JONA
Volume 40, Number 7/8, pp 329-335
Copyright © 2010 Wolters Kluwer Health | Lippincott Williams & Wilkins

THE JOURNAL OF NURSING ADMINISTRATION

Nurses' and Nursing Assistants' Reports of Missed Care and Delegation

Gayle Gravlin, EdD, RN, NEA-BC
Nancy Phoenix Bittner, PhD, RN, CCRN

Objective: Measure RNs' and nursing assistants' reports of frequency and reasons for missed nursing care and identify factors related to successful delegation.
Background: Routine nursing tasks were identified as the most commonly occurring omissions. Reasons for omissions included poor utilization of staff resources, time required for the nursing interventions, poor teamwork, ineffective delegation, habit, and denial.
Methods: Quantitative, descriptive design.
Results: Widespread reports of missed care included turning, ambulating, feeding, mouth care, and toileting. Frequently reported reasons were unexpected increase in volume or acuity, heavy admission or discharge activity, and inadequate support staff. Factors affecting successful delegation were communication and relationship, nursing assistant competence and knowledge, and attitude and workload.
Conclusion: Nurse leaders must focus on implementing strategies to mitigate factors and the consequences of care omissions, including poor patient outcomes. An analysis of point-of-care delivery system failures and ineffective processes is essential.

Outcome transparency has put significant pressure on nurse executives to achieve high-quality nursing care. As these pressures mount, so has the call for urgent change to transform the hospital patient care environment.[1-3] Work environment inefficiencies that serve as obstacles to efficient performance of RNs threaten patient safety and care quality by decreasing the amount of nurse practice time devoted to direct patient and family care activities.[4]

Inpatient staff nurses are kept from the bedside by a variety of system inefficiencies and failures.[5] Storfjell et al[6] reported that medical-surgical nurses spent more time in support activities than providing patient care. More than one-third of RNs' time was spent on non–value-added tasks, representing an average of 28% of RN wages. Annually, non-value-added activities totaled more than 1 million dollars for the average medical-surgical unit. Strategies to increase nurse-patient time, frequently targeted at increasing nurse-staffing levels, have failed because system inefficiencies, the root cause of the problem, remain unaddressed.[6] Improving the hospital care environment and increasing the amount of nursing time spent with patients positively affect patient outcomes.[7,8]

Impact of Work Environment on RNs' Cognitive Work

The impact of the work environment on nurses' clinical decision making in acute-care settings has been examined.[9,10] Nurses wasted valuable time managing and working around system failures instead of focusing on critical clinical reasoning about patients.[9] Potter et al[10] reported that a high frequency of interruptions (average, 30 per shift) and cognitive shifts distracted the attention of the RN. High cognitive stacking loads of the RN were found to contribute to care omissions. When the cognitive stacking load was 16, the RNs averaged 4 omissions each per shift.[10]

Errors of Omission

Until recently, errors of omission have received little attention in the patient safety movement.[11] Missed

Authors' Affiliations: Associate Chief Nurse (Dr Gravlin), Nursing Education, Research & Professional Development, Lahey Clinic, Burlington, Massachusetts; Assistant Dean and Professor (Dr Phoenix Bittner), School of Nursing and Health Professions, Regis College, Weston, Massachusetts.
Corresponding author: Dr Phoenix Bittner, Regis College, 235 Wellesley St, Weston, MA 02493 (*nancy.bittner@regiscollege.edu*).
DOI: 10.1097/NNA.0b013e3181e9395e

Copyright © 2010 Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.

nursing care, defined as any aspect of required care that is omitted in part or in whole or delayed,[12] has the significant potential to lead to adverse patient outcomes. The failure to carry out necessary nursing tasks has also been defined as care rationing and was found to be a strong independent predictor of patient outcomes.[13]

Kalisch et al[14] reported 9 elements of regularly missed nursing care: ambulating, turning, delayed or missed feedings, patient teaching, discharge planning, emotional support, hygiene, intake and output documentation, and surveillance. Reported reasons for missed care included too few staff, poor use of existing staff resources, time required for the nursing interventions, poor teamwork, ineffective delegation, habit, and denial.

