



Barriers and Facilitators to Delegation Among Clinical Nurse Managers: A Qualitative Study

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Abstract

Background: Delegation is a fundamental managerial competency that supports the effective distribution of responsibilities, continuity of care, optimal workforce utilization, and quality of care. However, delegation remains a complex and context-dependent process influenced by organizational, managerial, operational, and professional factors.

Objectives: This study aimed to explore the barriers and facilitators influencing delegation from the perspectives of clinical nurse managers.

Methods: This qualitative study was conducted between April and November 2025 in three hospitals in Tehran, Iran. Seventeen clinical nurse managers were recruited through purposive sampling with maximum variation and participated in semi-structured, face-to-face interviews. Interviews were audio-recorded, transcribed verbatim, and analyzed concurrently using conventional content analysis based on Graneheim and Lundman's framework.

Results: Key factors influencing delegation practices were classified into two main categories and seven subcategories. Barriers to delegation included a culture of control and distrust, restrictive managerial beliefs, operational and coordination barriers, and reward and recognition barriers. Facilitators of delegation included the professional competence of delegated staff, the leadership competence of nurse managers, and a supportive organizational climate.

Conclusions: Delegation among clinical nurse managers is shaped by interrelated organizational, managerial, operational, and professional factors rather than by individual managerial decisions alone. Addressing organizational barriers while strengthening leadership competencies, fostering a supportive organizational climate, and enhancing the professional competence of delegated staff may improve delegation practices and contribute to safer, more effective nursing care.

Keywords: Personnel Delegation, Nursing Administrators, Organizational Culture, Leadership

1. Background

Delegation is a core managerial component of nursing practice that supports the effective distribution of managerial responsibilities within healthcare teams (1, 2). In increasingly complex healthcare systems, it promotes continuity of care, optimal workforce utilization, and service quality (3-5). Clinical nurse managers play a central role by aligning patient needs, staff competencies, and

organizational priorities in delegation decisions (6-8). *Effective delegation* improves workflow efficiency and timely care delivery while enabling managers to focus on clinical oversight, coordination, and decision-making (9-13). It requires appropriate task assignment, clear communication, competency assessment, adequate supervision, and accountability, all of which are essential for patient safety and consistent care quality (1, 3-5).

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In the Iranian nursing context, nurse managers play an important role in managing nursing services, and their roles and practices are shaped by factors such as staffing shortages, structural deficiencies, and limited managerial authority (14). Ineffective delegation may result in delayed care, clinical errors, compromised patient safety, inefficient use of nursing resources, reduced care quality, increased managers' workload, lower staff engagement and job satisfaction, weakened teamwork, and poorer organizational performance (3-5, 13, 15-17). Thus, effective delegation is not only a managerial responsibility but also an important strategy for improving patient outcomes, workforce efficiency, and healthcare quality (3, 12).

Despite these benefits, effective implementation of delegation remains a complex, context-dependent process (3, 8). In many healthcare environments, particularly those affected by workforce shortages, high patient acuity, and organizational constraints, delegation may be applied inconsistently (3, 5, 15). Inadequate delegation practices, including unclear roles, insufficient supervision, limited competency assessment, and weak organizational support, are associated with delayed care, increased clinical errors, and compromised patient safety outcomes (4, 18). These challenges underscore that delegation is not merely task allocation but a multifaceted clinical judgment influenced by individual-, team-, and system-level factors (19-21).

Although the literature on nursing delegation has expanded, most studies have focused on nurses or assistive personnel who receive delegated tasks, providing only a partial understanding of how nurse managers make and negotiate delegation decisions (1, 2, 22). In Iran, research on nursing management and leadership has examined nursing shortages, structural deficiencies, limited managerial authority, burnout (14), transformational leadership and organizational change, communication, trust, and change facilitation (23, 24), professional power and authority (25), nurse empowerment (26), clinical nurse managers' experiences during the COVID-19 pandemic (27), and the importance of organizational culture, climate, and empowerment (28). Collectively, these studies highlight organizational, relational, structural, and professional influences on nursing management and leadership (14, 23, 25-28). However, they have not specifically addressed delegation as a distinct managerial process or how nurse managers navigate it in everyday clinical practice. Therefore, this study addresses this gap by exploring the barriers and facilitators influencing delegation among clinical nurse managers and how delegation is enacted and adapted in everyday clinical practice in the Iranian context.

