PRACTICE OF NURSING: RN ASSIGNMENT & DELEGATION

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PRACTICE OF NURSING: RN ASSIGNMENT & DELEGATION

I. INTRODUCTION

The purpose of this document is to clarify the professional role and accountabilities of registered nurses (RNs) in assigning and delegating within the clinical nursing practice environment. Central to all RN assignment of nursing care, tasks and delegation, must be the assurance of safe, quality nursing care. Nursing assignment and delegation must be consistent with provincial nursing legislation.

Position descriptions for health care providers must be consistent with the scope of practice identified through professional legislation. The concepts of assignment and delegation differ. RNs have distinct responsibilities and accountabilities for each. It is important that RNs understand the difference between assignment and delegation and the circumstances within which each of these can safely take place. It is the RN who assigns and delegates nursing responsibilities, at the point of care. Assignment and delegation are essential to the RN role and cannot be carried out by employer agencies, organizations and institutions.

While the SRNA supports maximizing the scope of practice of each nursing care provider, the quality of client care and client safety must remain at the center of all nursing care decisions. All members of the health care team are essential to ensure safe, quality care. There is one discipline of nursing and only RNs work to the full scope of that discipline. Within the discipline of nursing, there are both regulated nursing care providers [RNs, RN(NP)s, licensed practical nurses (LPNs), registered psychiatric nurses (RPNs)] and unregulated care providers (UCPs), which includes special care aides, resident care aides, home health aides, special education assistants, etc. The RN (RPN, as appropriate) must assign and/or delegate nursing care, and in so doing, determine who would be the most appropriate care provider to handle the client's nursing care needs.

RNs have an obligation to direct and/or supervise nursing care services at the point of care. The level of RN direction and/or supervision is determined by the client's nursing care needs and predictability of outcomes. The RN cannot assign or delegate the nursing care plan including the nursing assessment and evaluation. RNs have a professional obligation to intervene if they become aware that any client care is unsafe or unethical. Interventions may include guidance, teaching and direction, clarification of the care plan and reporting to the appropriate authority.

II. CLARIFICATION OF TERMS

A. Accountability:

Accountability is being professionally answerable for one's own actions (RPNAS, SALPN and SRNA, 2000).

B. Supervision:

Supervision is the active process of directing, assigning, delegating, guiding and influencing the outcome of an individual's performance of an activity. Supervision (adapted from American Nurses Association, 1997) is generally categorized as direct (being physically present or immediately available while the activity is being performed) or indirect (provision of direction through various means of written and verbal communications).

C. Assignment of Client Care:

The assignment of client care to members of the nursing team must be performed by the RN (RPN, as appropriate) Section 2(k) of *The Saskatchewan Registered Nurses' Act (1988)*, hereinafter referred to as *The RN Act*, provides for the coordination of health care services. Assignment of client care is a decision regarding the most appropriate care provider for the provision of a client's care. The RN at the point of care retains the overall accountability for the appropriate assignment and oversight of client care. Each care provider is responsible for providing competent care to the client and remains accountable to closely communicate with the RN who has assigned the care. This RN accountability cannot be delegated.

D. Assignment of Nursing Tasks:

Assignment of nursing tasks is the selective designation of specific skills or responsibilities to a care provider. This implies that a specific skill is within the scope of practice of the care provider being assigned the task. The care provider performing the task is accountable for competently performing the assigned task. The assigning RN is accountable for appropriate assignment of tasks and for the overall assessment, care planning, intervention and care evaluation.

E. Delegation of Specific Registered Nursing Tasks:

Delegation is the transfer of responsibility for a task when it is not part of the scope of practice of the care provider. The care provider performing the task is accountable for competently performing the delegated task. An advanced level of knowledge, skill and judgment is required for delegation to occur. That being said, only the task can be delegated. It is not possible to delegate the required knowledge and judgment. Formal processes must be in place to support the delegator (the one who does the delegation) and delegatee (the one who receives the delegation). At no time should the safety of the client be compromised by substituting less qualified workers to provide care and/or perform a task when the competencies and full scope of the RNs knowledge, skill and judgment is required (Appendix A). A delegated task cannot be sub-delegated. The delegating RN is accountable for appropriate delegation of tasks and for the overall assessment, care planning, intervention and care evaluation (Appendix B).

III. SCOPE OF PRACTICE - REGULATED AND UNREGULATED CARE PROVIDERS

A. Regulated Care Providers

The scope of practice for regulated health care providers is identified in provincial legislation and interpreted by regulatory bodies. The provincial legislation is translated into action through minimum requirements for practice and identification of base level competencies by regulatory bodies [for RNs in Saskatchewan, this is identified in *The Standards and Foundation Competencies for the Practice of Registered Nurses Effective 2000 (1999)]*. Educational institutions deliver approved educational programs that meet the standards and competencies determined by the regulatory body, in accordance with the applicable legislation. Regulated health care providers are responsible for practicing within their own level of competence and are responsible for their own practice. When there is a requirement for a health care provider to perform a task that is outside a determined scope of practice, RNs must apply the SRNA delegation framework to ensure client safety.

B. Unregulated Care Providers

Unregulated care providers (UCPs) do not have a regulatory body or a legally defined scope of practice. UCPs do not have mandatory education or regulatory practice standards. *The RN Act* acknowledges and limits the role of UCPs for provision of care in Section 24: (c) auxiliary nursing care and (e) home care.

