, and nursing care co-ordination (College of Nurses Aotearoa (NZ) Inc, 1999, p. 5).

2001: Ron Paterson in his role as Health and Disability Commissioner (HDC) established by the Health and Disability Commissioners Act 1994 was called on by the Nursing Council of New Zealand for his opinion on the Enrolled Nurse and Nurse Assistant Scopes of Practice under the Health Practitioners Competence Assurance Act 2003. This request calls the patient and their family and whānau front and centre into the debate as it is the HDC's role to promote and protect the rights of all consumers of health and disability services. Mr Paterson cites as an example of his serious concerns related to a generic Scope of Practice, in his analysis of the tragic case of a mental health patient Mark Burton. Mr Burton who had been released from a Southland hospital, went on to murder his mother (Paterson, 2009, p. 1).

The Health and Disability Commissioners' report into the care of Mark Burton by Southland District Health Board raised serious concerns about the use of an Enrolled Nurse in an acute mental health unit. In that case there was confusion between an Enrolled Nurse who had had many years' experience and a less experienced Registered Nurse. The Registered Nurse appeared to believe erroneously that the Enrolled Nurse was sufficiently knowledgeable to make good assessment and discharge decisions. While the Enrolled Nurse had limited insight about the areas in which she lacked knowledge, I also accept that Enrolled Nurse A was *supervised* [emphasis added] in the general sense in that there was always a Registered Nurse on duty. Never-the-less, the Team Leader had recognised the problems with the primary nursing system and was aware that in some cases associate nurses were assuming a de-facto primary nurse role. In these circumstances I consider that she should have taken steps to ensure that Enrolled Nurse A did not assume an inappropriate level of responsibility for planning, implementing and coordinating Mr Burton's case (Paterson, 2009, p. 2).

2002: Enrolled nurse training, gazetted by NCNZ, was reintroduced via Northland Polytechnic at Level 4 as a one year programme (Diploma) on the NZQA framework and

included a less broad Scope of Practice than for a Registered Nurse (Meek, 2009; O'Connor, 2010).

2003: With the introduction of the Health Practitioners Competency Assurance Act (HPCAA) in 2003, the regulation of health care professionals in New Zealand came under the regulatory framework of the HPCAA. In addition, the legal framework that accompanied it enabled NCNZ to provide registration for nurses. This Act which aimed to protect the public and still allow for autonomy of professional groups is based on certification of title, rather than on licensing of an activity (Liu, 2011, p. 25). The Act 2003 replaced the Nurses Act 1977, and was designed to ensure that health care professionals practiced within their Scopes of Practice. One of the tasks created at this time was the requirement of NCNZ to define the title and the Scope of Practice of the Enrolled Nurse. This led to extensive discussions in the literature about the role of the Enrolled Nurse (College of Nurses Aotearoa (NZ) Inc, 2004; Nursing Council of New Zealand, 2009).

2003: A further Enrolled Nurse education programme was introduced by Christchurch Polytechnic Institute of Technology in 2003. The Enrolled Nurse certificate educational preparation was to be delivered at a Level 4 level on the NZQA framework, over 12 months. This contrasted with the Bachelor of Nursing students' undergraduate educational preparation, which started at Level 5 and finished at Level 7 on the NZQA framework, and was delivered over three years. The Enrolled Nurse that graduated with the Level Four certificate was to be awarded the title "Enrolled Nurse". The direction given by the Minister of Health was that the second level nurse would practice under the *direction and supervision* of the Registered Nurse. An Enrolled Nurse was only allowed to work with "health consumers with stable and predictable health outcomes" (Nursing Council of New Zealand, 2008, 2009).

2007: The term *delegated* is used in the Scope of Practice for Nurse Assistants.

Nurse Assistants assist registered nurses to deliver nursing care to individuals in community, residential and hospital settings. They perform *delegated* [emphasis added] interventions from the nursing care plan to provide care and comfort for individuals and groups, assist and support clients with activities of daily living, observe and report changes in individual /group conditions and behaviors, safe guard dignity and promote independence and health and safety (Nursing Council New Zealand, 2007b, p. 4).

The Scope of Practice for Enrolled Nurse used the term *direction*.

Enrolled Nurses practice under the *direction* [emphasis added] of a Registered Nurse or Midwife to implement nursing care for people who have stable and predictable health outcomes in situations that do not call for complex nursing judgment (Nursing Council New Zealand, 2007b, p. 4).

2007: The Scope of Practice for Registered Nurses identifies that Registered Nurses must “*delegate and direct* enrolled nurses and nurse assistants”. Competency 1.3 states that Registered Nurses need to: “Demonstrate accountability for *directing*, [emphasis added] monitoring and evaluating nursing care that is provided by nurse assistants, enrolled nurses and others” (Nursing Council New Zealand, 2007a, p. 3/11).

2008: *The Guideline: direction and delegation* in 2008 identified that Registered Nurses *direct and delegate* to Enrolled Nurses, Nurse Assistants and others, and provided definitions of these terms, as well as a definition of *supervision* (Nursing Council of New Zealand, 2008, p. 6/25).

2009: There are calls for a broadened Enrolled Nurse Scope of Practice by Tony Ryall as Minister of Health at that time.

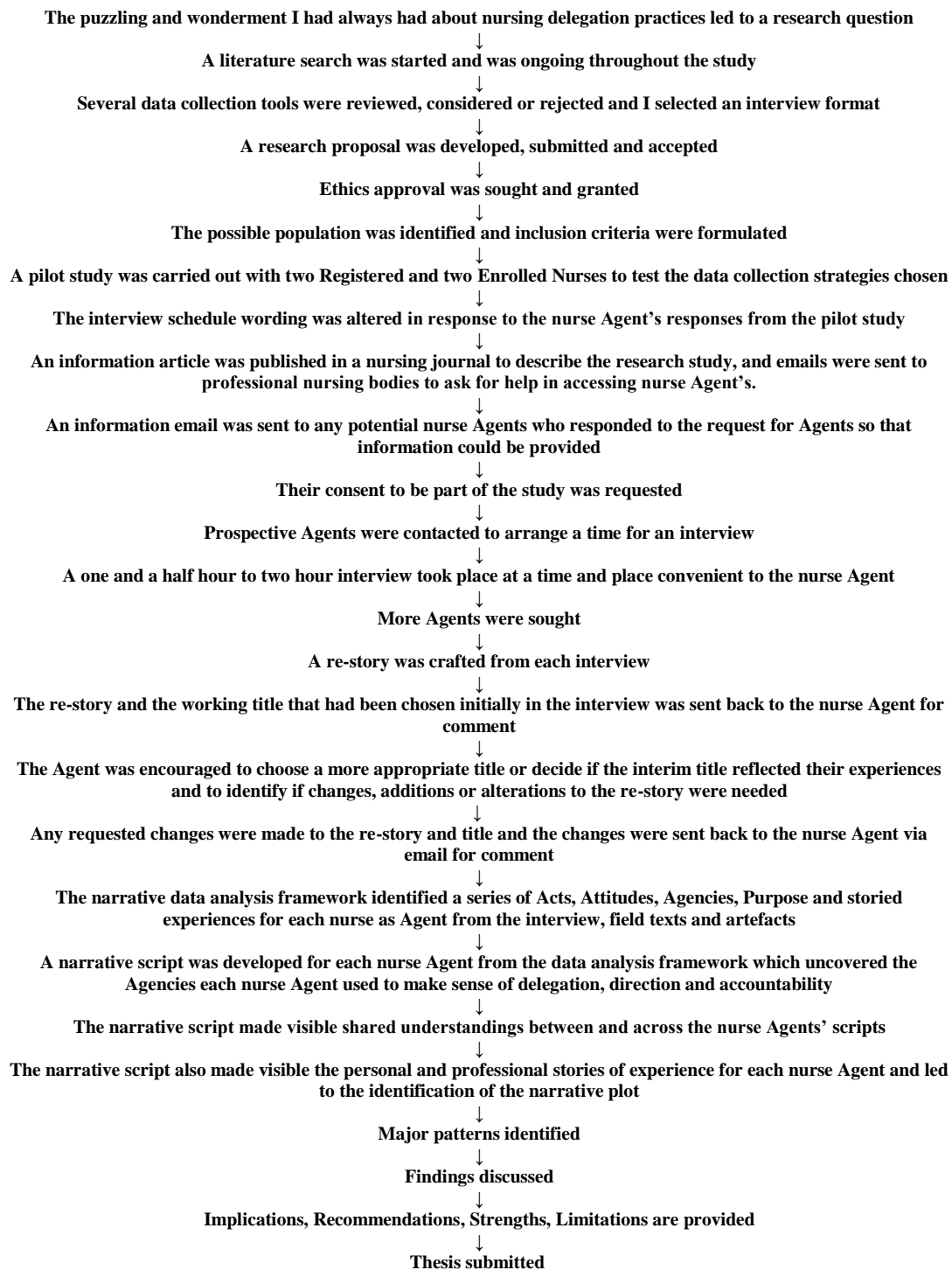
2010: An announcement was made in 2010 that the title Enrolled Nurse would be used for all second level nurses, and that they were to have a greater role in assessment, and work as part of a team with Registered Nurses in a variety of settings, including acute areas and mental health settings. They could coordinate a team of unregulated workers but must continue to work under the *direction and delegation* of a Registered Nurse, and definitions of these terms were provided (Nursing Council of New Zealand, 2010). Various documents listed what a nurse should do (New Zealand Nurses Organisation, 2011, p. 8) before or during delegation but none identified or described *how* this professional obligation should be carried out, how it should be communicated or the skills needed to do direction or delegation well. The New Zealand Nurses Organisation (NZNO) did identify that it was a “dialogue” and suggested the skill mix decision be accompanied by the seven elements of safe staffing and healthy workplaces identified in the *Safe Staffing/Health Workplaces Committee of Inquiry* in 2006 (New Zealand Nurses Organisation, 2006; 2011, p. 8).