2. Objectives

Without a comprehensive understanding of the barriers and facilitators influencing delegation from clinical nurse managers' perspectives, developing evidence-informed leadership training and organizational strategies remains challenging. Addressing this gap may inform approaches to strengthen managerial competence, delegation practices, team performance, and patient safety. Therefore, this study aimed to explore the barriers and facilitators influencing delegation from clinical nurse managers' perspectives.

3. Methods

3.1. Study Design

This qualitative study used conventional content analysis based on Graneheim and Lundman's framework to explore clinical nurse managers' experiences of barriers and facilitators to delegation (29). The framework provides a systematic yet flexible process for identifying, condensing, coding, and abstracting meaning units into subcategories and categories while preserving contextual meaning. Its inductive approach was well suited to the exploratory aim and the limited existing knowledge of nurse managers' experiences of delegation, allowing categories to emerge from participants' accounts rather than from predetermined frameworks.

3.2. Relationship to the Overarching Research Project and Prior Publication

This study was conducted as part of a larger PhD research project in nursing at the University of Social Welfare and Rehabilitation Sciences, Tehran, which examined delegation in nursing management. A related study from this project was previously published in *BMJ Open* (30) and focused on nursing managers' experiences, strategies, and practices of delegation, whereas the present study examines the barriers and facilitators influencing delegation among clinical nurse managers. Although both studies used conventional qualitative content analysis, coding and categorization were guided by their respective research questions and analytical objectives rather than by a shared predetermined framework. Accordingly, the present study provides a distinct and complementary analytical contribution and does not reproduce the findings of the *BMJ Open* study.

3.3. Setting and Participants

The study was conducted between April and November 2025 in 3 hospitals in Tehran (2 public university-affiliated hospitals and 1 private hospital), selected to capture variation in organizational and institutional contexts and

diverse perspectives on delegation. Eligible participants were clinical nurse managers with a bachelor's degree in nursing, at least 5 years of clinical nursing management experience, active involvement in delegation, and a current managerial position. In the Iranian healthcare system, a matron is the senior nurse manager responsible for overseeing and managing nursing services at the hospital level. Managers who declined participation or could not complete the interview were excluded. A total of 17 managers were purposively recruited using maximum variation sampling based on managerial position, management experience, education, gender, and hospital type. Of these, 7 participants were recruited from the first public university-affiliated hospital, 6 from the second public university-affiliated hospital, and 4 from the private hospital. Potential participants were identified through the nursing management offices and approached by the first author, who explained the study and invited participation. All 17 eligible managers agreed to participate, and none withdrew. The study was not designed to compare public and private hospitals; therefore, differences between hospital types were not systematically analyzed.

3.4. Data Collection

Participants took part in semi-structured, face-to-face interviews lasting 45 - 60 minutes, conducted by the first author, who had prior experience in clinical nursing management and qualitative research. Interviews were conducted at convenient times in quiet, private locations within the hospitals. Interviews began with the open-ended question, "Please describe your experiences with delegation in clinical settings," followed by questions about participants' understanding of delegation, strategies, and decision-making regarding task assignment. The interview guide was developed based on the study objectives and relevant literature and was reviewed by the research team for clarity, relevance, and alignment with the study objectives. No formal external expert review or pilot interview was conducted; however, the guide was refined during the initial interviews to improve question clarity and sequencing without changing the study focus. Flexible probing questions, such as "Could you explain further?" and "Can you provide an example?", encouraged participants to elaborate. All interviews were audio-recorded and transcribed verbatim (29). Data saturation was reached by the 15th interview, at which point no new categories or substantive dimensions relevant to the research question were emerging, and sufficient depth and variation had been achieved within the existing categories (31). Two subsequent interviews (P16 and P17) confirmed the stability and adequacy of the identified categories.

