Received: 25 September 2023 | Revised: 7 March 2024 | Accepted: 11 March 2024

DOI: 10.1111/jocn.17127

Journal of Clinical Nursing WILEY

EMPIRICAL RESEARCH MIXED METHODS

Factors impacting nursing assistants to accept a delegation in the acute care settings: A mixed method study

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Funding information
Western Australian Nurses Memorial Trust

Abstract

Aims: To investigate the experience of nursing assistants being delegated nursing tasks by registered nurses.

Design: Mixed method explanatory sequential design.

Methods: A total of 79 nursing assistants working in an acute hospital in Australia completed surveys that aimed to identify their experience of working with nurses and the activities they were delegated. The survey data were analysed using descriptive statistics. Interviews with 11 nursing assistants were conducted and analysed using Braun and Clarke's thematic analysis. Results were triangulated to provide a richer understanding of the phenomena.

Results: Most nursing assistants felt supported completing delegated care activities. However, there was confusion around their scope of practice, some felt overworked and believed that they did not have the right to refuse a delegation. Factors impacting the nursing assistant's decision to accept a delegation included the attitude of the nurses, wanting to be part of the team and the culture of the ward. Nursing assistants who were studying to be nurses felt more supported than those who were not.

Conclusions: Delegation is a two-way relationship and both parties need to be cognisant of their roles and responsibilities to ensure safe and effective nursing care is provided. Incorrectly accepting or refusing delegated activities may impact patient safety.

Implications for the profession and/or patient care: Highlights the need for implementing strategies to support safe delegation practices between the registered and unregulated workforce to promote patient safety.

Impact:

- Describes the experiences of nursing assistants working in the acute care environment when accepting delegated care from nurses.
- Reports a range of factors that inhibit or facilitate effective delegation practices between nurses and nursing assistants.

- Provides evidence to support the need for stronger education and policy development regarding delegation practices between nurses and unregulated staff.

Reporting method: Complied with the APA Style JARS-MIXED reporting criteria for mixed method research.

Patient or public contribution: No patient or public contribution.

KEYWORDS
acute care, assistant in nursing, decision-making, delegation, healthcare assistants, mixed methods, nurse, nursing assistant registered nurse, unregulated healthcare worker, workforce

1 | INTRODUCTION

Factors such as an ageing nursing workforce, nursing shortages, changes to nurses' scope of practice and efforts to reduce healthcare spending resulted in a change to the way nursing care was delivered (Crevacore, Jacob, et al., 2022). Globally, the increased use of the nursing assistant workforce has been adopted to address some of these issues. In Australia, over the past decade, there has been a significant increase in the use of nursing assistants, with over 95,500 currently employed, and 5-year growth rates expected to be more than 9.5% (Department of Employment, 2023). Similarly in the United States of America (USA), an average of 220,000 openings for nursing assistants is projected each year over the next decade (Bureau of Labor Statistics – U.S. Department of Labor, 2023). Across Europe, there has been an increase in the assistant workforce in many countries including the United Kingdom (UK), Germany and Romania, however, some countries, such as Estonia and Lithuania, recorded a reduction in the number of nursing assistants in the hospital setting (Eurostat, 2023). There are multiple terms used to describe this workforce, however, for this paper, the term nursing assistant will be used.

What does this paper contribute to the wider global community?

- Explores the experience of nursing assistants when being delegated to by registered nurses.
- Suggests mechanisms to improve teamwork between the registered nurse and the nursing assistant in the acute care environment.

2 | BACKGROUND

Nursing Assistants are employed in a variety of clinical environments including metropolitan, rural and remote settings. Traditionally, nursing assistants have worked in the disability and residential aged care sectors here and internationally (Australian Institute of Health and Welfare, 2020). Today, nursing assistants are employed in a variety of clinical environments including metropolitan, rural and remote settings. Importantly, they work in a wide range of acute care settings where they can be found in almost all clinical environments including paediatric intensive care units (Rodríguez-Rey et al., 2019), emergency departments (Yuzeng & Hui, 2020) and operating theatres (Perioperative Care Collaborative, 2015).

A range of activities are undertaken by the nursing assistants depending upon their work environment and they can be engaged in both direct and indirect patient care (Blay & Roche, 2020; Crevacore, Jacob, et al., 2022).

Indirect patient care includes clerical activities, such as transportation of specimens, reports and requisitions within departments and cleaning activities such as making beds and maintaining the ward environment (Bureau of Labor Statistics – U.S. Department of Labor, 2023; Government of Western Australia, 2022). Direct care includes monitoring and recording patient observations, showering, dressing of wounds, last offices and assessing and monitoring health of clients (Blay & Roche, 2020; Crevacore, Coventry, et al., 2022).

Many of the activities that are delegated to the nursing assistant have traditionally been the role of registered nurses. There has been little progress made in identifying those activities which are 'nursing activities' and those which are not. The evidence suggests that the boundaries between nursing and nursing assistant activities are very blurred (Blay & Roche, 2020; Kessler et al., 2015; Maben & Griffiths, 2008) causing confusion for both the registered nurse in what they are able to delegate, and for the nursing assistant, in what they should accept as a delegation (Havaei et al., 2019).

Nursing Assistants do not have a licence to practice nor are they regulated by any professional/government agencies with the exception of the Assistant Practitioner in the UK (Royal College of Nursing UK, 2021). As a consequence, these workers do not have a regulated scope of practice, protected title, compulsory education requirements or professional practice standards and there is no professional conduct review process (College of Nurses of Ontario, 2014; National Council of State Boards of Nursing, 2016a; Schwartz, 2019). Although employers may have a list of activities that nursing assistants are permitted to perform, there are no national practice standards. This may result in nursing assistants not understanding the activities they can complete as part of the delegation process (Schwartz, 2019).