2011: In the *Guideline: responsibilities for direction and delegation of care to enrolled nurses* and the *Guideline: delegation of care by a registered nurse to a health care assistant* the terms direction, delegation and supervision are used and defined (Nursing Council of New Zealand, 2011a, 2011b).

2010/2012: A revised and broadened Scope of Practice for Enrolled Nurses was introduced. The educational preparation was set at Level 5 on the NZQA framework. *The Competencies for the Enrolled Nurses* require Enrolled nurses to practice under the *direction and delegation* of Registered nurses. Further: “In acute settings, enrolled nurses must work in a team with a registered nurse who is responsible for *directing and delegating* [emphasis added] nursing interventions”. “In some settings enrolled nurses may work under the *direction and delegation* [emphasis added] of a registered medical practitioner. In these situations the enrolled nurse must have registered nurse *supervision [emphasis added]*” (Nursing Council New Zealand, 2010, p. 1; 2012a, p. 5). These three terms are defined in the definitions section of the competencies document.

Appendix B

A summary of the main steps within the research process from the initial wondering about direction and delegation to the final chapter of the thesis.



Appendix C

Introducing the Agents

Introducing the Agents provides a profile of each of the nurse Agents. Each profile provides a background and introduction to the nurse Agent and includes their experience either as an Enrolled or Registered Nurse, and their initial thoughts about the direction or delegation interactions they had been involved in. The profiles also include a brief discussion about the re-story and the title that was created and sent to the nurse Agent. This acknowledges their courage in coming forward to share their “good” and “bad” delegation interactions, and was also intended as a sign of respect, and a thank-you for the time they spent with me. The re-story also served as a member check. The profile forms a backdrop to the script that was created for each of the 18 Enrolled and 16 Registered Nurse Agents. The nurse Agent is presented as the main character, speaker or actor who performs an Act within the narrative. Pseudonyms have been allocated to each nurse Agent and no real names or place names have been used.

The Enrolled Nurse Agents

Agent 7: Karl

Karl had been working as an Enrolled Nurse in mental health for a number of the years both here in New Zealand and overseas. He had “*kept on top of all his appraisals*” over the years, transitioned to the new Level Five Scope of Practice for Enrolled Nurses and he had worked in nearly all of the areas within mental health. He had completed the ‘Fluid and Medication booklet’ and wanted to do other courses and certifications if they became available for Enrolled Nurses in the future as was the case in Australia. Karl’s stories were initially about the changes he had been through as an experienced Enrolled Nurse and were captured in his re-story as: *Changing times*. Throughout Karl’s stories about his delegation experiences in the mental health services in Canterbury he showed balance and fairness towards the nurses he worked with, and a preference for an egalitarian approach with other nursing colleagues.

Agent(s) 8: Eloise and Sally

Although Eloise and Sally were frightened about speaking out about their delegation experiences they came forward to be part of the study. There had been a serious and fatal

outcome for a patient on their ward and they hoped that by sharing their experiences, they could make it better for other Enrolled Nurses, and the patients they cared for. Some Registered Nurses in their workplaces wrote incident reports about having to work with Enrolled Nurses, and spoke disrespectfully in front of them and to them, as the Registered Nurses struggled to come to terms with a new and increasing Enrolled Nurse workforce. Eloise and Sally concluded that for them the actual communication within the direction and delegation interaction about patient care was kept to a minimum and they were concerned about how this might impact on their ability to safely do their jobs, and work within their Scope of Practice. Their re-story simply entitled: *Eloise and Sally's re-story* clearly shows that they loved working in mental health, and wanted to stay but were not sure if they could keep going under this type of negative pressure. In the end their stories showed a desire to be valued for their contribution to nursing practice, to feel safe within the workplace, and to keep their patients safe.

Agent 9: Melanie

I met with Melanie in her quake damaged home. Even though she was surrounded by reminders of the quake she felt it was important to meet with me to talk about her delegation experiences. Melanie was an experienced Enrolled Nurse who had accumulated over 40 years of nursing experience. She liked her role working in the community with terminally ill patients. Melanie explained that she was well aware of the need to work under the direction and delegation of the Registered Nurse. Sometimes however she found this professional requirement difficult when working alongside newly graduated Registered Nurses who understandably lacked the knowledge and experience to lead the shift in this specialised area. She explained that there is a lot of communication among and between the Enrolled and Registered Nurses, as they “checked in” with each other regularly throughout the shift and they all worked *as* a team. Melanie described this as the team members being: *Closely connected* and I chose this to be the title of her re-story. In the end Melanie's stories were about showing leadership and having access to good leadership.

Agent 10: Davinia

Davinia was a new, young, inexperienced Enrolled Nurse working in a medical ward in Canterbury. She came to our interview prepared with notes to share, and was very interested in the topic of delegation. She was able to paint a vivid picture of her direction and delegation interactions. Davinia liked her job and the ward where she worked because there were a lot of Enrolled Nurses. All of them were older experienced Enrolled Nurses though and it was not clear to her or them where she belonged as a new graduate Enrolled Nurse. Although there

were some Enrolled Nurses who had transitioned to the new Level 5 and associated Scope of Practice, many of the Enrolled Nurses on this ward had remained at Level 4. The advice Davinia was given by one of the experienced older Enrolled Nurses on her ward was to “stand up politely for yourself and confidently and respectfully challenge any unfairness”. This friendly Enrolled Nurse told Davinia she would probably be given the heaviest workloads, and from Davinia’s experiences so far this seemed to have been an accurate assessment. Davinia’s stories were about: *Needing support*, and this became the title of her re-story.

Agent 11: Lynda

Lynda had agreed to meet with me even though it was a Saturday afternoon and it was her day off. I am glad she did because the many stories Lynda shared with me were invaluable. She was balanced and fair and like all the Enrolled Nurses I had interviewed she had come prepared with notes and examples. Lynda currently worked in a smaller hospital in Canterbury. Her background was in surgical nursing and the operating theatre. In the earlier days of her nursing when her children were young she had worked in an emergency department. She had enjoyed this work as well but noted that no Enrolled Nurses work in A and E these days. At the end of the meeting she summed up the interview by saying that not all Enrolled Nurses were strong enough to speak up for themselves about workload allocation and this could result in them being taken advantage of with heavier workloads. The ability to speak up for yourself was dependent on your personality and confidence levels and this was different for everyone. She had learned over many years of experience to speak up for herself but it had not come naturally in the beginning. She feels comfortable now, but it had taken time. Lynda’s re-story came to be called: *The enjoyable workplace* because she obviously liked the people she worked alongside, she was treated well, and her workplace experiences were positive and enjoyable.

Agent 12: Dallas

Dallas had worked in the same ward for over 25 years and over her many years working in a variety of medical settings she had notched up nearly 40 years’ experience as an Enrolled Nurse. Dallas contacted me to be a part of the research study after reading about the study in the NZNO. Kai Tiaki nursing journal. Dallas worked part time as an Enrolled Nurse in a specialised medical ward in Canterbury and therefore met the criteria to be part of the study. She had a major body of knowledge related to this area of nursing.

Dallas was able to throw some light on the knowledge, skills and attitudes required during positive delegation interactions. It is clear from the experiences that Dallas shared in the interview that nurses need good assessment skills in order to lead a team. And in order to assess and lead the team they also need advanced communication skills. Therefore, the re-story sent to Dallas to comment on was entitled: *Communication, assessment and leadership*.

Agent 14: Amy

Amy kindly agreed to meet with me on her day off. We met in a cafe in a small township outside of Christchurch. Amy was a very experienced Enrolled Nurse who had originally trained in the United Kingdom and transitioned to the new Level 5 Enrolled Nurse Scope of Practice in New Zealand. She came well prepared with ideas and examples to share with me, and she had clearly done her homework with typed notes that addressed the prompt questions I had suggested in my research information pack. Although Amy said she loved her job the way she said this indicated to me that there might be some concerns for her too. Amy's re-story was entitled: *Leadership and Communication*. This captured the importance that leadership and communication skills played when Enrolled and Registered Nurses communicated. Together we discussed what good communication between nurses during delegation would look like. She felt it was important to have her professional opinion acknowledged and valued and that the tone that nurses used when talking to each other was important too. When I got back in touch with her to ask her if she was happy with the way I had represented her stories she told me that she had retired as she was so frustrated with the nursing system. She added in the email that she had enjoyed "getting it [her concerns] about the delegation relationship off her chest".