These interviews generated no new categories or substantially new dimensions but supported existing concepts. Accordingly, quotations from P16 and P17 in the Results illustrate established concepts and provide further depth rather than representing newly emerging concepts.

3.5. Data Analysis

Data were analyzed concurrently with data collection using the conventional content analysis approach described by Graneheim and Lundman (29). Transcripts were read repeatedly, and relevant meaning units were identified, condensed, and assigned initial codes while preserving their core meaning. All 17 transcripts were independently coded by 2 researchers. Codes were continuously compared and grouped into subcategories, which were progressively abstracted into broader categories. For example, a condensed meaning unit reflecting managers' belief that they could perform tasks better than their staff was coded as "Belief that managers perform tasks better than their staff" and grouped under "Restrictive managerial beliefs" within the main category "Delegation barriers." Coding discrepancies were reviewed by a third researcher, and the research team discussed differences in coding, abstraction, and categorization until consensus was reached. Throughout the analysis, researchers iteratively compared transcripts, meaning units, codes, subcategories, and categories to ensure that the findings remained grounded in participants' experiences. All qualitative data analysis was performed manually, without qualitative data analysis software.

3.6. Trustworthiness

Trustworthiness was established using Lincoln and Guba's criteria (32). Credibility was enhanced through prolonged engagement, participant checking, and research team discussions. At the end of each interview, the interviewer summarized the main points and invited participants to clarify or elaborate on their statements. Following preliminary analysis, emerging findings were checked with 8 participants selected to provide variation in managerial position, management experience, gender, educational background, and hospital type. No repeat interviews were conducted, and full interview transcripts were not returned to participants. Participants' feedback was considered in refining the findings. Dependability was established through an audit trail; confirmability through reflective note-taking, comparison of interpretations with the original transcripts, and peer debriefing; and transferability through maximum variation sampling and thick description of the study context and participants. The first author's prior experience in clinical nursing management and qualitative research provided contextual

familiarity with delegation but may have influenced the interpretation of the “Culture of control” finding. Reflexive notes were maintained, and emerging interpretations were discussed within the research team and compared with the original transcripts. The study was reported according to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.

4. Results

A total of 17 clinical nurse managers participated in this study, including 4 matrons, 7 supervisors, and 6 head nurses. The participants' mean age was 45.9 years. All participants held a bachelor's or master's degree in nursing. Their mean managerial experience was 9.8 years (Table 1). Data analysis identified 2 main categories and 7 subcategories reflecting the major barriers and facilitators influencing delegation practices in clinical nursing management (Table 2).

4.1. Delegation Barriers

Delegation was perceived as a complex process influenced by organizational, managerial, and operational challenges. Four barrier subcategories were identified: a culture of control and distrust, restrictive managerial beliefs, operational and coordination barriers, and reward and recognition barriers.

4.1.1. Culture of Control and Distrust

Participants described a culture of control and distrust as a major organizational barrier to delegation. Expectations for direct managerial control, negative judgments, fear of blame, limited support, and strained relationships reduced managers' confidence and willingness to delegate. These findings suggest that delegation was shaped not only by managerial decisions but also by organizational culture and trust within the clinical environment.

“In our hospital, there is still a belief that a good manager is someone who does everything personally. When we delegate responsibilities, it is sometimes interpreted as a sign that we are unable to manage the ward or have lost control. As a result, many managers prefer not to take that risk.” (P6, matron)

“Even when I know that a nurse is capable of doing the task, I may still hesitate to delegate because I will ultimately be held responsible if something goes wrong. When the culture is focused on blaming the manager for mistakes, it feels safer to keep control of the work myself.” (P10, matron)

“Whenever I delegate part of the work to a nurse, some colleagues—and even senior managers—assume that I am

trying to avoid responsibility. In fact, my intention is to empower the team, not to avoid my responsibilities.” (P1, supervisor)

4.1.2. Restrictive Managerial Beliefs

Participants described several restrictive managerial beliefs that discouraged delegation. Fear of losing control, authority, or professional credibility, together with perceptions that their own performance was superior, reduced managers' willingness to delegate responsibilities. These experiences indicate that managerial beliefs themselves could become barriers to delegation, even in supportive organizational environments.