An important aspect of the registered nurse role is to supervise the completion of patient care activities when delegated to other

staff including licensed nurses and other nursing assistants (National Council of State Boards of Nursing, 2016b; Nursing and Midwifery Council, UK, 2018; Nursing and Midwifery Board of Australia, 2016). In Australia like most other countries, delegation is the responsibility of the registered nurse (Nursing and Midwifery Board of Australia, 2016, 2020). Registered nurses need sound clinical judgement, strong critical thinking skills and excellent interpersonal skills when delegating to members of the healthcare team. Delegation decision-making becomes more critical as use of the nursing assistant role increases (Crevacore et al., 2023).

The Nursing and Midwifery Board of Australia (2020) describes delegation as a two-way relationship that exists when a registered nurse delegates care or tasks to another person including the nursing assistant. The aim of delegation is to meet patient needs by ensuring the 'right person is available at the right time to provide the right service' (NMBA, p. 12). Importantly, the delegating nurse remains accountable for the decision to delegate. They are also accountable for monitoring communication of the delegation to the relevant persons and for the practice outcomes (NMBA, 2020).

All delegatees have responsibilities when accepting a delegated activity including identifying the degree of support and teaching required for the task to be completed successfully, informing the registered nurse of the outcomes of the activity, understanding the level of feedback required within the delegation, seeking support and supervision from the registered nurse until they are competent to perform the activity independently, completing the task safely and participating in an evaluation of the delegation and its outcomes (Bryant, 2015; Haugen et al., 2019; Marquis & Huston, 2021). These 'delegatee' responsibilities in Australia are explained in the Nursing and Midwifery Board of Australia's (2020) Decision-making framework for nursing and midwifery. However, as this document is aimed specifically at registered [licensed] nurses, it is uncertain as to when or how this information is communicated to the delegatee [nursing assistant] as it is not a document that they would necessarily be aware of or read.

Recently, there has been a growing interest in examining delegation practices in the acute setting in Australia (Blay & Roche, 2020; Crevacore, Coventry, et al., 2022), the USA (Campbell et al., 2020; Wagner, 2018) and Jordan (Saqer & AbuAlRub, 2018). The focus of the literature is on the registered nurse experience, and there is a lack of research regarding the experience of nursing assistants working with the registered nurse in the acute care environment and acceptance of delegated activities. It is imperative that we understand the impact delegation practices have on the assistant in nursing and how best to support all staff involved in the process to ensure safe care provision.

3 | THE STUDY

This study aims to explore the experience of nursing assistants working in the acute care environment and the factors that impact their decision to accept or reject a delegated activity while providing patient care. The objectives of this research were to

- Identify the factors that the nursing assistant considers when accepting or refusing a delegation from the registered nurse in the acute care environment.
- Discover the strategies that support a nursing assistant in the acute care environment to complete a delegated activity.

4 | METHODS

4.1 | Study design

A sequential explanatory mixed methods research design was adopted to enable the researchers to fully explore the phenomena (Creswell & Plano Clark, 2011). The first quantitative phase aimed to provide a baseline understanding of the factors that impacted the decision of a nursing assistant to accept or refuse a delegation from the registered nurse and the mechanisms that were in place to support them in completing delegated activities. This phase involved the distribution of a questionnaire to nursing assistants. The second qualitative phase aimed to explore the delegation factors identified through the questionnaire in greater depth and involved individual face-to-face interviews. Data collection occurred over 4 months.

4.2 | Participants and setting—Phase one

Purposive sampling was used to collect data at a large tertiary teaching hospital in metropolitan Western Australia across six wards including medical, surgical and rehabilitation specialities between March and May 2018. Nursing assistants working morning or afternoon shifts during the study period were invited to participate by the nurse manager via email invitation or using hard copy surveys provided on the ward by the researcher. The survey was either completed online or in hard copies placed in locked collection boxes on each ward. As the survey was anonymous consent was implied if completed. This study was exploratory, and a sample size was not calculated.

4.3 | Phase one—Questionnaire

The questionnaire comprised two instruments and demographic details. The first instrument, developed by the researchers based on common themes repeated in the literature, aimed to investigate the experience of the nursing assistant receiving a delegation of nursing tasks from the registered nurse and the level of support and supervision that they received during the delegation process. Questions included areas such as how the nursing assistant knew what needed to be done during the shift (Bellury et al., 2016; FurÅker, 2008), receiving delegations from more than one registered nurse, being provided with time to complete delegated activities (Bellury et al., 2016; Potter et al., 2010) and being supported and supervised to complete the delegated activity (Huang

et al., 2011; Saccomano & Pinto-Zipp, 2011). The nursing assistant was asked to respond to the statements on a 4-point Likert scale from 'all shifts' (1), 'most shifts' (2), 'some shifts' (3) to never (4) (see Tables S1 and S2).

The second instrument was a list of 15 nursing activities detailed in the scope of practice document for the nursing assistant role in the State where this research was completed (Health Department of WA, 2018). This list included activities approved for delegation and items that were not on the approved list such as starting intravenous lines. Participants were asked to rate how often they completed the activities as delegated by the registered nurse on a 4-point Likert scale from always (1), sometimes (2), rarely (3), never (4). The final section collected demographic data including gender, age, work experience, location of work and level of education.

4.4 | Validity and reliability

Students ($n = 33$) who were studying to be acute care nursing assistants completed pilot testing of the instrument looking at face validity. We established the questionnaire was comprehensible, non-ambiguous and pertinent to the phenomena under study (Nevo, 1985). There were no suggestions made by the participants on how to improve the questionnaire, thus supporting face validity of the instrument.