IV. DELEGATION OF SPECIAL NURSING PROCEDURES (SNPs)

Special nursing procedures have been defined in the *SRNA RN Scope of Practice: Special Nursing Procedures & Transfer of Medical Function (1993)* as a category of nursing functions in the practice of registered nursing. These RN functions are not taught in the entry level nursing education programs: they provide neither the specific theory nor clinical practice to achieve competence (adapted from SRNA, 1993, p. 6). The RN is accountable for appropriate delegation of the task within the special nursing procedure and for the overall assessment, care planning, intervention and care evaluation involved in the special nursing procedure. Delegation of SNPs to other health care providers must be in the best interest of the client. In clinical situations where a care provider other than a RN is involved, only the task can be delegated to a regulated health care provider and the RN must be available for ongoing support and supervision. The care provider receiving the delegated task is accountable for competently performing the delegated task.

For delegation of a SNP task, the SRNA requires that the following exists at the point of care:

- Clear nursing unit program goals including explicit planning, implementation and evaluation processes;
- Standardized educational program of theory and practice and a method of testing competence;
- Evaluation of client outcomes;
- Opportunity to maintain competence;
- Clear differentiated education, roles and responsibilities for involved nursing and allied health personnel functioning as part of the nursing team;
- Evidence of adherence to SRNA standards, codes and guidelines;
- Provision of adequate resources;
- Ongoing support and monitoring by the RN; and
- A method to determine patient stability.

V. ENVIRONMENTAL SUPPORTS

The RN Act establishes the SRNA as the professional regulatory body for RNs and defines the scope of practice for RNs. No employer policy can contravene the legislated accountability of the RN.

Environmental supports are required for appropriate client care assignments. There must be:

- Sufficient skilled nursing staff, other health care providers and support staff;
- Visible nursing leadership at senior administrative and local clinical service levels;
- Adequate policies, equipment and other system resources to ensure a safe practice environment for staff and the clients; and
- Access to necessary technology, data and evidence to support the provision of evidence-based care/best practice guidelines (adapted from CNA, 2001).

Overall system supports include:

- Organizational Design: Agency policies, staffing patterns, provider roles and responsibilities, assignment and supervision policies must be consistent with prudent risk management, which includes: research based practice, legislated scopes of practice, client needs, intended health outcomes, nursing practice standards and competencies of the health care provider and other resources to enable the delivery of care (AARN, 2003, p. 7).
- RN Accountability: The RN is accountable for the decision to assign patient care. The individual accepting the care assignment is responsible for carrying out the activity in a safe, competent manner and for seeking consultation and guidance of a RN, as needed. The RN at the point of care should make the patient assignment decisions (AARN, 2003, p. 7).
- Evidence–Based Practice: Nursing practice must be based on the systematic application of the best available evidence (observation, fact or organized body of information) to the evaluation of options and decision-making in clinical management and policy settings. Evidence in nursing practice is derived from the application of the nursing process (assessment, identification of care needs, appropriate selection of interventions, evaluation and readjustments of care) while integrating current research, client preferences and ethics. In the delivery of interventions, decisions about supervision and avenues of communication must be determined. (Adapted from AARN, 2003; RNAO, 2002; National Forum on Health, 1997).
- RN Supervision: The level of supervision is a critical factor in determining the assignment of specific care for specific clients. The more complex and unpredictable the environment, the more qualified the care provider must be to provide the full range of potential care requirements, assess changes, re-establish priorities, and recognize the need for additional resources as needed (CNO, 1997, p. 6).

VI. RESOURCE TOOLS FOR ASSIGNMENT AND/OR DELEGATION

The following are resource tools to assist the RN in the assignment and/or delegation in the clinical practice environment. These resources may also be used by employers in the creation of nursing policy:

A. General Issues for Consideration in Decision-Making

In deciding whether or not to assign or delegate, there are eight areas that should be considered in light of safe client care:

1. Client choice.
2. Level of client stability and predictability: the greater the complexity and unpredictability, the greater the need for RN care.
3. Scope of practice and competencies of each care provider.
4. Potential for harm: What are the supports for the health care provider performing the task?
5. Frequency of occurrence: Does the provider perform the skill often enough to maintain competence?
6. Level of decision-making: Are there critical points to consider during the performance of the task?
7. Scope of employment: Did the employer describe this task appropriately within the agency? Is this supported by employer policy? What is the reason there have been limits to what the care provider can or cannot do?
8. Ability for self care: Can the client perform the skill or direct the care?

B. The Five Rights

The Five Rights of Delegation (National Council of State Boards of Nursing, 1995) can be used as a mental checklist to assist nurses from multiple roles to clarify the critical elements of the decision-making process. Nursing service administrators (all levels of executive/management nurses) and RNs each have accountability in assuring that the delegation process is implemented safely and effectively to produce positive health outcomes. Nursing service administrators and the nursing team must work collaboratively and cooperatively to protect the public and maintain the integrity of the nursing care delivery system.

