Critical Thinking, Delegation, and Missed Care in Nursing Practice

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Objective: The aim of this study was to understand how nurses use critical thinking to delegate nursing care.

Background: Nurses must synthesize large amounts of information and think through complex and often emergent clinical situations when making critical decisions about patient care, including delegation.

Method: A qualitative, descriptive study was used in this article.

Findings: Before delegating, nurses reported considering patient condition, competency, experience, and workload of unlicensed assistive personnel (UAP). Nurses expected UAP to report significant findings and have higher level knowledge, including assessment and prioritizing skills. Successful delegation was dependent on the relationship between the RN and the UAP, communication, system support, and nursing leadership. Nurses reported frequent instances of missed or omitted routine care.

Conclusion: Findings from this project provide insight into factors that influence delegation effectiveness. These can guide CNOs and frontline nurse leaders to focus on implementing strategies to mitigate the consequence of missed care. Ineffective delegation of basic nursing care can result in poor patient outcomes, potentially impacting quality measures, satisfaction, and reimbursement for the institution.

Critical thinking is frequently discussed by nurse leaders from education and practice who agree that developing the ability to think critically is fundamental to nursing practice in these constraining times. Nurses need to be able to synthesize large amounts of information and think through complex and often emergent clinical situations to make critical decisions about patient care, including the delegation of some aspects of care to other registered nurses (RNs) and unlicensed personnel. This requires nurses to possess critical thinking skills. There is, though, a lack of agreement on a universally accepted definition of critical thinking. Bittner (unpublished doctoral dissertation, 2001) noted support in the literature for knowledge, reasoning, reflection, judgment, and creativity as being aspects of critical thinking.

Scholars who have researched critical thinking and the link to clinical judgment have concluded that clinical judgment is more influenced by what the nurse brings to the situation than objective data and that clinical judgment is influenced by the context in which the situation occurs as well as by the unit environment. Research that provides insight into potential ways to enhance critical thinking, improve delegation and communication, and promote teamwork can provide guidance for nursing leaders and educators.

Identifying a Practice Issue

Preparing nurses for practice requires a dense curriculum of nursing knowledge, essential clinical skills, and abilities to apply principles from a variety of scientific disciplines to the practice setting. Most nursing leaders and educators agree that fostering these higher level process skills is the most significant challenge facing nursing practice.
Critical thinking is an essential skill and fundamental for nurses in practice. Nurse leaders from education and practice have adopted the consensus statement that nurses who think critically exhibit certain habits of the mind and practice an array of cognitive skills.

In addition to critical thinking, nurses are expected to use a variety of cognitive processes in everyday practice. Critical thinking and decision making are complicated by the fact that nurses care for multiple patients within environments that are fast paced and unpredictable, where access to resources and information may be unreliable. Factors driving clinical decision making, work complexity in the acute care environment, work flow strategies, and cognitive processes are described by Ebright et al. Potter et al describes the nurse’s cognitive workload and the cognitive stacking of information, cognitive shifting, and interruptions in relationship to errors in the acute care environment. The research in this area is groundbreaking in relation to the nature of the complexity of nurses’ work and the potential of disrupting nurses’ cognitive processes and the relationship to errors and the omission of care that may result.

Omitting or “missing care” was the focus of a qualitative research conducted by Kalisch, who delineated 9 elements of care that are routinely missed. Embedded within these 9 elements, 5 are considered tasks that can be delegated to unlicensed assistive personnel (UAP). These include ambulation, turning, delayed or missed feedings, hygiene, and intake and output documentation. When asked the reason for not completing care, nurses responded with some predictable responses. These included too few staff, poor use of staff, time required for intervention, not being their job, ineffective delegation, habit, and denial. Several of these are directly related to the delegation of tasks to UAP and the failure of the RN to carry out the supervision and evaluation components of the delegation process. Both nurses and UAP reported that activities such as ambulation required too much time, whereas patients would be more likely to be turned in bed because it took less time.

Ineffective delegation has been reported as a substantial issue with missed care. Nurses reported a lack of collaboration and communication with UAP in the delegation process. Specifically, once delegated, the task becomes the UAP’s responsibility, for which the nurse remains accountable. This accountability requires the nurse to supervise, monitor, and evaluate the UAP to ensure that the task is completed. Many nurses identify aspects of care that are the responsibility of the UAP included in the UAP job description. These include hygiene, mouth care, ambulating, and other tasks that nurses view as primarily the UAP’s responsibility for assuring completion. According to Kalisch, nurses coped with the problem of missed care by prioritizing care ordered by physicians or care that physicians asked about regularly. The consequence of this behavior may be that routine basic nursing care is the least likely to be done. Nurses reported that patient’s medications and physician orders were carried out first. The rationale reported by nurses for delaying or omitting nursing interventions was the length of time required to complete the tasks. Patient education and patient and family emotional assessment and support were sighted as elements of care that were frequently not carried out.

