

Delegation and supervision guidelines for Victorian nurses and midwives



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Foreword

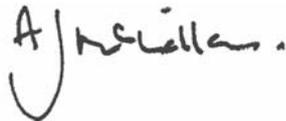
As part of the healthcare team, nurses and midwives are essential to the community's health and wellbeing, playing a critical role in delivering safe, compassionate and quality care. The Department of Health encourages Victoria's nurses and midwives to provide the best possible care for the community by providing clear strategic direction for the profession and supporting health services to implement initiatives across workforce development and reform.

While traditionally nurses and midwives worked in hospitals, they now work across multiple settings including general practice clinics, community-based services and aged-care services. Additionally, nurses and midwives often work within a team that can include other health professionals, health assistants and support staff.

In order to ensure consumers receive safe and effective health care, it is essential that nurses and midwives are able to work together, with each other and with other members of the care team. To do this requires good delegation and supervision skills.

This guideline has been prepared to assist nurses and midwives with this activity. It does not represent 'new science' on the topic of delegation and supervision but brings together, in a series of recommendations and a framework, a process for ensuring the nursing and midwifery workforce of Victoria has the capability to delegate and supervise appropriate tasks and activities to others.

I would like to take this opportunity to thank the Victorian nurses and midwives who have contributed to the development of this guideline. I look forward to continuing the journey through a program of shared works, as the recommendations within are realised.



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Executive summary

Delegation and supervision of nursing and midwifery tasks and activities is a fundamental component of a professional registered nurse and registered midwife's role and responsibilities. This document has been prepared to assist Victorian nurses and midwives to make decisions relating to delegation and supervision in a safe, effective and efficient manner. The guide seeks to reinforce the obligations outlined in existing Nursing and Midwifery Board of Australia (NMBA) publications relating to decision making, and to provide practical recommendations and a framework that will help implement the NMBA's requirements.

While delegation and supervision has always been a core component of a nurse and midwife's role, the prevailing healthcare climate is encouraging of team-based models of care where registered nurses and midwives work increasingly with enrolled nurses and care assistants. These changes largely arise from the challenges facing Australia's healthcare system including: an ageing population; increased chronicity and acuity of disease; technological and practice advances; an ageing workforce; and a constricting labour market.

As the largest component of Australia's health workforce, nurses and midwives will increasingly be impacted upon by these challenges and must continually look for ways to enhance the delivery of safe, effective and efficient nursing and midwifery care.

Delegation and supervision of nursing and midwifery tasks and activities that is based on the needs of the person receiving care allows nurses and midwives an enhanced opportunity to deliver high-quality, person-centred care. In order to be effective, however, nurses and midwives need to have a clear understanding of the requirements of delegation and supervision. These requirements are outlined within documents from the NMBA including its publication *A national framework for the development of decision-making tools for nursing and midwifery practice*, parts of which are reproduced within the body of this document and its appendices.

While the NMBA's requirements appear to be reasonably straight forward, an international review of the literature relating to delegation and supervision, as well as discussions with Victorian nurses and midwives, has identified that delegation and supervision is in fact a complex, multifactorial component of a registered nurse and midwife's role. This process has led to identifying key factors influencing good delegation and supervision practices, which are outlined below and noted in the body of this document as key findings.

Key findings

- Registered nurses and registered midwives require access to education specifically designed to develop knowledge and skills in the practice of delegation and supervision of nursing and midwifery tasks and activities.
- Clear organisational policy and procedure will assist delegators/supervisors and delegates/supervisees to understand the requirements and responsibilities associated with delegation and supervision.
- Development of leadership skills encompassing communication and team engagement is important for safe and effective delegation and supervision.

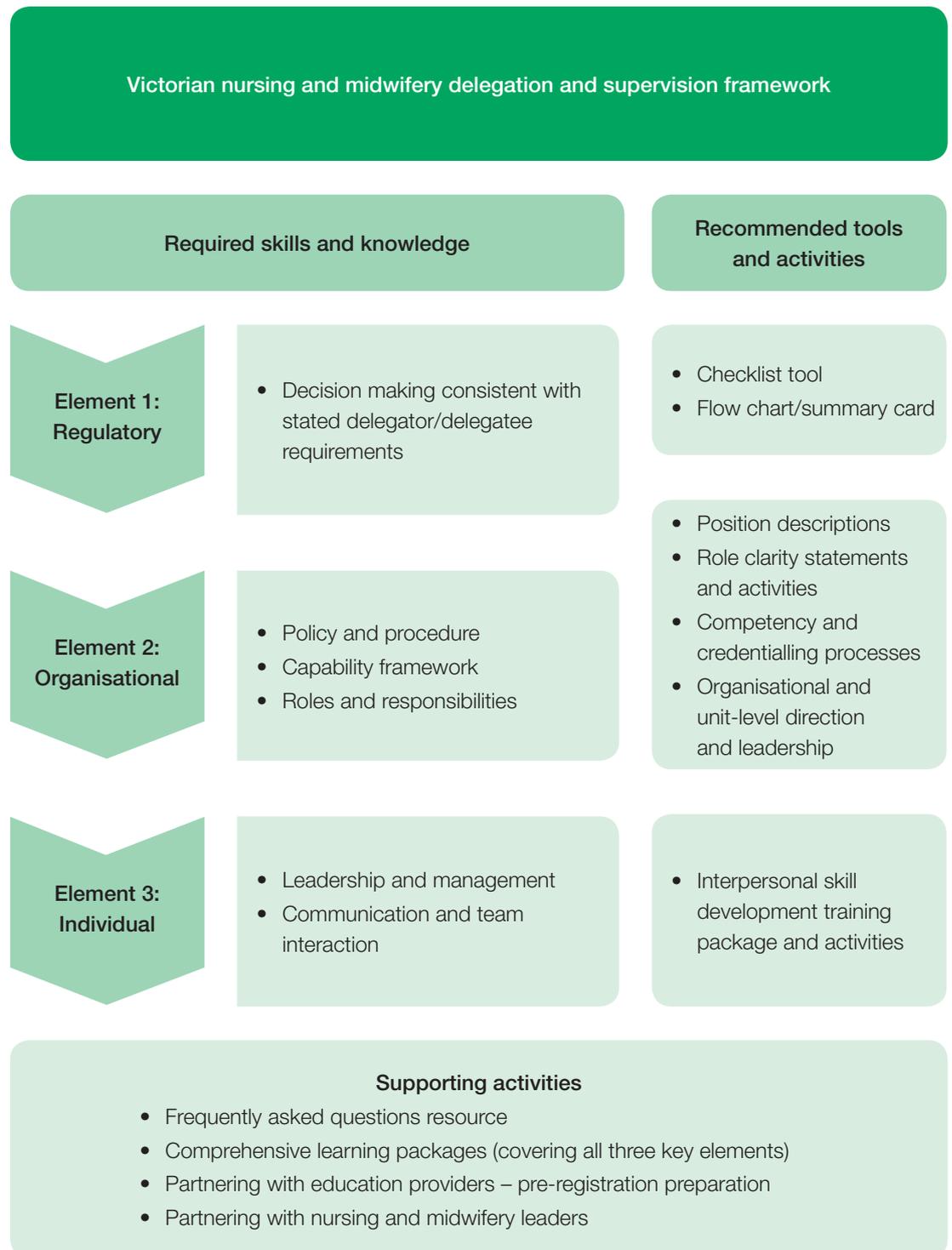
- Role clarity tools and activities are required. These should include:
 - clear, informative position descriptions for all members of the nursing/midwifery care teams
 - development and implementation of a capability framework to assist registered nurses and registered midwives to identify skills and competency
 - development of documentation that explicitly addresses the key role differentiation between registered nurses, enrolled nurses and care assistants.
- Tools and activities that assist nurses and midwives to fully comprehend and embrace professional accountability and responsibility will enhance delegation and supervision outcomes.
- Point-of-care tools to support delegation and supervision activities will assist nurses and midwives with their practice.

These key findings have formed the basis of the recommendations and a framework to assist Victorian nurses and midwives to safely and effectively undertake the professional requirement of delegation and supervision. The program of work necessary to adopt these recommendations and the associated framework assumes a shared responsibility where individuals, education providers, employers, the Victorian Department of Health and professional bodies all contribute to the development and implementation of the associated tasks and activities. The recommendations are outlined below.

Recommendations for safe, effective and efficient delegation and supervision of nursing and midwifery tasks and activities

1. Nursing and midwifery leaders should be aware of and understand the key regulatory, organisational and individual factors that create opportunities for safe and effective delegation and supervision.
2. Employers of nurses and midwives should include delegation and supervision as a core component of their continuing education activities.
3. Employers of nurses and midwives should ensure there is a clear and consistent policy and procedure in place that outlines requirements for safe and effective delegation and supervision of nursing and midwifery tasks and activities. This should be inclusive of roles and responsibilities for delegators/supervisors and delegates/supervisees.
4. Nurses and midwives should have access to a range of educational learning tools that include the key elements of effective and efficient delegation and supervision addressing regulatory, organisational and individual matters.
5. A suite of tools should be developed and implemented to assist in strengthening role clarity between registered, enrolled and assistant workforces (for example, comparing/contrasting different roles and responsibilities).
6. Delegators/supervisors and delegates/supervisees should have access to point-of-care decision-making aids such as:
 - a. a delegation and supervision summary card and/or flow chart that could be displayed and/or carried
 - b. a decision-making checklist aid modelled on the 'five rights' style of statements noted in the literature.
7. Nursing and midwifery leaders should work closely with education providers to enhance opportunities to prepare pre-registration students for their role as delegators and supervisors.

These recommendations and associated activities have been formulated to create the Victorian nursing and midwifery delegation and supervision framework, presented below.



1. Introduction

This document has been prepared as a guide to assist Victorian nurses and midwives with the professional practice of delegation and supervision of nursing and/or midwifery tasks and activities. Notably, this work *does not* seek to replicate or replace the Nursing and Midwifery Board of Australia's (NMBA) publications relating to delegation and supervision. Rather, it aims to assist and provide additional support for Victorian nurses and midwives to implement the NMBA's requirements when faced with delegation and supervision decisions across all Victorian practice contexts.

Victoria has a large nursing and midwifery workforce which is crucial to ensuring the delivery of safe, effective and efficient care to consumers of health services. Increasingly models of care are focusing on an interdisciplinary approach to delivering best practice and nurses and midwives are an integral component of this team-based model. Within the nursing and midwifery arena, team-based approaches are also increasingly adopted as a mechanism to provide more effective care delivery, particularly within a differentiated skilled workforce. With this broader adoption of a team-based model of care, registered nurses and registered midwives will be increasingly required to delegate and supervise nursing and midwifery tasks and activities performed by enrolled nurses, assistant staff and other healthcare workers within the care team.

In acknowledging the increasing requirement of health professionals to delegate and supervise aspects of their role to others, the Victorian Department of Health developed the *Supervision and delegation framework for allied health assistants* (Department of Health, Victoria, 2012) to assist allied health professionals to delegate and supervise safely and effectively. Where possible, *Nursing and midwifery delegation and supervision: Guidelines for Victorian nurses and midwives* is closely aligned with the above-named document in relation to professional requirements and together they aim to support a large proportion of the Victorian health professional workforce to work safely, effectively and efficiently in a team-based environment.

As regulated professionals, nurses and midwives are required to make decisions in the best interests of people within their care (Nursing and Midwifery Board of Australia, 2008). Delegation and supervision of nursing and midwifery care is a complex but important part of professional nursing and midwifery practice that nurses and midwives must be able to perform safely and effectively.

2. Context

It is now well documented that Australia's healthcare system is facing considerable challenges. An ageing population, increased chronicity and acuity of disease, practice advances and evolving technologies continue to grow demand for health services. At the same time, an ageing health workforce and changing labour market constricts the supply of health professionals and the overall cost of healthcare delivery continues to escalate (Health Workforce Australia, 2012). Health Workforce Australia reports further health system changes including decreased lengths of stay, increased demand for inpatient beds, an increase in both the overall volume of care and the complexity of care being delivered in the community and an increase in the number of aged-care beds. Health Workforce Australia states that the expanding role of nurses is being employed as one mechanism to meet these increasing demands (Health Workforce Australia, 2013).