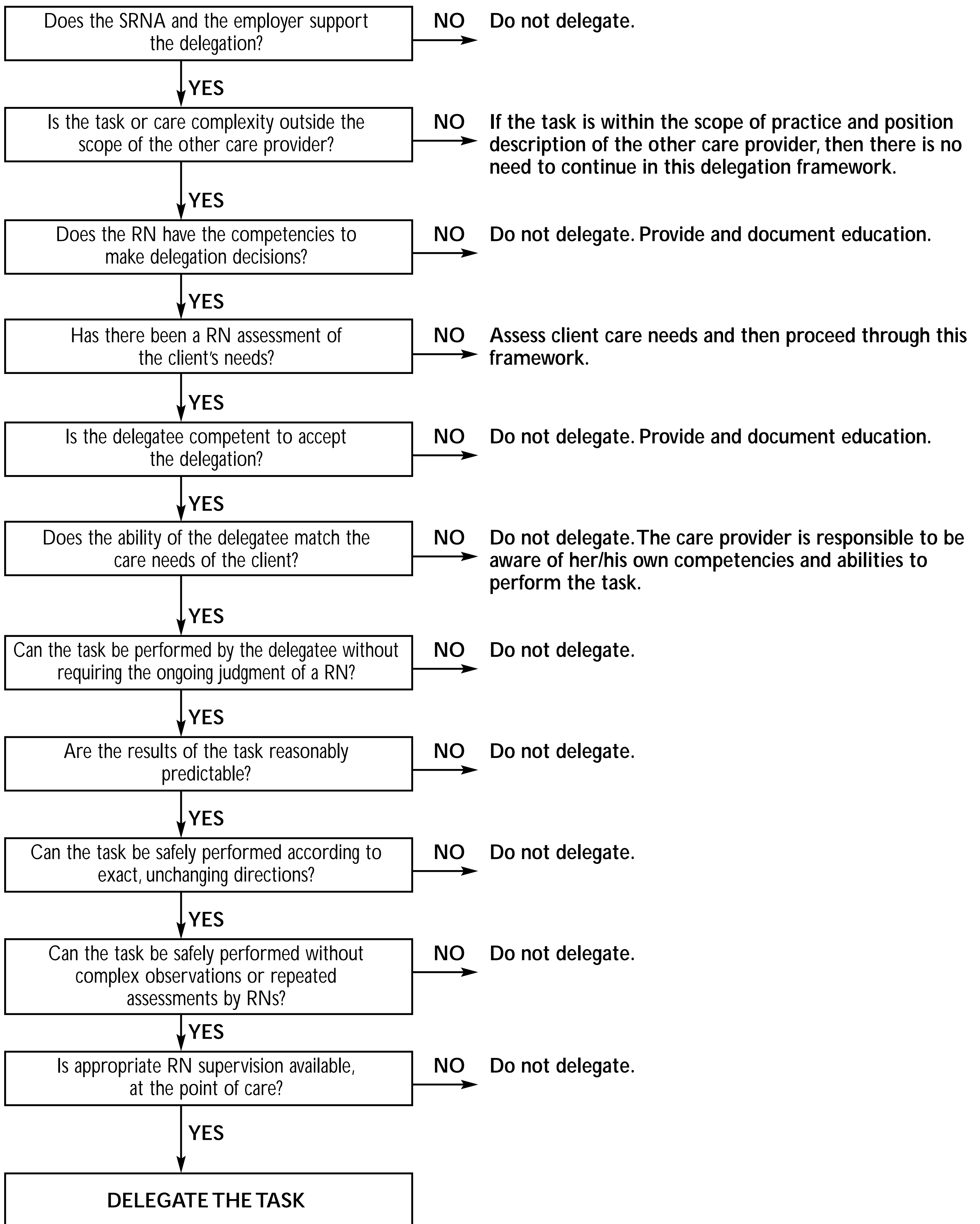
A RN at the point of care must consider The Five Rights during the entire delegation process:

1. **Right Task**
   - Appropriate activities for consideration in delegation decisions are identified in LPN, other licensed health professional or UCP job descriptions/role delineation.
   - Organizational policies, procedures and standards describe expectations of and limits to activities.
   - Appropriate delegation activities are identified for specific client(s).
   - Appropriate activities are identified for specific delegatees.
2. **Right Circumstances**
   - Assess the health status of the client community, analyze the data and identify collective nursing care needs, priorities and necessary resources.
   - Provide appropriate staffing and skill mix, identify clear lines of authority and reporting, and provide sufficient equipment and supplies to meet the collective nursing care needs.
   - Provide appropriate preparation in management techniques to deliver and delegate care.
   - Assess health status of individual client(s), analyze the data and identify client specific goals and nursing care needs.
   - Match the complexity of the activity and stability of the client with the LPN, other licensed health professional and/or UCP competency and with the level of supervision available.
   - Provide for appropriate monitoring and guiding for the combination of client, activity and personnel.
3. **Right Person**
   - Establish unique organizational standards consistent with applicable law and rules which identify educational and training requirements and competency measurements of each licensed nursing category and UCP.
   - Incorporate competence standards into institutional policies; assess delegatees' performance; perform evaluations based upon standards and take steps to remedy failure to meet standards, including reporting nurses who fail to meet standards to appropriate regulatory body.
   - Instruct and/or assess, verify and identify the delegatee's competency on an individual and client specific basis.
   - Implement own professional development activities based on assessed needs; assess performance; perform evaluations based upon standards and take steps to remedy failure to meet standards.
4. **Right Direction/Communication**
   - Communicate acceptable activities, nursing care provider competencies and qualifications and the supervision plan through a description of a nursing service delivery model, standards of care, role descriptions and policies/procedures.
   - Communicate delegation decision on a specific client and specific basis. The detail and method (oral and/or written) vary with the circumstances.
   - Situation specific communication includes:
     - specific data to be collected and method and timelines for reporting;
     - specific activities to be performed and any client specific instruction and limitation; and
     - the expected results or potential complications and time lines for communicating such information.
5. **Right Supervision/Evaluation**

   Appropriate supervision (indirect or direct) must be provided by the delegating RN at the point of care. The competencies and qualifications of the nursing care provider, the nature of the tasks that have been delegated and the stability/predictability of client condition must be considered.