Bittner and Gravlin's[15] exploration of delegation and critical thinking built on Kalisch's work and the understanding of delegation as a significant cause of missed care. Factors relevant to delegation effectiveness were reported as tasks delegated, knowledge expectations, nurse and nursing assistant (NA) relationships and roles, RN-NA communication, and system support.[15] These authors suggested that nurse executives closely examine what is occurring at the nurse-patient interface and urge nurse executives to design a care delivery model that will support the delegation process.

The Delegation Process

The use of the RN-NA care delivery model is likely to continue as organizations strive to contain costs and maintain quality.[16-18] In this model, nurses must be competent with the delegation process. Nurses are faced with increasingly complex delegation decisions. Berkow et al[19] reported that the delegation proficiency of newly licensed nurses, who comprise more than 10% of a typical hospital's nursing staff, was ranked lowest among 36 competencies by front-line nurse leaders. Both novice and experienced nurses may have an unclear understanding of their accountability for implicitly delegated tasks in the NA job description.[16,20]

Ineffective delegation practices resulting in negative patient outcomes have been reported.[20,21] The larger number of actual or potential negative patient outcomes resulted from lower level tasks such as ambulating, toileting, bathing, feeding, and skin care. Factors leading to negative outcomes, such as falls, were most often related to RN-NA direction/communication or RN supervision. These basic care activities are so routine that NAs may become complacent in carrying out these activities, and RNs may become less vigilant in supervising these activities.[20] Whereas nurses must have a clear understanding of their accountability for delegation at the RN-NA microsystem level, the chief nursing officer has the ultimate accountability for compliance with delegation standards.[16,22,23]

Purpose

The purpose of this descriptive, exploratory study was to (1) measure RNs' and NAs' reports of missed nursing care and reasons for missed care, (2) identify factors related to successful delegation as reported by RNs and NAs, and (3) describe nurse managers' (NMs') reports of missed care. This research followed an initial qualitative research study[15] that used a focus group methodology to explore how 27 medical-surgical nurses used critical thinking to delegate nursing care. These 27 nurses identified factors affecting successful and unsuccessful delegation, including frequent instances of routine nursing care omissions.

Methods

This current study used a quantitative design using the MISSCARE Survey 2[12] and a delegation questionnaire that was distributed to RNs and NAs on 16 medical-surgical units in 3 acute-care hospitals in the northeast. In addition, a unit characteristic questionnaire was distributed to the 16 NMs. Following institutional review board approval at all 3 institutions, surveys were distributed to 568 RNs and 232 NAs. Accompanying each survey were a recruitment notice delineating the terms of voluntary participation, a description of the study, and the investigators' contact information . Individual packets were addressed to all potential participants and delivered to 16 units at all 3 institutions. Anonymity was guaranteed by providing a self-sealing return envelope and a drop box on the unit. Informed consent was implied by the return of the survey.

The MISSCARE Survey 2 was developed by Kalisch and Williams[12] to determine the frequency of and reasons for missed care. The MISSCARE Survey 2 is divided into 2 parts: part 1 asks the RNs and NAs to identify how frequently elements of nursing care are missed. Using a 5-point Likert scale, with anchors labeled as always missed to nonapplicable. Part 2 asks the RNs and NAs to report their perceptions of the reasons care is being missed. The reasons for missed care are categorized within 3 factors: labor resources, communication, and material resources. Part 2 uses a 4-point Likert scale, anchored from not a reason to a significant reason for why care is being missed. Validity and reliability of the tool have been reported elsewhere.[12] The

Copyright © 2010 Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.

Cronbach α was .86 in the original instrument and .89 for this study.

In addition to the MISSCARE Survey 2, participants completed a delegation questionnaire developed by the researchers, with face validity established by a panel of doctorally prepared experts. The RN delegation questionnaire asked the nurses to rate factors that contributed to successful delegation on a 5-point Likert scale (1 being very relevant to 5 being irrelevant). Questions including the RN-NA relationship and communication and NA judgment, knowledge, confidence, and attitude were asked. The nurses were also asked to rate their perceived effectiveness in carrying out the delegation process: assessment and planning, communication, supervision, and evaluation, on a 5-point Likert scale (1 being very effective to 5 being ineffective). In addition, the nurses were asked questions regarding prehire and posthire delegation education, comfort level with delegation, the number of NAs delegated to on a routine shift, and the value of a well-trained, experienced NA to them in their daily practice. Lastly, nurses were asked to rate their satisfaction with both their current job, with the nursing profession, and intent to leave their current job at present or within the next 6 months.