2.1. The nursing and midwifery workforce

Nurses and midwives in Australia are registered and regulated under the *Health Practitioner Regulation National Law Act*. This national law establishes the National Registration and Accreditation Scheme and confers statutory powers on the NMBA, supported administratively by the Australian Health Practitioner Regulation Agency (AHPRA) (NMBA, 2013). The NMBA is responsible for the following statutory functions:

- registration of nurses and midwives, and nursing and midwifery students
- development of standards, codes and guidelines for the nursing and midwifery profession
- handling of notifications, complaints, investigations and disciplinary hearings
- assessing overseas-trained practitioners who wish to practise in Australia
- approving accreditation standards and accredited courses of study (NMBA, 2013).

Nurses and midwives in Victoria are required to be registered by the NMBA in order to practise under the professional titles 'nurse' or 'midwife'. While it is beyond this review to explore registration categories in depth, the NMBA maintains two registers: the *Register of nurses* and the *Register of midwives*. The *Register of nurses* includes two divisions: registered nurses (division 1) and enrolled nurses (division 2). Nurses and midwives can obtain additional endorsement on their registration; for example, a registered nurse who meets the NMBA's qualification and other requirements may be granted endorsement as a nurse practitioner.

The most common entry mechanism for registration as a nurse or midwife is via an approved undergraduate degree in either nursing or midwifery. Less frequently, undergraduates may complete a double degree in nursing and midwifery. There are also some postgraduate entry-to-practice options, and at this stage, the majority of registered midwives have completed an undergraduate nursing degree and a postgraduate midwifery qualification. Current enrolled nurses have typically completed a pre-registration program within the Vocational Education and Training (VET) sector to certificate IV with entry to practice programs required to be taught to diploma level from 1 July 2014.

The National competency standards for the enrolled nurse, produced by the then Australian Nursing and Midwifery Council (ANMC) in 2002 (now Australian Nursing and Midwifery Accreditation Council) and adopted by the NMBA, states that a core aspect of enrolled nurses' practice requires enrolled nurses to work under the direction and supervision of registered nurses¹ (NMBA, 2002). The change in the enrolled nurses' entry-to-practice qualification level noted earlier, may ultimately have an

¹ The separate register for midwives was not in place at this time.

impact on their role and responsibilities because the NMBA has commissioned Monash and Curtin Universities to partner in developing revised competency standards for enrolled nurses, due for release mid-2014 (Monash University, 2013). At this stage, however, existing practice parameters remain. With Victoria's staged introduction of medication administration and management for enrolled nurses, Victorian enrolled nurses already have a degree of variation in their scope of practice; for example, they can be prepared to administer and manage medication at a variety of levels, with enrolled nurses currently falling into one of the four medication administration and management categories:

- registration notation – not educationally prepared to administer or manage medication
- able to administer and manage enteral and topical medication
- as above plus subcutaneous and intramuscular medication
- as above plus intravenous medication.

2.2. Nursing and midwifery demographics

Nurses and midwives are the largest component of the health workforce and are therefore well placed to contribute to health delivery reform. Table 1 provides a brief look at Australia's current nursing and midwifery workforce. This information has been extracted from Health Workforce Australia's 2013 report *Australia's health workforce series: Nurses in focus* and relates to 2011 data.

In summary, of the approximately 330,000 nurses and midwives in Australia, approximately 90,000 work within Victoria. Approximately 80 per cent of nurses are registered nurses and 20 per cent enrolled nurses. The average nurse is aged in their mid-40s and has slightly fewer than 20 years of experience. Only a very small cohort have been endorsed in the clinical category of nurse practitioner (0.3 per cent or 736). The majority of nurses are female, with males retaining a steady proportion of the workforce at 11 per cent. Finally, Australia's overall proportion of nurses per 1,000 head of population sits around the middle of all OECD countries at 10.1 per 1,000, with the average being 8.6 (Health Workforce Australia, 2013).

Table 1: Nursing/midwifery data, 2013

Category	Registered nurse	Enrolled nurse	Total/combined
Number of nurse registrants (Australia)	268,883	59,934	328,817 (plus additional 1,863 registered exclusively as midwives)
% of total registrants	82%	18%	
Total working in Victoria	26% of total Aust. RN workforce (69,910)	34% of total Aust. EN workforce (20,378)	90,288
% of Australian total currently employed in nursing	93.7%	92.8%	
Australian nurse practitioner numbers	736 (or 0.3% total RNs)	N/A	736
Gender (all nurses, all categories)	89% female	11% male	
Average age	44.1 years	45.5 years	
% of total workforce aged over 55 years	21.6%	23.6%	
Average working hours per week	33.3 hours	31.4 hours	
Average number of years of experience	17.3 years	15.6 years	
Number of nurses per 1,000 population* (*based on 2009 data)	Aust. 10.1 OECD average 8.6 per 1,000 Australia is 12th in the OECD ranking per 1,000 population, with Switzerland first at over 16 and Chile last at under two per 1,000		

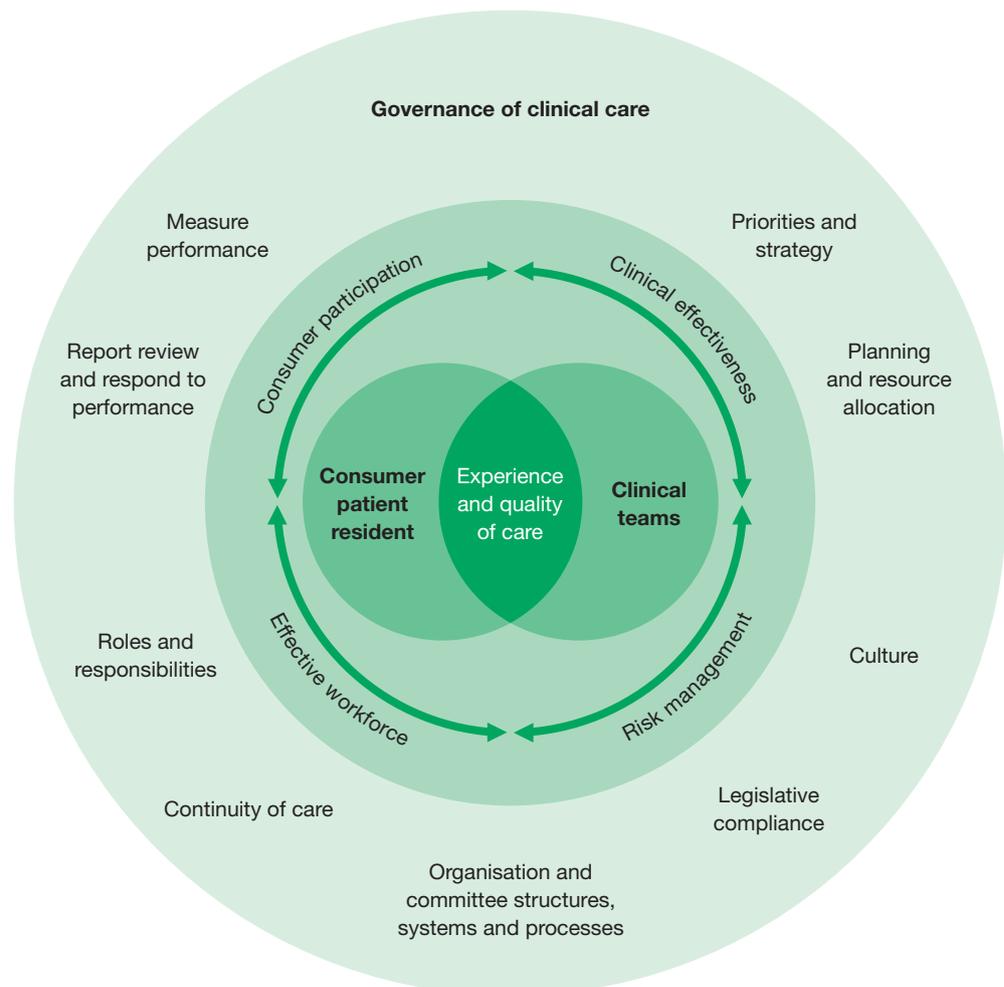
Source: Health Workforce Australia, 2013

2.3. Clinical governance

The Department of Health, Victoria defines clinical governance as ‘the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the safety and quality of care’ (Department of Health, Victoria, 2013a). The department’s clinical governance policy framework outlines four domains of clinical governance, which are shown in Figure 1 and include:

1. consumer participation
2. clinical effectiveness
3. an effective workforce
4. risk management (encompassing incident reporting and management)
(Department of Health, Victoria, 2013b).

Figure 1: Victorian clinical governance policy framework



Source: Department of Health, Victoria, 2013a

A significant component of clinical governance is ensuring that health professionals are adequately equipped to provide safe and effective care. An important aspect of this is ensuring registered nurses and registered midwives have the confidence and competence to appropriately delegate and supervise nursing and midwifery activities and tasks. The NMBA directs this process via published competency standards for registered nurses, registered midwives, enrolled nurses and nurse practitioners, which outline requirements for delegation and supervision. They further support the process with published documents and visual aids to assist decision making.

In acknowledging the importance of safe and effective delegation and supervision, this guide seeks to complement the NMBA requirements and provide Victorian nurses and midwives with a range of information, skills and activities that will assist in the undertaking of sound delegation and supervision practices.

As noted earlier, team approaches are increasingly being adopted as a mechanism to ensure safe, effective and efficient delivery of healthcare. Good teamwork requires an effective contribution from the entire team, so the skills, capability and scope of practice of individuals must form part of the overall clinical governance process for nursing and midwifery management. These requirements were stressed recently through the deficits of care chronicled by Robert Francis in the inquiry into care provided within the Mid Staffordshire NHS Foundation Trust (2005–2009) (Mid Staffordshire NHS Foundation Trust Inquiry, 2010; Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). Much can be learned from the Mid Staffordshire experience and it is vital to consider nursing and midwifery practices from the perspective this delivers.

The inquiry clearly reports significant shortfalls in nursing care. The trust has been condemned for reducing overall nursing and care staff numbers to a critically low level and for a lack of clinical governance and appropriate training and supervision for all levels of nursing (including the assistant workforce) (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013).

An earlier report of the initial inquiry in 2010 notes a nursing workforce that changed its skill mix, resulting in 'a predominance of healthcare assistants over qualified nurses' (Mid Staffordshire NHS Foundation Trust Inquiry, 2010, p. 18). It goes on to state that not only was there a lack of recorded dialogue over how this crucial decision was reached but that the Director of Clinical Standards could not account for the process (Mid Staffordshire NHS Foundation Trust Inquiry, 2010). There are clear portrayals, detailed within the 2013 report of the final inquiry, of healthcare assistants failing to provide adequate care in many aspects of their role including toileting, feeding, assisting with ambulation, maintaining hygiene and infection control and providing compassionate care (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013).

This together with other noted issues within the nursing workforce, including significant staff shortages, a lack of training and education, insufficient equipment, a lack of adequate supervision and a failure to provide adequate clinical governance, all contributed to the 'appalling care provided at the trust' (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013, p. 37). Both the 2010 and the 2013 reports clearly highlight that a poorly trained, poorly supervised and over-burdened workforce can lead to disastrous outcomes. This situation reinforces the need to support nurses and midwives to make sound, informed delegation and supervision decisions and to engage fully with the crucial undertaking of ensuring stringent clinical governance frameworks are in place and adhered to.

3. What is delegation?

The NMBA provides a comprehensive definition of delegation within its document *A national framework for the development of decision making tools for nursing and midwifery* (2007, p. 17) stating:

A delegation relationship exists when one member of the multidisciplinary health care team delegates aspects of consumer care, which they are competent to perform and which they would normally perform themselves, to another member of the health care team.

The delegator retains accountability for the decision to delegate and for monitoring outcomes. Delegations are made to meet consumers' needs and to ensure access to health care services — that is, the right person is available at the right time to provide the right service to a consumer. The delegator retains accountability for the decision to delegate and for monitoring outcomes. Delegation may be either the:

- transfer of authority to a competent person to perform a specific activity in a specific context or
- conferring of authority to perform a specific activity in a specific context on a competent person who does not have autonomous authority to perform the activity.

Delegation is a two-way, multi-level activity, requiring a rational decision-making and risk assessment process, and the end point of delegation may come only after teaching and competence assessment. Delegation is different from allocation or assignment which involves asking another person to care for one or more consumers on the assumption that the required activities of consumer care are normally within that person's responsibility and scope of practice. Many of the same factors regarding competence assessment and supervision that are relevant to delegation also need to be considered in relation to allocation/assignment.