To determine test–retest reliability of the instrument, a weighted Kappa using the two composite scores as outcome variables was calculated. Weighted kappa (Kw) with linear weights was completed to determine if there was an agreement between the nursing assistants judgement on day 1 and day 7 for all questions. For interpretation purposes, a Kappa (and weighted Kappa) scale was used (poor, <0.40; fair to good, 0.40–0.75; excellent, >0.75) (Fleiss et al., 2003). A total of 26 nursing assistants completed the test–retest in its entirety. Question 1 reported their experiences when registered nurses asked them to care for patients during a shift on a 4-point Likert scale (all shifts, most shifts, some shifts, never). The strength of agreement for questions 3–6 and 8 was ranked as 'excellent' and questions 1, 2, and 7 were ranked as 'fair to good' (Fleiss et al., 2003). Question 2 reported the activities a nursing assistant completed when working in the acute care environment on a 4-point Likert scale (always, sometimes, rarely, never). All activities ranked 'excellent' except for activities 1–3 [electrocardiogram, showering or bathing a patient and blood glucose monitoring] which were 'fair to good' (Fleiss et al., 2003) (see Tables S3 and S4).

4.5 | Phase one—data analysis

Descriptive statistics were used to describe nursing assistants' characteristics and the items of the questionnaires including mean and standard deviation (SD), or median and interquartile range (IQR) expressed as 25th and 75th percentile for continuous variables. Numbers and percentages were reported for categorical variables. Mann–Whitney U tests were completed to compare the demographic characteristics of the nursing assistant with the questionnaires when there were two groups and Kruskall–Wallis H tests when there were more than two groups. Following the identification of a significant difference, post hoc analysis was performed via Mann–Whitney U tests with a Bonferroni adjustment. Data were analysed using SPSS version 18. The information collected during phase one guided the development of the questions for the semi-structured interviews in phase two.

4.6 | Phase two

Nursing assistants who had responded in phase one of the study and gave consent for the researcher to make direct contact with them were invited for an interview. The nursing assistant's role and responsibilities in the delegation process were explored as well as their understanding of their scope of practice. Finally, the mechanisms registered nurses put in place to support the nursing assistant to complete their role were discussed. Seven questions served as a basis for the interviews however, each participant's answers were probed to fully explore the nursing assistant's situation regarding delegated activities from the registered nurse (see Table S5). As suggested by Polit and Beck (2013) saturation is achieved when 'a sense of closure is attained because new data yield redundant information' (p. 742). Throughout the interview process, the sample size was monitored continuously to identify when saturation occurred.

Audio recordings of each interview were made, transcribed verbatim, and then coded for de-identification purposes. Thematic analysis of the transcribed interview employed Braun and Clarke's (2006) six-step process using both an inductive and deductive approach. The analysis was completed by all four researchers. Steps one and two of the process were completed by author one. This is where the initial transcription and coding of the data were completed. The transcriptions and codes were shared with the remaining authors so that they could become familiar with the data. Steps three to six were completed together by all authors, whereby themes and subthemes were identified. Throughout the entire process where different interpretations of the data occurred, these were repeatedly discussed and re-interpreted until consensus was achieved.

4.7 | Integration of data and emergent themes

To integrate the qualitative and quantitative data, the findings are first presented separately and then merged in the discussion to provide a thorough understanding of the factors impacting the nursing assistant decision to accept or refuse a delegation from a registered nurse and the mechanisms in place to support them complete the required care. Both sets of data were reviewed to identify similarities and differences between the data. Possible causes for any inconsistencies were explored. Priority was given to the qualitative phase in

this study (Creswell & Plano Clark, 2011) as it focussed on in-depth explanations of the quantitative results obtained in phase one.

4.8 | Ethical considerations

Ethics approval was obtained from the Metropolitan Health Service (HREC: RGS0000000675) and Edith Cowan University (HREC:20129) on 1 March 2018. The researcher was not employed at the health service and had no power relationship with participants. All participants in phase one were provided with a participation information sheet. As the questionnaire was anonymous consent was implied if completed. All participants in phase two were provided with a participant information sheet and a consent form.

5 | RESULTS

5.1 | Phase one

Of the 84 nursing assistants who were working at the hospital during the data collection period, 79 completed the questionnaires resulting in a 94% response rate. The nursing assistants who participated had a mean age of 35.8 years. The majority ($n=47$, 61%) had been working as a nursing assistant for <3 years. Over half had completed a Vocational Education Certificate qualification ($n=41$, 51.9%) and almost a third had completed an undergraduate degree ($n=22$, 27.8%). Most participants had completed a nursing assistant Acute Care qualification ($n=70$, 88.6%), a few had completed a nursing assistant Aged Care Certificate ($n=8$, 10.1%) and one participant had no qualifications. Nearly one-third ($n=26$, 32.9%) were studying to be either an enrolled nurse (similar to a Licensed Practice Nurse) ($n=9$, 11%) or a *registered* nurse ($n=17$, 21%) (see Table S6).

The quantitative data presented in Tables 1 and 2 show that not all nursing assistants are fully aware of their roles and at times can feel unprepared for their shifts, however, they did feel supported by the RNs and were usually supervised when working. In general, they were reluctant to refuse a delegation. Nursing assistants generally completed many activities of daily living that aligned with the scope of practice directive including showering and mobilisation. However, some nursing assistants are not working to their full scope of practice, whereas others are working outside of their scope of practice.

Further statistical analysis was completed using Mann–Whitney U and Kruskall–Wallis tests (see Tables S7, S8). There were a few statistically significant differences noted ($p<.05$). Male nursing assistants reported that they felt more supported in their role compared to female nursing assistants. The nursing assistants who were employed by an outside agency compared with those employed directly by the hospital did not usually complete activities without being requested by the nurse. Female nursing assistants compared to males were more likely to know what care activities fell within their scope of practice and were more likely to complete activities including showering or bathing a patient, and bed making. Whereas male assistants were more likely to escort a patient from the operating theatre back to the ward.

