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Citation for the original published paper (version of record):

Gransjön Craftman, Å., Grape, C., Ringnell, K., Westerbotn, M. (2016)

Registered nurses' experience of delegating the administration of medicine to unlicensed personnel in residential care homes.

Journal of Clinical Nursing, 25(21-22): 3189-3198

<https://doi.org/10.1111/jocn.13335>

Access to the published version may require subscription.

N.B. When citing this work, cite the original published paper.

Permanent link to this version:

<http://urn.kb.se/resolve?urn=urn:nbn:se:shh:diva-2416>

Registered nurses' experience of delegating the administration of medicine to unlicensed personnel in residential care homes

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Abstract

Aims and objective: The aim was to describe registered nurses' experience in the context of delegating the administration of medication to unlicensed personnel in residential care homes.

Background: The residents in residential care homes have a need for extensive care and nursing and large amounts of medicines are common practice. Registered nurses' workload and difficulties in fulfilling their duties, such as administration of medicines, have led to frequent delegation of this task between the registered nurses and unlicensed assisting personnel. It is of course a great responsibility to ensure that the care of the elderly remains safe while maintaining quality in the prevailing situation.

Design: A qualitative inductive descriptive study.

Methods: Data were collected using audio-recorded semi-structured interviews with a purposive sample of 18 registered nurses and interpreted using manifest content analysis. The study was approved by the Ethical Research Committee.

Results: Registered nurses found the organization unsupportive with regards to nursing interventions. The delegation context was experienced as a greyzone; the rules and regulations were not in line with the unspoken expectation to delegate the administration of medicine to unlicensed personnel, in order to be able to manage their daily work.

Conclusions: The slimmed organization of residential care homes relies upon registered nurses use of delegation of medicine administration to unlicensed assistant personnel. It

becomes an inevitable assignment entailing a challenging responsibility for patient safety and the quality of care.

Relevance to clinical practice: The results of this study may contribute to a better understanding of the complexity of caring for older people in residential care homes and to improving the work environment of all healthcare personnel.

Keywords: Delegation; Medicine administration; Older people; Registered nurse; Residential care homes; Unlicensed assistant personnel.

What does this paper contribute to the work of the wider global clinical community?

- Defining the challenges for RNs to ensure patient safety when delegating the administration of medicine to unlicensed personnel in residential care homes.
- Stresses the need for properly trained personnel in residential care homes.
- Highlights the fact that the whole context of the delegation of administration of medicines needs to be reviewed.

Introduction

Older people who are provided with residential care are extremely frail and incapable of independent living. Registered Nurses (RNs) and unlicensed assistant personnel (UAP) are responsible for caring for and nursing older people living in residential care homes in Sweden (Karlsson *et al.* 2008). Medicine administration is a time consuming assignment due to older peoples' medical condition in residential care homes; they often require a number of medicines (Gransjön Craftman *et al.* 2016, Norell *et al.* 2013). Errors in medicine administration have may have grave consequences for patients, which makes this assignment a considerable responsibility.

Background

Previous research (Craftman *et al.* 2013) has found that RNs have a high workload and encounter difficulties in completing their duties during working hours. RNs have the responsibility of caring for and nursing large groups of patients, especially during evenings and weekends when the staffing is limited. Nilsson *et al.* (2009) describes RNs' role as consultative meaning that you are only present at the residential care home if a patient is for some reason in need of care. A consequence is that RNs are obliged to delegate a number of tasks to the UAP, to whom the administration of medicine is frequently delegated (Bystedt *et al.* 2011, Craftman *et al.* 2013a, Josefsson *et al.* 2007).