In 2007 the then Nurses Board of Victoria defined delegation as 'the conferring of an authority to a competent individual to perform care activities for a health consumer that they do not have the autonomy to perform' (Nurses Board of Victoria, 2007, p. 4) and, in 2005, the then Queensland Nursing Council (QNC) defined delegation as 'the conferring of authority on a person to perform activities' (Queensland Nursing Council, 2005, p. 17). Further the QNC differentiated between new and established delegation, stating that a new delegation is 'the conferring of authority on a person to perform activities which *are not normally part of their role*' (QNC, 2005, p. 17) and an established delegation is 'when the conferring of authority has already occurred and the context has not changed' (QNC, 2005, p. 17).

Other similar definitions of delegation abound, however, this guideline does not seek to redefine delegation from that provided by the NMBA. Rather, its aim is to support Victorian nurses and midwives to accurately interpret and apply the NMBA's intention.

4. What is supervision?

The NMBA acknowledges three types of supervision in a practice context. These include managerial supervision, professional supervision and clinically focused supervision (Nursing and Midwifery Board of Australia, 2007). The NMBA notes that clinically focused supervision specifically relates to supervision of delegated nursing and/or midwifery tasks and activities and states that it includes:

- providing education, guidance and support for individuals who are performing the delegated activity
- directing the individual's performance
- monitoring and evaluating outcomes, especially the consumer's response to the activity (Nursing and Midwifery Board of Australia, 2007, p. 19).

Further, the NMBA states that there is a range of clinically focused supervision from direct supervision (supervisor is present and observes, guides and directs supervisee) to indirect supervision where 'the supervisor works in the same organisation or facility but doesn't constantly observe their activities' (Nursing and Midwifery Board of Australia, 2007, p. 19). The NMBA states that the appropriate level of supervision will be determined in consultation with the individual accepting the delegation and will consider the context, the needs of the health consumer and the person being supervised (Nursing and Midwifery Board of Australia, 2007).

It is pertinent to note that the supervision being considered in this context is routine supervision of delegated clinical care and this should be differentiated from clinical supervision used as a practice development tool and supervision that has arisen via a registration notation or practice improvement requirement.

5. Responsibilities for delegators and delegates

Delegation and supervision of nursing and midwifery tasks and activities brings with it responsibilities for both those delegating (delegators) and those accepting the delegation (delegates). Those involved in any aspect of delegating or accepting a delegation from a registered nurse or registered midwife must at all times be aware of their responsibilities when doing so. The NMBA clearly outlines these requirements for both delegators and delegates. These are reproduced below.

Responsibilities when delegating

To maintain a high standard of care when delegating activities, the professional's responsibilities include:

- teaching (although this may be undertaken by another competent person, and teaching alone is not delegation)
- competence assessment
- providing guidance, assistance, support and clinically focussed supervision
- ensuring that the person to whom the delegation is being made understands their accountability and is willing to accept the delegation
- evaluation of outcomes
- reflection on practice.

Responsibilities when accepting a delegation

A key component of delegation is the readiness of the recipient of the delegation to accept the delegation. The recipient has the responsibility to:

- negotiate, in good faith, the teaching, competence assessment and level of clinically focussed supervision needed
- notify in a timely manner if unable to perform the activity for an ethical or other reason
- be aware of the extent of the delegation and the associated monitoring and reporting requirements
- seek support and direct clinically focussed supervision until confident of own ability to perform the activity
- perform the activity safely
- participate in evaluation of the delegation.

Activities delegated to another person by a registered nurse or midwife cannot be delegated by that person to any other individual, unless they have since obtained the autonomous authority to perform the activity. If changes in the context occur that necessitate re-delegation, a person without that autonomous authority must consult with a registered nurse or midwife (Nursing and Midwifery Board of Australia, 2007, p. 17).

6. Summary of findings from the literature and discussions with Victorian nurses and midwives

To assist in the preparation of this document, a review of the literature relating to delegation and supervision was conducted. This included an examination of the relevant documentation from the NMBA and a range of international nurse and midwife regulators and professional groups. Using the search engines CINAHL, Medline and ProQuest, as well as the internet, a search was conducted with a combination of the terms 'delegation', 'supervision', 'accountability', 'responsibility' and 'scope of practice'. This process led to the preparation of an initial set of recommendations. Following this, discussions were conducted with a small range of nurses and midwives in metropolitan, regional and rural settings to explore current practice issues, test the preliminary recommendations and explore potential activities and tools to enhance practice (Appendix 2). From this, the recommendations were refined and a delegation and supervision framework was developed. A consultation guide was presented to the Ministerial Advisory Council on Nursing and Midwifery for review and comment, then the final document was prepared.

The following summarises the key findings of theses undertakings. References and complete texts are available within the appendices of this document.

6.1. Complexity and preparation

Findings from the literature include the acknowledgement that delegation and supervision is a complex and difficult skill to master and is often not formally taught within pre-registration programs or within ongoing education activities. The discussions undertaken suggest that at a local level the role of the nurse as leader, and therefore delegator and supervisor, is incorporated into undergraduate programs, but is not a key focus and could be strengthened. In addition, participants from the health services consulted noted limited opportunities to develop delegation and supervision capability within their health service education programs, although some stated this formed part of entry-level management training. Both the literature and the clinicians report, however, that delegation and supervision is a skill largely developed 'on the job'. The literature identified a lack of delegator confidence as a barrier and this was also acknowledged in the consultation conversations. As a skill that is noted to be complex and difficult to learn, a lack of delegator confidence is not surprising.

Key finding:

Nurses and midwives require access to education specifically designed to develop knowledge and skills in the practice of delegation and supervision of nursing and midwifery tasks and activities.

6.2. Leadership, team and communication

As noted above, delegation and supervision inherently requires leadership, teamwork and communication. As could be anticipated, these factors therefore featured highly within both the literature and conversations. The literature is at times quite prescriptive regarding recommended communication styles. Interestingly, within the discussions there were suggestions of providing scripts to assist new delegators with the task of delegation/supervision.

A well-functioning team, where the individuals are supportive of one another's role within that team, will reduce the reluctance to delegate. Noted both in the literature and in the conversations, individuals expressed concern that delegation could be seen as over-burdening others or not 'pulling your weight'. Role clarity is important here, as this sense of reluctance raises the notion of 'permission giving' as an important aspect to encourage appropriate delegation and supervision.

Key finding:

Clear organisational policy and procedure will assist delegators /supervisors and delegates/ supervisees to understand the requirements and responsibilities associated with delegation and supervision.

Key finding:

Development of leadership skills encompassing communication and team engagement is important for safe and effective delegation and supervision.

6.3. Role clarity, scope of practice and capability identification

In order to be fully supportive of one another's roles, individuals require a comprehensive understanding of each position within the team. The literature and discussions frequently raised the issues of role clarity, scope of practice and capability identification as confounding the practice of delegation and supervision. Reliable decisions regarding delegation and supervision require the delegator to have a sound knowledge of both the individual capabilities and role expectations of those to whom they delegate. This challenge formed a significant aspect of all consultation discussions. In order to overcome this concern, consideration needs to be given to more clearly identifying roles and responsibilities and individual capacity.

Key finding:

Role clarity tools and activities are required to ensure safe and effective delegation and supervision practices. These should include:

- clear, informative position descriptions for all members of the nursing/midwifery care teams
- development and implementation of a capability framework to assist registered nurses and registered midwives to identify skills and competency
- development of documentation that explicitly addresses the key role differentiation between registered nurses, enrolled nurses and care assistants.

6.4. Accountability, responsibility, supervision and competency

The literature refers to a reluctance to delegate through fear of retained accountability and responsibility. This concept was explored in the discussions and while there were certainly elements of concern identified, this did not appear to be a major issue for the participants. The notion of trust, however, arose on numerous occasions, with clinicians expressing concern for how they can develop trust in an unknown colleague to attend appropriately to a delegated task or activity. Most reported a trial process, where increasingly demanding requirements were delegated following the successful completion of less taxing activities. Most clinicians reported a preference for initially providing direct supervision until skill capability was identified. Many reported that this was challenging when working frequently with unknown staff, for example with agency staff. The literature is consistent with the consultation conversations on this issue. Commentators noted that ineffective supervision can lead to poor outcomes and that where supervision is close, planned and intentional outcomes for care recipients are more positive.

While the majority of those participating in the discussions worked within traditional inpatient hospital units, those working in different models of care, such as community care, faced particular challenges and expressed a higher level of concern. In these areas especially, a variety of methods were used to identify capability including self-reporting, checklists and competency records.

While it appears that nurses and midwives are aware of their professional requirements in relation to accountability and responsibility, these concepts remain variously understood.

Key finding:

Tools and activities that assist nurses and midwives to fully comprehend and embrace professional accountability and responsibility will enhance delegation and supervision outcomes.

6.5. Regulatory authorities

The nursing and midwifery regulatory authorities reviewed, including the NMBA, offer considerable direction on the activity of delegation and supervision. The NMBA outlines requirements for both delegator and delegatee, identifies four 'rights' of delegation and supervision, and provides assistance by way of decision-making frameworks and documents. International authorities have also addressed this issue and offer similar tools (a review is provided in Appendix 1).

In consultation discussions, however, not all clinicians were fully conversant with these NMBA documents and many identified that they believed them to be impractical tools to deploy at the practice interface. Clinicians were attracted to the notion of a 'rights' statement similar to the medication administration rights, as these appear to be both well understood and well utilised by nurses and midwives in practice. Additionally, a simplified flow chart that could be used as a 'ready reckoner' tool was seen as having the potential to add value, and there were those who remembered an earlier iteration from the Nurses Board of Victoria as being a useful tool.

A review of the international regulatory bodies identified that New Zealand nurse regulators have developed a simple flow chart that is clear and easy to follow, that the United Kingdom (UK) has a clear six aspects statement and that the United States has embedded a five rights of delegation and supervision process into practice. These warrant further consideration as tools that could be adapted and applied effectively to the Victorian context.

Key finding:

Point-of-care tools to support delegation and supervision activities will assist nurses and midwives with their practice.

7. Recommendations for enhancing delegation and supervision: a practice framework

The literature review and consultation summarised above has provided insights into effective delegation and supervision practices, noted above as key findings. It has been shown that delegation and supervision is a difficult but necessary activity to master. Changes to our healthcare delivery systems are necessitating an increase in its requirement and delegators at the care interface need preparation and support to develop and maintain their skills.

'Delegation and supervision ... is a complex critical thinking process requiring expert clinical judgment, superb emotional intelligence, and flexible, innovative leadership skills' (Hansten, 2008 p.19)

Existing documentation from the NMBA is comprehensive but not suitable as a ready reckoner tool. There are, however, examples from the international nurse/midwife regulation community that could be adapted for the Victorian context. At the point of care, clarification of arising delegation and supervision queries needs to be readily accessible and consideration should be given to user-friendly, plain-English summary documents and flow charts that can be carried or displayed to assist decision making and prompt desirable outcomes.

Some clinicians have requested clarity through providing task lists and it is possible that in some circumstances these could provide assistance to delegators and delegates. However, their construct will be insufficient to ensure safe and effective delegation and supervision, as continual application of critical thinking and assessment by the registered staff member for all delegation decisions is crucial. Exclusive reliance on delegation task lists does not account for individual differences in delegator and delegatee competence and confidence, nor does it account for differences in care or care delivery circumstances. It can be seen therefore that delegation decisions made purely on task lists are unreliable and unsafe and ultimately could also limit legitimate delegation activity if they fall behind practice development.

Understanding all team members' roles and individual capability at the clinical interface is crucial for developing trust and a willingness to delegate, and to ensure safe and effective delegation. Nursing and midwifery leaders should consider how best to provide clinically based staff who are required to delegate, with mechanisms that enable the ready access of this information. Some clinicians spoke of 'credentialing' processes, referring to assessing and recording scope of practice and capability. These should be carefully considered; however, the administrative burden of not only maintaining accurate credentialing records but also ensuring each staff member is 'competent' in the range of identified tasks or activities is a significant undertaking. The Victorian clinicians consulted believed skill and ability were readily assessable through supervision of 'regular staff' in traditional inpatient care models. Transient (for example, agency) staff and other care models, especially community-based care or care delivery that does not have ready access to direct supervision, present a particular challenge that must be considered.