The NA delegation questionnaire also asked them to identify factors that contributed to successful delegation, which included 10 items using the same Likert scale. Nursing assistants were asked to report the training they had received related to delegation and the number of RNs delegating to them per shift. Lastly, the NAs were also asked to rate their satisfaction with their occupation and current job, along with their intent to leave their position at present or within the next 6 months.

A unit characteristic form was developed by the researchers and administered to the 16 NMs. The data collected included basic information regarding the number of beds, skill mix by shift, number of patients assigned per shift to the NA, and number of RNs delegating per shift to the NA. The NMs were also queried about missed care, specifically if routine care had been reported to them, and the frequency with which missed care had been reported.

Results

From among the potential sample of 568 RNs, 232 NAs, and 16 NMs, 241 (42.4%) of the RNs and 99 (42.6%) of the NAs responded. One hundred percent of the NM group returned the unit characteristic form. Table 1 highlights demographic characteristics and satisfaction of the RN and NA groups. Years of experience in role, highest degree of education obtained, and work hours are also reported.

Notable is that 48% of the RNs reported being satisfied in their current job, with 85% reported being satisfied or very satisfied with nursing as a profession. Also of interest is that 63% of NAs reported satisfaction in their current job, with 76% reporting satisfaction with the occupation of being an NA. Ninety percent of both RNs and NAs reported that they had no plans to leave their job within the next 6 months. Information regarding formal delegation education was sought and is reported in Table 2, which highlights the delegation data as reported by the RN and NA groups.

Of interest is that 48.6% of the nurses reported as never having a formal course in delegation provided by their employer. Despite this, 82% reported they were comfortable with the delegation process. Fifty-nine percent of the NAs reported as never having a formal course in delegation. Regarding their delegation practices, 83% of the nurses reported that

Table 1. *Demographic Characteristics and Satisfaction of RN and Nursing Assistant Groups*

Item	RN Percentage (n = 241)	Nursing Assistant Percentage (n = 99)	Pearson *r*
Years of experience in your role: >10 y	33+	29	−0.016
Years of experience in your role: 4-10 y	19	21	
Years of experience in your role: 1-2 y	17	15	
Highest degree of education attained: BSN	43		
Highest degree of education attained: AD	33		
Highest degree of education attained: diploma	9		
Highest degree of education attained: high school and certification		24	
No. of hours usually worked per week greater than 30	77.5 (187)	72.6 (69)	−0.072
Work hours			
Day shift	44.8 (108)	40 (38)	0.076
Night shift	21.6 (68)	12.6 (12)	
Satisfied in your current position	48	63	−0.103
Satisfied or very satisfied with nursing/nursing assistant as a profession	85	76	0.130
No plans to leave your current position within the next 6 mo	90	90	−0.003

Copyright © 2010 Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.

Table 2. RN and Nursing Assistant (NA) Delegation Data

Item	Nurse, % (n = 241)	NA, % (n = 99)
Had a formal delegation course	56 (136)	
Delegation education provided by employer	51.4 (124)	41 (41)
No. of NAs delegated to during a routine shift	1-2 NAs: 83 (197) 3 NAs: 13 (32) 4 NAs: 3 (7)	
High comfort in delegating to NAs	82 (195)	
Delegation education provided by your employer	53.2 (124)	41 (41)
No. of RNs delegate to you on a routine day		1-2 RNs: 13 (13) 3-4 RNs: 53.5 (53) 5-6 RNs: 28.3 (28)
No. of patients (PT) assigned on a routine day		1-5 PTs: 1 (1) 6-8 PTs: 0 8-9 PTs: 34 (34) >10 PTs: 65 (64)

they delegated to 2 NAs per shift on average. Nursing assistants reported that 3 to 4 RNs per shift delegate to them. More concerning was the report by NAs regarding the number of patients that they are assigned to each shift. Sixty-five percent of NAs reported that they are assigned more than 10 patients per shift with patient loads increasing on the off-shifts.

Missed Care

The reports of missed care by RNs and NAs were consistent with that of Kalisch et al.[14] The most frequently reported missed care items included ambulating, turning of patients, feeding patients warm food, and mouth care. In addition, the nurses reported that attending interdisciplinary meetings was frequently missed. Table 3 displays data for most frequently reported missed care items.