“Sometimes I feel more comfortable doing the work myself. Delegation requires time for training and follow-up, and ultimately, I remain accountable for the outcome. So, subconsciously, I prefer to do it myself.” (P5, intensive care unit (ICU) head nurse)

“Sometimes managers believe that they can perform a task better than anyone else. Even when capable nurses are available, they prefer to do the task themselves because they feel more confident about the outcome.” (P2, supervisor)

Taken together, these findings suggest that delegation decisions were influenced not only by external organizational conditions but also by managers' beliefs about professional identity, responsibility, and authority. These beliefs reinforced self-reliance and limited opportunities for shared responsibility within clinical teams.

4.1.3. Operational and Coordination Barriers

Participants described operational and coordination barriers as practical challenges that limited effective delegation in clinical settings. They reported that unclear role expectations, communication gaps, insufficient training, and complex delegation procedures created uncertainty during task assignment and follow-up, reduced coordination among team members, and made delegation more difficult to implement safely.

“Sometimes the details of a delegated task are not communicated clearly. The nurse may have a different understanding of what is expected or when to report back to the manager. This creates problems during follow-up and makes the delegation process more difficult.” (P11, ICU head nurse)

“Delegation can become very complicated and time-consuming, particularly during busy shifts.” (P3, supervisor)

“Sometimes it is not clear who should be responsible for a task, especially when responsibilities overlap between

Table 1. Characteristics of the Participants

ID	Age (y)	Gender	Position	Education	Management experience (years)
P1	42	Female	Supervisor	Master's	8
P2	47	Female	Supervisor	Master's	6
P3	43	Female	Supervisor	Master's	12
P4	39	Female	Intensive care unit head nurse	Master's	7
P5	47	Male	Intensive care unit head nurse	Master's	9
P6	56	Female	Matron	Master's	22
P7	50	Male	Supervisor	Bachelor's	10
P8	48	Male	Matron	Master's	13
P9	45	Female	Supervisor	Master's	5
P10	51	Male	Matron	Bachelor's	15
P11	40	Female	Intensive care unit head nurse	Master's	6
P12	48	Male	Supervisor	Bachelor's	10
P13	45	Female	Supervisor	Master's	10
P14	50	Female	Coronary care unit head nurse	Bachelor's	9
P15	42	Male	Matron	Master's	7
P16	45	Male	Emergency head nurse	Master's	13
P17	42	Female	Coronary care unit head nurse	Bachelor's	5

Table 2. Categories, Subcategories, and Codes

Categories and subcategories	Codes
Delegation barriers	
Culture of control and distrust	Delegation perceived as avoiding managerial responsibilities; Preference for maintaining personal control over delegated tasks; Negative attitudes toward managers who delegate responsibilities; Fear that delegated errors will not receive organizational support; Interpersonal tensions reducing willingness to delegate
Restrictive managerial beliefs	Reluctance to transfer responsibilities to staff; Fear of losing control or credibility; Belief that managers perform tasks better than their staff
Operational and coordination barriers	Difficulty implementing delegation effectively in practice; Perception that delegation is a complicated process; Unclear professional roles and overlapping responsibilities; Insufficient communication and training for safe delegation
Reward and recognition barriers	Lack of motivation due to weak incentive systems; Perceived absence of fair compensation for delegated responsibilities; Additional responsibilities not matched by recognition or rewards
Facilitators of delegation	
Professional competence of delegated staff	Demonstrating professional responsibility and ethical commitment; Ability to solve clinical problems independently; Showing initiative and willingness to accept responsibility
Leadership competence of nurse managers	Ability to delegate responsibilities appropriately; Providing guidance and empowering staff during delegation; Developing confidence through managerial experience
Supportive organizational climate	Availability of organizational support for delegation; Professional relationships that encourage delegation; Work environment that facilitates shared responsibility

different units. When the boundaries of responsibility are unclear, delegation becomes more difficult and may lead to confusion, duplication of work, or disagreements about who is accountable.” (P4, ICU head nurse)

4.1.4. Reward and Recognition Barriers

Participants reported that inadequate incentives, compensation, and recognition for delegated responsibilities reduced nurses’ motivation to accept additional tasks. Financial incentives, overtime compensation, and performance-based recognition were

mentioned as potential motivators, whereas their absence discouraged acceptance of additional responsibilities.