Consideration should also be given to assisting the nursing and midwifery workforce to better understand the differences between nursing roles. At present, this is most evident in the lack of clarity reported between registered and enrolled nurses. Education programs that focus on supporting a better understanding of role delineation would potentially reduce confusion and assist both levels of nurse to work towards their full scope of practice.

Key to successful delegation and supervision has been repeatedly shown to sit with sound skill development and regular reinforcement in the delegator. Opportunities to formally develop these skills and to regularly practice, maintain and improve them, is therefore essential for all staff required to delegate and supervise. Delegates, too, would benefit from clear direction and the opportunity to practise and develop skills to ensure they accept only suitable delegations and are fully conversant with their responsibilities once accepted. This skill development must include the capacity to competently communicate, as this has been identified as key to enhancing all aspects of delegation and supervision interaction. Similarly, development programs should focus on skills such as team management and participation, leadership, conflict resolution and assertiveness.

7.1. Recommendations

The key findings noted in section 6 above have been formulated into the following recommendations and framework. It is anticipated that the implementation of these will create an environment where delegation and supervision of nursing and midwifery tasks and activities is safe, effective and efficient.

The program of work necessary to adopt these recommendations, and the associated framework, assumes a shared responsibility where individuals, education providers, employers, the Department of Health and professional bodies all contribute to the development and implementation of the associated tasks and activities.

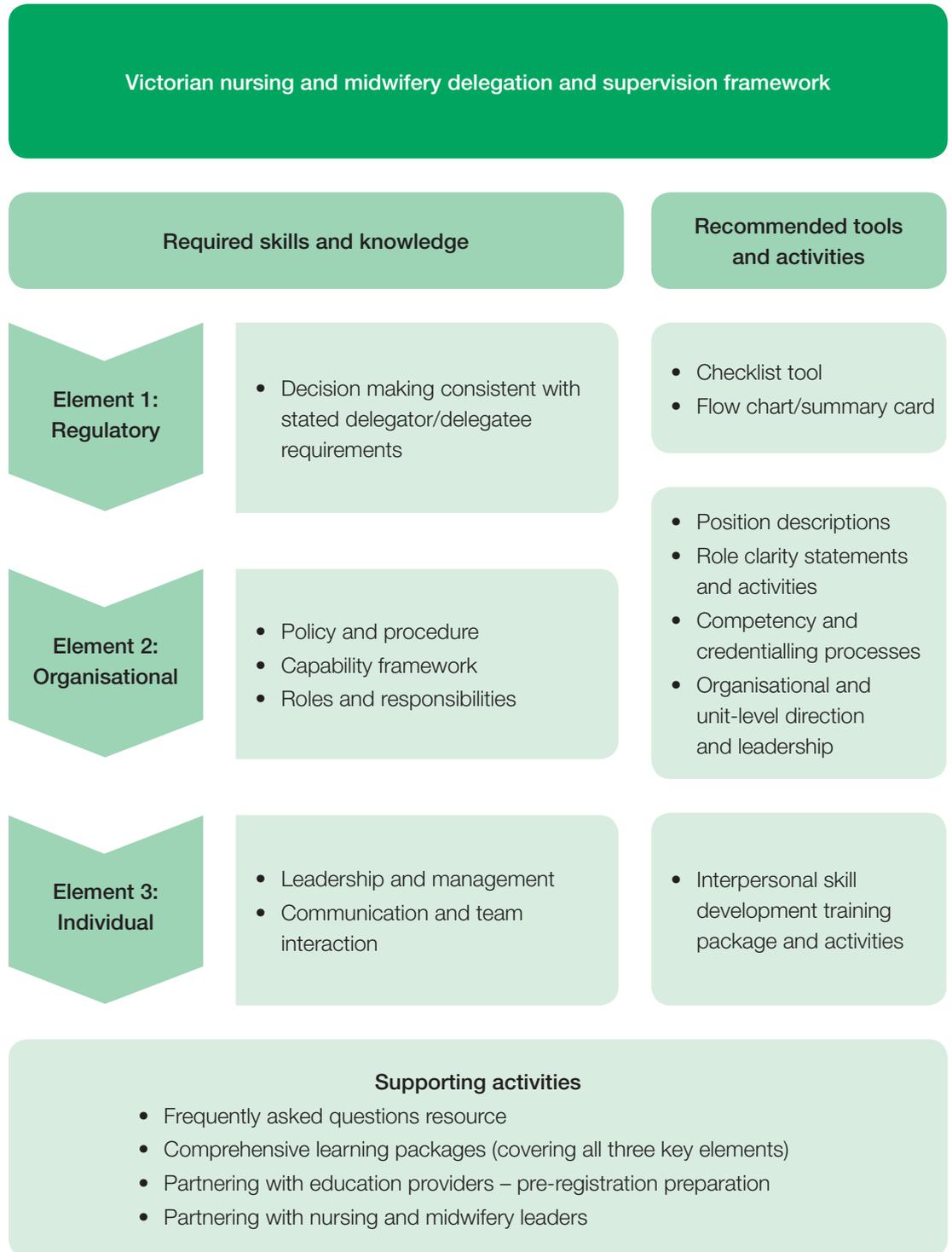
Recommendations for safe, effective and efficient delegation and supervision of nursing and midwifery tasks and activities:

1. Nursing and midwifery leaders should be aware of and understand the key regulatory, organisational and individual factors that create opportunities for safe and effective delegation and supervision.
2. Employers of nurses and midwives should include delegation and supervision as a core component of their continuing education activities.
3. Employers of nurses and midwives should ensure there is a clear and consistent policy and procedure in place that outlines requirements for safe and effective delegation and supervision of nursing and midwifery tasks and activities. This should be inclusive of roles and responsibilities for delegators/supervisors and delegates/supervisees.
4. Nurses and midwives should have access to a range of educational learning tools that include the key elements of effective and efficient delegation and supervision addressing regulatory, organisational and individual matters.
5. A suite of tools should be developed and implemented to assist in strengthening role clarity between registered, enrolled and assistant workforces (for example, comparing/contrasting different roles and responsibilities).

6. Delegators/supervisors and delegatees/supervisees should have access to point-of-care decision-making aids such as:
 - a. a delegation and supervision summary card and/or flow chart that could be displayed and/or carried
 - b. a decision-making checklist aid modelled on the 'five rights' style of statements noted in the literature.
7. Nursing and midwifery leaders should work closely with education providers to enhance opportunities to prepare pre-registration students for their role as delegators and supervisors.

These recommendations form the basis of the delegation and supervision framework for nurses and midwives represented in Figure 2. This framework shows the three key elements of delegation and supervision on the left as being the regulatory, organisational and individual requirements and the corresponding skills and knowledge needed within each element. Specific tools and activities to support these requirements are noted, as are underpinning activities that will enhance all elements.

Figure 2: Delegation and supervision framework for nurses and midwives



Appendix 1: Literature review

Delegation and supervision literature review

'Delegation and supervision skills are fundamental ... Without being expert at these basic practices, we cannot deliver safe, optimal care and engage passionately purposeful workers' (Hansten, 2008, p. 24)

It is an important part of a professional registered nurse and registered midwife's role to delegate aspects of consumer care to more junior registered nurses and registered midwives as well as enrolled nurses and assistant personnel, and to supervise the undertaking of these activities and the staff who carry them out (Nursing and Midwifery Board of Australia, 2006a; Nursing and Midwifery Board of Australia, 2006b). It is therefore necessary for registered nurses and registered midwives to have a sound level of competence and confidence with the skill of delegation and supervision; however, as Wedyt (2010, n.p.) notes, while 'Delegation belongs to the practice of registered nurses ... it is not well understood or practiced'.

The following is an examination of the existing literature relating to the concept of delegation and supervision within the nursing and midwifery professions. Using the search engines CINAHL, Medline and ProQuest as well as the internet, a search was conducted with a combination of the terms 'delegation', 'supervision', 'accountability', 'responsibility' and 'scope of practice'. Existing guidelines and documents from Australian and international nurse and midwife regulators, professional bodies and industrial organisations representing nurses and midwives were also studied. The review examines the current definitions of delegation and supervision, explores the need for nurses and midwives to delegate aspects of their role, and identifies barriers and enablers to effective and efficient delegation and supervision.

1. Current healthcare context

Delegation and supervision has been a prevalent component of the nursing role for generations, reportedly dating back to Florence Nightingale times (Henderson, et al., 2006). It is therefore not a new requirement but one that is currently on the rise. Australia and other western nations are currently experiencing a contextual shift within the broader population demographic, the health workforce and the drivers for healthcare delivery. It is anticipated that these changes will increase the requirement for registered nurses and registered midwives to delegate and supervise nursing and midwifery activities (Munn, Tufanaru, & Aromataris, 2013). An ageing population, living longer with a greater degree of chronic disease (thereby necessitating more complex care), rapidly evolving technology, changes in consumer expectations and increasing costs of healthcare delivery are now well understood aspects of the current and perceived future Western healthcare context (Anthony, Standing & Hertz, 2000; Hansten, 2008; Henderson, et al., 2006; Munn, et al., 2013; Wedyt, 2010). Nursing and midwifery models of care must therefore evolve to meet demand. This includes redefining care teams that will continue to impact on the registered nurse and registered midwife's requirement to delegate and supervise aspects of nursing and midwifery work.

Many authors note that these changing conditions require a different way of organising and delivering nursing and midwifery care, acknowledging that nurses and midwives will increasingly be required to delegate aspects of their activities to others (Anthony, Standing, & Hertz, 2000; Cipriano, 2010; Duffield, Gardner, & Catling-Paull, 2008; Gillen & Graffin, 2010; Gravlin & Bittner, 2010; Hansten, 2008; Milton, 2008; Munn, Tufanaru, & Aromataris, 2013; Neumann, 2010; Saccomano & Pinto-Zipp, 2011). In the Victorian context, this includes assistant staff and enrolled nurses. Saccomano and Pinto-Zipp (2011) and Munn et al. (2013) note that the previously prevalent allocation model of nursing/midwifery care delivery is now giving way more frequently to a team-based model where assistant and second-tier nursing staff work together with registered nurses and registered midwives (albeit less frequently at this stage). This model increases the requirement for delegation and supervision by the registered nurse / registered midwife (Cipriano, 2010; Weydt, 2010), which is noted to be a complex and difficult task (Gravlin & Bittner, 2010; Weydt, 2010). This suggests that for this new model to be an effective method of care delivery, registered nurses and registered midwives will need to access mechanisms that improve their ability to undertake delegation and supervision with confidence and competence.

Nursing and midwifery commentators note that delegation unburdens registered staff from unnecessary work that others can do (Cipriano, 2010; Duffield, Gardner & Catling-Paull, 2008; Gillen & Graffin, 2010; Parkman, 1996), an important fact when the above conditions are taken into account. In addition, Gillen and Graffin (2010) provide clear support for delegation of suitable activities stating, 'Delegation benefits the patient in that it can match the right person with the right expertise for the right job' (Gillen & Graffin, 2010, n.p).

Taking this increased requirement to delegate, together with the complexity of delegation and supervision, it is not surprising that there is frequent mention of the potential impact on quality of care of delegation practices by registered nurses and registered midwives (Bittner et al. 2011; Gravlin & Bittner, 2010; Hansten, 2008; Weydt, 2010). Bittner et al. (2011) claim that ineffective delegation can lead to care omissions. They note inconsistency in delegated tasks, poor understanding of delegatee skill and knowledge, role confusion and poor communication as key aspects that contribute to delegation errors resulting in missed care. This further highlights the importance of supporting registered staff to undertake effective delegation and supervision of nursing and midwifery activities.

It has been noted that there are a number of definitions of delegation in the nursing literature; however, common elements are apparent in the majority and include: that an activity is assigned to another and accepted by this person; that the registered nurse or registered midwife delegator retains accountability and responsibility for the work allocated; and that once accepting the delegation, the delegatee or work performer accepts responsibility for carrying out the activity (Gillen & Graffin, 2010). Accountability and responsibility are important concepts within this definition and these will be further examined in following sections of this review.

2. Existing directions/guidelines

A number of nursing and midwifery authorities have published on the topic of delegation and supervision and these publications can assist in building a deeper understanding of the related issues. It must be acknowledged, however, that there are contextual, legislative and regulatory differences that exist between the authorities and these must be considered in any direct comparison to the Victorian context.