Agent 16: Jody

Jody was an experienced Enrolled Nurse with over 40 years' of nursing experience in a number of different nursing settings. She was currently working in a busy medical ward in Canterbury. She agreed to meet with me to tell me about how direction and delegation between Enrolled and Registered Nurses worked in her workplace. Jody was respectful and balanced in all her comments and examples about the other nurses she worked alongside. She used the word partnership to describe how she worked with the other nurses. The Registered Nurse and Jody work in partnership and together, and workload allocation is negotiated. She had recently changed her shift pattern and she described how this new shift felt like a totally different culture as there was even more close contact between the Registered and Enrolled

Nurse. Jody's re-story was entitled: *Communication is all*, which captured the need to work together, and highlighted how vital good communication was for Jody.

Agent 17: Barbara

Barbara met me at my office at polytech to talk about her experiences with direction and delegation. She has previously shared with me via email before the interview that she had had many years of experience. This turned out to be over 30 years' experience in a variety of general medical settings. When Barbara talked about her job, her whole face lit up! She spoke glowingly of the nurse leadership above her and appreciated working with people who shared their knowledge with her. The teaching role that her work in the clinic offered her was especially important and enjoyable for Barbara, and the ability to share her own knowledge with others was another important value within Barbara's nursing practice. She loved this role working more or less autonomously but seeking help if and when it was needed. Barbara's re-story was entitled: *Barbara's story: Getting the facts right*. The reason for this title becomes apparent in the first story she shares about a delegation interaction which was a sad and moving story about the pitfalls of Registered Nurses who do not understand the Enrolled Nurse Scope of Practice.

Agent 18: Judith

Judith, an experienced Enrolled Nurse, agreed to meet with me late on a Saturday afternoon even though she had been working since 7am that morning. It was another example of the good will that many of the Enrolled and Registered Nurses had shown to me throughout the research study. Judith generously acknowledged that she was happy to meet with me because she would learn something about delegation too. Like many of the Enrolled Nurses I had interviewed she had come prepared with notes, and had used the interview prompts to guide the ideas and thoughts she wanted to share when she met with me. Judith had accumulated over 40 years' experience as an Enrolled Nurse and she had seen many changes in that time. The first item Judith wanted to discuss with me was team nursing. Judith worked in a medical unit and she worked together with the Registered Nurse, working *in* and *as* a team, talking to each other throughout the shift ("in dialogue"), negotiating tasks, and working in with each other in a delegation *relationship*. This ability to *Communicate well* became the title of Judith's re-story.

Agent 19 Katie

Katie had at least 28 years' experience as an Enrolled Nurse. Katie's stories about delegation focus on an acute mental health setting in Canterbury where she had worked for many years.

Katie was efficient and business like, and had kindly agreed to meet with me at her workplace to talk about direction and delegation. Katie shared that direction and delegation interactions require communication between Registered and Enrolled Nurse and this happens in a negotiated way. Katie and the other Registered and the Enrolled Nurses decide together and might start with: “This is happening, what should we do?” It was never: “You go and do...” This sounded like an intriguing description and was an excellent introduction to direction and delegation practices in Katie’s workplace. Her preference was for a relationship between Enrolled and Registered Nurses based on two way discussions and inclusion of the Enrolled Nurses’ professional opinion which unfolded as the technique Katie used during delegation interactions. This was reflected in her re-story entitled: *The culture decides* which captured how the way delegation happened depended on the culture of the ward. However, as the interview progressed it became apparent that there was a lack of information about direction and delegation, and some confusion about who should be ‘doing’ the delegating.

Agent 20: Annabelle

Annabelle was an Enrolled Nurse with more than 40 years nursing experience. She came to the interview prepared with a number of documents relating to her transition to the new level and Scope of Practice. She had a wealth of life skills and life experiences in a number of nursing and non-nursing employment settings. Annabelle valued learning new things so much that she preferred to work at three jobs. She was employed in a clinic in Canterbury, but she was also involved in another nursing role in health promotion work, and she worked privately in a non-nursing role. Annabelle’s re-story had the title: *Figure of eight team work, crossing paths and learning and sharing information* because as Annabel said in her interview, a good working team with good leadership skills was like a ‘figure of eight’ with RNs and ENs working together, crossing paths, sharing and working as a team, debriefing, explaining and learning from each other.

Agent 22: Maryanne

Maryanne articulately described the actions she had to take to ensure she worked safely with the patients in her care, work within her Scope of Practice; advocate for her patients, and provide compassionate nursing care. Maryanne was a polite and respectful lady with more than 30 years’ experience as an Enrolled Nurse, both in Canterbury and other New Zealand settings. Throughout the two hour interview Maryanne apologised frequently for “being negative”, or “sounding like a trouble maker”. Maryanne’s first question to me after our introductions was: “Did you have a good response to your research study and call for nurses to participate in it?” She suggested that Registered Nurses might not respond to be part of the

study because in her experience many of the Registered Nurses she had worked with had “varying degrees of understanding about direction and delegation relationships.” This question acted as a bridge to the stories she shared with me about her delegation experiences. Maryanne’s re-story and the title: *The compassionate and rebellious Enrolled Nurse* attempted to capture the way she preferred to nurse her patients, and how she communicated with her colleagues.

Agent 23: Trudy

Trudy met with me in spite of being a “bit nervous” about how the research study would work and what might be expected of her. She came prepared with notes and ideas to share with me as many of the Enrolled Nurses had throughout the study. She had worked in a number of different nursing areas over her extensive career and she had transitioned twelve months earlier to the new Scope of Practice at Level 5. As well as her role as an Enrolled Nurse on an acute specialised medical ward and outpatient unit she had also been responsible for an auditing role and a rostering role, however these last two roles had ended very recently.

Trudy laughed when I described how direction and delegation works in some nursing areas as my description bore no resemblance to her working life. She described direction and delegation on a typical morning shift for her and named the nursing model as ‘geographical nursing’. “You’re allocated to the room not the person. Some of the rooms contain more acutely unwell patients and if you’re allocated to a room you usually stay with that room and those patients for that week”. Trudy’s re-story developed the intriguing title: *Passing the parcel both ways*, as she often felt like the meat in the middle of the sandwich passing information, making suggestions if asked, and receiving instructions from the team.

Agent 24: Julie

Julie was an Enrolled Nurse working in a medical outpatient clinic in Canterbury. She was an enthusiastic and motivated person and she was also an experienced Enrolled Nurse with over 25 years’ experience both here in New Zealand and overseas, mostly in the general medical setting. Julie made contact with me to be part of the study and met with me after a busy shift in her place of work. She had prepared for our interview by thoroughly reading the information about the study and the possible prompts in the interview schedule. Julie enjoyed her work as she was able to work autonomously and independently. She explained that she did not really work under the direction and delegation of a Registered Nurse in the formal sense where the Registered Nurse allocates patients and issues instructions at the beginning of a shift. She discussed direction and delegation and its relevance to her work area and

concluded it was a unique situation working alongside many other medical health care professionals, not just Registered Nurses, and everyone worked as a team. For Julie the way people communicate with each other is very important. This included how people talked to each other and if they listened as well. She felt that personality played a big part in the way communication occurred in the workplace. Julie's re-story was entitled: *The role of personality* which reflected her concerns about how a person's personality shapes and influences how people communicate with each other.

Agent 26: Alison

Alison was a new inexperienced Enrolled Nurse who had graduated six months earlier and she had found employment as an Enrolled Nurse in the community. Alison started our discussion clearly identifying the difference between direction and delegation. She said: "There isn't a lot of distinction between these terms where I work though. There is some delegation occurring". The examples she gave showed she understood the two terms and the difference between them. She went on to describe how direction and delegation between Enrolled and Registered Nurses was meant to happen and was then able to contrast this to how it actually did happen. Her workplace was busy and chaotic, "there were too many chiefs (managers) and not enough Indians (people doing the work)" and this statement initially became the title of her re-story. When I sent Alison her re-story she asked if the title could be changed to: *The Lone Wolf without a pack* as she felt this truly represented the 'aleness' of her delegation experiences and struggle to even get delegation.

Agent 27: Elaine

Elaine was a softly spoken and professionally presented woman. She had a gentle manner and a pleasant lilting accent. Elaine had come to the interview well prepared with written notes and examples to offer based on the interview question and prompts provided to her when the interview session was scheduled. *Elaine's re-story: Extracting delegation* captured her need to request, extract and ask for delegation input. This meant triggering or prompting an interaction by contacting the Registered Nurse and politely asking for help, advice or input. For Elaine working within her Scope of Practice was important and her ability to "extract" the direction and delegation interaction from the Registered Nurse helped her to do this.