Delegation of medical tasks e.g. medicine administration in ranging from distributing, handing over or reminding the person is in use in different countries and contexts (Denton *et al.* 2015) Heat, 2012; Walsh, 2013; Lee, 2011) The American Nurses Association (2006) (ANA) (2006, p. 4) has defined delegation as “the transfer of responsibility for the performance of an activity from one individual to another while retaining accountability for

the outcome”, but only if the UAP is skilled enough to undertake the task (Nursing and Midwifery Council 2012). The Swedish National Board of Health and Welfare [SNBHW] has issued statutes to the effect that delegation of medical tasks to unlicensed personnel must not compromise patient safety is an individual arrangement between the RN as delegator and the UAP as the receiver of the delegation is accountable for both accepting the delegation and the actions taken in executing it. The delegation is also time-limited and must be renewed once a year to be valid. Keeping the obligation of safe practice it adheres to the nurse delegator to decline delegating a task if he or she anticipates that it would not be in the resident's best interest.

There are several factors influencing RNs' decision to delegate the administration of medicine to UAP. It mainly concerns how comfortable the nurses are in their ability to teach and evaluate UAP knowledge and skills. Some RNs may fear liability in connection with the delegation and would rather perform the task themselves, but when there is no time for such considerations, RNs are forced to delegate the responsibility to UA instead. The availability of trained staff is limited, which may give the consequence that the RN not feel there that there is enough time to implement the necessary training to delegate appropriately (Craftman *et al.* 2013a, Mitty *et al.* 2010). In practice, this may lead to rationalization of the risk of delegation. In addition, delegation of the administration of medicine to UAP can, over time, be implicit included in the work task and the outlines for each profession can become increasingly blurred (Craftman *et al.* 2013b, Gransjön Craftman *et al.* 2014, McIntosh *et al.* 2000). The wrong dose and the wrong time for administration are the most usual deviations (Craftman *et al.* 2013a). Such deviations can be related to the fact that UAP have inadequate training in the administration of medicine and/or cannot maintain full focus on the task because of the many other tasks that they will usually need to cope with simultaneously (Mitty 2009). Weman *et*

al. (2004) underscore the importance of good care organization. If the organization is dependent on limited resources, this will have negative consequences for the quality of care.

A precondition for the provision of satisfactory care is to have adequate collaboration and good, continuous communication between RNs and UAP (Potter *et al.* 2010). The RNs are expected to assume the responsibility for being experts in providing care, to make stand-alone decisions and to create a safe environment for both residents and the UAP. Delegation is one of the most difficult tasks that licensed health care professional meet in their daily work (Karlsson *et al.* 2008). Functional delegation, besides relational aspects and communication, depends on system support and nursing leadership (Bittner & Gravlin 2009). Previous studies (Bystedt *et al.* 2011, Craftman *et al.* 2013b) found that district nurse's heavy workload stresses them to delegate the administration of medicine regardless percept skills of the delegatee. According to Bystedt *et al.* (2011) and Craftman *et al.* (2013b), it is impossible to adhere to the statutes and regulations framing the whole delegation context. (Fröberg 2004) points out that the delegation context is a subject that raises the most questions among health professionals regarding of medical law. Therefore, our aim was to describe RNs' experience in the context of delegating medicine administration to unlicensed personnel in residential care homes.

In this study, the term UAP is used to denote unlicensed personnel; however, different terms are used in different countries as well as in the literature, e.g., unlicensed assistive personnel, health care assistants, and unlicensed caregivers.

Methods

Design

Polit and Beck (2012) argues that qualitative studies use an emergent design, meaning that the design emerges in reflection of what has already been learned in the subject. This study has the intent to describe and to reach a holistic understanding of the RNs' experience of the delegation of medicine administration in the context of residential care homes which is why a qualitative inquiry was preferred in line with Patton (2015) and Polit and Beck (2012). A semi structured interview guide was used to collect data.

Participants and setting

Altogether, 18 participants were sampled purposefully. The sample consisted of 17 women and one man who accepted the invitation, from 11 different residential care homes in an urban area of Sweden, ranging in size from 33 to 180 resident beds. The inclusion criterion was RNs who had delegated administration of medicines for more than a year in residential care home settings. The average duration of the participants' work experience as RNs was 15 years, with a total span of 2–25 years. Their ages ranged between 38 and 66 years and the number of active delegation decisions ranged from 5 to 30.