2.1. National

2.1.1. Nursing Midwifery Board of Australia

The *National competency standards for the registered nurse* (Nursing and Midwifery Board of Australia, 2006b) and *National competency standards for the registered midwife* (Nursing and Midwifery Board of Australia, 2006a) outline the requirements for the respective professions regarding delegation, noting that the registered nurse or registered midwife retains accountability and responsibility for the delegated activity. In addition, the documents note the requirement for registered nurses and registered midwives to ensure the delegatee has the skills and experience to undertake the delegated activity and to ensure that delegating the activity is in the consumer's best interest (Nursing and Midwifery Board of Australia, 2006a; Nursing and Midwifery Board of Australia, 2006b). The *National framework for the development of decision-making tools for nursing and midwifery practice* provides a list of responsibilities for delegators and delegates (Nursing and Midwifery Board of Australia, 2007), requiring delegators to:

- undertake teaching (although this may be via a competent third party)
- undertake competence assessment of the delegatee
- provide guidance, support and clinical supervision
- ensure the delegatee understands their accountability
- ensure the delegatee agrees to undertake the role
- evaluate outcomes
- reflect on practice.

Delegatees are required to:

- negotiate teaching, competence assessment and the level of clinical supervision required
- notify the delegator if they are unable to perform the activity
- be aware of the extent of the delegation and monitoring and reporting requirements
- seek support and direct supervision until they are confident of their own ability
- perform the activity safely
- participate in an evaluation of the delegation (Nursing and Midwifery Board of Australia, 2007).

In addition this document states that once a registered nurse or registered midwife has delegated an activity, the delegatee cannot further delegate this activity 'unless they have autonomous authority to perform the activity' (Nursing and Midwifery Board of Australia, 2007, p. 17).

The *National competency standards for the enrolled nurse* (Nursing and Midwifery Board of Australia, 2002)² further confirm the second tier nurse's responsibility when accepting a delegation, stating that the enrolled nurse works under the direction and supervision of the registered nurse,³ retains responsibility and remains accountable for their own actions. It is important to note that the NMBA has engaged Monash University in conjunction with Curtin University to review the national competency standards for enrolled nurses. The stated purpose of this is to revise the 'Competency Standards for relevance and currency against the contemporary Enrolled Nurse Role and Scope of Practice' (Monash University, 2013 n.p). While the revised standards are not expected to be released until the middle of 2014, it is plausible that their revision may impact on the current delegation and supervision arrangements, particularly in relation to those enrolled nurses who are prepared to the diploma level under the National Training Package.

The NMBA provides an explanation of the delegation relationship in its document *A national framework for the development of decision-making tools for nursing and midwifery practice* (2007), stating that a delegation relationship occurs when a member of the healthcare team delegates aspects of care that they are competent to perform and would normally perform themselves, to another member of the healthcare team who may be either from the same discipline or a different discipline. It states that the delegation must be made in order to meet the needs of a care consumer, ensuring safe and timely access to healthcare delivery. The NMBA (2007) defines delegation of aspects of nursing or midwifery work to be either the:

- transfer of authority to a competent person to perform a specific activity in a specific context or
- conferring of authority to perform a specific activity in a specific context on a competent person who does not have autonomous authority to perform the activity (Nursing and Midwifery Board of Australia, 2007, p.17).

The Board differentiates delegation from allocation or assignment, stating that the latter is based on the assumption that the care requirements are normally within that individual's responsibility and scope of practice (Nursing and Midwifery Board of Australia, 2007).

Within the document *A national framework for the development of decision-making tools for nursing and midwifery practice* is a statement that outlines four 'rights' to consider when making decisions about nursing practice. They are that 'the right person (nurse or non-nurse) is in the right place to provide the right service for the client at the right time' (Nursing and Midwifery Board of Australia, 2007, p. 7). As noted below in further detail, the United States adopted five rights for delegation and supervision in 1995 (National Council of State Boards of Nursing, 2005). These appear to be widely accepted and utilised in the United States, suggesting that further development and publication of the NMBA 'rights' could assist nurses and midwives with point-of-practice decisions in Victoria.

2 It is noted that these NMBA documents were originally developed by the Australian Nursing and Midwifery Accreditation Council under its previous iteration as the Australia Nursing and Midwifery Council and have been adopted by the Nursing and Midwifery Board of Australia since its inception in 2010.

3 this 2002 document preceeded the establishment of the title 'registered midwife'.

As they stand currently, the NMBA documents are necessarily comprehensive, and when followed carefully, provide a thorough guide that is instructive in the process of decision making. This complexity suggests, first, that potential delegators will need assistance to learn to effectively apply these guidelines, and second, that delegates will need assistance to understand their obligations when accepting a delegation. Third, at the point of care, these tools may be too involved to be an effective and efficient guide. It can therefore be seen, that a more readily accessible, user-friendly option, that supports the interpretation of the NMBA's requirements, will be of value for use at the point of care delivery.

2.1.2. Australian Nursing and Midwifery Federation

The Australian Nursing and Midwifery Federation (ANMF) is the largest industrial member organisation for registered nurses, enrolled nurses, registered midwives and assistants in nursing (Australian Nursing and Midwifery Federation, 2013). The ANMF publishes opinion and guidance documents for its members and has published guidelines for registered nurses and registered midwives when delegating activities to enrolled nurses, assistive staff or other non-nursing/non-midwifery personnel. These guidelines predominately reflect the NMBA's requirements outlined above, particularly in relation to delegatee and delegator accountability and responsibility, and also outline their interpretation of requirements for employers. These requirements largely centre on the ANMF's focus to ensure registered staff have access to information relating to: the delegatee's skill, training and competence; registered nurses / registered midwives not being required to delegate unlawfully; and clear policy and procedures in place to guide the registered staff member when making a delegation.⁴ The guide cautions members not to assume organisational policy and procedure is in line with legislative requirements and urges individual members to seek ANMF advice, or advice from other relevant organisations (Australian Nursing and Midwifery Federation, 2004 (re-endorsed 2011)).

2.1.3. Professional organisations

The Royal College of Nursing Australia and The College of Nursing merged in July 2012 to become the Australian College of Nursing (ACN) (ACN, 2013). The ACN advocates and educates on behalf of the nursing profession; however, at the time of writing, the college was undertaking a review of all position statements and had no published comment or guide relating to delegation and supervision (ACN, 2013).

The Australian College of Midwives is a professional organisation, stating to be the peak professional body representing midwives in Australia (Australian College of Midwives, 2013). A review of the freely available content on their website did not reveal any comment or publication relating to delegation and supervision by midwives (Australian College of Midwives, 2013).

2.2. International position

International nurse regulation agencies provide a valuable reference for information and comparison with our Australian and Victorian context and a number of Western nursing regulators are therefore examined below. Given differences in legislative, educative and other nursing practices, however, caution must be exercised when considering international guidelines for Victorian nursing and midwifery practices.

⁴ It should be noted that these recommendations are also in line with NMBA requirements.

2.2.1. International Council of Nurses

The Australian College of Nursing is Australia's member organisation on the International Council of Nurses (ICN) (Australian College of Nursing, 2013). The ICN is a federation of more than 130 national organisations representing more than 16 million nurses. The ICN publishes a range of position statements relating to health policy and nursing (ICN, 2013).

Given the breadth of the ICN's coverage, it would be beyond scope for the federation to outline specific mechanisms to undertake nursing work; however, its 2003 position statement on the scope of nursing does state that nursing practice includes supervising and delegating to others (ICN, 2003). Further, the ICN *Position statement: Assistive nursing personnel*, states that registered nurses are responsible for delegation and supervision of nursing care to assistive staff and are responsible for identifying care that can be safely delegated to maximise team effectiveness and promote access to quality healthcare (ICN, 2008). This statement is consistent with the documents published by the NMBA.

2.2.2. New Zealand

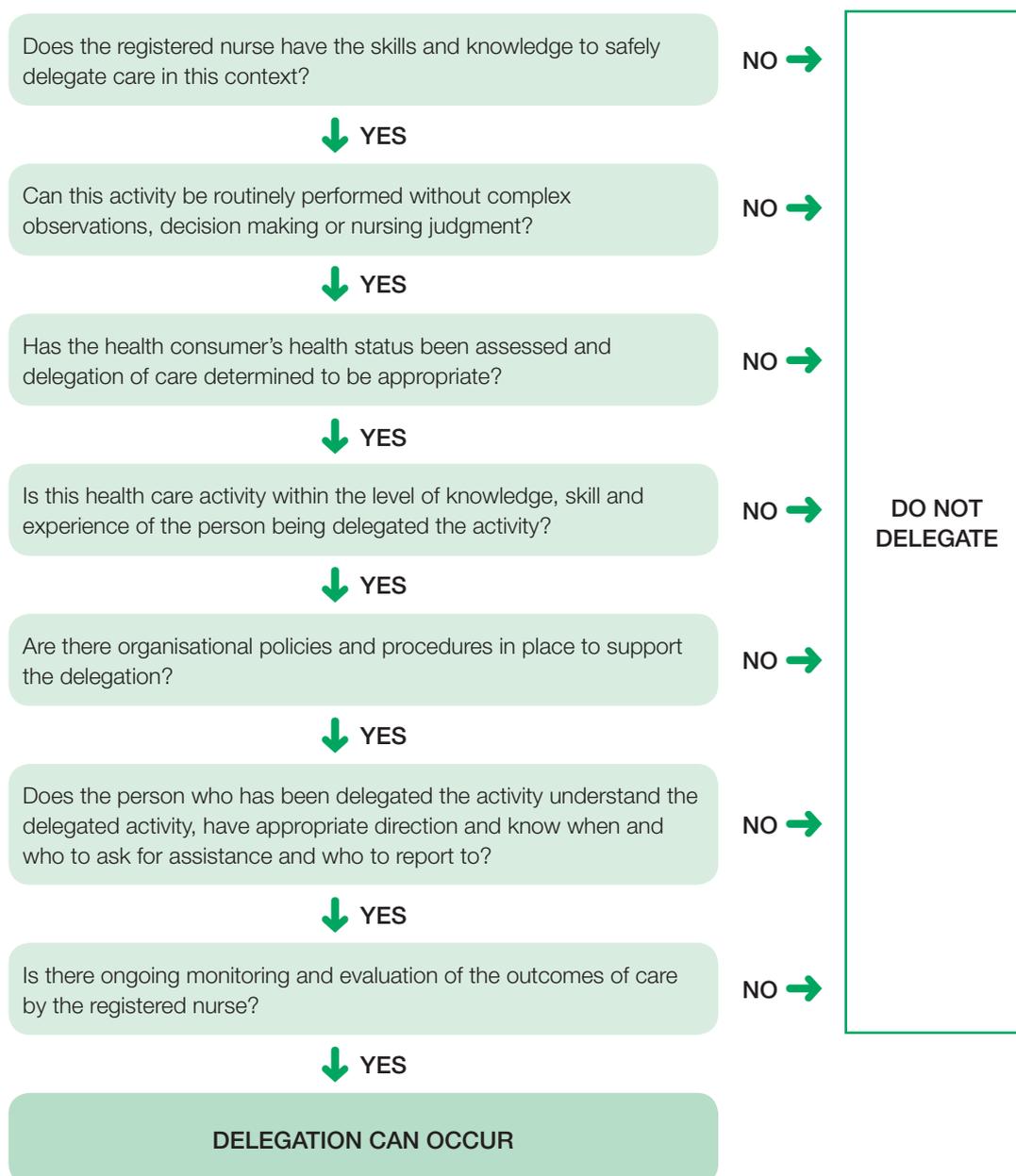
New Zealand nurses are registered by the Nursing Council of New Zealand (Nursing Council of New Zealand, 2013). The council has a number of publications that address the issue of registered nurses delegating and supervising care provided by others. Midwives are registered by the Midwifery Council of New Zealand. The Midwifery Council's website and associated publications that were freely accessible are silent on the issue of delegation and supervision of midwifery work (Midwifery Council of New Zealand, 2013).