Agent 28: Dianne

Dianne contacted me to be part of the study. She presented as a busy, practical and to the point person. It was obvious that Dianne had a variety of different skills stemming from the roles she played outside of her nursing role, such as a mother and business partner. She

believed that this gave her well-honed communication skills which she needed in order to be able to interact with the other members of the nursing team in a busy specialised rehabilitation ward. She had worked in a variety of nursing settings over her 30 year nursing career as an Enrolled Nurse and had learned about direction and delegation interactions during her training as an Enrolled Nurse. In those days it was called ‘direction and supervision’. Since the change in the Enrolled Nurse Scope of Practice she had learned just about everything she knew about direction and delegation by doing the exemplars required for the completion of the Professional Development Recognition Programme (PDRP) and attending some in-service sessions about legal and ethical responsibilities in nursing at the hospital where she worked. Otherwise she felt you just had to “learn on-the-job”. She has found the lack of teaching about direction and delegation interactions “very unhelpful for Registered Nurses as well as Enrolled Nurses”. The re-story sent to Dianne was simply entitled: *Dianne’s story*. This plain and simple title represented the practical and business-like approach Dianne displayed at the interview. Dianne believed that successful delegation interactions happened when people were treated fairly.

The Registered Nurse Agents

Agent 1: Susan

I met with Susan in her home. Susan had worked in a myriad of nursing environments in her time, both in New Zealand and overseas. In fact when we tallied it up together we worked out that she had over 40 years’ experience as a Registered Nurse. She had also bridged to the Bachelor of Nursing degree from her Diploma of Nursing many years previously. Susan currently worked as a Registered Nurse Coordinator in a community health setting. One of her roles was to delegate and direct workload allocation to Enrolled Nurses. In order to keep all the people involved safe Susan carried out a number of assessments, provided leadership and communicated in a skilled way. However, this all happened on such a daily basis in a busy working environment that these tasks were almost taken-for-granted. The title of Susan re-story therefore was ‘*Hidden skills*’ which highlighted the many invisible skills Susan used within her direction and delegation interactions.

Agent 2: Miriam:

Miriam’s narrative, the title of her re-story captures a number of stories as told by Miriam. Miriam was a Registered Nurse and nurse educator with over 30 years nursing experience currently working in an acute medical surgical unit. She was interested in all concepts related

to the nursing profession, which included direction and delegation. While she was not engaged in daily, face-to-face direction and delegations interactions with Enrolled Nurses, her role within the ward meant that she was responsible for providing direction and delegation information to staff. Miriam started the interview by looking back to past times and experiences about working with Enrolled Nurses. She had trained in the days when the Enrolled Nurse “*was seen as those with the greatest knowledge and they knew quite a lot about how the place functioned*” and they were often the most approachable. Miriam then described the nursing family and nursing culture at that time, as a “*colony*” where there were a number of levels of nurse who worked like worker bees in a colony. The queen bee was the Charge Nurse and the worker bees were the Registered, Enrolled and student nurses. It was a powerful analogy that conjured up a colony of workers, busy, effective and working together at different levels “*a hive of activity*”.

Agent 3: Bronwyn

Bronwyn had worked as a Registered Nurse in a small rural community hospital for approximately 18 months. She had travelled some distance to meet with me to talk about direction and delegation as she felt strongly that this professional obligation could, and should, go well. Although she described herself as a relatively new Registered Nurse she was articulate, confident, and caring of the people that were in her charge, and this included the carers as well as the clients. However, she was coming to the conclusion that nursing in the private, older care setting where she was employed was not for her. Instructions and orders were “*barked out*” rather than explained or negotiated, and she felt that the carers were not treated with respect. As Bronwyn identified as Māori, Mana and working in partnership were important to her, but these were not evident in this workplace or in any of the delegation interactions she witnessed between other registered nursing staff and carers. Bronwyn was responsible for over 100 clients and was supported by a team of carers. The carers wanted to learn ‘the how and why’ of caring and they wanted to do the right thing, not just ‘do things to’ their clients. Bronwyn’s re-story was given the title *Creating lieutenants...* because she believed that the delegation relationship was about valuing team members contribution, encouraging them, and taking the time to find out what the team members were good at. When this is done properly the team members win, and so do the clients because you have ‘created lieutenants’.

Agent 4: Barb

Barb was a Registered Nurse who had started her working life as an Enrolled Nurse. She eventually bridged to a Registered Nurse role and Scope of Practice and was able to provide

some insight into what it was like in the earlier days of being an Enrolled Nurse. Barb shared with me that she had worked on both an older care ward and an acute ward as an Enrolled Nurse and in her Enrolled Nurse role in acute care she carried out many tasks that in hindsight were not really appropriate to the role, level or training of an Enrolled Nurse. For instance, she was required to put up bags of IV fluids and write and change the dates on them. Most of the work and tasks were done by the Enrolled Nurses. Currently, as a Registered Nurse on an acute medical ward of a busy hospital, Barb struggles with the concept of having a transitioned Level 5 Enrolled Nurse working on the ward *and* a Level 4 Enrolled Nurse and the difference between them and what they could and could not do. She also identified confusion among patients as well. There had been no information available about this from a management point of view, and she described it as: *A grey area* which summed up her re-story. Barb's re-story was one about confusion and the difficulty of being informed and up-to-date in the absence of information about changes such as the re-introduction of Enrolled Nurses, and the impact this change would have on the need for more direction and delegation interactions.

Agent 5: Harry

Harry was an experienced Registered Nurse who had worked in mental health here in New Zealand and overseas in both medical and mental health areas. Harry had often worked with Enrolled Nurses and agreed to meet with me to discuss some of the communication interactions that had occurred with Enrolled Nurses and Enrolled Nurse students. We also talked about the reactions other Registered Nurse colleagues had when told they would be working with Enrolled Nurse students and Enrolled Nurse graduates in the future. Harry was adamant that working with a registered workforce was preferable to working with an unregulated workforce. Harry described an environment overseas where Enrolled Nurses were considered part of the fabric of the health system, someone you went to for advice if you yourself were new to the area, a valued part of the team, a health care professional. Harry found that there needed to be a continual flow of information-giving to colleagues about the role of the Enrolled Nurse but there was very little responsibility taken by them to access information. This is captured in the title of his re-story: *You can lead a horse to water but you can't make it drink.*

Agent 6: Janine

Janine had worked as a Registered Nurse in mental health for many years. She worked with Enrolled Nurses on a daily basis, both experienced Enrolled Nurses with a number of years' experience in mental health and new, inexperienced Enrolled Nurses. Janine immediately

started talking in the language of ‘direction and delegation’ within the first few minutes of our interview. She was able to separate out direction and delegation, and direct and indirect direction. She knew the difference between direction and delegation, the difference between the Level 4 and Level 5 Scope of Practice and the need for Enrolled Nurses to ‘check in,’ and report to the Registered Nurse. The importance of working in a team became obvious during the interview and was reflected in her re-story as: ***Working as a team and in a team.*** The Enrolled Nurses in this workplace know what they are able to do clinically and what they cannot do and are often overheard teaching the Registered Nurses about the Enrolled Nurse’s Scope of Practice, their level and their competencies. Janine did not spell it out in these terms but this sounded like a Registered Nurse assessing the Enrolled Nurse and the Enrolled self-assessing, and both were communicating with each other.

Agent(s) 13: Ellen and Eleanor

Ellen and Eleanor met with me in Ellen’s home. They were both extremely experienced Registered Nurses who were currently working in a small rural area. Ellen started the interview by sharing with me that the interview questions sent to here were a timely reminder that as a team they were not really dealing with new Enrolled Nurses. Ellen worked with Enrolled Nurses, but they were older, very experienced Enrolled Nurses who had previously worked in a variety of nursing areas and workplaces. These Enrolled Nurses had accumulated great knowledge and skill in wound care, assessment, and diabetes and ulcer management for example. Ellen said: “*I would trust their judgement and I listen to them when they tell me something*”. They were both reflective nurses who were able to describe the importance they placed on paying attention to the way they communicate, and the need to understand why people communicate and respond the way they do, and this was captured in Ellen and Eleanor’s re-story as: ***The jigsaw of communicating well.***

Agent 15: Jocelyn

Jocelyn was a young enthusiastic Registered Nurse with approximately six years’ experience in a variety of medical and surgical wards. It was clear throughout the interview that she was passionate about nursing. Initially Jocelyn failed to see a role for Enrolled Nurses in her workplace because of the ‘acuteness’. However, as the interview unfolded it seemed as though Jocelyn was unsure about what Enrolled Nurses’ could and could not do and it was this that may have initially coloured her view of the appropriateness of the Enrolled Nurse role. Jocelyn felt that some nurses would be reluctant to work with Enrolled Nurses because of the extra amount of assessment and documentation that direction and delegation to an Enrolled Nurse would entail. In addition, there was a perception that the Registered Nurse

was always accountable for an Enrolled Nurse's practice in a direction and delegation relationship. She felt the new inexperienced Enrolled Nurses would need even more input and support than the current experienced Enrolled Nurses she worked with needed, further adding to the Registered Nurse workload. *Waving a flag for team nursing* was the title of Jocelyn's re-story because in many ways Jocelyn strongly believed in team nursing.