Data collection

An initial contact with the RN was made through each of the nurse managers of 11 residential care homes. The manager handed out letters of invitation to the RNs, and those who agreed to participate contacted the authors to set a time and place for interviews, in accordance with the participant's wish. All interviews were held on site in the respective residential care homes. Eighteen individual semi-structured interviews were carried out from January to February, 2013. An interview guide with adjustments to suit the context of

a residential care home was used based on the Craftman *et al.* (2013b) interview guide. All interview had a specific open question: “Could you please tell me about your experience of the administration of medicine?” Probing questions were asked to clarify and confirm how the answers were being understood. The interviews lasted about 30 minutes on average and were audio-recorded with the participant’s consent. Afterwards, they were transcribed *verbatim* and checked in comparison with the corresponding audio file.

Data analysis

Content analysis using an inductive approach according to Graneheim and Lundman (2004) was chosen to analyze the data. Content analysis is a dynamic form of text analysis, with the main purpose of summarizing the content. The latent analysis was performed in the steps defined by Graneheim and Lundman (2004). The analysis began with reading the interview text several times to obtain an overall sense of the content. Each transcript was checked for correctness against the corresponding audio file. The text content was divided into meaning units (e.g. word, sentence or a whole paragraph) relevant to the aim of the study. These units were condensed on a descriptive level, keeping close to the text. In the next step of the analysing process units were put together in codes, describing the visible text of RNs’ perception. The codes were then compared and two different themes reflecting the RNs’ experiences were identified as a result of the latent analysis, in line with Graneheim and Lundman (2004). The main theme, *Balancing organizational limits, quality of care and patient safety*, is an expression of the latent content of the text and was understood to be a common core through the sub-theme and links the themes together (Table 1). An example of the analytical process is shown in Table 2. Lastly, all authors reviewed the analysis, aiming to reach a consensus of the findings regarding categories and themes reflecting the RNs’ experiences of delegating medicine administration to unlicensed personnel.

(Insert Tables 1 and 2 about here)

Ethical considerations

The study was carried out in accordance with Ethical Guidelines for Nursing Research in the Nordic Countries. Participants were informed in writing and verbally about the study, the voluntary nature of their participation and their right to withdraw at any time.

Moreover, that confidentiality would be ensured and that any quotes from the interviews would be reformulated as to provide confidentiality in line with Swedish Research Council (2011). The participants gave an informed consent to participate and each transcribed interview was coded with a number. The Regional Ethical Review Board in Stockholm, Sweden (EPN 2008/103-331/2) has approved the study.

Results

The findings are presented under the main theme: *Balancing organizational limits, quality of care and patient safety* and two themes: *Working in an unsupportive framework; To handle a requirement in an unspoken grey zone*. The four sub-themes are: *The residential care home organization relies upon the use of delegation to unlicensed assistant personnel; Follow-up of delegations: time-limited tutoring and communication* *Handing over a crucial nursing responsibility under jeopardizing circumstances; Trust and communication bridges the gap of uncertainty in the delegation context*;. Together these describe RNs' experiences in the context of delegation of the administration of medicine to UAPs in residential care homes (Table 1).

Working in an unsupportive framework

The residential care home organization relies upon the use of delegation to unlicensed assistant personnel. It was argued that due to the slimming of the organisation in terms of

personnel and finances, the RNs were required to delegate the responsibility to UAPs. This was a prerequisite for properly managing everyday work. Medicine administration was regarded as part of the professional role of an RN working in a residential care home, and some participating RNs preferred managing and administering the medicines by themselves even if it was time consuming. One RN asserted that she could not manage her workload without delegating medicine administration to UAPs, citing too few RNs and a lack of time. It was regarded as a mandatory procedure in a slimmed organization.

This is a solution to make it possible to be able to operate with as few RNs as possible. It is cheaper to have an assistant than to have more nurses. If I didn't delegate, it would increase the workload of all my colleagues. (P.13)

The delegation freed time for the RNs to perform other tasks such as nursing assessments, having contact with relatives, and teaching UAP.