Hospital-employed nursing assistants were more likely to complete activities including showering a patient, mobilising a patient from the bed to chair and making beds. However, nursing assistants who were employed by an outside agency were more likely to complete pre-operative shaves and escort a patient from the operating theatre back to the ward.

Regarding length of service, those nursing assistants who had been working for 7–12 months compared with those working for 3–5 years and more than 5 years were less likely to answer call bells. The nursing assistant who is not studying to be a nurse compared to those who were completed pre-operative shaves on occasion.

5.2 | Phase two

During the interviews factors impacting a nursing assistant's decision to accept a delegation were explored including the strategies that support a nursing assistant in the acute care environment to complete a delegated activity. A total of 11 nursing assistants completed an interview with the average interview time being 38 minutes, 6 were employed directly by the hospital where this study was completed

TABLE 1 Nursing assistant's experience with registered nurses asking them to care for patients during a shift ($n=79$).

Questions	All shifts, *n* (%)	Most shifts, *n* (%)	Some shifts, *n* (%)	Never, *n* (%)
When I come into work I know what I need to do for the rest of the shift.	33 (41.8)	37 (46.8)	6 (7.6)	3 (3.8)
I say no when someone asks me to do something	1 (1.3)	1 (1.3)	38 (48.1)	39 (49.4)
I am asked to do activities that I do not have enough time to complete	1 (1.3)	1 (1.3)	34 (43)	43 (54.4)
I am given enough support to complete my job	34 (43)	36 (45.6)	7 (8.9)	2 (2.5)
Nurses supervise me when I am completing my job	26 (32.9)	19 (24.1)	31 (39.2)	3 (3.8)
I complete a nursing task without the *registered nurse* telling me to do so	12 (15.2)	16 (20.3)	24 (30.4)	27 (34.2)
I know what care activities I am allowed to do in my job	67 (84.8)	10 (12.7)	2 (2.5)	0 (0)
I only complete a task when a *registered nurse* tells me to do so	12 (15.2)	10 (12.7)	28 (35.4)	29 (36.7)

TABLE 2 Frequency of activities completed by the nursing assistant while working in the acute care environment ($n = 79$)

Nursing activity	Always, *n* (%)	Sometimes, *n* (%)	Rarely, *n* (%)	Never, *n* (%)
Electrocardiogram (ECG)[a]	2 (2.5)	5 (6.3)	9 (11.4)	63 (79.7)
Shower or bathe a patient	55 (69.6)	23 (29.1)	1 (1.3)	0 (0.0)
Blood glucose monitoring	21 (26.6)	31 (39.2)	16 (20.3)	11 (13.9)
Recording urine output on a Fluid Balance Chart (FBC)	28 (35.4)	38 (48.1)	10 (12.7)	3 (3.8)
Starting Intravenous (IV) Lines[a]	4 (5.1)	2 (2.5)	3 (3.8)	70 (88.6)
Mobilise patient from bed to chair	53 (67.1)	24 (30.4)	2 (2.5)	0 (0)
Perform and record patients' observations	32 (40.5)	35 (44.3)	10 (12.7)	2 (2.5)
Cutting or trimming of nails[a]	4 (5.1)	7 (8.9)	16 (20.3)	52 (65.8)
Assist patient to toilet	67 (84.8)	12 (15.2)	0 (0.0)	0 (0.0)
Escort a patient from the Operating Theatre to the ward[a]	9 (11.4)	13 (16.5)	14 (17.7)	43 (54.4)
Answer call bells	42 (53.2)	31 (39.2)	5 (6.3)	1 (1.3)
Medication preparation[a]	1 (1.3)	1 (1.3)	2 (2.5)	75 (94.9)
Medication administration[a]	0 (0)	1 (1.3)	6 (7.6)	72 (91.1)
Complete pre-operative shaves[a]	5 (6.3)	10 (12.7)	21 (26.6)	43 (54.4)
Bed making	62 (78.5)	17 (21.5)	0 (0)	0 (0)

[a]Activity not approved for completion by the nursing assistant as per the WA Operational Directive for nursing assistants working in the acute care environment where this research was conducted.

and five were employed as agency nurses (three worked for a government nursing agency and two worked for private nursing agencies). All were working in a casual capacity. Interviewees who participated had a mean age of 35.2 years. Six nursing assistants were studying to be registered nurses with one studying to be an Enrolled Nurse.

Two main themes were identified during the analysis of the interviews. The first theme 'working as a team' relates to the strategies that support a nursing assistant to complete delegated care. The second theme 'accepting or refusing a delegation' relates to the factors that influence the nursing assistant to complete delegated care.

5.2.1 | Theme 1: Working as a team

The first theme related to the nursing assistant and registered nurse working together as a team in providing patient care. Three subthemes were identified including (1) mutual respect, (2) ward culture and (3) studying to be a nurse. When the nursing assistant felt part of the nursing team they stated that 'open communication was enhanced' (AIN4), 'self-worth increased' (AIN7), 'anxiety and stress levels decreased' (AIN2, 3) and 'productivity was improved' (AIN8, 9). However, not all reported that they felt part of the team with some stating they felt 'isolated' (AIN3), 'working in a silo' (AIN5) and believed they 'don't belong' (AIN3). These feelings were exacerbated by the nursing assistant being rostered to different wards which did not allow for either the nursing assistant or registered nurse to 'get to know one another' (AIN9).

Mutual respect

Mutual respect was recognised by assistants-in-nursing as an important characteristic of the workplace relationship which supported them in completing delegated care. In some instances, they felt respected by one registered nurse but not others. One nursing assistant discussed how having 'your name on the board next to their name made her feel as though the nurses are considering me' (AIN7). However, the same nursing assistant stated that at other times she felt 'dismissed' by the registered nurse or was made to feel like an 'inconvenience' (AIN7).