Agent 21: Milena

Milena described herself as a relatively new Registered Nurse. Originally from overseas she had trained in New Zealand and had graduated 18 months earlier. She enjoyed working in her chosen clinical area in medical rehabilitation and found the nurses she worked with supportive and experienced. She had come prepared for the interview and had even completed the on-line learning package for delegation offered in her workplace so that she could "contribute in the interview". She understood that Enrolled Nurses worked under the delegation of the Registered Nurse but this was not really reflected in her workplace. Enrolled Nurses in her work area were often much older than her, had accumulated 30 and sometimes 40 years of nursing experience and it felt more like "working alongside" rather than Enrolled Nurses "working under". These experienced Enrolled Nurses were pleasant, professional and hard working. However, she did not believe they would accept any direction or delegation, nursing instruction or questioning of their practice in any way especially from a new graduate like herself. She felt it was noticeable that she only had 18 months experience as a Registered Nurse and this was captured in her re-story as: *The new graduate Registered Nurse*.

Agent 25: Hayley

Hayley worked in a small rural hospital in Canterbury. She worked in a part-time position as a Registered Nurse in the ward and in this role she worked with Health Care Assistants (HCAs), not Enrolled Nurses. The intention of management in this hospital had been to employ only HCAs instead of Enrolled Nurses who had almost been phased out by attrition over the preceding years. Hayley felt this decision had not been based on any research or consultation and she believed this was fiscally driven. After approximately six months it was found that patient care had deteriorated. The HCAs weren't qualified and there was a lot they could not do. In addition, they themselves did not seem to understand what they could or could not do, and patients had commented on this too. There has now been a change in approach to employing Enrolled Nurses instead of HCAs and this is being led from the top nursing management levels. In addition to this position she was also employed as a manager, and it was in this capacity that she worked with Registered Nurses who were responsible for delegating to Enrolled Nurses. In her management role she might be contacted by an Enrolled

Nurse who was not happy with the way things were going in the ward or she might be called on to attend to a dispute between nurses. In summarising the interview Hayley rated her workplace as “*doing fairly well*” in terms of direction and delegation interactions. “*We need to keep the pressure on though especially around communication, assessment and leadership*”. Hayley’s re-story was therefore captured as: ***Good communication is all.***

Agent 29: Gail

Gail had worked as a Registered Nurse both in New Zealand and Australia. She returned to New Zealand and was now working in a High Dependency Unit (HDU). Gail was a bubbly, humorous and experienced nurse with a wealth of knowledge about the need for good communication and assessment when working with Enrolled Nurses. Gail described the importance of negotiation and checking in with each other, and also supporting Enrolled Nurses to have their skills and strengths valued. Gail’s re-story was entitled: ***They were just considered part of the staff***, which acknowledged the difference Gail had observed between how Enrolled Nurses were accepted as part of the team in Australia, compared to her perception of how they worked in New Zealand.

Agent 30: Jill

Jill was an experienced Registered Nurse both in New Zealand and in the United Kingdom. Throughout the interview she attempted to provide a balanced assessment of any situation she described. Currently, Jill worked in a busy outreach clinic. She started our interview off by sharing with me that she had worked with Enrolled Nurses both in Canterbury and in Auckland and had found them to be knowledgeable and helpful and believed there was definitely a place for Enrolled Nurses in the New Zealand health system. Jill had good experiences with the experienced Enrolled Nurses she had worked with and it was this that had motivated her to be part of the study. Jill’s re-story simply entitled: ***Re-story for Jill*** captures a number of stories she shares about the role of personality and her past understanding of delegation.

Agent 31: Sandy

Sandy had nursed in a variety of medical wards within Canterbury and had accumulated approximately 15 years’ nursing experience. She clearly had a passion for nursing and nursing education. She had worked in a number of non-nursing roles in the health system before coming into nursing as a mature student and it had been that experience that had shaped Sandy’s interest in how direction and delegation worked as she had been on the receiving end of it as a hospital aide. Sandy was concerned about the lack of access to

information about direction and delegation. She pointed out that you could access pamphlets, posters, flow charts and guidelines and she had done so whenever possible. However, these concepts also needed to be brought to life through question and answer opportunities and in forums where Enrolled and Registered Nurses could discuss the issues together. She had developed a technique to support good delegation interactions and felt that for delegation to go well nurses needed to prepare for the shift together. Sandy's re-story highlighted this need for planning as: *Setting up the shift and checking in*, and summed up the importance she placed on planning and preparation when Enrolled and Registered Nurses worked together.

Agent 32: Ginny

Ginny was an extremely experienced Registered Nurse who had worked in New Zealand and Australia. Her nursing background was predominantly acute hospital settings. Her Australian and New Zealand stories explored how and why people react in different situations in the way they do and how this affects the way we communicate during delegation interactions. Ginny's experience had shown her that the way people are talked to, has a great impact on the way they hear the message. She was also able to describe how some people react in certain ways because of a sort of "anxiety" they may bring to the relationship, and as expert communicators this also needs to be taken into consideration during delegation interactions. Ginny's stories led to the title of her re-story as: *The nurse as expert communicator*.

Agent 33: Valerie

Valerie came to the interview well organised and prepared with notes and all her paper work completed. At the beginning of the interview Valerie stated that she had offered to participate in the study because: "*getting communication right was an important part of the nursing role and not everyone achieved this*". Valerie believed there was little information available about direction and delegation or professional communication in her workplace in the medical unit where she worked, and access to courses on delegation were non-existent. This made it difficult to know how best to interact with the newly emerging Enrolled Nurse students and graduates. It was possible that Enrolled Nurses could be employed in the medical surgical ward attached to the outreach clinic in the future. If this happened then knowing about the changes to the Enrolled Nurse Scope of Practice and what this meant for Registered Nurses, the new level, and how to be in successful and safe direction and delegation relationships then became important. But it was "*almost as if Registered Nurses had to learn this by osmosis!*" She used this interesting term twice in order to make the point that she felt nurses were required to find and absorb this information themselves. *Learning delegation by osmosis* then became the title of her re-story.

Agent 34: Gloria

Gloria was a relatively new Registered Nurse who had trained in Canterbury three years earlier. She had acquired a lot of experience of working with Enrolled Nurses over her three years as she was often asked to go and work in other areas of the hospital, and she had therefore seen a lot of Enrolled and Registered Nurses working together. However, she described herself as less “experienced.” In her travels between wards she had seen a lot of Enrolled and Registered Nurses working together. She was a fair and balanced person and wanted to make sure I understood that this interview was based on her own experiences and that other nurses might have a different perspective. Gloria’s stories relate to a number of acute nursing settings in one of the hospitals in Canterbury. Gloria’s re-story: ***Were all in this together***, highlighted the importance she placed on the need for Enrolled Nurses and Registered Nurses to work together.

Appendix D



Invitation Letter:

Title: 'An exploration of Enrolled and Registered Nurses' perceptions of the direction and delegation relationship in nursing practice'.

Dear colleague,

My name is Margaret Hughes and I am a doctoral candidate in the Health Sciences Centre, Canterbury University. I am conducting a research study as part of the requirements of my doctoral studies and I would like to invite you to participate. I am studying Enrolled and Registered Nurses perceptions of the direction and delegation relationships they have been involved in, in clinical practice settings. In particular, I would like to know about the direction and delegation interactions you have had, what skills you believe nurses need when they are involved in direction and delegation interactions, and the guidance and support you believe nurses need to ensure effective direction and delegation occurs. If you decide to participate, the meeting will take place at a time and place agreeable to you in 2013, and should last about one to two hours.

If you:

- Are a Registered or Enrolled Nurse living and working in the Canterbury region
- Hold a current practicing certificate and are registered with the Nursing Council New Zealand,
- Are or have been involved in direction and delegation relationships
- Are keen to share your valuable first hand experiences, perceptions and perspective around direction and delegation interactions

Please contact me at the phone numbers or email addresses listed below and I will send you an Information Sheet.

Enrolled and Registered nurses will benefit from the outcome of this study, as we will gain valuable knowledge about the skills and knowledge and guidance *nurses* believe are important when involved in direction and delegation relationships. Currently, this information does not exist, so it is nursing's opportunity to share their experiences and perceptions about direction and delegation

The results of the study may be published or presented at professional meetings, but your identity will not be revealed. Taking part in the study is your decision and participation is confidential

I will be happy to answer any questions you have about the study. You may contact me at 03 940 8044 or 0210705472 or Margaret.hughes@pg.canterbury.ac.nz or Margaret.hughes@cpit.ac.nz if you have any research study related questions or problems. If you have any questions about your rights as a research participant, you may contact the Research Ethics Office 03 364 2390 or human-ethcis@canterbury.ac.nz.

Thank you for your consideration to be involved in this research study into the professional obligation of direction and delegation.