“When nurses take on additional responsibilities, they expect their extra efforts to be recognized. However, when there is no difference in recognition or rewards compared with those who only perform their routine duties, they may lose motivation to accept delegated responsibilities.” (P13, supervisor)

“In our hospital, nurses who are assigned additional responsibilities through delegation do not receive any additional financial compensation or overtime payment.

There is no extra payment at all. When other nurses see this, they are also less willing to take on additional responsibilities.” (P15, matron)

4.2. Facilitators of Delegation

Participants identified several factors that facilitated delegation. The analysis identified three subcategories: professional competence of delegated staff, leadership competence of nurse managers, and a supportive organizational climate.

4.2.1. Professional Competence of Delegated Staff

Participants identified the professional competence of delegated staff as a key facilitator of delegation. Professional responsibility, ethical commitment, clinical problem-solving ability, and proactive engagement strengthened managers’ trust in staff members’ ability to perform delegated responsibilities safely and responsibly.

“When I see a nurse who takes responsibility for their work, reports problems honestly, and shows initiative without being prompted, I feel much more confident delegating responsibilities to them.” (P12, supervisor)

Participants also emphasized that delegation depended on sound clinical judgment as well as technical competence.

“Delegation is not only about technical competence. I need to know that a nurse can make sound decisions in unexpected situations and solve problems independently before bringing the issue to the manager. When I see those abilities, I feel much more comfortable delegating greater responsibilities.” (P16, emergency head nurse)

Overall, managers evaluated delegated staff based not only on clinical competence but also on professional judgment, accountability, and willingness to assume responsibility, indicating that delegation was fundamentally a trust-based process.

4.2.2. Leadership Competence of Nurse Managers

Participants identified nurse managers’ leadership competence as an important facilitator of delegation. *Effective delegation* skills, supportive and empowering leadership, and confidence gained through managerial experience facilitated delegation and increased staff confidence in accepting delegated responsibilities.

“Supportive managers make nurses much more willing to accept delegated responsibilities.” (P9, supervisor)

“When I delegate a responsibility, my colleague should never feel abandoned. I remain available to provide guidance, and if problems arise, I am the first person to help resolve them.” (P8, matron)

Participants emphasized that effective delegation depended not only on assigning responsibilities but also on ongoing guidance and supportive supervision, which strengthened staff confidence, reinforced trust, and encouraged acceptance of delegated responsibilities.

4.2.3. Supportive Organizational Climate

Participants identified a supportive organizational climate as an important facilitator of delegation. Organizational support, positive professional relationships, and enabling work environments strengthened managers’ confidence in delegating and encouraged staff to accept delegated responsibilities, thereby fostering trust and collaboration.

“In wards where collaboration and mutual respect are part of the culture, delegation becomes much easier. When staff feel supported by both their colleagues and managers, they are far more willing to accept new responsibilities.” (P7, supervisor)

“A supportive work environment encourages nurses to accept delegated responsibilities without fear.” (P14, coronary care unit (CCU) head nurse)

“When nurses know that they will receive support if they encounter difficulties after accepting a delegated responsibility, they are more confident in taking on that responsibility. A work environment where staff feel safe to ask for help makes delegation much easier.” (P17, CCU head nurse)

5. Discussion

This study provides a comprehensive understanding of delegation as a multidimensional leadership process shaped by interacting organizational, managerial, operational, and professional factors, rather than by individual decisions alone. Whereas previous studies have often examined specific barriers, facilitators, or leadership factors, our findings integrate these dimensions and demonstrate how they interact to shape delegation in everyday clinical practice. This perspective extends prior qualitative evidence by conceptualizing delegation as a context-dependent organizational process rather than as the product of isolated barriers or facilitators.