Being delegated 'dirty work', which they defined as dealing with bodily fluids also influenced their opinion of being respected. When the nursing assistant was delegated tasks that they felt were 'dirty' and they did not see the registered nurse completing similar tasks they felt less respected. Nursing assistants suggested that on occasion the registered nurses 'embellished' (AIN4) tasks that needed to be completed to make them appear 'better than, or easier than what they ended up being' when really it was 'dirty work' (AIN4).

Culture of the ward

The culture of the ward also impacted the level of respect that existed between the registered nurse and assistant in nursing. When the culture of the ward was inclusive of the nursing assistant, they were more willing to help the nurses and accept delegated tasks. Nursing assistants shared stories of working on wards where the staff were 'really nice, they treat me like I belong, and they make me feel valued' (AIN8). They also voiced feeling supported by the registered nurse when they 'check[ed] in every now and then to make sure I am okay' (AIN2) or 'as if they are there to help me out' (AIN1). However, others reported that they 'were left to fend for themselves' (AIN4) and they felt that the registered nurse was 'avoiding' (AIN2, 10, 11) them, and they had to 'muddle through' by themselves (AIN6).

Studying to be a nurse

Nursing assistants who were studying to be registered nurses stated this influenced the way the registered nurse respected, supported and

welcomed them to the ward. They commented that once the registered nurse learnt that the nursing assistant was a student nurse, they spent more time with them to 'help them understand certain procedures [in greater depth]' (AIN11). It was suggested by a few nursing assistants that the registered nurses liked to 'share their knowledge and experiences' (AIN2, 3); and that they were afforded 'privileges' that allowed them 'to do [extra] things, or they teach you' (AIN3).

In contrast, if they did not share with the registered nurse that they were also studying to be a nurse they were 'just treated like a doormat' (AIN3). Additionally, if nursing assistants returned to a ward where they had previously attended a clinical placement for their university studies, the registered nurse would delegate to them more frequently. They also reported feeling a sense of belonging within the team as they had been able to 'develop great relationships with those nurses' (AIN2) and 'we work really well as a team together' (AIN4).

5.2.2 | Theme 2: Accepting or refusing a delegation

The second theme was 'accepting or refusing a delegation which identified that the nursing assistant needed to understand their scope of practice and what was required from them to safely complete delegated tasks'. Four sub-themes were identified including (1) 'knowing what to do', (2) 'handover', (3) 'declining a delegated task' and (4) 'scope of practice knowledge'.

Knowing what to do

Knowing what to do in their role was often linked to familiarity with a ward. The nursing assistant initially discussed the need to understand the physical layout of the hospital, which included the location of different wards and departments in relation to one another, and the specific layout of an individual ward. When they were sent to a diverse range of wards within the hospital such as the emergency department, dementia-specific units and rehabilitation units they felt as though they did 'not really knowing what is going on' (AIN5). Additionally, nursing assistants reported a sense of 'being lost' (AIN4) and 'just standing there hoping that someone would rescue them' (AIN9) when arriving i ndover before commenn the allocated ward.

They voiced the need to work on one ward for a while as 'it is hard when they keep changing us around' (AIN9). This would allow them to 'get some idea of where I am and what I am meant to be doing there' (AIN8), as they felt that they did not 'know where anything is, where the equipment and supplies are…it is hard when they keep changing us around' (AIN5).

Handover

Receiving handover before commencing a shift was identified as an important way of gaining information to determine what the role and work of the nursing assistant would be for that shift. Nursing assistants received a handover from the nursing assistant who had worked the previous shift and the registered nurse who would be supervising them for the current shift. An ideal handover was not always provided, and the quality of the handover was reported as being 'beneficial' (AIN4) to 'non-existent' (AIN7) depending on the individual registered nurse or nursing assistant. Nursing assistants also identified factors that impacted the nursing assistant/nursing assistant handover including the time of the day with night duty/morning handovers described as 'the worst' (AIN8). Some suggested that 'I don't think some of the assistants in nursing know how to give handover, I am not sure if they have ever been taught to do one' (AIN4). One nursing assistant recounted that she was not informed that the 'patient was nil by mouth' (AIN3) resulting in the patient not fasting for a procedure.

Enunciation of the handover also impacted the nursing assistant's ability to understand the handover and provide the required care. When English was not the first language for the nursing assistant providing the handover, it also caused problems with reports that 'language barriers were a big issue' (AIN2). When the nursing assistant spoke 'so quietly, or sometimes so quickly, that I have no idea what they are on [talking] about' (AIN7) or when there was a 'really strong accent' (AIN2, 9) they struggled to understand the handover.

Specific issues pertaining to the registered nurse to nursing assistant handover included timeliness of handover. Receiving a handover from the registered nurse could be very delayed, in some instances they reported waiting up to 'two hours' (AIN2, 10). In some situations, the nursing assistant had *to* 'chase up' (AIN4) the registered nurse for a handover. These delays resulted in them not necessarily understanding care requirements and they 'just try and work out what I am meant to be doing by myself' (AIN10).

Nursing assistants who were studying to be nurses wanted a more 'comprehensive handover' (AIN1 2, 3), compared to those who were not studying, similar to what they received while on 'clinical practicum as a student nurse' (AIN6, 11). When the handover failed to follow the structured format they were familiar with, these nursing assistants were 'frustrated' (AIN2, 4) as they had not received a handover that they 'need[ed] to provide safe patient care' (AIN1, 4, 11).

Declining a delegated task

This sub-theme discussed factors surrounding the ability of the nursing assistant to say 'no' to the registered nurse when being delegated a task. These included the nursing assistant not being able to complete all delegated tasks, safety issues, job security concerns and wanting to help the registered nurse despite refusing a delegation. Many remarked that it was 'not in my character to say no in their everyday life and find it difficult to say no in my work role' (AIN 9).