Problem-Solving Approach

A task force composed of staff nurses, nurse educators, nurse leaders, and a nurse research consultant was formed to review the role of the nurse and nursing assistant in delegation within the institution. A review of RN and UAP job descriptions and orientation skills check list was completed. In addition, information regarding specific tasks that were being delegated to the UAP in all practice areas was solicited. Knowledge gaps and practice variability were identified, prompting the decision by the task force to develop a delegation competency for the nurse and UAP roles. Institutional guidelines for delegation were established in conjunction with the Massachusetts Board of Registration in nursing regulation 244 CMR 3.0. The competencies were implemented and required as an expectation for both the licensed and unlicensed roles.

After these activities, a qualitative, descriptive study using focus group method was initiated. Focus group method is described as a method for gathering information in a nonthreatening environment with the purpose of generating detailed narrative data.10 After institutional review board approval was obtained, participants were recruited by a flyer posted on the unit and were asked to participate in the study. Informed consent was signed, and a total of 27 participants were enrolled in the study to participate in focus groups.

Four focus groups containing 4 to 8 medical surgical care RNs were conducted in a 300-bed teaching hospital in the Northeast United States. Nurses were asked to provide the following information: years as a nurse, years in current
medical-surgical practice, and level of educational preparation. The participants were then asked to describe clinical scenarios (without identifying patients, information, or colleague information) in which they have been involved regarding delegation. The participants were specifically encouraged to describe the process of delegation in these scenarios. In addition, participants were asked to describe an example of a successful and an unsuccessful delegation. The final questions dealt with care omissions. Each focus group session was tape recorded. The tapes were transcribed verbatim. Independent content analysis with coding into key categories was completed.11

Findings and Insights
Nurse participants had a range of years of experience from less than 1 year to greater than 20 years of nursing experience. They had a variety of educational backgrounds, including associate and baccalaureate degree preparation. These nurses reported that the process of participating in the focus group was a good experience and increased awareness to the process of delegation. Researchers gained insight into the nurse’s perception of critical thinking and the process of delegation. New information regarding omitted and missed care was revealed. The data revealed 7 categories detailed by the nurse participants as factors relevant to critical thinking and delegation. The 7 categories delineated from the coding were tasks delegated, knowledge expectation, relationships, role uncertainty, communication barriers, system support, and omitted care. The limitations of this study include the use of a single acute care hospital and the small sample of participants. Inherent in focus group techniques is the possibility that participants were influenced by others’ thoughts and beliefs.

Tasks Delegated
Nurses reported that there were several tasks routinely delegated. These included vital signs, blood glucose, weights, intake and output, feeding, ambulating, transport, bathing, activities of daily living, answering call lights, toileting, stocking rooms, and others. The participants reported tasks that were identified as appropriately delegated per national standards and institutional guidelines. However, in the course of the focus group discussions, participants shared examples of tasks where they were unclear as to whether the task was within the UAP scope of practice or where delegation of the task would not be in keeping with institutional policy.

Knowledge Expectations
In addition to specific competency and knowledge expectations, nurses expected UAP to report significant findings, follow up tasks, and exhibit assessment and prioritizing skills that are not within the UAP scope of practice. Many participants reported that they were anticipating that the UAP would be able to determine the level of reportable findings without any prompting. Nurses expressed frustration when the UAP were not able to report findings that were abnormal or concerning. Participants shared that they had, in many instances, expected the UAP to follow up on tasks that had been delegated to them. The participants could often verbalize how they delegated tasks to UAP but frequently did not say that they ensured that the UAP understood the task or accepted the delegation nor did the nurse follow up to ensure that the task had been completed in a timely manner. It was often at the end of the 8- or 12-hour shift when the nurse learned that the UAP had not followed up on a designated task. The discussion of the “failure to report” led the nurse participants to verbalize the expectation that the UAP should know that they should report these findings without having to be given specific, clear instructions to do so.

They don’t know the critical values for blood sugars...or the ranges for vital signs.

I think that’s the biggest thing...vital signs not being reported, since we’re not able to go in there every 15 minutes for the 4 hours.

The discussion regarding the nurse’s expectation of the UAP’s knowledge included specific assumptions by the nurse participants. The expectation was that UAP use higher levels of decision making when accepting, completing, and reporting on delegated tasks. Critical thinking was mentioned several times as a skill expected in the UAP.

Relationships
Nurse participants in each group reported that successful delegation was dependent upon several factors influencing the relationship between the nurse and the UAP. This was nearly universal with each participant in his/her responses when asked what makes delegation successful. Developing and maintaining a trusting and respectful relationship were presented as imperative to successful teamwork and, hence, delegation of tasks. Most participants felt that a positive relationship was the most important aspect to successful delegation as the level of support and cohesion influenced every
aspect of the care of the patient and environment of the unit.

A lot of it's comfort level depending on who's there.

They have to respect you and you have to respect them.