With kind regards,
Margaret Hughes
03 940 8044 or 0210705472

Margaret.hughes@cpit.ac.nz
Margaret.hughes@pg.canterbury.ac.nz

Appendix E

Margaret.hughes@pg.canterbury.ac.nz

Margaret.hughes@cpit.ac.nz

Phone: 03 940 8044



Information sheet for the research project ‘An exploration of Enrolled and Registered nurses’ perceptions of the direction and delegation relationship in nursing practice’

What is the research all about?

My name is Margaret Hughes and I am a senior lecturer in nursing at Christchurch Polytechnic Institute of Technology. I am currently undertaking a research study at the University of Canterbury for my doctoral studies. I am interested in how Enrolled and Registered nurses communicate with each other during the direction and delegation relationship. This research study investigates the perceptions of Enrolled and Registered nurses about delegation direction interactions in nursing practice in order to answer the research question: How do Enrolled and Registered nurses communicate with each other during the direction and delegation interaction?

What will the research project look like?

I would like to invite you to participate in the research study and if you agree to be part of the study you will be asked to do the following:

- Be involved in a face to face interview with me as the researcher. This will take approximately one to two hours.
- There will also be a follow up session for you to check the accuracy of what I captured in the interview. This may take 30 minutes or as long as you need it to take.
- After the interview if you feel you would like more information about direction and delegation interactions, or any topic that has been highlighted for you from the interview this will be provided to you.

My commitment to you

As a participant in this research study you have a number of rights. My commitment, as the researcher, to you is to ensure you that your rights will be respected and supported. Your participation in the interview is appreciated and is of course voluntary. You may withdraw yourself and your information at any time. If you do participate, you have the right to withdraw at any time without any penalty. If you withdraw I will do my best to remove any information relating to you, providing this is practically achievable. I am happy to provide a report on the study after its completion. If you would like a report can you please indicate this on the consent form attached and where you would like this posted/electronically delivered to?

Anonymity

If you agree to be part of the study you and the organisation(s) you work within will have your identity safeguarded and only the researcher will know your identity. You will be known only by a pseudonym of your choosing and your name and the name of their organisation(s) will not be used. Your designation will be known as

“R.N” or “E.N” as this is one of the aspects of the research study. That is, accessing the perceptions R.Ns *and* E.Ns.

Confidentiality

The information shared will be kept private and safe. Any information, transcripts, raw data, interview schedules will be stored in locked file cabinets or in a password protected computer system. Back up data will also be password protected and you will not be identified in any case. The data and information will be stored for seven years and destroyed in a secure manner using the security systems at C.P.I.T. Permission for this had been obtained. Data will be transcribed by a reputable transcription firm used and recommended by Canterbury University and a separate confidentiality form will be required from that firm.

The complaints process

If you have any questions you can contact me as the researcher. The research project has received ethical approval from the University of Canterbury Human Ethics Committee. If you have any complains about the research study or the process of the research you can contact the Chair, Human Ethics Committee, 03 364 2390, University of Canterbury, Private Bag 4800, Christchurch or human-ethcis@canterbury.ac.nz.

What will you get out of the research?

- This research study will be beneficial to Registered Nurses who are required to direct and delegate and Enrolled Nurses who are required to be directed and delegated to. Nursing management involved and responsible for the selection of nursing skill mix, models of care and rostering requirements.
- Team Leaders responsible for leading teams of nurses and non-regulated staff
- Nurse Educators responsible for preparing nurses for future employment will also benefit from the outcome of the study.
- In addition to this, gaining clarity around who is accountable and when, will ensure that the client/consumer’s journey is safe.

Why have you been approached?

You have been approached because you are a Registered or Enrolled Nurse with a current registration working in New Zealand in a hospital or community setting. Enrolled and Registered nurses each have a Scope of Practice which means they may be required to use, or are currently using direction and delegation interactions. In addition, you are involved in direction and delegation interactions.

How disruptive will this be to you?

The interviews will be approximately two hours and can take place at a time and place of your choosing. There is one main question with some suggestions to guide you if you need extra help or information. These will be provided to you before the interview.

What will I do with the findings?

The concepts and ideas that are identified in the research study will be used to support nurses who may need information about direction and delegation. The results, findings and themes I find in the course of the research study will be used to write a PhD thesis and publish articles in nursing journals. There may also be opportunities for conference presentations about nurse’s perceptions of direction and delegation.

What does this research mean to me as the researcher?

This research study is important to me as the interviewer and researcher because the interviews are part of my commitment towards a PhD thesis. However, I also believe that “getting direction and delegation interactions right” will contribute to positive and safe working environments, good communication practices and a safer journey for the client/consumer. If you agree to be part of the research study can you fill out the consent form attached? This can be returned to Margaret Hughes, Senior Lecturer, C/- CPIT, PO Box 540, Christchurch, 8140.

Yours sincerely

Margaret Hughes

Appendix F



Consent Form

Title: 'An exploration of Enrolled and Registered Nurses' perceptions of the direction and ~~ucicgauru~~ relationship in nursing practice'

Researchers' name and designation: Margaret Hughes, Registered Nurse, Christchurch Polytechnic Institute of Technology, Christchurch

I have been given an explanation of the research study and my part in it, to my satisfaction. I have been offered an opportunity to ask questions. I understand that my participation is voluntary and that I can withdraw my information at any time without having to give any reason for this withdrawal. I can also refuse to take part in the research. This of course will incur no penalty of any sort. I also understand that my identity and the information that I share will be kept private.

I understand what is required of me, that is, to be involved in an interview. I understand that interview material will be kept in locked cabinets and in pass word protected electronic storage sites. I also understand that my identity will be kept private and confidentiality of the information I share will be maintained. Any material published by the researcher will not identify me or my place of work.

I understand that I can ask questions of the researcher or her supervisors at any time and I have her contact details and the contact details of the supervisors. I also understand that I can make a complaint if I am not happy with the research process and I have the contact details if needed.

I have read the information sheet provided. I agree to take part in this research. In my opinion I have given informed consent and with an understanding of the research study.

Date _____

Name in full and signature _____

I would like a copy of the report of the research study. This is the address that I would like this sent to or an email is: _____

Address of the researcher

Margaret Hughes
Christchurch Polytechnic Institute of Technology
P.O. Box 540
Christchurch 8140
Ph: 03 940 8044 or 0210705472
Margaret.hughes@pg.canterbury.ac.nz or Margaret.hughes@cpit.ac.nz

Address of the supervisors

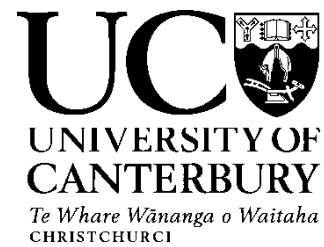
Dr Ray Kirk, Associate Professor and Senior Lecturer, Health Sciences and Director Health Sciences Centre, University of Canterbury, Private Bag, Christchurch Ray.kirk@canterbury.ac.nz

Dr Lesley Seaton, Principle Academic lecturer (PASM), Department of Nursing & Human Services, Christchurch Polytechnic Institute of Technology (CPIT) PO Box 540, Madras Street, Christchurch, 8140
Lesley.Seaton@cpit.ac.nz

Address of Ethics Committee

The Chair: University of Canterbury, Private Bag 4800, Christchurch
Human Ethics Committee human-ethics@canterbury.ac.nz
Ph: 03 3642390

Appendix G



Margaret.hughes@pg.canterbury.ac.nz

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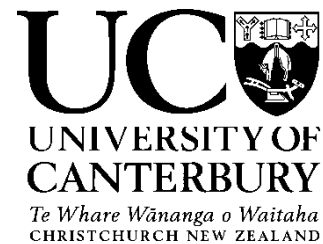
Phone: 03 940 8044

Question for Registered Nurses

Can you tell me about your recollections of the direction and delegation interactions you have been *Before you come to the interview you might like to consider some of the following ideas when you a your story. You do not need to cover all the questions and ideas listed here as this is your story. Please feel free to write on/beside the questions, or ask me for clarification.*

- How did you learn about direction and delegation? (Did you read anything or attend any meetings, study days or watch a DVD to help you understand?).
- What else do you think needs in be in place for you to learn how to be involved in effective direction and delegation interactions? (What sort of environment needs to be in place for you to learn this? What are you preferences for leaning about direction and delegation relationships?)
- Tell me what a positive, professional or satisfying direction and delegation experience would look like or feel like to you?
- Can you give me some examples of when direction and delegation went well and was positive, professional or satisfying? (Describe what the nurse said, how they said it and what the non-verbal communication was. How did the communication you had affect the outcome?)
- Tell me what a worrying or unsatisfying direction and delegation interaction would look like or feel like to you?
- Can you give some examples of when direction and delegation didn't go well and felt unsatisfying or worrying to you? (Describe what the nurse said, how they said it and what the non-verbal communication was. How did the communication you had affect the outcome?)
- What skills and knowledge do you think Registered Nurses need in order to direct and delegate effectively? (Do you believe other Registered Nurses you have worked with have those skills and that knowledge?)
- What skills and knowledge do you think Enrolled Nurses need to be able to accept a directed and delegated task or skill safely and effectively? (Do you believe the Enrolled Nurses you have worked with have those skills and that knowledge?)
- What communication, assessment or leadership skills do nurses need when using delegation interactions? (Do you believe you have those skills?)
- What are your preferences when having a task delegated to you or delegating a task to someone? How do you/do you make your preferences known?
- As a Registered Nurse, do you make an assessment of the Enrolled Nurse's skills and knowledge, confidence level and experience before you delegate or direct a task?(Do you ask them about their Scope of Practice? Please describe the questions you would ask)
- What sort of information support or guidance have you had around direction and delegation interactions? Was this sufficient in your opinion?