   - Assure adequate human resources including sufficient time for supervision to assure that nursing care is adequate and meets the needs of the client.
   - Identify the RN responsible for supervision by position, title and role delineation.
   - Supervise performance of specific nursing activities or assign supervision to other licensed nurse.
   - Provide directions and clear expectations of how the activity is to be performed:
     - monitor performance;
     - obtain and provide feedback;
     - intervene if necessary; and
     - ensure proper documentation.
   - Evaluate outcomes of client community and use information to develop quality assurance and to contribute to risk management plans.
   - Evaluate the entire delegation process:
     - evaluate the client, and
     - evaluate the performance of the activity.

C. RN Delegation Decision-Making Framework (adapted from National Council of State Boards of Nursing, 1995 & SRNA, 1993)



VII.SCENARIOS

1. Delegation in Group Home for Young Offenders with Addictions

Question: I am an off-site RN supervisor for a group home with a mandate to provide intensive rehabilitation for young offenders with addictions. Is it safe for an auxiliary youth worker to routinely give medications to the youth in this setting?

Answer: No. These are the factors to consider in determining the appropriate care provider:

i) Client stability and predictability: The SRNA would consider these clients to be complex and unpredictable and thus require a RN/RPN to administer any medications.
ii) Scope of practice: Because the stability and predictability of clients is complex and unpredictable, the SRNA believes that the RN's or RPN's scope of practice would be the most appropriate to meet the client's needs.
iii) Potential for harm: This situation is considered a high potential for harm and would require the RN/RPN to manage the care.
iv) Frequency of occurrence: This is not applicable as this is routine in RN/RPN scope of practice.
v) Level of decision-making: These complex environments require critical thinking skills and knowledge, skill and judgment of a RN or RPN.
vi) Scope of employment: This is not applicable as the full scope of practice of the RN or RPN would include the care of these clients.
vii) Ability for self-care: The SRNA considers that this client population would not have the ability for self-care.

2. Delegation in Long Term Care (LTC)

Question: In a long term care facility, special care aides (SCAs) are hired to provide basic care to residents, obtain vital signs and perform bowel care, which includes the administration of suppositories. How can SCAs be supported to safely administer suppositories?

Answer: With appropriate delegation, the SCAs can routinely administer suppositories, with specific exceptions. In this situation, the administration of suppositories is a delegation of nursing task from the RN. There must be an education process in place to verify/certify that the SCA has received the adequate education by a nurse educator employed within the facility. The delegation is not transferable between employers.

3. Home Care

Question: Ann is a RN working in Home Care. One of the clients requires eye drops daily. She lives by herself and is physically unable to manage the eye drops on her own. Doreen, a home health aide (HHA) comes into the home every morning to help the client out of bed and assist her with dressing. Ann believes that it would be safe and appropriate and in the client's best interest to delegate this procedure to Doreen. Is this an appropriate practice and why?

Answer: In accordance with section 24(2)(e) of *The RN Act*, auxiliary personnel can provide nursing services in a client's home under the direction of a RN, RPN or physician. The RN discusses the administration of eye drops by Doreen with both Doreen and the client. Since both agree that this would be appropriate and acceptable, Ann develops a teaching plan for Doreen. After teaching Doreen, Ann is responsible to assess Doreen's knowledge and determine Doreen's competency in administering eye drops by having Doreen demonstrate how to put in the eye drops. Ann provides supervision to Doreen in the client's home the first time that Doreen puts in the eye drops. Ann ensures that all the necessary information is in the care plan in the client's home and that Doreen knows the signs and symptoms that require the immediate attention of the RN.

Ann is taking responsibility for delegating this procedure to Doreen. She maintains overall responsibility for the nursing care of the client and continues to monitor/supervise as necessary. Ann documents what she delegated, to whom, when and keeps a record of the teaching plan used. Doreen is responsible for carrying out the procedure as taught. Doreen is aware that this delegated procedure is client-specific. In order for Doreen to put in eye drops for another client, the RN would have to assess the unique needs of that client and Doreen's competence, provide teaching and instruction based on that client's needs. There must be an ongoing support and supervision for Doreen.