The main Nursing Council of New Zealand publications addressing delegation are; *Guideline: Delegation of care by a registered nurse to a health care assistant* (2011a) and *Guideline: Responsibilities for direction and delegation of care to enrolled nurses* (2011b). These documents provide a definition of delegation and supervision that is consistent with Gillen and Graffin's (2010) assessment of common elements of delegation definitions and states that '[d]elegation is 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, 2011a; Nursing Council of New Zealand, 2011b). These documents outline principles of delegation that are consistent between enrolled nurses and assistants in nursing (despite the differences in registration status, education and competency between the two). These principles include:

1. Delegation is a professional judgement by a registered nurse, which considers the health consumer's condition, the complexity of the delegated activity, the context of the care delivery setting and the capability of the delegatee or work performer.
2. Delegation must be consistent with the policy and procedures of the employing organisation.
3. The registered nurse must ensure the work performer understands the activity delegated, are provided with clear direction, know when and from whom to seek assistance and know who to report to.
4. The registered nurse retains responsibility for monitoring and evaluating the outcomes of delegated nursing care (Nursing Council of New Zealand, 2011a; Nursing Council of New Zealand, 2011b).

Figure 3 is taken from the Nursing Council of New Zealand's *Guideline: Delegation of care by a registered nurse to a health care assistant* (2011a). It provides a clear and useful tool for registered nurses when making delegation decisions. Deliberation should be given to the inclusion of this type of decision tree in the preparation of the Victorian delegation and supervision guidelines.

Figure 3: Decision-making process for delegation by a registered nurse in New Zealand



Source: Nursing Council of New Zealand 2011a

2.2.3. United Kingdom

Nurses and midwives within the UK are regulated via the Nursing and Midwifery Council (NMC) (Nursing and Midwifery Council, UK, 2013). The NMC provides guidance to nurses and midwives regarding delegation and supervision that is predominately in keeping with that provided for our Australian context by the NMBA. The NMC clearly states six aspects to consider when contemplating delegation. These are:

1. the needs of the people in their care
2. the stability of the people being cared for
3. the complexity of the task being delegated
4. the expected outcome of the delegated task
5. the availability of resources to meet those needs
6. the judgement of the nurse or midwife (Nursing and Midwifery Council, UK, 2013).

Further, the NMC also highlights that nurses and midwives are accountable for the decision to delegate care, that they must ensure the delegatee or work performer has appropriate training and is competent to perform the task, and that this person understands the task and what is expected of them. Additionally, the delegatee or work performer must know their practice limitation and know when and from whom to seek assistance. Once these conditions are met, the NMC states that care can be delegated and from this point the delegatee becomes accountable for their actions and decisions. Similar to other nursing regulator positions considered in this review, the nurse or midwife 'remains accountable for the overall management of the person in their care' (Nursing and Midwifery Council, UK, 2013, n.p.).

The document, *The code: Standards of conduct, performance and ethics for nursing and midwifery* (Nursing and Midwifery Council, 2008) outlines 64 standards covering a wide range of nursing and midwifery requirements. Three of these relate directly to delegation:

- You must establish that anyone you delegate to is able to carry out your instructions.
- You must confirm that the outcome of any delegated task meets required standards.
- You must make sure that everyone you are responsible for is supervised and supported (Nursing and Midwifery Council, 2008).

In keeping with the NMC's apparent focus on accessible language, the language used in this document is simplistic and it may be that there is some loss of depth and meaning because of that; however, it is highly comprehensible and readily accessible. Noting the concerns raised above regarding the complexity of the NMBA documents, a similar clear language style could be considered an important aspect of guidance documents that are intended to be accessed at the point of care.

2.2.4. Canada

Canadian nurses and midwives are regulated via local provincial regulation agencies of which there are 12 across the country. The Canadian Council of Registered Nurse Regulators (CCRNR), established in 2011, is a national organisation that is made up of representatives from the 12 regulating bodies providing a national platform for consideration of nurse regulation issues (CCRNR, 2013); however, at this stage it does not appear that the CCRNR has published its position on either delegation and supervision or other nursing issues.

With the Canadian nurse regulation process being provincially based and the national regulation representation body being silent on the concept of delegation and supervision, it is necessary to look to the Canadian Nurses Association for a national perspective. The Canadian Nurses Association is a national professional organisation representing Canadian nurses and is also Canada's member on the International Council of Nurses (Canadian Nurses Association, 2013). The Canadian Nurses Association's range of position statements includes a statement on staff nursing care where the organisation's perceptions of delegation and supervision are explored (Canadian Nurses Association, 2003). This document provides a number of principles for decision making related to the delivery of safe nursing care, one of which includes:

Responsibility and accountability of care providers are clear. *RNs are familiar with the job description/scope of practice of any [care provider] to whom they are assigning or delegating.* *Regulated care provider groups are held accountable to identify their competencies. Care providers must 'identify when assignment of care exceeds their individual competency level, and ... seek support and direction appropriately*

(Canadian Nurses Association, 2003, p. 2)

This principle is consistent with other international positions, including that expressed by the NMBA (Nursing and Midwifery Board of Australia, 2007).

A number of Canada's provincial nurse regulation agencies have published documents relating to delegation and supervision that support the development of an international perspective on this complex nursing/midwifery activity. Ontario is Canada's most populated province and its nurses are regulated by the College of Nurses of Ontario. The college has published widely on delegation and supervision and the related concepts of accountability and responsibility (College of Nurses of Ontario, 2013); however, practice differences between the Ontario and Australian legislative frameworks limit the applicability of the Ontario perspective to our local context. Ontario's nurses are required to provide care under a task list of 'authorised acts' (College of Nurses of Ontario, 2013) that, although provides clarity to the nursing and broader health workforce, has been avoided by Australian nurse/midwife regulators due to the notion that tasks or authorised act lists can quickly become outdated and unnecessarily limit practice (Nursing and Midwifery Board of Australia, 2007).

2.2.5. United States

Nursing and midwifery within the United States is regulated via local state-based councils and regulation authorities. The National Council of State Boards of Nursing (NCSBN) is a national organisation that supports the state authorities to come together on issues of common interest (National Council of State Boards of Nursing, 2013).

The NCSBN has developed and published comprehensive guidelines for delegating nursing work. Core to these are the five rights of delegation initially published by the NCSBN in 1995 (National Council of State Boards of Nursing, 2005). These rights are 'to be sure that the delegation or assignment is:

1. The **right task**
2. Under the **right circumstances**
3. To the **right person**
4. With the **right directions** and communication
5. Under the **right supervision and evaluation'** (National Council of State Boards of Nursing, 2005).

The NCSBN and the American Nursing Association (ANA) have published a joint position statement on delegation. It notes that both organisations define delegation as 'the process for a nurse to direct another person to perform nursing tasks and activities' and highlights the registered nurse's retention of accountability for the delegated activity (American Nurses Association & National Council for State Boards of Nursing, 2006, p. 1). This document also outlines a series of principles under the headings of 'over-arching', 'nurse related' and 'organization'. Largely, these principles are consistent with the notions expressed within the NMBA documents.

Similar to the NMBA and the Nursing Council of New Zealand, the NCSBN has published a decision-making tree that can assist registered nurses when making delegation decisions (National Council of State Boards of Nursing, 2013). While the NCSBN version is more comprehensive than the New Zealand tool, as with the NMBA documents, ease of use should be considered and this may be an impractical tool for registered staff to rely on at the practice interface. It is reproduced in Figure 4 for information.

The decision-making process in relation to delegation then considers three further issues in some detail. These include communication, surveillance/supervision, evaluation and feedback (National Council of State Boards of Nursing, 2005).

Nurse regulators in the United States have provided a significant amount of guidance to the registered workforce regarding effective processes to delegate nursing/midwifery activities. While the decision trees and related documents could be considered too involved to provide ready assistance for point-of-care decision making, the five rights process may be of significant benefit within the Victorian practice context. The 'rights' for medication administration appear to be well embedded nursing/midwifery concepts in Victoria, suggesting that using this technique to assist delegation decisions is worthy of further consideration.

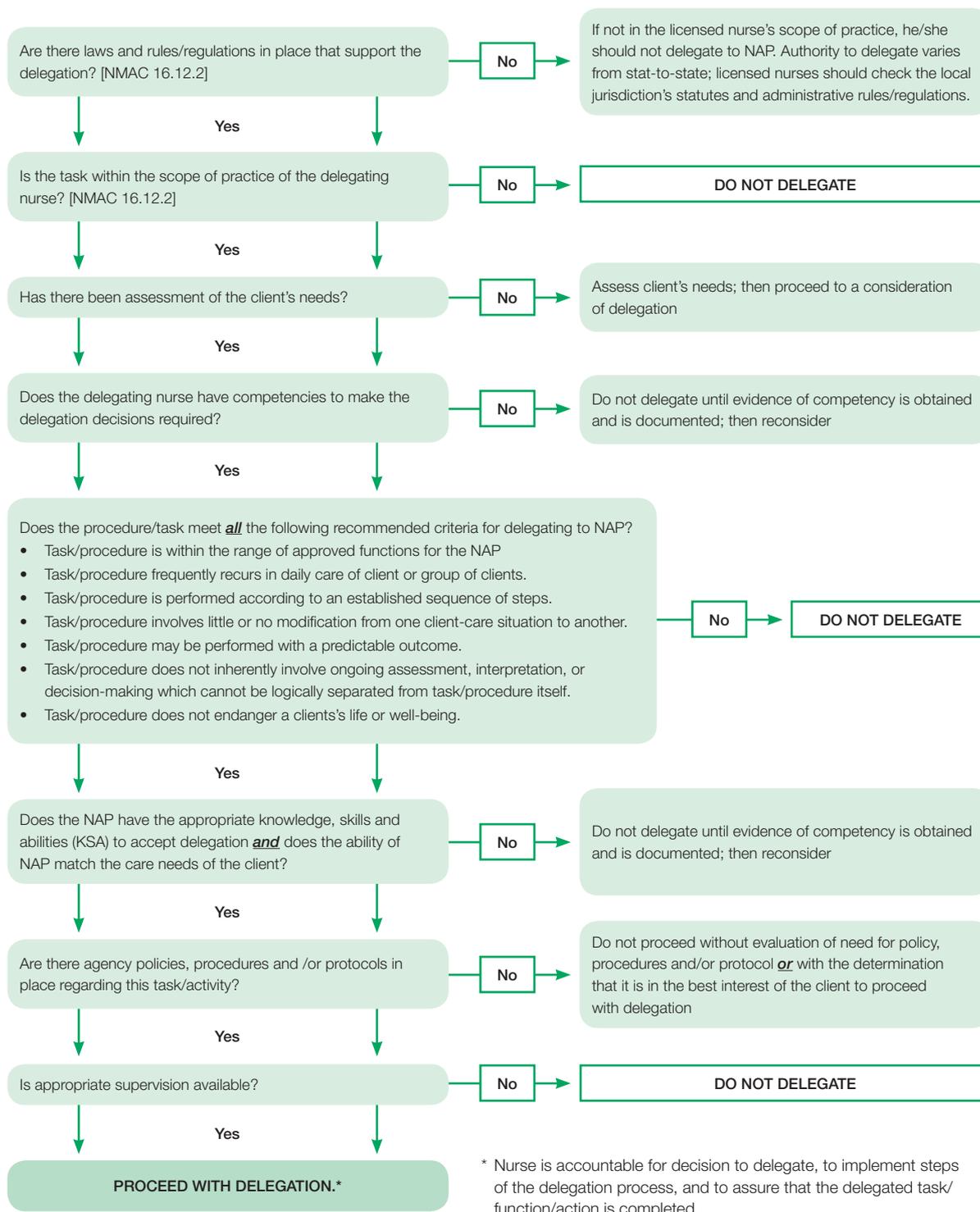
3. Barriers and enablers to effective delegation and supervision

The current literature on delegation and supervision is largely written from the reference point of delegating and supervising nursing activities to assistive personnel rather than other registered nurses, registered midwives, enrolled nurses (or equivalent) or other health professionals. The literature is virtually silent on delegation by registered midwives; however, many of the barriers and enablers to effective delegation and supervision discussed are considered to be applicable to all forms of delegation and supervision of nursing and midwifery activities regardless of to whom they are delegated.

This, coupled with the aforementioned requirement to increase delegation and supervision as a response to workforce and health delivery pressures, provide compelling reasons to ensure that the registered nurse / registered midwife workforce is confident and competent in their role of delegator and supervisor. In order for this to be the case, the key barriers must be mitigated and key enablers exploited to ensure the most effective and efficient processes for delegation and supervision are in place.

As stated earlier, Wedyt (2010) notes that delegation is a complex nursing/midwifery. This in itself is a significant barrier to effective delegation and supervision, but there are additional barriers and enablers that should be considered when exploring ways to enhance this practice.