The good thing, I think, is that it relieves us nurses; it would not work otherwise in a place like this. The task would not get done if you were alone with 48 residents; there's no way that you can give medicine to everyone. No one can question this. (P.4)

Some residential care homes only had RNs on site during the daytime on weekdays; other times, such as evenings, nights, and weekends, UAP were supposed to contact a RN who is on call. This situation requires that medicine administration is delegated to UAP. RNs stated that the UAP have the right to refuse; however, that is not a possible option in practice, it is an implicit require to work. Usually, only a few UAP did not agree to accept delegation and therefore it did not constitute a problem to administrate the medicines.

Actually you can, but not really ... if everyone (UAP) would say no, then I would just have to hire more nurses – that would not work. (P.4)

“When it comes to hiring new staff, to delegate is a prerequisite for being able to work here; therefore, you are forced to agree to accept the delegation (P.1)

Even the RNs expressed a pressure to delegate even if they were unsure of the UAP ability, it could come from the management in order to solve staff shortages.

There have been a few times when I have been a bit hesitant, but then, for example, my boss came to me and said “I believe in this person and he/she will work in various departments; therefore, I wish that you could try giving him/her a delegation (P.17)

The RNs argued that the policymakers, e.g. SNBHW, did not know how much about the context of their task of delegating medicine administration to unlicensed personnel, and how complex the task was, but, most importantly, the challenge it presents to the quality of care and the patients’ safety. The RNs found the politicians’ decisions concerning the organization for elderly care unclear. They felt that the politicians were aware of the strained organization in resident care homes, but choose to ignore, the challenge situation in personnel staffing, also were unaware of how delegation of medicine administration was built into the organizational structure.

I don’t know if they (politicians) realize that it would never work if you didn’t use delegation. It would never work and, furthermore, we (RNs) work Monday to Friday

here. At other times the elderly must of course also have their medicines and then there is no nurse on site. I don't know if they realize that. (P.10)

Doubts about the politicians' source of information about the situation was voiced, an example given being a refined image of the residential care home that was shown during the politicians' study visit.

I know they make their point visits sometimes, but then you know all about when they'll come. So, everybody does their best to make everything look good. (P.17)

The RNs believed that the policymakers' focus was on that all care personnel should be trained assistant nurses. However, this training did not include administration of medicines in actual practice.

Follow-up of delegations: time-limited tutoring and communication. One participant argued that it was up to the RN to assure her or himself of how the delegated tasks were performed by the UAP. It was voiced that the delegation procedure itself was regarded as a frequent low-priority assignment among RNs and that this could be the reason why it was not discussed more frequently. Lack of time was also considered to be a problem connected with not being able to back up the UAP when they felt unsure about the way they should perform the assignment. Delegation decisions were followed up primarily in connection with renewals of the delegation. The RNs pointed out that there was no standard routine for follow-ups and that time should be set-aside solely for this purpose. The RNs argued that whether or not UAP should pass knowledge test depends on the skills required carrying out the administration of medicines. In one residential care home, restrictions were set on the number of delegation decisions per RN. This limit was set by the Medical Director Nurse to enable the tutoring and

follow-up included in the RN's delegation assignment. One RN gave the example that she had delegated to a number of UAP at the nursing home but they had never worked together.

So every week we talked about deviations, but it is not the content of the delegation itself ... we've never sat down and talked about how you do it when you delegate and how to teach it? It should only be done so that the official documents look fine. (P.8)

To handle a requirement in an unspoken grey zone

Delegation to the UAP was perceived as *handing over a crucial nursing responsibility under jeopardizing circumstances*. To reduce the workload RNs felt that they surrendered the task that they were responsible for. RNs did not get the same ability to review, and they expressed uncertainty about whether the medicine administrations were properly performed. They felt that most UAP understood the meaning of the delegation; however, this understanding could vary. Cases where the understanding of the task failed were explained by a lack of knowledge and interest on the part of the UAP, who had very often worked for a long time in the same setting. When they were uncertain of if they had insufficient language skills, occasionally they did not dare to ask the RNs for help. However, even if the UAP knew how the delegated task should be performed, continuous worry about correct performance was a cause of stress among the RNs.