4. Obstetrics

Question: Martha, 24 years of age came into the Labour & Delivery Unit experiencing contractions 5 minutes apart. She is 38 weeks gestation, gravida 2 para 1, and has a history of gestational diabetes. Martha's physician orders continuous fetal monitoring. Samantha is the RN in charge of the Labour & Delivery Unit for this shift and assigns the care of Martha to Sara, a novice RN in Labour & Delivery, who has very little experience in fetal heart monitoring. Sara is also assigned one other client who is in active labour. Sara informs Samantha that she has very little experience in fetal monitoring and is concerned that her workload may endanger the care of a high risk client such as Martha. Samantha

encourages Sara to work faster and be more efficient, but to bring any concerns regarding Martha's progression directly to Samantha. Martha's fetal monitor begins to show early decelerations, which goes unnoticed by Sara. Subsequently Martha's baby was born severely brain damaged due to oxygen deprivation. Legal action is being pursued by Martha. Who is legally accountable in this situation?

Answer: A 1996 decision of the Ontario Court of Justice (General Division) addressed a similar case (CNPS, 2002). The court, in addressing causation, looked at the role of the team leader and found that she was a delegate of the supervisor of nursing and required to ensure that the nursing assignments be carried out in a way to adequately maintain patient care. The court concluded that the team leader completely failed to perform her assigning and supervisory duties in accordance with the standard of nursing care. Assignment is not a single act but is a process that includes ongoing oversight (assessing, evaluating and supervising).

In considering an assignment of care, the supervising RN needs to consider:

- Competency of the nursing care provider (novice RN) to provide the care;
- Client need including stability and predictability; and
- The team leader's ability to perform her supervisory role.

5. Pediatrics

Question: A community hospital is unable to find RN day shift coverage for a pediatrics nursing unit. On the previous evening, a 6 month old baby was admitted to this pediatric unit with dehydration related to gastroenteritis. The baby was given intravenous replacement fluids and is currently receiving a potassium chloride intravenous infusion. Sally is the only RN on an adjacent medical unit and has been asked by the RN supervisor to "keep an eye on the baby in the pediatric unit where no RN is present". A LPN has been assigned to care for the infant on the pediatrics unit. What are the responsibilities for the safety of the child?

Answer: Some points to consider in determining the appropriate care for the child are:

- Decision/Supervision: The SRNA requires that there be ongoing direct RN supervision of any client that is acutely ill.
- Scope of Practice: Providing overall care to this ill infant is outside the scope of the LPN.
- Level of client stability and predictability: An acutely ill child is unstable and has a high level of unpredictability. The greater the complexity and unpredictability, the greater the need for RN care.
- Potential for Harm: There is significant risk involved in caring for children who are acutely ill.

The child must be transferred to a unit where there is appropriate RN supervision or a RN with the required knowledge, skill and judgment must be in place on the pediatrics unit.

6. Nursing Care Assignment: RN or LPN

Question: How do I know whether a nursing care assignment or task should be carried out by a RN or a LPN?

Answer: First and foremost, staffing and skill mix needs to match the client care needs of a nursing unit, in accordance with current best practice literature. While the SRNA support maximizing the utilization of all health care providers, one must consider the appropriate staff and skill mix based on sound evidence and subsequently the specific client needs and staff competence when creating a client care assignment.

You will need to consider:

- the RN and LPN scope of practice;
- the model of care delivery (i.e. primary nursing, team nursing or functional nursing);
- the complexity of the client's nursing care needs; and
- the context of care and the degree of direction and/or supervision available.

More specifically, LPNs are prepared to function independently in accordance with their basic nursing education program entry level competencies. The practical nursing program prepares LPNs to function independently within the nursing team where client nursing care needs are predictable (not complex, where crises are not anticipated). Where a client's nursing care needs are increasingly complex and/or a crises must be anticipated and/or the outcome is not predictable, then the LPN needs to function under the direction and/or supervision of a RN or RPN, as appropriate. Like RNs, LPNs are accountable to only perform nursing care and/or tasks independently if and when they are confident in their competence to safely perform that care and/or task with a specific client.

If the client does not have complex nursing care needs and the client's outcome is predictable with no crises anticipated, the LPN can independently perform nursing tasks in accordance with her/his legal scope of practice and competencies obtained in the basic nursing education program.

7. Assignment or Delegation of Complex RN Functions

Question: I am working on a nursing unit with a team of RNs, LPNs and UCPs. Can I assign or delegate more complex RN tasks to an LPN or UCP if there are not enough RNs?

Answer: Some points to consider prior to assigning or delegating RN tasks to a LPN or UCP are:

- Need to adhere to the SRNA delegation framework. The task has been defined as a complex RN task and thus must be formally delegated to non-RNs. Assignment cannot occur for tasks that are not part of another care provider's scope of practice;
- If the client requires the knowledge, skill and judgment of a RN to provide care or perform a specific task, then that standard must be maintained. Clients have a right to expect competent, nursing in any registered nursing care environment;
- The impact on client outcomes based on nursing staff and skill mix evidence; and
- If there is insufficient staffing to provide safe, competent nursing care, then as a RN you have an obligation to immediately report the situation to your nursing supervisor. The agency has an obligation to ensure adequate staffing to ensure safe nursing care. If the standards of nursing care cannot be maintained, the agency has an obligation to provide the quality of nursing care required and/or to transfer the client to a care area where safe nursing care can be provided.

8. Supervision of UCPs

Question: Can a RN assign a LPN to supervise UCPs?