Figure 4: NCSBN delegation decision-making tree, 2006



Source: Nursing Council of New Zealand, 2011a

3.1. Scope of practice

A sound understanding of the concept of a registered nurse and registered midwife's scope of practice is an important enabler to effective delegation and supervision.

Scope of practice can be divided into the profession's scope and the individual's scope with a profession's scope of practice being 'the full spectrum of roles, functions, responsibilities, activities and decision-making capacity that individuals within that profession are educated, competent and authorised to perform' (Nursing and Midwifery Board of Australia, 2007, p. 1), and the individual's scope being 'that which the individual is educated, authorised and competent to perform' (Nursing and Midwifery Board of Australia, 2007, p. 2). In this regard it can be seen that while an activity may be within the profession's scope of practice, it could fall outside of the current scope of practice of an individual if they have not fulfilled one or more of the criteria for education, authorisation or competence.

The NMBA has published competency standards for registered nurses, registered midwives, enrolled nurses and nurse practitioners (NMBA, 2013). These standards outline scope of practice via categorisation under a number of practice domains for the respective professional groups. Unlicensed assistive personnel (however titled) are by definition unregulated and therefore do not work to a professional 'scope of practice' but rather their work is defined by: the role description provided by their employer; the delegation of activities by a registered nurse / registered midwife; and their training and experience to undertake a specific task. In this way, avoiding the term 'scope of practice' when referring to unlicensed assistive personnel helps to retain an important distinction between regulated and non-regulated care providers.

Within the registered nurse and registered midwife's professional scope of practice is the capacity to make and receive delegations of care (Nursing and Midwifery Board of Australia, 2007). As noted earlier, however, a registered nurse or registered midwife can only delegate activities that fall within their own scope of practice and this therefore must be taken into account when delegation decisions and models of care are being considered. The NMBA states that an enrolled nurse provides care under the delegation and supervision of the registered nurse / registered midwife; however, the competency standards for enrolled nurses do not provide them with the capacity to delegate nursing activities (Nursing and Midwifery Board of Australia, 2002). While it is noted that these competency standards are currently under review, at this stage delegation of nursing or midwifery activities is the sole responsibility of the registered nurse or registered midwife respectively.

3.2. Accountability and responsibility

The NMBA (as well as the international regulators noted above) state that the registered nurse / registered midwife retains accountability and responsibility for tasks or activities delegated to others (Midwifery Council of New Zealand, 2013; National Council of State Boards of Nursing, 2005; Nursing and Midwifery Board of Australia, 2007; Nursing and Midwifery Council, UK, 2013; Nursing Council of New Zealand, 2013). Specifically the NMBA states that the registered midwife '[i]s accountable for actions in relation to the decision to educate, delegate and supervise other health care workers' (Nursing and Midwifery Board of Australia, 2006a, p. 5) and that the registered nurse 'practises independently and interdependently assuming accountability and responsibility for their own actions and delegation of care to enrolled nurses and health care workers' (Nursing and Midwifery Board of Australia, 2006b, p. 1). Additionally, the enrolled nurse 'retains responsibility for his/her actions and remains accountable in providing delegated nursing care' (Nursing and Midwifery Board of Australia, 2002, p. 2).

It is this notion of retained accountability and responsibility that has been reported as a deterrent to delegation (Hansten & Washburn, 1996). Yet, if an increase in delegation and supervision by registered staff is required to meet a changing health context, as noted in previous sections of this paper, then registered nurses / registered midwives need to be comfortable with the concept of retaining accountability and responsibility for their delegated activities.

Hansten and Washburn (1996) state that the concept of delegating and then retaining accountability sounds to many nurses like 'double jeopardy', reporting that nurses state '[n]ot only are they accountable for the task, but they are responsible for the delegate's performance as well' (Hansten & Washburn, 1996, p. 26). This suggests that accountability may be either not well understood or feared. Either way, starting with a simple definition is valuable in overcoming this concern and this is offered in the following: 'Simply put, when you delegate, you give someone else the authority to carry out a care task, but you remain accountable for the overall nursing care of the patient' (Parkman, 1996, p. 43). Further, Wedyt (2010, n.p.) provides a useful way of differentiating accountability and responsibility in stating 'accountability rests with the *decision to* delegate, while responsibility rests within the *performance of* the task' (emphasis added). As noted earlier, registered staff are both accountable and responsible for delegation decisions and care outcomes resulting from that delegation.

Rowe (2000) provides a compelling argument to engage nurses (and midwives) with the concept of accountability and states:

Accountability in nursing is to be welcomed as without it nursing could not claim to be a profession and patients would have no rights ... Nursing is not simply a series of tasks or interventions but has at its core the therapeutic relationship between client and carer. True accountability as a result of true professionalism will protect and enhance this partnership
(Rowe, 2000, p. 552).

On accepting accountability, the registered staff member must accept an associated requirement to supervise delegated tasks or activities. Anthony et al. (2000) note that supervision that is 'closer, planned and intentional' is associated with positive delegation outcomes (Anthony et al., 2000, p. 479) Hansten (2008) reports that deficiencies in care provision by delegates can frequently be traced back to ineffective supervision by the registered staff. Support for the development of sound supervision processes and skill therefore has the capacity to improve the quality of care delivered via delegation.

3.3. Awareness, education and training

The literature reports on the potential for poor delegation to lead to a negative impact on care consumers via care omissions (Bittner & Gravlin, 2009; Bittner, Gravlin, Hansten, & Kalisch, 2011; Gravlin & Bittner, 2010) and Hansten (2008, p. 22) states that 'common sense would advise that better delegation and supervision skills would prevent errors and omissions as well as unobserved patient decline.'

Conway and Kearin (2007) claim that registered staff may lack awareness of their role and responsibilities regarding delegating and supervising unregistered care assistants, and suggest that further education is required to assist nurses with this aspect of their role. A more intimate relationship with the NMBA's competency standards for the registered nurse and registered midwife (Nursing and Midwifery Board of Australia, 2006a; Nursing and Midwifery Board of Australia, 2006b) may address this knowledge deficit. However, it would seem that many of those who *are* aware

of this requirement lack the skills to do so effectively. Hansten (2008) states that frequently nurses do not know how to delegate, and others report that registered nurses are often poorly prepared to perform delegation and supervision (Gillen & Graffin, 2010; Hasson, McKenna, & Keeney, 2013; Hansten, 2011; Saccomano & Pinto-Zipp, 2011). Unsurprisingly, this lack of preparation can lead to a lack of confidence when required to lead and delegate (Saccomano & Pinto-Zipp, 2011). This lack of confidence is likely to lead to a preference to undertake the task themselves rather than delegate.

It is reported that when registered nurses and registered midwives do learn delegation and supervision it is often through 'trial and error' and on-the-job training via observation (Kleinman & Saccomano, 2006). Of concern, given Kleinman and Saccomano's (2006) assertion of on-the-job learning, is Hansten's (2008) findings that registered nurses feel they do not have good role models or mentors from whom to learn delegation and supervision skills. This suggests that, if an important function such as delegation and supervision is going to be learnt 'on the job' then expert role models will be required for this lesson to be learnt well.

Gravlin and Bittner (2010) acknowledge that on-the-job training is not adequate and say 'delegation competency will be realized only if opportunities for prelicensure practice occur in the classroom, laboratory, and clinical setting' (Gravlin & Bittner, 2010, p. 334). These authors stress the importance of education and training through the pre-registration process and also following registration, calling for annual competency testing and routine baseline assessment of post-registration staff, which should include the capacity to provide clear communication, planned supervision and vigilance in evaluation (Gravlin & Bittner, 2010). This is supported by Wedyt (2010), who states that educators should ensure opportunities for pre-registration practise of delegation and supervision and recommends simulation as an effective method to create realistic practice settings.

3.4. Communication

Clear communication is vital and needs to include 'what you want done, why and how soon' (Parkman, 1996, p. 46)

A lack of knowing 'how to' is not the only barrier. General communication has been cited as a frequent contributor to poor delegation and supervision outcomes, with poor handover of information between delegator and delegate noted as particularly problematic (Hansten, 2008; Saccomano & Pinto-Zipp, 2011). Avoidance of conflict has also been linked to an unwillingness to delegate activities (Hasson et al., 2013; Saccomano & Pinto-Zipp, 2011) and it is plausible to suggest that this too can be connected to a lack of general communication skills. Parkman (1996) recommends providing comprehensive directions to delegates including information on 'what you want done, why and how soon' (Parkman, 1996, p. 46). Parkman suggests that rather than asking 'Can you take Mr Smith's temperature?' the registered nurse asks 'Can you please take Mr Smith's temperature as a baseline so we can commence his infusion of packed cells as quickly as possible?' (Parkman, 1996, p. 46). Providing context would seem to be an important aspect of this communication skill. In addition, Parkman (1996) is at pains to point out the importance of adding 'please' as a mechanism to facilitate cooperative team engagement.

3.5. Team functioning

Several commentators have discussed the team dynamics of members in the delegatee–delegator relationship as a potential barrier to effective delegation and supervision, citing a lack of trust as a potential obstruction (Anthony et al., 2000; Gillen & Graffin, 2010; Parkman, 1996; Saccomano & Pinto-Zipp, 2011; Weydt, 2010). This lack of trust often arises when there is poor understanding of one another’s skills and competency (Gillen & Graffin, 2010; Weydt, 2010). Similarly, a lack of role clarity also contributes to poor outcomes (Milton, 2008; Parkman, 1996). Munn et al. (2013) specifically note this issue in relation to assistive personnel, stating that ‘[d]ue to the lack of clarification surrounding the role of assistants, there are different views regarding their role, and what they can and cannot do’ (Munn et al., 2013, p. 14). Anthony et al. (2000) also note that this hesitation to delegate arises when new members join the team who are unknown to the delegator, perhaps another expression of lack of role clarity or understanding of individual capability.

Team skills are also seen as a barrier when delegation is resisted through a preference of working alone, which may arise from a sense of insecurity or a desire to retain control (Gillen & Graffin, 2010). Additionally, the registered staff member may be concerned about being resented by delegatees (Corazzini, et al., 2010) and resist delegation. Delegatees may also avoid delegation through a sense of being overburdened (Gillen & Graffin, 2010; Hansten, 2008) or not feeling included as part of the team (Hansten, 2008). Additionally, a real or perceived lack of skill (Gillen & Graffin, 2010) may prevent delegatees from accepting a delegation from a registered staff member.

Conversely, factors that have a positive impact on team functioning will improve delegation and supervision efficacy. Corazzini et al. (2010) state that if all members, registered, enrolled and assistive personnel, feel part of a team, then this will lead to better delegation outcomes. Hansten (2008) states that good communication and leadership is vital to achieving this, particularly valuing and celebrating each member’s contribution. In addition, as noted above by Parkman (1996), providing context to delegatees, so they are aware that their activities contribute directly to benefitting care consumer outcomes, will also impact positively on the team.

Ruth Hansten has been a consistent commentator on the issue of delegation and supervision for more than 20 years (Hansten & Washburn, 1992; Hansten & Washburn, 1996; Hansten, 2008; Hansten, 2011). Her 2008 article *Why nurses still must learn to delegate* (Hansten, 2008) outlines six recommendations to improve delegation and supervision teamwork at the bedside. These recommendations represent much of what has been captured above, and could readily be adapted to the Victorian context. In summary Hansten (2008) recommends:

1. Obtain a baseline: Ask staff confidentially to provide a self-assessment of their current delegation and supervision skill.
2. Observe: Ask how registered staff plan their delegation activities including how supervision and evaluation is planned for. Listen to handover to ascertain if all team members are included.
3. Ensure all care units articulate a model of care that is clear to each staff member.
4. Recognise the importance of coaching and mentoring. (Hansten (2008) recommends an education session outlining the five rights of delegation and supervision [see above 2.2.5 United States section].)

5. Provide ongoing coaching, feedback and celebrate success.
6. Re-evaluate delegation and supervision practices, correlate to indicator measures such as nurse-sensitive indicators and selected human resource metrics for example overtime, turnover and patient satisfaction measures.

It is anticipated that the implementation of these recommendations will strengthen the nursing and midwifery team's capability to effectively incorporate delegation and supervision into everyday practice.

3.6. Leadership

Leadership is a well-known important contributor to optimal care outcomes. For delegation and supervision to be safe and effective, leadership must be shown by registered nurses and registered midwives at all levels. Indeed, Saccomano and Pinot-Zipp (2011, p. 524) state 'leadership style may be the key to successful delegation'.