Role Uncertainty

The nurse participants discussed aspects of the nursing and UAP’s scopes of practice and indicated that there was a sense of role uncertainty. Newly licensed nurses who were participants in the focus groups were very explicit about their sense of role uncertainty regarding delegation. They discussed their fear in making errors in all aspects of their practice. This varying sense of confidence prevents them from delegating any care to UAP. This failure to delegate burdens newly licensed nurses, who already face several challenges as they enter practice. The burden increased if the newly licensed nurse had previously worked on the same unit in the UAP role owing to feelings of discomfort and disloyalty to their UAP colleagues.

In addition, there were significant examples provided of delegation overload to the UAP and RNs, resulting in safety concerns and the lack of follow-through on delegated tasks. Even nurses who stated their understanding that the accountability remained “under the RN’s license” reported that it was simply not possible for them to follow through on delegated tasks. The participants discussed the increased workload, increased patient acuity, too few UAP, and ineffective UAP utilization as the essential causative factors for delegation overload.

Communication Barriers

The participants discussed communication or lack of communication as key in delegation success or failure. Nurses reported that there was a lack of communication between the nurses and the UAP. Although communicating to the UAP the task that was to be done, nurses reported that, often times, they realized at a later point that the UAP had not understood what had been delegated to them. In some instances, this was due to a language barrier. An additional communication issue was that the UAP had little or no information regarding the patients whom they were caring for. On some units, participants reported that the UAP give a handoff report to the oncoming UAP. The nurses whose unit engaged in UAP handoffs felt that the UAP were much more prepared to care for the patients on the unit.

Omitted Care

Every participant reported occurrences of omitted care. The frequency of the incidence of was described as occurring on every shift, every day, often more than one incident per shift. Nurse participants did not speak of the number or frequency of episodes of omitted care with surprise but rather with a sense of “resignation” and great frustration, leading to dissatisfaction with the nursing profession and thoughts about leaving their position and organization. The episodes of omitted routine nursing care were consistent with findings in the literature. The care omitted included hygiene, feeding, turning and positioning, skin care, vital signs and frequent vital signs, ambulation, and mouth care. The participants felt that the accountability for this care rests with the UAP as “implied” by virtue of their position description.

Ambulating is always an issue.

Mouth care seems to be forgotten.

Feeding and hygiene, those are the first things to go, and sometimes the turning of patients.

Yeah you’re going to get people with bedsore because they are incontinent.

System Support

The final category that was coded was the system support or lack of support that nurses felt was essential for successful delegation. Groups discussed issues around retention as well as burnout of both nurses and UAP. Staffing levels were discussed as a significant issue, citing that several patients were assigned to 1 UAP and multiple RNs were delegating to a single UAP, with little knowledge of the totality of the UAP assignment load. In addition, the lack of clerical support was reported, as well as missing equipment and supplies. Nursing leadership at the unit level was noted as an important factor. Participants shared their recommendations for strategies to resolve the major unit operational problems that they reported.

Future Research

This research pointed to the need to explore this phenomena using a quantitative study design. A second study was conducted by the authors in January 2008 to measure the phenomenon of missed care using the MISSCARE Survey-2 tool recently developed by Kalisch (unpublished survey, 2007). The survey was distributed to 800 RNs and UAP working on 16 medical-surgical units in 3 acute care hospitals in the Northeast. The aims of
this descriptive, exploratory follow-up study were to measure RNs’ and UAP’s reports of missed routine care and to identify whether nurses’ delegation effectiveness is related to care omissions. In addition, nurse managers were asked to complete a unit characteristic survey identifying data such as staffing levels, skill mix, percentage of newly licensed nurses on the unit, and the care delivery model. The information obtained will shed light on the relationships between demographic variables of RNs’ and UAP’s delegation effectiveness, omissions of care, reasons for missed care, and unit characteristics, which have not been previously reported in the nursing literature.

**Implications for Practice**

The information gained from this project provides chief nursing officers (CNOs) and frontline nurse leaders with valuable insights to the factors affecting delegation, including knowledge expectations, relationships/roles, communication/teamwork, and system support. Of major significance was the report by nurses by routine care omission. Because this finding is consistent with reports from other researchers, this necessitates nurse leaders to pay immediate attention. Ineffective delegation of nursing care, resulting in poor patient outcomes, could yield a direct impact on quality measures, satisfaction, and reimbursement for the institution.

The CNO and frontline nurse leaders have the opportunity to mitigate some of the potential variables through the implementation of a well-defined care delivery model. A model that supports organizational accountability for resource management, quality patient outcomes, professional development, and a safe environment is essential. Although the RN has clinical accountability for the delegation process, nurse leaders need to assure that the nurse at the bedside remains focused on the delivery of basic patient care. In light of the increasing acuity and complexity of care, combined with enhanced technology, nurses and nurse leaders must work collaboratively to assure that basic nursing care, the cornerstone of professional nursing practice, is maintained.

**References**