- What sort of information support or guidance *would you like* to support your direction and delegation interactions?
- Can you think of any hidden, invisible, taken-for-granted or unspoken rules around direction and delegation practices or accountability and responsibility? (What did you “just know” about direction and delegation and the ‘how to’ of it?)
- What personal factors facilitate or hinder positive direction and delegation interactions? (for example, respect, partnership, trust, leadership styles)
- What organisational factors facilitate or hinder positive direction and delegation interactions? (for example, learning support, information supplied, skill mix, models of care)



Margaret.hughes@pg.canterbury.ac.nz
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Phone: 03 940 8044

Question for Enrolled Nurses

Can you tell me about your recollections of the direction and delegation interactions you have been involved in *Before you come to the interview you might like to consider some of the following ideas when you are telling me your story. You do not need to cover all the questions and ideas listed here as this is your story. Please feel free to write beside/on the questions, or ask me for clarification.*

- How did you learn about direction and delegation? (Did you read anything or attend any meetings, study days or watch a DVD to help you understand?).
- What else do you think needs to be in place for you to learn how to be involved in effective direction and delegation interactions? (What sort of environment needs to be in place for you to learn this? What are your preferences for learning about direction and delegation relationships?)
- Tell me what a positive, professional or satisfying direction and delegation experience would look like or feel like to you?
- Can you give me some examples of when direction and delegation went well and was positive, professional or satisfying? (Describe what the nurse said, how they said it and what the non-verbal communication was. How did the communication you had affect the outcome?)
- Tell me what a worrying or unsatisfying direction and delegation interaction would look like or feel like to you?
- Can you give some examples of when direction and delegation didn't go well and felt unsatisfying or worrying to you? (Describe what the nurse said, how they said it and what the non-verbal communication was. How did the communication you had affect the outcome?)
- What skills and knowledge do you think Registered Nurses need in order to direct and delegate effectively? (Do you believe the Registered Nurses you have worked with have those skills and that knowledge?)
- What skills and knowledge do you think Enrolled Nurses need to be able to accept a directed and delegated task or skill safely and effectively? (Do you believe other Enrolled Nurses you have worked with have those skills and that knowledge?)
- What communication, assessment or leadership skills do nurses need when using delegation interactions? (Do you believe you have those skills?)
- What are your preferences when having a task delegated to you or delegating a task to someone? How do you/do you make your preferences known?
- As an Enrolled Nurse, do you make your concerns known to the Registered Nurse if you have concerns about the directed and delegated task you have been asked to do? (Why? Why not?)
- How confident are you to say "no" to a delegated task? (Can you give an example?)

- What sort of information support or guidance *have you had* around direction and delegation interactions? Was this sufficient in your opinion?
- What sort of information support or guidance *would you like* to support your direction and delegation interactions?
- Can you think of any hidden, invisible, taken-for-granted or unspoken rules around direction and delegation practices or accountability and responsibility? (What did you “just know” about direction and delegation and the ‘how to’ of it?)
- What personal factors facilitate or hinder positive direction and delegation interactions? (for example, respect, partnership, trust, leadership styles)
- What organisational factors facilitate or hinder positive direction and delegation interactions? (for example, learning support, information supplied, skill mix, models of care)

Appendix H

Data analysis framework: Burke's adapted framework Script no: _____

<p><u>PART ONE</u> - -Data transcription and the Summary Contact Sheet.</p>			
<p>My initial thoughts/findings from the audio tape</p>			
<p>My initial thoughts/findings from the transcribed data</p>			
<p>Artefacts: notes, policy, photos, certificates offered in the interview</p>			
<p><u>PART TWO</u> - Re-story the story(s) from the interview.</p>	<p>Develop story based on the transcript, audio taped interview, artefacts.</p> <p>Send back to nurse-Agent with interim working title discussed in interview and/or ask for a suggested title</p> <p>Follow up with email and/ or phone call to check that each nurse Agent satisfied with the portrayal and interpretation of their stories, and the content and title of re-story.</p> <p>Make any changes as suggested and/or incorporate concerns</p>		

<p><u>PART THREE</u>– Develop the Script through Act, attitude, Agent, scene, agency, and purpose</p>			
<p>Act</p>	<p>The purposeful action that represents our attitudes.</p> <p>What took place in thought and deed?</p> <p>Identifies the reasons for ‘Acting’</p>		
<p>Attitude</p>	<p>The precursor to the Act Asks how does the Agent prepare for the Act?</p> <p><i>How</i> are things said? Including emphasis/repeated words or sentences. Capture word chosen that emphasise purpose or why. (See Riessman 1993 p19 for (Hyden 1992 and Burke 1945).</p> <p>Compare and contrast choice of words/topics/views/language</p>		
<p>Agent</p>	<p>The person or group of people that perform the Act. NB. Organisations can also be Agents.</p> <p>What person or kind of person carried out the act?</p> <p><i>Sociality: Clandinin and Connelly’s 3 dimensional framework personal, social and professional</i></p>		
<p>Scene /context</p>	<p>The place where the Act or action occurs. Not just physical but also contextual, occasion, event and time.</p>		

	<p>The background of the act/the situation in which it occurred.</p> <p>Situation and place: <i>Clandinin and Connelly's 3 dimensional framework situation and place</i></p>		
Agency	<p>The technique or method by which the Agent changes or achieves their goals. May be a sequence of Acts encompassed by a principle or idea.</p> <p>The means or instruments used.</p>		
Purpose	<p>The reason why the Agent Acts, and why the Act was done this way.</p> <p>What is the outcome they are seeking from what they do?</p> <p>Maybe be covert and hidden. Maybe layered and distracting, an apparent good purpose may cloak a selfish move.</p> <p><i>Include motives as they are the moving force.</i></p>		
Temporality – past, present and future	<p>Clandinin and Connelly's 3 dimensional framework - past, present and future - temporality.</p>		
Sociality: How do the cultural, social and political influences shape the lived experience?	<p>Include feelings, dilemmas, hopes, desires and understanding of local knowledge.</p>	<p><i>Interpretation of motivation to act</i> based on the act-scene-agent-agency-purpose, attitudes.</p>	<p>Why does the nurse Agent act/speak/not speak/not act</p>
<p>PART FOUR- Developing the narrative Script for each Agent: Identify patterns <i>across and between</i> the stories</p>	<p>Identify the '<i>group</i>' of nurse eg EN or RN experienced or less experienced the <i>level</i> eg Level 4 or 5 and the role adopted.</p>		

<p>told within each narrative</p> <p>Script for shared understandings</p>	<p>Including:</p> <p><i>Clandinin and Connelly's 3 dimensional framework -past, present and future (temporality).</i></p> <p><i>Clandinin and Connelly's 3 dimensional framework - situation and place</i></p> <p><i>Clandinin and Connelly's 3 dimensional framework - personal, professional and social</i></p>		
<p>PART FIVE –</p> <p>Developing the narrative script for each nurse Agent</p> <p>Identify individual approaches to direction and delegation as patterns <i>within</i> each narrative script for personal and professional stories</p>	<p>Identify any unique perspectives and personal and professional stories</p> <p>Identify Agency</p> <p>Including:</p> <p><i>Clandinin and Connelly's 3 dimensional framework -past, present and future temporality.</i></p> <p><i>Clandinin and Connelly's 3 dimensional framework - situation and place</i></p> <p><i>Clandinin and Connelly's 3 dimensional framework - personal, professional and social</i></p>		
<p>Skeleton plot for this script</p>	<p>Identify the narrative plot.</p>	<p>The narrative plot of</p>	

Appendix I

University of Canterbury Human Ethics Committee Letter of Approval



HUMAN ETHICS COMMITTEE

Secretary, Lynda Griffioen
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2012/171

10 December 2012

Margaret Hughes
Health Sciences Centre
UNIVERSITY OF CANTERBURY

Dear Margaret

The Human Ethics Committee advises that your research proposal "An exploration of registered and enrolled nurses' perceptions of the delegation and direction relationship in nursing practice" has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 6 December 2012.

Please confirm that the telephone number on forms for participants is your office telephone number. If not, please remove personal landline telephone number and replace with either a CPIT telephone number or mobile telephone number.

Best wishes for your project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'L. MacDonald'.