The nursing assistants wanted to be viewed by the registered nurses as capable and competent in care provision without appearing 'lazy' (AIN7, 9, 11), and they did not want to be thought of as 'poorly' (AIN11) in their work ability and so they were reluctant to say 'no'. Nursing assistants did not have the confidence to say no especially if the delegation was from a 'senior nurse' (AIN6) which resulted in work overload for the nursing assistant.

Those who experienced work overload described having 'three different nurses telling me what to do and expecting me to be able to do it all' (AIN9); and 'sometimes I can have different nurses asking me

to do things all at the same time' (AIN8). For example, one participant stated that the coordinating nurse allocated them to one patient for behaviour management reasons, however, they were asked to care for an additional patient (or patients) by the staff nurses. These requests caused confusion and internal conflict for them as they tried to meet the needs of the different nursing personnel. Some nursing assistants stated that they would prefer not to complete a task if overloaded with work than to say 'no', and instead would report to the nurse that 'they ran out of time' (AIN3). These actions resulted in care being missed or not completed in some instances.

Although nursing assistants were reluctant to say 'no' they indicated that if patient safety was jeopardised, they would refuse a delegation. Some nursing assistants emphasised that their 'number one priority is patient safety' (AIN3) and if they thought 'there is any chance of a patient getting hurt I will say no' (AIN5). However, this was not always the case. The following quote highlights a situation where the nursing assistant did not refuse a delegation in the best interest of patient safety:

> I was allocated officially to one patient but then asked to also 'just keep an eye' on the other patients in the room… one of them, when I wasn't with her…had a fall which of course was going to happen
>
> (AIN6).

During the early stages of employment, nursing assistants recounted feeling 'panicked and stressed' (AIN4, 9) when deciding to accept or refuse a delegation. However, for most nursing assistants, their ability to say 'no' developed over time and despite it being 'difficult to say no' (AIN10) they were 'getting better at saying no' (AIN9, 11).

For all nursing assistant interviewees job security was a major concern. They were concerned that they might 'lose their job' (AIN7), be 'reported to management' (AIN2); have their weekly shifts 'reduced in number' (AIN4) or be sent to a ward that is known to be 'bad' (AIN6) or 'very heavy' (AIN10). Being concerned about job security and wanting to be seen as a useful member of the healthcare team placed the nursing assistant in a vulnerable position and increased the pressure on them to not refuse a delegation.

Most nursing assistants knew that they had a scope of practice, however, some did not necessarily follow the scope of practice document, nor did they know specifically the tasks that they were allowed to complete. Some nursing assistants offered an explanation that they were 'not really sure about it' (AIN5), and 'I am not 100% sure [of their scope of practice] if you were to test me on it' (AIN11).

Scope of practice

Nursing assistants looked to the registered staff for leadership regarding delegation and expected them to be fully cognisant of the nursing assistant's role and scope of practice. However, a few recounted that 'some of them [registered nurses], don't know, they're not fully clear, of what we can do' (AIN11, 4). However, if a nursing assistant was unsure about their own scope of practice and the registered nurse delegated an activity to them, they assumed that the registered nurse was knowledgeable about the nursing assistant's scope of practice and would delegate appropriately and within their scope of practice.

Issues arose with nursing assistants who were studying to be a nurse. Role blurring occurred for some between their scope of practice as a nursing assistant and their scope of practice as a pre-registration nursing student. Some of these nursing assistants stated that they 'consider whatever point I am at uni' (AIN4, 11) and used that as a guide when considering their scope of practice, rather than the hospital policies. Others considered the point during their degree 'when I became an assistant-in-nursing' (AIN2, 3), and others accepted a delegation if they had a previous relationship with the delegating nurse during a clinical practicum associated with their university studies.

Many nursing assistants who were studying to be nurses stated that they were aware that they were being asked to complete activities such as 'hang some antibiotics' (AIN6), were not in line with their nursing assistant scope of practice and were comfortable informing the registered nurse that an activity was 'outside of my scope of practice' (AIN6). However, some knowingly stepped outside of their scope of practice and completed activities, including 'subcutaneous injections' (AIN11), administering 'Panadol' (AIN4) and 'catheterising' (AIN2). The reasons offered to explain why they worked outside of their scope of practice included the room being under 'contact precaution … and I was gowned up' (AIN11); 'the patient was really difficult and non-compliant' (AIN4) and 'it was a great opportunity to learn' (AIN2).

Several nursing assistants voiced feeling conflicted when they were asked to complete an activity that they knew was outside of their scope of practice which is highlighted in the following comment:

> I told the nurse 'I'm not supposed to give medication' and she goes 'I know you're not supposed to' she just left it there…and I was like 'I don't know if I should do this', but I did, I did give it …
>
> (AIN2).

Conversely, to ensure that they did not step outside of their scope of practice some nursing assistants who were studying to be a registered nurse decided not 'to tell the registered nurse that I am studying [nursing]' (AIN7). They supported this decision as they had experienced registered nurses delegating to them outside of their scope of practice and were concerned that the registered nurse 'will expect me to do things that I know I shouldn't do' (AIN6).

6 | DISCUSSION

Results from this study identified a range of factors and working conditions that impact the nursing assistants' decision to accept or refuse a delegation from the registered nurse. The Nursing and Midwifery Board of Australia's decision-making Framework (2020) stipulates that delegation is a two-way relationship between the registered nurse and the nursing assistant. As stated by the Board, nursing assistants are responsible for understanding the delegation, providing the delegated care, seeking support and supervision until

they are competent to perform the activity and participating in the evaluation of the delegation (NMBA, 2020).