The least frequent items of missed care reported by nurses were patient assessment, bedside glucose monitoring, and hand washing and ensuring discharge planning. The most frequently reported reasons for missed care were consistent with those in the report of Kalisch et al.[14] (See Table 4 below, which reflects the reasons for the most frequently reported missed care items by both the RN and NA groups.) The RNs and NAs were similar in their reports of the reasons for care being missed on a routine basis. The top 6 reasons cited were items that made up the labor resources factor. They included an unexpected rise in patient volume or patient acuity, inadequate number of assistive personnel, heavy admission or discharge activity, level of staffing, and urgent patient situations. The top 3 reasons that nurses reported for missed care reflected the ability to manage patient flow and rapidly changing patient and unit needs. Another reason cited by the RN in the communication factor was that the NA failed to communicate that care was not done.

Approximately 50% of both RNs and NAs reported tension or communication breakdown

Table 3. Most Frequently Reported Missed Care Items Reported by RNs and Nursing Assistants

Item	Nurse (n = 241)	Nursing Assistant (n = 99)	Pearson *r*
Ambulation 3 times per day as ordered	88%	59%	0.310
Turning patient every 2 h	88%	46%	0.407
Feeding patient warm food	86%	51%	0.377
Attend interdisciplinary care conference	86%	Not applicable	Not applicable
Mouth care	84%	44%	0.430

Table 4. Reasons for Missed Care Most Frequently Reported by RNs and Nursing Assistants (NAs)

Item	RN Percentage (n = 241)	NA Percentage (n = 99)	Pearson *r*
Unexpected increase in patient volume and/or acuity	95	63	0.434
Inadequate no. of assistive personnel	93	70	0.319
Heavy admission or discharge	93	59	0.439
Level of staffing	91	76	0.184
Urgent patient situations	81	52	0.317
NA did not communicate that care was not done	69	30	0.388

Copyright © 2010 Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.

occurring with support departments, medical staff, and the nursing staff as reasons for missed care. Kalisch et al[14] reported that tension or communication breakdown with physicians was most frequently reported as a reason for missed care.

Correlations With Role

To identify differences between the role of the nurse and the NAs on all items, correlations were completed. A positive significant relationship was found between RN role and the factors contributing successful delegation. These factors were reported as communication between the nurse and the NA and the NA's level of competence and knowledge and their attitude. In addition, there was a correlation with the NA's ability to follow directions. A positive significant relationship was also found between NAs' role and reports of factors affecting successful delegation. The NAs reported that communication with the nurse, their relationship with the nurse, and the level of confidence and attitude exhibited by the nurse were significant factors affecting successful delegation. These results supported the findings of Bittner and Gravlin[15] from a previous study regarding factors affecting successful delegation and are consistent with the findings from other studies.[18,20,21]

Unit Characteristics

The reports of the 16 NMs regarding reports of missed care on their unit were very concerning. Eighty-eight percent of NMs indicated that care omissions had been reported to them by their staff. Of those NMs who had received reports of care omissions, 66.7% also reported that the occurrence of the omissions was frequent. Asked to respond to questions regarding delegation on their units, 54% of NMs reported that 5 or more RNs delegated to the same NA on a routine shift. The delegation ratios on the off-shifts were reported as being higher. The reports of 62% of NMs supported the alarming findings from participating NAs who reported more than 10 patients per shift are routinely assigned to 1 NA.

Discussion

Reports of RNs and NAs of missed care were widespread across the 3 institutions. The most prevalent care omissions from the 2 groups were lower-level care activities that were routinely performed by the NA and included turning, ambulating, feeding, toileting, and mouth care. These activities of daily living are implicitly delegated activities seen in the NA job description, but may not be recognized as such by either the RNs or NAs. The most common reasons for missed care cited by both groups were an unexpected increase in volume or acuity, heavy admission or discharge activity, and inadequate support staff. Disturbing findings not previously noted in the literature were that 88% of the NMs stated that omissions had been reported to them, with 67% reporting that these omissions occurred frequently. Prime factors affecting successful delegation indicated by both groups were good communication, positive relationships and attitudes, workload, and the NA's competence and knowledge.