Answer: In accordance with The RN Act, UCPs are limited to providing auxiliary nursing tasks on their own, i.e. activities of daily living such as bathing, toileting, mouth care, assistance with dressing, hygiene and mobility. In areas where a specific client's nursing care needs are basic (not complex i.e. personal care home), then a LPN may be involved in supervising those clients whose nursing care needs are basic and not complex. In more complex care environments such as long term care, home nursing care and acute care, auxiliary nursing care providers need to work under the direction and/or supervision of a registered nurse or registered psychiatric nurse, as deemed appropriate.

9. Sub-delegation by RNs

Question: Can I delegate a 'delegation of medical function' to a LPN?

Answer: No, you cannot sub-delegate a delegated task. Likewise, a LPN can not sub-delegate a RN task.

10. RN Delegation in High Risk Situations

Question: In a community hospital, there are LPNs wanting to work in the labour and delivery suite to care for clients in active labour including fetal monitoring. Can the RN delegate care and or fetal monitoring to the LPN?

Answer: Clients in active labour and/or requiring fetal monitoring have complex needs and crises must be anticipated. The knowledge, skill and judgment of a RN is required and the LPN competence is not sufficient to provide care for this client population. This is not an appropriate situation to consider delegation or client assignment to an LPN.

VIII. SUMMARY

Decision-making about how to best match the needs of the client with the appropriate care provider is complex. While the SRNA supports maximizing the scope of practice of each nursing care provider, client safety and client outcomes are paramount. Having the most appropriate care provider in the most appropriate context within an appropriate time frame is essential.

RNs are central to decision-making to ensure safe, quality nursing care outcomes. RNs determine what constitutes safe nursing care. The need to ensure positive client outcomes through an evidence-based approach is vital. Nursing practice is knowledge-based, not task-based. It is the responsibility of the RN to determine how and when components of care will be assigned or delegated. The act of assignment and delegation is an effective, complex process. Because one can, does not mean one should perform a task or provide the required nursing care.

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CANADIAN NURSES ASSOCIATION
ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

Position Statement

PATIENT SAFETY

Canada's health care system is thought to be among the safest in the world. However, as large studies in several countries have shown,[1] health care systems are prone to error and failure, and the risk of adverse events[2] is significant. Problems with patient safety are seen as being driven by systemic factors such as rapid changes in the health care system, increased use of technology, restricted resources including shortages of qualified professionals and the quickening pace of work.

Canadian nurses[3] have increasingly expressed concern about the ability to deliver safe care in today's health care system. Given the commitment of nurses expressed in the first value of the *Code of Ethics for Registered Nurses* to provide "safe, competent and ethical care,"[4] nurses are experiencing increasing moral distress as they continue to work in environments that are not able to support quality professional practice. Much work has been done by nurses to address concerns for patient safety, as evidenced by the growing body of research on best practices and the Canadian Nurses Association's (CNA's) promotion of quality practice environments[5] and appropriate human resource planning in the health system, but much remains to be done.

CNA POSITION

Patient safety is the prevention and mitigation of unsafe acts within the health care system. But for nursing it must mean more than that. It means being under the care of a professional health care provider who, with the person's informed consent, assists the patient to achieve an optimum level of health, while at the same time ensuring that all necessary actions are taken to prevent or minimize harm. Patient safety is fundamental to nursing care and health care across all settings and sectors. It is not merely a mandate; it is a moral and ethical imperative in caring for others.

Providing safe, competent and ethical care to patients within the health care system is a shared responsibility of all health care professionals, health care organizations and governments and requires the involvement of the public.

CNA believes that providing for patient safety involves a wide range of actions at the level of the individual nurse, the profession, the multidisciplinary team, the health care organization and the health care system[6]. These actions must include adequate clinical support for nurses by nurse managers. It is also critical to patient safety that nursing care data are collected and interpreted at the national level[7] to support research on best nursing practices.

1 Studies in the United States, United Kingdom, Australia and New Zealand indicate that adverse events occur in the range of 3.7 - 16.6 per cent of all hospitalizations, summarized in Nursing Sensitive Outcomes (Doran, 2003). Canadian rates of adverse events in acute care are being investigated and are expected to be released in early 2004.

2 An adverse event is an unintended injury or complication that results in disability, death or prolonged hospital stay and is caused by health care management. This is the definition being used by researchers in the CIHI-CIHR research on Adverse Events in Canadian Hospitals (Canadian Institute for Health Information, 2002).

3 Nurses refer to registered nurses, throughout.

4 (Canadian Nurses Association, 2002, p. 9).

5 (CNA, 2001).

6 (ICN, 2002).

7 (CNA, 2001).

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CNA further believes that the escalating shortage of registered nurses, the use of inappropriate staffing practices and the understaffing and underskilling of health care services pose a significant threat to patient safety[8, 9] and contribute to incidents of failure to rescue.[10] Present workloads are at times so heavy that nurses are unable to develop therapeutic relationships,[11] make the comprehensive assessments needed and seek nursing or other expertise as required. Such workloads also prevent experienced nurses from being available to guide less experienced nurses. The casualization of the nursing workforce over the last decade, in the interest of cost-reductions, has also contributed to decreasing the availability of nurses to mentor other nurses and, at the same time, reduced the continuity of care, which in and of itself is a threat to patient safety.