As recommended in early research by Bittner and Gravlin (2009) and McKenna et al. (2004) for safe effective delegation practice to occur both the registered nurse and the nursing assistant must understand the role of the nursing assistant within the clinical environment and their scope of practice. However, this study highlighted that some nursing assistants are confused as to what activities fall within their scope of practice. In the first questionnaire, nearly all nursing assistants stated that they knew what activities they were able to complete. Whereas, in the second questionnaire and during the interviews, it became evident that some assistants were working outside of their scope of practice by completing tasks such as the preparation and administration of medications, hanging IV lines and catheterisations. Not only are these activities the remit of the registered nurse but as stated by Blay and Roche (2020) the nursing assistant may not have the underpinning skills and knowledge to complete these activities which may impact patient outcomes and patient satisfaction.

Compounding this issue is the belief by most of the assistants who were interviewed that they should undertake all the activities delegated to them by the registered nurse and this belief prevented them from refusing a delegation, regardless of their capacity or skills and knowledge to complete the task. Furthermore, the findings would suggest that some registered nurses are also not aware of the nursing assistants' scope of practice as they are delegating to the nursing assistants activities that are their responsibility.

The notion that registered nurses and nursing assistants are not fully conversant about the nursing assistant's scope of practice is not unique to this research with the literature reporting that registered nurses were unsure of the suitability of tasks for delegation (Gravlin & Bittner, 2010); and both registered nurses and nursing assistants lacked understanding of the assistant scope of practice (Kaernested & Bragadottir, 2012; Potter et al., 2010; Standing & Anthony, 2008; Spilsbury et al., 2011). As discussed in a recent review of delegation literature by Wilson et al. (2023), the accountability and responsibility of delegation lies with the registered nurse including decisions surrounding who is the most appropriate person to complete a task at any given time. When nurses fail to delegate correctly, they are legally liable for their practice (Wilson et al., 2023) and it would appear that some registered nurses in this study may not be meeting their legal obligation.

Nursing assistants were concerned that refusing a delegation would send a negative message to registered nurses which may result in retribution such as the reduction in the number of shifts allocated to them or being ostracised from the team. Maintaining employment was a high priority for the nursing assistants. Their lack of power or control in the relationship placed them in a vulnerable position where some assistants may choose to accept a delegation against their better judgement, again potentially jeopardising patient safety at risk. This power and the fear that the nursing assistants experienced is mirrored in the literature (Capone, 2009; Coe, 2019; Nelson, 2012; Siegel & Young, 2010). Our findings are similar to an early study by Jervis (2002) where it was reported that registered nurses used an autocratic management style to ensure compliance through the use of rewards or punishments in relation to what registered nurses would delegate to nursing assistants. The nursing assistants maintained a distrustful view of management and believed that their position was dispensable as soon as they did not conform to nursing management's demands (Jervis, 2002). As suggested by Kim et al. (2016), these power differentials must be addressed within teams to reduce the negative impact on patients, staff and the wider organisation.

The quantitative data reported that most nursing assistants knew what was required of them before commencing work. However, during the interviews, the importance of the quality of the handover became apparent to some assistants when deciding whether to accept or refuse a delegation. The literature stresses the importance of structured handovers occurring at the start of the shift for members of the healthcare team to have a shared understanding of the nursing care required (Kalisch, 2009; Potter et al., 2010) and that a comprehensive handover is provided between all staff (Bittner & Gravlin, 2009; Johnson et al., 2016).

However, during the interviews, it was identified that some nursing assistants received more than one handover which confused them as to what was expected of them, particularly if different handovers presented conflicting information or omitted pertinent information. Reports of handover being one-way communication and poor quality between the nursing assistants/nursing assistant and the registered nurse/nursing assistant or when nursing assistants are waiting a considerable period of time are also of concern. Kalisch (2009) identified that where there was an inadequate handover between the registered nurse and nursing assistants it resulted in missed patient care, poor working relationships between the registered nurse and nursing assistants and risk for patient harm.

Similarly, a study by Johnson et al. (2016) discussed the importance of registered nurses communicating clearly and efficiently to assistants-in-nursing regarding care provision requirements. The nursing assistants reported that they become frustrated and disenfranchised when they receive inadequate handovers. Poor patient outcomes and missed care can result from poor communication practices between the registered nurse and assistants-in-nursing (Johnson et al., 2016).

Of concern are the inconsistencies between ensuring patient safety and refusing a delegation described by some of the nursing assistants in this research. Conflicting reports existed between the nursing assistants with some stating that they would refuse a delegation if it jeopardised patient safety, and others suggesting they would accept a delegation knowing that they would not have the capacity to complete the delegation but would prefer this rather than saying no to a registered nurse. A potential result of this is missed care leading to negative patient outcomes and decreased satisfaction in care provision (Crevacore, Coventry, et al., 2022). There was no literature identified that mirrors this issue experienced by the nursing assistant in this study.

This research also aimed to identify the mechanisms in place to assist nursing assistants in completing delegated tasks. Nursing assistants in this study placed importance on being part of an effective team, where members were respected regardless of position, and this was paramount to them feeling supported to complete the delegated activities. In many instances, the nursing assistant felt 'isolated' from the team, and they did

not feel respected. These findings are thoroughly documented in the literature with nursing assistants reporting inadequate teamwork between registered nurses and nursing assistants (Bellury et al., 2016; Lancaster et al., 2015), feeling undervalued (Butler-Williams et al., 2010; Lancaster et al., 2015; Spilsbury & Meyer, 2004) and a lack of respect from registered nurses for the nursing assistant role (Kalisch, 2009; Potter et al., 2010; Saccomano & Pinto-Zipp, 2011).