Limitations

This study was conducted in 3 hospitals in the same region of 1 northeastern state using a small convenience sample. Although findings were similar to a study that was conducted in 4 hospitals in a single Midwestern state, generalizations should not be made to other groups of nurses and NAs. Inherent in self-reported data was the limitation that nurses and NAs may not have provided a full and accurate description of missed care. In addition, although face validity was established, the RN and NA delegation questionnaire and the NM unit characteristic form were developed by the researchers.

Implications

An evidence-based approach is needed to address concerns regarding delegation and missed care in nursing practice. The potential negative patient, staff, and financial outcomes of ineffective delegation processes and care omissions should be a call to action for nurse executives. If concern for patient safety and publicly reported nurse-sensitive outcomes are not enough to stimulate the change needed in the acute-care environment, then financial outcomes should. The estimated annual loss of 1 million dollars on non–value-added tasks that continue to keep nurses away from the bedside must be addressed.[6] Additionally, high turnover rates for newly licensed nurses and their impatience with inefficient and ineffective systems should compel nurse leaders to act.[24]

If a culture of safety is to be achieved, an honest assessment and analysis of the care delivery model and microsystem work structures and processes are essential. Nurse practice leaders must focus their efforts on improving the care environment. Magnet hospitals are the best model for building a strong, positive work environment that supports professional nursing practice.[25] Transforming Care at the Bedside model[26] engages frontline nurses in redesigning

Copyright © 2010 Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.

ineffective structures and processes to enhance patient safety. Registered nurses' decision-making authority to temporarily halt unit admissions when patient acuity rises is a strategy that would address a top reason for missed care found in this study. Another innovative problem-solving strategy could focus on the RN-NA microsystem, specifically assignment planning, communication, and supervision. One RN-NA team could conduct a small test of change with 1 group of patients, for 1 shift, during hourly rounding, to uncover ineffective delegation practices that could lead to care omissions.

Although the development of working skills in delegation is an outcome expectation of baccalaureate nursing program graduates,[27] delegation competency will be realized only if opportunities for prelicensure practice occur in the classroom, laboratory, and clinical settings. Novice and experienced nurses as well as NAs should receive delegation education upon hire, as part of the review of the state's Nurse Practice Act, and the organization's scope of practice and job descriptions. Nurses must have a clear understanding of their accountability for the actions or inactions of others in the delegation process. In addition, RNs and NAs must fully understand what activities may be delegated implicitly as part of the NA job description. Ongoing delegation education stressing the need for clear communication of delegation instructions, with frequent, planned supervision and vigilance in evaluation should be included in the annual competency program.

Hansten and Jackson[28] have outlined a best-practice bundle of delegation and supervision skills that may mitigate factors attributed to care omissions and potential negative consequences. These bedside practices include planning assignments so that an NA reports to no more than 2 RNs; including NAs in shift handoffs; RN and NA patient rounding; check-in points during the shift with "real-time" feedback provided; reevaluating delegation and supervision practices at intervals; and coaching and mentoring.

Communication factors appear to play not only a vital role in delegation effectiveness, but also a leading factor in the success of nursing teams on acute-care units.[29] Practices to improve unit teamwork including team leadership, team orientation, mutual performance, backup behavior, adaptability and mutual trust, and communication should also be implemented. Communication failures such as handoff disconnects, lack of knowledge about the workload of other team members, inability to deal with conflict, and inconsistent staff members are likely linked to omissions of nursing care and delegation ineffectiveness.

Nurse managers should routinely complete a baseline assessment of delegation, communication, and teamwork practices on their individual units. Identification of RN-NA communication and relationship problems, so often at the root of ineffective delegation practices and teamwork failures, could be linked to undesirable outcomes such as missed care and/or care rationing. These recommendations for future performance improvement initiatives and nursing research can serve as a guide for nurse executives and frontline nurse leaders.