Human health resource issues impacting on patient safety, such as those indicated above, must be addressed on a system level and be evidence-based. An appropriate balance must be sought between full-time nursing personnel and part-time, casual and temporary personnel. In terms of staff mix, an evidenced-based approach must be central to decisions on the nursing competencies; therefore, the level and mix of nursing staff required for a particular patient population in a particular setting.[12] Even with the right numbers of nurses and the right mix of nursing competencies, nurses in clinical leadership and unit management roles must have a span of control that reasonably permits them to provide supervision and support for nurses that will ensure patient safety.

Patient safety cannot be achieved without system accountability and system competence. Efforts to analyse and reduce adverse events in the provision of health care are most effective when such events are viewed as system failures. This concept represents a paradigm shift from a culture of individual blame to a culture of safety in which reporting adverse events is required and promoted. While individual competency may be a contributing factor, and individuals remain accountable for their own actions, it is increasingly evident that system competency plays a major role in patient safety. Only when adverse events and near misses are reported can they be analysed collaboratively to identify and address problems in the system.[13, 14]

Patients have the right to know when an adverse event has occurred in their care and to have appropriate treatment to address the problem as far as possible. When such an event results in injury or even death, there must be open and honest communication with the patient or the family as soon as possible. The implementation of clear agency policies on the reporting of adverse events and near misses, and on disclosure of adverse events to the patient and family, are necessary to support good clinical practice and to the overall improvement of patient safety in the system.

Nurses must advocate for an environment in which nurses and other health care workers are treated with respect and support when they raise questions or intervene to address unsafe or incompetent practice.[15] Whistleblowing legislation should be enacted in all jurisdictions so that, after all avenues of addressing the problem have been tried, nurses who speak out publicly in good faith[16] can be protected from reprisals.[17, 18]

8 (Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2001).

9 (Aiken, Clarke, Cheung, Sloane, & Silber, 2003).

10 (Clarke & Aiken, 2003).

11 "Nurses must be committed to building trusting relationships as the foundation of meaningful communication, recognizing that building this relationship takes effort. Such relationships are critical to ensure that a person's choice is understood, expressed and advocated" (CNA, 2002, p. 11).

12 (CNA, 2003).

13 (National Steering Committee on Patient Safety, 2002).

14 "Nurses must strive to prevent and minimize adverse events in collaboration with colleagues on the health care ream" (CNA, 2002, p. 9).

15 (CNA, 2002, p. 11).

16 Whistleblowers are people who expose negligence, abuses or dangers, such as professional misconduct or incompetence, which exist in the organization in

which they work. In health-care institutions, nurses may be the first to recognize unsafe practices or to identify actual or potential hazards (CNA, 1999).

17 (CNA, 2002, p. 17).

18 (Sinclair, 2000, chap. 10).

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The practice environment enables or hinders nurses and other health care professionals in their ability to provide safe care. Developing and supporting quality professional practice environments is a responsibility shared by practitioners, employers, governments, regulatory bodies, professional associations, educational institutions, unions and the public.[19]

Strong leadership across the nursing profession is essential to moving forward the cultural reform that is required to ensure the delivery of safe quality care in professional practice environments.[20] The number of first-line managers should be sufficient to allow reasonable levels of contact with nurses in the practice environments. In settings where the majority of the staff are nurses, the first-line manager should be an experienced nurse with strong leadership abilities.[21]

Nurses have a significant contribution to make in protecting and improving patient safety. As the principal health care providers with the patients, overseeing, co-ordinating and providing care 24 hours a day, seven days a week, nurses are ideally positioned to strengthen the safety net for patient care. The nursing perspective on reducing errors and improving systems must be part of a collaborative approach involving the public, other professions, employers and governments. Adequate resources must be made available to undertake this work at all levels of the health care system.

BACKGROUND

Studies in the United States, the United Kingdom, Australia and New Zealand have shown that adverse events may occur in anywhere from 3.7 per cent to 16.6 per cent of all hospital admissions and a significant portion of these may be preventable.[22] Canadian rates of adverse events in acute care hospitals are being investigated through research funded by the Canadian Institute of Health Information and the Canadian Institutes of Health Research.[23]

Nursing has always given the highest priority to patient safety. Nursing associations at the provincial, territorial and national levels have centred their work around patient safety and promoting excellence in nursing practice in the interest of the public. CNA, over many decades, led the development of standards of nursing practice, education, administration and the Code of Ethics for Registered Nurses. CNA develops and advocates nursing and public policy that promotes not only patient safety but also high standards of health care and excellence in nursing practice.

Provincial and territorial nursing associations and colleges regulate the practice of nurses. They continually develop and maintain standards of nursing within their jurisdictions through many programs, including licensure, disciplinary procedures and requirements for continuing competence, often with the involvement of other health care professionals and public representatives. CNA develops and maintains the Canadian Registered Nurse Examination.

This combination of setting and promoting standards for the profession at the provincial/territorial and national levels has worked well in guiding individual practice to ensure patient safety. What has changed in recent years is the recognition that while the systems aimed at promoting and ensuring individual competence and accountability are very necessary, they are not enough. Patient safety cannot be achieved without system accountability and system competence.

Patient safety concerns need to be evaluated and addressed as system-wide problems. The various movements for continuous quality improvement have tried to bring appropriate attention to system issues, but there continues to be a strong reliance on what is expected to be the flawless performance of individuals. Often this is the expectation without regard to circumstances. We are still working in a 'culture of blame' in which the investigation of adverse events is focused on assigning responsibility to individuals.