Consideration should therefore be given to enhancing leadership skills at undergraduate and early graduate levels, with specific emphasis on delegation and supervision activities. In addition to ongoing educational opportunities, policy and practice guidelines are important tools to assist those who are required to delegate. Gillen and Graffin (2010) state: 'The publication of comprehensive, professional-practice guidelines that equip the nurse with the fundamentals of her role vis-à-vis delegation is a major facilitator (of effective delegation)'. Senior nurses and midwives must therefore show leadership in the development and implementation of policy, procedure and guidance documents/tools that will assist registered staff with their delegation and supervision requirements.

4. Literature summary

The literature and publications discussed above provide an indication of the increasing importance safe and effective delegation and supervision will play in quality care delivery. It has been noted that this is a complex task for registered staff to undertake, and performed inadequately, it has the potential to impact negatively on team functioning and care consumer outcomes.

The importance of clear support and guidance documents has been established and examples from Australian and international nurse/midwife regulators have been examined. 'How to' documents will not be enough; however, to drive safe and effective practice, suggestions from the literature relating to education, training, teamwork and communication have been noted.

Appendix 2: Initial consultation findings

Initial consultation discussions

For this consultation document, discussions across a limited range of practice settings were undertaken to develop a beginning understanding of the views and opinions of Victorian nurses and midwives. Although far from exhaustive in its reach, collectively, the participants represented a broad range of clinical environments. The discussions suggest a sufficient degree of consistency such that the issues raised should be carefully considered and addressed in the framework as outlined. It should be noted that the views expressed within the discussions are personal opinions of the participants and do not necessarily reflect those of their employer organisations or the Victorian Department of Health.

The issues, barriers and enablers relating to delegation and supervision raised in these discussions closely link to those highlighted within the literature. Repeatedly the notions of role clarity, team functioning, communication, competency and preparation arose.

The concepts of 'tell me' and 'show me' became noticeably important across a range of practice settings. Consistently, nursing and midwifery managers and leaders demonstrated a strong preference for providing guidelines that afford clear directions to staff, in essence a process to 'tell' staff what to do. The nursing and midwifery educators interviewed predominately shared the views of the managers and leaders; however, their articulated preference was towards developing tools and educative processes to 'show' staff how to delegate and supervise. The clinical staff, however, whether newly registered graduates or experienced clinicians, consistently requested that they be provided with both clear directions and given the tools and assistance to implement, essentially displaying a sound preference for both 'show' and 'tell'.

These findings were instructive in the development of this framework and strongly suggest that a range of activities that: (a) clearly describe delegation and supervision requirements across a range of practice settings; and (b) assist nurses and midwives to implement these requirements, will lead to the most effective outcomes.

1. Role clarity

Without exception, across all conversations, the notion of role clarity arose.

From a graduate nurse discussing the confusion she experienced when first encountering an unregistered assistant:

'Who is she? What can she do? Can I ask ... show me your badge?'

From a senior nursing/midwifery leader in rural Victoria:

'We need to make it clear for all what the difference is between roles.'

From a senior clinician in metropolitan Melbourne:

'It's just really hard and you just have to know, what does everyone do.'

From a senior nursing/midwifery leader:

'Some people still don't understand the difference between an RN and an endorsed EN; we need to provide role clarity.'

It can be seen from the above that the issue of role clarity revealed in the literature is a lived experience of nurses and midwives in our Victorian context. Therefore, activities to support safe and effective delegation and supervision will necessarily need to address the issue of role clarity. Clearly defined position descriptions can assist here, as can well-understood scopes of practice (and scope of activities for non-registered staff). Tools and activities designed to draw out the differences in the roles and responsibilities between registered nurses and registered midwives, enrolled nurses and non-registered staff will be valuable, with possibly the most instructive comment coming from a senior nursing/midwifery leader:

'The registered nurse, registered midwife role needs to be differentiated. They are asking "Who am I?", and we need to be able to answer that.'

2. Competence and confidence

Closely aligned to role clarity are the concepts of confidence and competence and these were mentioned frequently in the consultation discussions. Across all practice settings, nurses and midwives regularly referred to needing to know if an individual can safely perform a specific task or activity. Competency by way of formalised assessment and record keeping was a commonly cited mechanism that nurses and midwives rely on to determine who can undertake a specific task and therefore to whom they can safely delegate this task. Limitations of competency testing were articulated, including it being a 'moment in time' measure and not necessarily transferrable to practice. However, competencies were often cited as the best available way of ensuring that an individual can safely undertake a specific task or activity. Across the practice settings where these conversations occurred, there were a variety of processes used to both measure and record competence, as well as variation across what activities were deemed necessary to 'test'. Frequency of competency measurement was relatively consistent, with all nominating yearly as a reasonable measure. On further questioning, however, none could provide validation for this time scale other than convenience and tradition (this is not to say that annual testing is not valid, just that those interviewed could not articulate how they came to accept this to be so). Processes for recording competence also varied and included tools as basic as unit-based lists, up to the introduction of sophisticated computer software. The key challenges of who maintains, checks and determines what should become part of competency lists were articulated in most of the conversations.

From a rural nurse:

'Competencies are not perfect, but they do provide a degree of reassurance.'

3. Scope of practice

Aligned to competencies was the notion of scope of practice, with many participants stating that there is a standard scope of practice for registered nurses, registered midwives and enrolled nurses and that it is an expectation that everyone registered in a particular category is able to safely perform a common set of tasks and activities.

From an experienced clinician:

'There's a level of assumed knowledge that an RN can do certain things and so can ENs; you know, their scope of practice.'

Key activities were often cited as being those taught in preparatory courses where it is considered that there was a common skill set that could be relied upon by those required to delegate; however, this contrasted with a number of comments that included the following.

From a nurse educator:

'Scope of practice is poorly understood.'

From an enrolled nurse in rural Victoria:

*'We're just trying to work out: What is my scope of practice?
What is the difference between me and an RN?'*

From this it can be seen that scope of practice, while a widely used term, is still differently understood, therefore activities that develop understanding could assist in delivering better informed and more consistent delegation and supervision practices.

4. Trust

The concept of trust was raised in several conversations and this links closely with that raised in the literature.

From an experienced clinician discussing working with an unfamiliar nurse:

'Trust is important ... at first you follow up and check charts.'

'You get a feel from the sort of questions they ask, if you can trust them.'

From senior regional nurse leaders:

'Trust develops over time.'

'Trust and reliability are the foundations.'

5. Communication

The concept of providing clear direction to facilitate safe and effective delegation and supervision was frequently articulated through the consultations. This was voiced most clearly by a senior nursing and midwifery leader, who stated that 'individual units need to be prescriptive' in how delegation and supervision is undertaken in their specific work environment. This raises the notion of 'permission giving' as an enabler to delegation and supervision because many participants said there is a reluctance to delegate in case you are 'over burdening others' or seen to be 'palming off work'. It is anticipated that, with delegation and supervision requirements clearly articulated and broadly understood for a specific work area, this would act as an enabler by decreasing reticence to delegate. Another nursing/midwifery leader stated that assistance with communication would support nurses and midwives and suggested providing:

'... a script, five sentences or so, that could be used to help staff communicate their requirements with delegation.'

6. Education, support and empowering

Education, support and empowering staff were other concepts that were frequently raised in conversations. Much discussion centred on nurses and midwives learning to delegate and supervise 'on the job', and while many veteran nurses recounted experiences of being in charge when very new to the role, current practices suggest that delegation and supervision is still often learnt on the job. When asked if there is current training and support to develop delegation and supervision skills a range of responses were received including:

From a senior nurse educator:

'There is no current education framework to develop these skills.'

From experienced clinicians:

'You're only exposed to training in the management course, then its good, but there's nothing before that.'

'You just learn by doing, you're thrown in really.'

'There's a need for educator support.'

From a graduate nurse:

'The educators have spent ages talking to us about supervision, accountability and responsibility, but it's more about us being supervised.'

From senior nursing/midwifery leaders:

'There is need for a support person and for formal learning.'

'Formal training is required.'

'It's a skill that's learnt on the job.'

And from academics, acknowledgement that formal training can only go so far:

'Delegation and supervision is partly a life skill that improves with experience'

'At the end of the day, it's the culture of the unit that will over-ride what we can provide here.'

7. Consultation summary

In summary, the conversations with Victorian nurses and midwives provided a wealth of information that largely correlated with that articulated in the contemporary literature. Of uppermost concern appears to be the provision of clear roles and responsibilities for all members of the care team, well-articulated expectations, leadership, communication and educative support. Guidelines to assist nurses and midwives with delegation and supervision should therefore consider these requirements and provide the necessary support and direction to ensure safe and effective care delivery for healthcare consumers.

Appendix 3: NMBA definitions of delegation, delegate and supervision/supervise

As noted in section 3 of this document, the Nursing and Midwifery Board of Australia provides a comprehensive definition of delegation/delegate and supervision/supervise. These are reproduced, for reference, below.

Delegation/delegate

A delegation relationship exists when one member of the multidisciplinary health care team delegates aspects of consumer care, which they are competent to perform and which they would normally perform themselves, to another member of the health care team from a different discipline, or to a less experienced member of the same discipline.

Delegations are made to meet consumers' needs and to ensure access to health care services — that is, the right person is available at the right time to provide the right service to a consumer. The delegator retains accountability for the decision to delegate and for monitoring outcomes. Delegation may be either the:

- transfer of authority to a competent person to perform a specific activity in a specific context or
- conferring of authority to perform a specific activity in a specific context on a competent person who does not have autonomous authority to perform the activity.

Delegation is a two-way, multi-level activity, requiring a rational decision-making and risk assessment process, and the end point of delegation may come only after teaching and competence assessment. Delegation is different from allocation or assignment which involves asking another person to care for one or more consumers on the assumption that the required activities of consumer care are normally within that person's responsibility and scope of practice. Many of the same factors regarding competence assessment and supervision that are relevant to delegation also need to be considered in relation to allocation/assignment.

Responsibilities when delegating

To maintain a high standard of care when delegating activities, the professional's responsibilities include:

- teaching (although this may be undertaken by another competent person, and teaching alone is not delegation)
- competence assessment
- providing guidance, assistance, support and clinically focussed supervision
- ensuring that the person to whom the delegation is being made understands their accountability and is willing to accept the delegation
- evaluation of outcomes
- reflection on practice.

Responsibilities when accepting a delegation

A key component of delegation is the readiness of the recipient of the delegation to accept the delegation. The recipient has the responsibility to:

- negotiate, in good faith, the teaching, competence assessment and level of clinically focussed supervision needed
- notify in a timely manner if unable to perform the activity for an ethical or other reason

- be aware of the extent of the delegation and the associated monitoring and reporting requirements
- seek support and direct clinically focussed supervision until confident of own ability to perform the activity
- perform the activity safely
- participate in evaluation of the delegation.

Activities delegated to another person by a registered nurse or midwife cannot be delegated by that person to any other individual, unless they have since obtained the autonomous authority to perform the activity. If changes in the context occur that necessitate re-delegation, a person without that autonomous authority must consult with a registered nurse or midwife (Nursing and Midwifery Board of Australia, 2007, p. 17).

Supervision/supervise

There are three types of supervision in a practice context:

- 1 managerial supervision involving performance appraisal, rostering, staffing mix, orientation, induction, team leadership, etc.
- 2 professional supervision where, for example, a midwife preceptors a student undertaking a course for entry to the midwifery profession, or a registered nurse supports and supervises the practice of an enrolled nurse
- 3 clinically focussed supervision, as part of delegation.

In relation to consumer care activities delegated to another person by a midwife from a midwifery plan of care or by a registered nurse from a nursing plan of care, clinically focused supervision includes:

- providing education, guidance and support for individuals who are performing the delegated activity
- directing the individual's performance
- monitoring and evaluating outcomes, especially the consumer's response to the activity.

There is a range of clinically focussed supervision between direct and indirect. Both parties (the delegator and the person accepting the delegation) must agree to the level of clinically focussed supervision that will be provided.

Direct supervision is when the supervisor is actually present and personally observes, works with, guides and directs the person who is being supervised.

Indirect supervision is when the supervisor works in the same facility or organisation as the supervised person, but does not constantly observe their activities. The supervisor must be available for reasonable access. What is reasonable will depend on the context, the needs of the consumer and the needs of the person who is being supervised (Nursing and Midwifery Board of Australia, 2007, p. 19).

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