There will be some uncertainty. There can be a loss of certainty that a thing will really get done... if it really gets done completely correctly. You could still never be one hundred per cent sure that this is really the way it should be. You may as well learn to live with some uncertainty, and it will always be a bit of a gamble. (P. 17)

For the most part, I think the nursing staff (UAP) understands. But I also know that, in practice, they don't always follow everything that I say because they think they don't have time and they help each other to administer (medicine). Or if there is someone who works a night and doesn't have the delegation, I know that they say "you can give the pills" even though they know it is not entirely correct. (P.13)

According to the RNs, UAPs lack knowledge regarding the medicine's indications and effects, which complicates prioritization and assessing need for medicines in specific situations.

I, as a RN, can of course customize the medicines because I know what effect the different medicines have. (P.1)

The lack of knowledge about medicines and their effects among UAP was a factor that increased the risk of deviations, such as an incorrect method of administration, inadequate understanding of the importance of time intervals for specific medicines or improper handling of the signing list. All RNs had experienced deviations that had been linked to improper management of medicines. The most common deviations were not signing the list after giving the dose, missed doses, and giving incorrect or double doses. In the quality council meetings, which are held regularly regarding care, these issues were often discussed. The agenda was to find out the underlying reasons for the mistakes and work to prevent future mistakes which led to routine changes to try secure or facilitate the management of medicines. Some examples of mistakes the RNs mentioned were inhalants administered as eye drops, sleep medicine administered in the morning, antihypertensive medicines that had been administered

in double doses and blood pressure-lowering medicines that had been given to a patient with low blood pressure.

Some residential care homes made use of warnings to alert about deviations that occurred. If you had not thought that it was so important before now, you knew that you had to improve. (P.7)

In several residential care homes, delegation of medicine administration was not renewed or had been revoked. In those cases, the causes had been repeated failure to pay attention by the same person, or failure due to insufficient language skills. The RNs experienced that UAPs were affected by a non-renewal or retracted delegation decision, as they felt humiliated and hurt. One example was an UAP who had quit her job due to non-renewal.

Trust and communication bridges the gap of uncertainty in the delegation context and was experienced to be important factors if the delegation was to be performed and managed properly. By having a constant dialogue the RNs could empower UAP and help them to note and report changes in resident's behaviour and health. If communication improved monitoring, it would also decrease the risk of misunderstandings and deviations in medicine management. A constant discussion between UAP and RNs was said to be important because it advanced health professionals' interest and experience in the subject. Some frequently discussed issues were indication for medicines, administration routes, side effects, and dosage.

The RNs expressed the importance of UAP to understand given instructions and information, to communicate adequately, to inform the residents correctly, and report back to them. The

UAP should also have an interest in performing the task. Moreover, they have to be thorough in performing their duties and be reliable. The RNs meant that it was essential that the UAP dared to report any deviations back to them.

One wants to ensure that the nursing staff is reliable and precise in other tasks as well. If you don't care about the elderly in other ways, then one can imagine that this will also apply to the administration of medicines. (P. 3)

Some RNs felt that UAP should have to work at a residential care home for some time before a delegation. The reason for this was that the UAP should get to know the residents, but also allow the RNs to form an opinion as to whether the individual would be able to perform the task. A certain amount of knowledge is required to understand the importance of medicines and to carry out the procedures. Most RNs perceived UAP knowledge about medicines and their administration as being varied and mostly lacking.

This is very different depending on the individual ... Surely at least half of them (UAP) have no knowledge at all. (P. 13)

Some RNs expressed that the skills required for delegation differ depending on whether the person was a trained nursing assistant or not, while others felt that the formal level of training had no bearing on how to perform the administration. Characteristics mentioned as being important for medicine management and administration were the individual's own motivation, interest, curiosity, and ambition. Moreover, opinions were divided regarding experiences, i.e., whether delegation added something to the UAP work. Some RNs voiced that the delegation was something wanted by the UAP because it raised their status; it was enjoyable and led to

personal encouragement and development. Examples given as motives for UAP lack of motivation to administer medicine were disinterest in the task in general, being uncomfortable with the responsibility, and a heavy workload.