Within the national dialogue on patient safety, CNA participated in and was strongly supportive of the report of the National Steering Committee on Patient Safety,[24] which recommended, among other important directions, the creation of a Canadian patient safety institute. The 2003 federal budget provided for $10 million annually to support the creation of the new institute, and CNA continues to participate in the development of the institute.

19 (CNA, 2001).
20 (Affonso, Jeffs, Doran, & Ferguson-Paré, in press).
21 (Advisory Committee on Health Human Resources, 2002, p. 39).
22 See footnote 1.
23 See footnote 2.
24 See footnote 13.

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The work of CNA on promoting quality professional practice environments is one of our most important initiatives for patient safety. CNA is also a member of the Canadian Coalition on Medication Incident Reporting and Prevention and supports various efforts of other groups in relation to research on quality work-life indicators, dissemination of drug safety information, patient falls and other initiatives related to patient safety.

Central to CNA's work on patient safety is the recently revised *Code of Ethics for Registered Nurses.* The Code provides an up-to-date framework of values and professional obligations to guide nurses' actions in promoting and advocating for patient safety. It speaks to the many responsibilities for individual practice, such as obtaining informed consent, advocating for the patient's right to self-determination and disclosing of error. In addition, it highlights the importance of the practice environment, and nurses' duty to advocate for a quality practice environment and the human and material resources necessary to ensure safe and competent ethical care.

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Delegation to Other Health Care Workers

Delegation affects nurses who are dealing with the harsh reality of financial constraint in the health care sector. When traditional nursing tasks are delegated to other health care workers, nurses are concerned about patient safety, quality of care and their own responsibility.

1. What is delegation?

Delegation occurs when either the employer or the nurse transfers authority to a health care worker in a selected situation to do work traditionally performed by a nurse. Legislation defines the practice of nursing in very broad terms. The essence of nursing practice is the application the nursing process,1 which provides the foundation for nursing diagnosis, outcome identification, and care planning. Nurses should not delegate these responsibilities. For example, an unlicensed worker may measure vital signs but the nurse analyzes the data for comprehensive assessment, nursing diagnosis, and planning care.

2. Who is responsible for what?

Responsibility for delegation is shared between the employer, the nurse and the other health care worker.

The employer is legally responsible for hiring appropriate staff and for establishing written policies and procedures on delegation, including who the delegator is (facility or nurse), workers to whom authority has been or can be delegated, the process for delegation, and guidelines for care. Differences in roles of nurses and other health care workers must be reflected in policies. The employer is also responsible for: providing adequate education, training, and assessment of the competence of health care workers; establishing and maintaining quality control measures to ensure competent care; ensuring adequate supervision of health care workers; and prohibiting delegation when no suitably qualified health care worker is available.

The nurse is responsible for knowing the work approved for delegation by the employer and the circumstances under which work may be delegated. She is also responsible for making an appropriate decision to delegate and for adequately supervising health care workers. In order to determine whether a decision to delegate is appropriate, the nurse must take into account the employer's policies; patient needs; complexity of health problems; the health care worker's job description, knowledge base, and demonstrated competency; the knowledge needed to deliver the care required; the predictability of the anticipated outcome; and specific risk factors. Because the nurse is responsible for evaluating nursing care by monitoring patient outcomes, she must supervise workers to whom she has delegated. Supervision entails initial direction, periodic inspection and corrective action when needed.

The health care worker is responsible for having sufficient knowledge, skill, and judgment to accept delegation. The health care worker is also responsible for: following policies and procedures; performing tasks and giving care safely, effectively and ethically; documenting the care given; reporting observations and patient information to the nurse supervising the patient's care; and refusing to accept delegation of those acts for which she is not competent.

3. How can I delegate responsibly?

You can delegate responsibly by:

- knowing your unit's job descriptions and delegation policies;
- knowing each worker's qualifications and competencies;
- developing nursing care plans;
- determining which interventions, if any, can be safely delegated and to whom;
- ensuring the worker is available: is someone using her disproportionately or inappropriately?
- being specific by providing detail on who, what, where, when, and how. Include when and how to report outcomes and ask for assistance, e.g., "Tell me if Mr. Jones' blood pressure is higher than 160/100" provides a reportable parameter, in contrast to "Check Mr. Jones' BP";
- indicating priorities;
- checking comprehension;

- ensuring the patient knows who his nurse is and who his health care worker is;
- supervising either directly or indirectly based on patient's condition, nature of delegated tasks, resources available and worker's competence;
- intervening if necessary;
- continuing to do ongoing nursing assessments, care plan development, and evaluation of intervention's effectiveness; and
- remembering that the working relationships in your team rely on communication, respect, and positive reinforcement.

If in doubt about the appropriateness of delegation, you may wish to consult your professional/territorial practice advisor. If you have a concern about legal issues, contact a nurse lawyer at CNPS at no charge 800-267-3390). CNPS is for you®.

As knowledgeable professionals, nurses must continue to advocate for safe and ethical practice environments while striving to acquire new skills, such as supervising others, to practice competently.

1. Canadian Nurses Association, *A Definition of Nursing Practice – Standards for Nursing Practice*, 1987.

N.B. In this document, the feminine pronoun includes the masculine and vice versa.

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