Lindsey MacDonald
Chair
University of Canterbury Human Ethics Committee

Appendix J

Appendix J gathers together the nurses preferred communication strategies, skills and attributes to support safe and effective direction and delegation interactions

Enrolled Nurse Agents found that the following communication strategies, skills and attributes supported safe and effective direction and delegation	
Treating people fairly Enrolled Nurses who were honest about their abilities Having a good work ethic Getting along with others Being confident and competent	Dianne
Honest and “ <i>straight up</i> ” communication Not “ <i>lording it over</i> ” other nurses Tact and kindness Registered Nurses that could “ <i>decode</i> ” what the Enrolled Nurse was saying Working in partnership	Jody
Being open and empathetic A Registered Nurse who listened to the Enrolled Nurse and respects their contribution, encourages two way communication Could teach the other nurse Provide a leadership role	Melanie
Good team work Registered Nurses who could share their knowledge Leading by example Being valued for their Enrolled Nurse contribution Clear, succinct and concise interactions Enrolled Nurses who were ready to learn	Annabelle
Common courtesy Tact and diplomacy Mindful of the way a thing was said and how humour was used	Maryanne
Access to good leadership that was flexible Nurse leaders who listened to the nursing staff Being open Being receptive Being fair and equal with the workload allocation	Lynda
Negotiation, and “ <i>dialogue</i> ” Being fair and equitable Establishing trust A Registered Nurse who listens	Judith
A Registered Nurse who plans the shift with the Enrolled Nurse A non-hierarchical approach Being included in the discussion prior to allocation Being acknowledged for their contribution	Trudy
Being listened to Being accepted as part of the team Working with Registered Nurses who understood the Enrolled Nurse Scope of Practice Being able to use their assessment skills Being included in the decision making for their patients Valuing the clinical experience that the other nurse has	Sally and Eloise
Registered Nurses who were supportive, approachable and non-judgemental Having empathy	Davinia
Registered Nurses who can play a leadership role Understanding the role of personality Being aware of the tone used and choice of words A ‘soft’ delivery Listening to the other person	Julie
Being listened to/two way discussion A Registered Nurse who could give clear instructions and a time frame, and provide a rationale for their decisions Being respected Having your knowledge and experience valued	Katie

Registered Nurses who knew the skills of the team members and used those strengths within the team Enrolled Nurses who were honest about their abilities and understood their Scope of Practice	
A Registered Nurse who could assess right across the shift and provide leadership of the team A Registered Nurse who could assess the Enrolled Nurse abilities respectfully (mindful of tone and manner) Being polite and respectful Enrolled Nurse who spoke up if not feeling safe to do at task or skill A Registered Nurse who could say “thank you” at the end of a shift and give positive feedback when it was due Being aware of the ‘welcome’ nurses receive A Registered Nurse who could assess the skills of the team and use them to advantage	Dallas
A Registered Nurse who understood that the Enrolled Nurse needed to be able to self-assess before accepting a delegated task, and had a responsibility to decline to do a task if they felt it was unsafe. Being aware of the ‘welcome’ nurses received coming on to the ward Negotiation and discussion Respecting each other Scope of Practice Enrolled Nurses who could be polite but assertive and able to say “no” to a delegated task Having access to nurses who can teach and share their knowledge	Barbara
An egalitarian, fair approach between nurses Having a balanced view Being respectful Being mindful of the ways things were said Understanding there were a number of sides to any story Registered Nurses who could lead the shift	Karl
Being respectful and polite Using negotiation Being collaborative Common courtesy Respecting the Registered Nurses knowledge and experience	Elaine
Allowing the other nurse to “ <i>save face</i> ” Being respectful A Registered Nurse who listens A Registered Nurse who understood the delegation role	Alison
Being respectful A Registered Nurse who knew about the Enrolled Nurse Scope of Practice A Registered Nurse who knew about direction and delegation A Registered Nurse who could led the shift	Amy

Registered Nurse Agents found that the following communication strategies, skills and attributes supported safe and effective direction and delegation	
Access to relevant easily accessible information to identify the different levels, roles and responsibilities, and Scope of Practice Understanding who is accountable, responsible and answerable, and for what	Barb
Valuing the other nurse Including the Enrolled Nurse as part of the team Open communication Being fair Dealing swiftly with disrespectful communication Acknowledging the role that personality can play Leadership	Hayley
Understand <i>why</i> the other nurse might be saying what they saying, or doing what they are doing Monitoring how something was said Listening well Being non-judgmental Being polite Being a role model for good communication Understanding that nurses might be anxious about working within a delegation model	Ginny
Listening well Accepting the Enrolled Nurse Being consultative and collaborative Having empathy Clear communication Work as a team Valuing and respecting the experience of the Enrolled Nurse <i>Managing</i> the change that working with an Enrolled Nurse might bring Access to accessible information about the Enrolled Nurse role Nurses who could lead a team	Valerie
<i>“Creating lieutenants”</i> Working in partnership Working as a team Being empathetic and kind Supporting people’s mana Having faith in people abilities Sharing knowledge with others	Bronwyn
Making time for the Enrolled Nurse Making the Enrolled Nurse feel part of the team Being contactable Being in-tune and sensitive to what the Enrolled Nurse is saying Examining how you say something Working around people’s personalities/acknowledging the role of personality Working in partnership and playing to the nurse strengths Reading body language and facial expressions Stamping out <i>“second class citizen”</i> thinking	Ellen and Eleanor
Being polite Professional and pleasant communication Finding information about the direction and delegation role Avoiding conflict	Milena
Carrying out a <i>“mini assessment”</i> of the Enrolled Nurse Having a plan of care and discussing the plan with the Enrolled Nurse Using a template (grid) to guide the tasks completed/yet to do/managing potential missed cares/decreasing the need for micro-management Encouraging the Enrolled Nurse to self-assess Providing a safe, supportive environment Teaching, helping and guiding other nurses	Gail
Assessing the Enrolled Nurse’s skills and abilities, levels and experience, and the patient’s progress notes Providing leadership Expecting competencies to be developed by the employing organisation <i>“Being there”</i> and <i>“being available”</i> to nurses Listening well	Susan

<p>A pleasant and respectful manner Valuing and respecting the Enrolled Nurse's skills, experience and knowledge Common courtesy, good manners and an inclusive approach</p>	
<p>Role modelling required communication skills Using the DEU to role model required communication Politeness, good manners, respect and kindness Clarity around what the Registered Nurse was asking "Two way" trust Encouraging "conversations" A Registered Nurse who is clear as to why they were asking the Enrolled Nurse to do a task Working as a team with the patient at the centre of the process</p>	Miriam
<p>Knowing the Enrolled Nurse Scope of Practice and competencies Knowing how to delegate Being open, honest and ready to learn from others Mindful of the way a task was asked "Checking in" with the Enrolled Nurse Supporting negotiation and discussion with each other Generous, kind and polite Letting people "save face" Being aware of different learning styles Being aware not to expect too much of new nurses Treating people as you want to be treated</p>	Harry
<p>Supporting the Enrolled Nurse to say "no" to a delegated task and being listened to and respected when they did Asking for a task to be done in a kindly manner Open communication Being polite Really listening Being flexible and willing to change the plan and keeping an open mind if you need to "re-delegate"</p>	Jill
<p>Planning and preparing at the start of a shift/being organised at the start of shift Negotiating Having a common goal for the shift Assessing the Enrolled Nurse's experience <i>Not</i> commanding, finger pointing or instructing Doing a "mini assessment" Working as a team Using an "inquiry method" to find out information from the Enrolled Nurses Knowing each Scope of Practice Establishing trust Checking in Enrolled Nurses who are approachable</p>	Sandy
<p>Assessing the Enrolled Nurse Monitoring the tone you use Role modelling required communication interactions Taking a leadership role Dealing with poor communication Having access to "local area policy"</p>	Janine
<p>Team nursing as opposed to primary nursing Working <i>as</i> a team and <i>in</i> a team Having a blend of team and primary nursing models Enrolled Nurses having access to a certification model</p>	Jocelyn
<p>Honesty, kindness and getting along with others Working together Registered Nurses who were able to share their knowledge Being polite Being aware of the tone used Being sure the Enrolled Nurse is capable of what is being asked of them Being specific and clear when requesting tasks Being approachable Be prepared for feedback Nurses need time to make delegation work</p>	Gloria

Appendix K

Example of a tool to support Enrolled and Registered Nurse collaboration, communication, team work, working together and time management

Gail described using a grid for task completion of team workload with the patient names down one side and 'tasks' across the top and were designed so the Registered and Enrolled Nurse would put in the relevant nursing tasks together. This wasn't only a Registered Nurses task and the Enrolled Nurse could contribute to planning the nursing care too. The grid helped to manage time and to manage potential risks because time was almost 'automatically managed' within the plan (grid) and therefore tasks did not go 'undone'. Gail kindly got back to me after the interview with this grid to illustrate how it was used.

	0700	0800	0900	1000	1100	1200	1300	1400
John Smith		M		PAC	BSL	M	PAC	
Rob Light	IVT	IVT	IVT	IVT	IVT	IVT	IVT	IVT
Wendy Hill		M/IVAB		PAC	BSL		PAC	
Bob Kind		M			u/s	M	Dressing	

(Grid supplied by email from 'Gail' February 2014)