Discussion

The main theme derived from the present findings concerns experience of delegation of the administration of medication as a dialectal relation between being (aspects linked to a person) and doing (adjusting to frames in the organization in residential care homes and statutes). It defines nursing experience of delegation as an organizational approach who must meet the central goal of nursing and responsibility as a whole. The present findings elucidate the organizational limits expected RNs to delegate to UAP as a mandatory without discussion of voluntariness for the RN and the UAP to give or accept delegation, as well as the quality of care and patient safety. Some RNs assumed that the use of delegation to UAP was due to a high workload linked to a money-saving perspective of the employer with the aim “to be able to run the business with as few RNs as possible,” as one of the RNs expressed herself. This was also an option to free up time for RN’s to perform the defined nursing assessments, which cannot be delegated. Therefore, the time consuming administration of medicine was delegated to UAP who then perform a RNs assign. The SNBHW (SOSFS:1997:14; SOSFS 2001:1), underline the acceptance of the delegation of the administration of medicines is supposed to be voluntary on the part of the UAP and a delegation should never be used as a solution to reduce a workforce. However, Craftman et al. (2013) and Gransjön Craftman et al. (2014) described the situation as a mutual dependency and even as a “hostage” situation. This was in reference to situations where UAP refused to accept delegation; the RNs have to perform this task themselves. Consequently, the whole organization in the residential care homes would collapse due to RNs’ lack of time. Gransjön Craftman et al. (2014) echoes our findings that a

UAP can only deny in theory but not in practice. The question is how free the RNs are in their position with a personal responsibility of the delegation procedure and the outcome, as well as the UAPs in their acceptance of the proposed delegation? Altogether, this will challenge not only their personal responsibility but also how to fulfill the prerequisite to maintain quality of care and patient safety.

Our findings showed a RN's personal and professional decision to deny delegating may reflect back negatively on the RN because of the impact involving an increase of the workload for all colleagues. Similar experiences of balancing the personal consequences and the organizational structure involving RNs and UAP are highlighted in studies by Bystedt et al. (2011b), Craftman et al. (2013a), and Josefsson et al. (2007) where delegation of medicine administration was a presumed condition for managing the daily assignments of the RNs. Furthermore, our findings exemplify the fact that the residential care homes where RNs were on site only during the daytime on weekdays require implicit RNs to give and UAP to accept delegation. According to Weman et al. (2004), an organization that is depending on restricted resources will experience negative consequences for the quality of care. There is also a risk in this accepted and assumed procedure to permanently transmit nursing assignment to unprepared staff.

One of the major responsibilities that RNs have when delegating the administration of medicines to UAP is to ensure patient safety (SOSFS:1997:14; SOSFS 2001:1). The RNs in our study exemplify such deviations as failure to sign the list after a given dosage, missed doses, and incorrect or double dosage. All of this this endangers patient safety and an adequate knowledge of the risk of deviations. According to RNs in the present study, if UAP cannot fulfill a delegated task, they should not be working in this area. The interpretation of the present study is that the UAP perform a licensed person's task and therefore need to understand the significance of this responsibility. Therefore, the RNs have to ensure that the

UAP have, besides adequate knowledge and good judgment, a sufficient understanding of this complex situation to perform the task. RNs also have to trust UAP in their performances and hope that everything turns out well for the patients. Potter et al. (2010) stresses the importance of making clinical decisions in the right circumstances of a delegation.

The present study indicates that RNs regard the responsibility of delegating the administration of medicines, follow-up and tutoring of UAP as something important but, at the same time, a heavy responsibility to bear. Lack of time was given as a contributing explanation for the latter. According to the statute (SNBHW, 1997), a person delegating a task is obliged to follow up and tutor the delegate, which could not be fulfilled. Another aspect considered to be important for RNs in the present study was to have good communication between themselves and UAP, especially when the UAP felt unsure about any matter regarding medicine administration and the patients. The lack of formal competence of the UAP highlights the importance of encouraging communication between the two groups. Goodman et al. (2005) and Bittner and Gravlin (2009) found that there was always a risk of miscommunication between RNs and UAP, especially because of the language barrier. One conclusion drawn from this is that good communication and follow-up of the task are two important factors in delegating the administration of medicines.