While nursing assistants mainly reported knowing what to do when they came to work in the questionnaires, during the interviews many of them stated they had little chance of developing a sense of belonging to any team as they worked throughout the hospital on a 'needs' basis with little consideration for where they had previously worked. This prevented them from developing relationships with nursing staff and the opportunity to acquire skills and knowledge relating to the ward speciality or to develop an understanding of nuances in ward-specific scope of practice rules. Allocating nursing assistants back to the same ward would provide an opportunity for relationships to develop and potentially improve their sense of belonging. This finding is important in understanding the impact allocation of staff at a senior management level can have on delegation practices at a ward level. While there was no literature identified relating to this phenomenon for nursing assistants specifically, Batch and Windsor (2015) found similar results with casual pool nurses working in the acute setting. For these registered nurses, preparing themselves for the ward to which they were allocated was important; lack of familiarity with the ward decreased their ability to manage workload; they believed that continuity of care for the patient would be enhanced if they were returned to the same ward each day and they were able to develop meaningful relationships that enhanced patient care with the nursing staff that they worked with.

6.1 | Strengths and limitations

This study is one of the first to provide an understanding of the factors the nursing assistant considers when deciding to accept or refuse a delegation in the acute care environment. Furthermore, the supportive mechanisms that exist to support the nursing assistant to complete delegated tasks have been provided.

However, we do need to outline some limitations. Despite test–retest reliability and face and content validity being conducted with acceptable results, further research with these tools is necessary. Self-selection bias may have occurred in this research as participants in both phases one and two of the study self-nominated. Finally, while data were collected from nursing assistants working at a large tertiary hospital across a variety of wards, it may not be representative of their opinions or experiences globally.

6.2 | Implications for practice and research

A more considered approach to the allocation of nursing assistants to wards and to patients/groups of patients is required. Where possible, reducing the number of wards they rotate across would be of benefit. A staffing matrix to track the allocation of nursing assistants in the clinical environment will be of benefit to nursing management to ensure this is consistently achieved. This practice will allow nursing assistants to develop an understanding of the ward requirements specific to the speciality; become familiar with the location of nursing equipment and supplies; build relationships with staff and encourage the development of meaningful relationships between registered nurses and nursing assistants which in turn encourages teamwork and safe delegation practices.

Improving delegation practice requires registered nurses and nursing assistants to engage in education on the role of the nursing assistant and their scope of practice. In addition, the responsibilities and accountability of each team member need to be highlighted. This education needs to reiterate the importance of the pre-registration nursing assistants working within the mandated scope of practice regardless of the additional skills and knowledge they may bring to the role. Staff Development Nurses and other senior nurses need to be available on the ward to provide oversight and assistance where required.

Handover is the main mechanism by which these staff communicate care requirements. However, issues were identified with the current handover formats between nursing assistant to nursing assistant and, the registered nurse to nursing assistant. One timely handover between the outgoing staff (nurse and nursing assistant) and the staff (nurse and nursing assistant) that are coming on shift needs to occur to reduce potential confusion regarding delegation processes and respective roles in care delivery. A structured handover format such as ISOBAR should be implemented during the handover process.

Research into delegation practices between registered nurses and nursing assistants using a larger sample of acute care hospitals is warranted to identify similarities and differences in the factors that impact nursing assistants during the delegation processes. Comparing and contrasting the experience of a registered nurse with that of a nursing assistant is also necessary.

This research was conducted in an acute care tertiary teaching hospital where registered nurses are more available to supervise, support and monitor delegated care to the nursing assistant. In areas such as primary or residential care, indirect delegation is common resulting in the absence of the registered nurse to ensure the assistant is the most appropriate person to complete the required care. This results in increased complexity associated with delegating care, increased risks for staff and patients as well as a lack of support for the nursing assistant. Role confusion may result and the risk of working outside of one's scope of practice is increased. Research into delegation practices between the registered nurse and the nursing assistant in these areas is warranted with a focus on the impact of indirect delegations.

7 | CONCLUSION

This research has given voice to nursing assistants during the delegation process and highlighted the challenges they face. To complete delegated tasks, the nursing assistants in this research place

importance on teamwork, respect and a sense of belonging. While these are important attributes of a healthy working environment, it is essential that nursing assistants are being delegated to and are providing care in line with hospital policy and procedures. As the use of the nursing assistant and their scope of practice expands ongoing education supporting safe delegation practice must be provided for the registered nurse and the nursing assistant. Access to, and understanding of, the nursing assistants' scope of practice is essential for all persons involved in delegation to ensure the most appropriate person is completing the care required.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet the following criteria: (1) substantial contributions to conception and design, acquisition of data or analysis and interpretation of data; (2) drafting the articles or revising them critically for important intellectual content. Carol Crevacore: Conceptualisation, Methodology, Formal analysis, Investigation, Data curation, Writing—original draft, Visualisation, Project Administration, Funding acquisition. Christine Duffield: Conceptualisation, Methodology, Formal analysis, Writing—review and editing, Project Administration, Supervision. Beth Jacob: Conceptualisation, Methodology, Formal analysis, Writing—review and editing, Supervision. Linda Coventry: Data Curation, Methodology, Formal analysis, Writing—review and editing, Visualisation, Supervision.

FUNDING INFORMATION

This work was supported by the Western Australian Nurses Memorial Charitable Trust (grant number: G1003825).

ACKNOWLEDGEMENT

Open access publishing facilitated by Edith Cowan University, as part of the Wiley - Edith Cowan University agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST STATEMENT

No conflict of interest has been declared by the author(s).

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Crevacore, C., Coventry, L., Duffield, C., & Jacob, E. (2024). Factors impacting nursing assistants to accept a delegation in the acute care settings: A mixed method study. *Journal of Clinical Nursing*, *33*, 2153–2164. https://doi.org/10.1111/jocn.17127