References

1. Institute of Medicine (IOM). *Keeping Patients Safe: Transforming the Work Environment of Nurses*. Washington, DC: National Academies Press; 2004.
2. Hines P, Yu K. The changing reimbursement landscape: nurses' role in quality and operational excellence. *Nurs Econ*. 2009;27(1):7-13.
3. Storfjell J, Omoike O, Ohlson S. The balancing act: patient care time versus cost. *J Nurs Adm*. 2008;38(5):244-249.
4. Hendrich A, Chow M, Goshert W. A proclamation for change: transforming the hospital patient care environment. *J Nurs Adm*. 2009;39(6):266-275.
5. Tucker A, Spear S. Operational failures and interruptions in hospital nursing. *Health Serv Res*. 2006;41(3):643-661.
6. Storfjell J, Ohlson S, Omoike O, Fitzpatrick T, Wetasin K. Non–value added time: the million dollar nursing opportunity. *J Nurs Adm*. 2009;39(1):38-44.
7. Robert Wood Johnson Foundation. Charting nursing's future: addressing the quality and safety gap—part 1. Available at http://www.rwjf.org. Accessed February 5, 2010.
8. Aiken L, Clarke S, Sloane D, Lake E, Cheney T. Effects of hospital care environment on patient mortality and nurse outcomes. *J Nurs Adm*. 2008;38(5):223-229.
9. Ebright P, Patterson E, Chalko B, Render M, Lu Z. Understanding the complexity of registered nurse work in acute care settings. *J Nurs Adm*. 2003;33(12):630-638.
10. Potter P, Wolf L, Boxerman S, Grayson D. Understanding the cognitive work of nursing in the acute care environment. *J Nurs Adm*. 2005;35(7/8):327-335.
11. Kalisch B. Missed nursing care: a qualitative study. *J Nurs Care Qual*. 2006;21(4):306-313.
12. Kalisch B, Williams R. Development and psychometric testing of a tool to measure missed nursing care. *J Nurs Adm*. 2009;39(5):211-219.
13. Schubert M, Glass T, Clarke S, et al. Rationing of nursing care and its relationship to patient outcomes: the extension of the international hospital outcomes study. *Int J Qual Health Care*. 2008;20(4):1-19.
14. Kalisch B, Landstrom G, Williams R. Missed nursing care: errors of omission. *Nurs Outlook*. 2009;57:3-9.

Copyright © 2010 Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.

15. Bittner N, Gravlin G. Critical thinking, delegation and missed care in nursing practice. *J Nurs Adm*. 2009;39(3):142-146.
16. Hansten R. Why nurses still must learn to delegate. AONE. *Nurse Lead*. 2008;6(5):19-25.
17. Standing T, Anthony M. Delegation: what it means to acute care nurses. *Appl Nurs Res*. 2008;21:8-14.
18. Kleinman C, Saccomano S. Registered nurses and unlicensed assistive personnel: an uneasy alliance. *J Contin Educ Nurs*. 2006;37(4):162-170.
19. Berkow S, Virkstis K, Stewart J, Conway L. Assessing new graduate nurse performance. *J Nurs Adm*. 2008;38(11):468-474.
20. Standing T, Anthony M, Hertz J. Nurses' narratives of outcomes after delegation to unlicensed assistive personnel. *Outcomes Manag Nurs Pract*. 2001;5(1):18-23.
21. Anthony M, Standing T, Hertz J. Factors influencing outcomes after delegation to unlicensed assistive personnel. *J Nurs Adm*. 2000;30(10):474-481.
22. National Council of State Boards of Nursing. National council position paper: concepts and decision making process. Available at http://www.ncsbn.org. Accessed February 5, 2010.
23. Hudspeth R. Understanding delegation is a critical competency for nurses in the new millennium. *Nurs Adm Q*. 2007;31(2):183-184.
24. Pellico L, Brewer C, Kovner C. What newly licensed registered nurses have to say about their first experiences. *Nurs Outlook*. 2009;57(4):194-203.
25. American Nurses Credentialing Center. *Magnet Application Manual, Magnet Nursing Recognition Program*. Washington, DC: American Nurses Credentialing Center; 2008.
26. Robert Wood Johnson Foundation. The Transforming Care at the Bedside (TCAB) toolkit. Available at http://www.rwjf.org. Accessed February 5, 2010.
27. American Association of Colleges of Nursing. The essentials of baccalaureate education for professional nursing practice. Available at http://www.aacn.nche.edu/education/pdf/Baccessentials08.pdf. Accessed February 5, 2010.
28. Hansten R, Jackson M. *Clinical Delegation Skills*. 4th ed. Sudbury, Massachusetts: Jones and Bartlett Publishers; 2009.
29. Kalisch B, Weaver S, Salas E. What does nursing teamwork look like? A qualitative study. *J Nurs Care Qual*. 2009;24(4):298-307.

Copyright © 2010 Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.