Methodological considerations

Qualitative interviews were used to collect data for this study, which gave us the possibility to examine the experience of delegation in a deeper manner. Moreover, the findings might be relevant and transferrable to similar residential care home settings both in Sweden and elsewhere. However, there are some limitations to the study. First, it can be argued that it is a

small sample size. However, interviews were performed until there were no more variations in the answers. Secondly, the specific context from which the data was drawn from, in combination with the sample size, means that the result cannot be generalized. However, our aim was to generate new insights that are comprehensive and logical in line with qualitative intention. The final limitation to be considered is that the data is collected in an urban area, RNs' experience may differ from the rural parts, where the staff turnover is less frequent regarding UAP. According to Graneheim and Lundman (2004), trustworthiness rests upon dependability. In this study, two of the authors performed all of the interviews, and the prerequisites for the participants were consistent over the elapsed time. To increase trustworthiness, all authors were involved in the analytical process. Any disagreement, e.g. with regard to labeling, was discussed by the authors until consent was reached.

Further examinations of delegation, as a transfer of medicine administration, are necessary as well as how to enhance relevant recurring possibilities of competency development among UAP. The relevant regulatory acts should be reviewed in light of the prevailing situation, with lack of finances and registered nurses, hence delegation is used as a permanent solution.

Conclusion

There are particular challenges and opportunities for improvement in the framework steering work environment in residential care homes with a complex context of political frames and responsibility for the outcome of the patient care requires RNs to delegate the administration of medicines to UAP. To follow-up and good communication between RNs and UAP are two important factors to maintain patient safety in the context of delegation. However, time limitation and the given economical frames can make this responsibility a heavy challenge.

Relevance to clinical practice

- Findings of this study, based on the experience of Swedish RNs enrolled in residential care homes, can be regarded as part of the discussion of the critical responsibility for well-functioning medicine administration to old and frail patients.
- It is crucial in general for the patient safety and the quality of care as a whole but the resident's adherence to a medical treatment in specific.
- It is a contribution to a deeper understanding of the complexity of nursing and caring for older people in residential care homes and of the work environment for the personnel.
- There is a need for awareness and attention both on the part of the management and, most importantly, the policymakers concerning the safest and effective way to transfer or delegate medical assignments from licensed to unlicensed personnel if so is needed.

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Table 1. Content analysis of sub-theme, themes and main theme describing RNs experience in the context of delegation of medication administration to UAP in residential care homes.

Sub-theme	Themes	Main theme
The residential care home organization relies upon the use of delegation to unlicensed assistant personnel	Working in an unsupportive framework	Balancing organizational limits, quality of care and patient safety
Follow-up of delegations: time-limited tutoring and communication		
Handing over a crucial nursing responsibility under jeopardizing circumstances	To handle a requirement in an unspoken grey zone	
Trust and communication bridges the gap of uncertainty in the delegation context		

Table 2. Example of the data analysis process.

Meaning unit	Condensed meaning unit Description close to the text	Code	Sub-theme	Theme	Main theme
The good thing I think is that it relieves us nurses; it would not work otherwise in a place like this; and it is also possible to leave the task to someone else. It would not work when you are alone with 48 residents, there's no way that you can give medicine to everyone. No one can question this.	It relieves us nurses. It would not work otherwise. It is possible to leave the task to someone else and it would not work to give medicine to everyone.	Workload in a slimmed organization	The residential care home organization relies upon the use of delegation to unlicensed assistant personnel	Working in an unsupportive framework	Balancing organizational limits, quality of care and patient safety
For the most, I think the nursing staff (UAP) understands. But I also know that, in practice, they don't always follow everything that I say because they think they don't have time and they help each other to administer (medicine). Or if there is someone who works a night and doesn't have the delegation, I know that they (the UAP) say "you can give the pills" even though they know it is not entirely correct.	Most UAP understands but they don't always follow given frames, even if they know it's not correct.	Doubt on the performance of given delegation	Trust and communication bridges the gap of uncertainty in the delegation context	To handle a requirement in an unspoken grey zone	