Organizational resistance emerged as a major barrier, suggesting that organizational climate and leadership context influence managers’ willingness and confidence to delegate (8, 13, 28). Participants described negative judgments, fear of errors for which they would receive no organizational support, and interpersonal tensions that discouraged delegation despite staff competence. These findings align with evidence that organizational support, trust, communication, and interpersonal relationships

facilitate effective delegation and teamwork (1, 8, 33). Moradi et al. also identified organizational culture, communication patterns, and concerns about care quality as important influences on delegation in an Iranian clinical setting (8).

International evidence also suggests that tensions surrounding managerial control, trust, and power sharing are not unique to the Iranian context. A qualitative study of nurse managers in Tanzania similarly highlighted tensions associated with transactional management practices, limited delegation, trust, and power sharing within nursing teams (34). Similarly, an integrative review of nurse manager span of control highlighted challenges related to delegation, follow-up of delegated responsibilities, role demands, and manager-staff relationships (35). Taken together, these findings suggest that tensions between managerial control and shared responsibility may represent a broader issue in nursing management, although their specific manifestations may vary across organizational and cultural contexts.

In the Iranian nursing context, organizational culture, professional power dynamics, and organizational structures may shape how authority, responsibility, and control are experienced and exercised in clinical practice (25, 26). Previous qualitative research among Iranian nurses has highlighted the importance of authority, organizational support, and organizational culture and structure in shaping nurses' experiences of professional power and empowerment (25, 26). These contextual characteristics may help explain why some participants in the present study perceived delegation as potentially involving a loss of control or exposure to blame. Consequently, delegation may be perceived as avoiding responsibility rather than as an appropriate leadership practice, underscoring the need for organizational cultures that support trust, shared responsibility, and appropriately supervised delegation.

Restrictive managerial beliefs were another important barrier to delegation. Participants described managers who hesitated to delegate because they feared losing control, authority, or professional credibility and believed they could perform tasks better themselves. Previous studies similarly show that leadership style, managerial competence, and decision-making capacity influence delegation (6, 12). Patient safety concerns, accountability pressures, and fear of blame may further increase reluctance to delegate and contribute to defensive leadership (15, 19, 36). Our findings also suggest that managers' beliefs and self-perceptions shape delegation decisions. Confidence in their own abilities may discourage the transfer of responsibility and limit staff development, highlighting the need for leadership

development that addresses assumptions about authority, responsibility, and professional identity.

Operational and coordination barriers included role ambiguity, inefficient delegation, inadequate training, and communication gaps, indicating that delegation problems may stem from system-level deficiencies rather than individual performance (1, 3). Previous evidence similarly shows that unclear roles and fragmented team structures reduce delegation effectiveness (2, 5). Participants also emphasized insufficient interdepartmental coordination and inconsistent communication, consistent with Moradi et al. (8), who reported that unclear communication, coordination, and role expectations complicated delegation in Iranian clinical settings. These findings suggest that even competent managers may struggle to delegate effectively when systems lack clear roles and coordinated communication, highlighting the need for clearer communication pathways, role expectations, and standardized delegation procedures.

Reward and recognition systems were identified as structural barriers to delegation, particularly when additional responsibilities were not accompanied by fair compensation or acknowledgment (13). Previous studies similarly indicate that inadequate incentive systems reduce staff motivation, accountability, and engagement (18), while inconsistencies between workload and recognition undermine willingness to accept delegated responsibilities (13, 21). These findings suggest that successful delegation depends not only on interpersonal trust but also on organizational justice. When additional responsibilities are perceived as increasing workload without equitable recognition, staff may be less willing to accept delegated responsibilities despite managerial support, indicating that fair recognition is essential for sustainable delegation.

The professional competence of delegated staff emerged as a key facilitator of delegation. Consistent with previous evidence demonstrating the importance of nurses' competence, accountability, and clinical judgment (37, 38), the present findings suggest that managers base delegation decisions on a broader assessment of professional readiness. Beyond technical competence, ethical commitment, responsibility, and proactive engagement appeared to strengthen managerial trust, indicating that delegation depends on confidence in both clinical capability and professional conduct.

The leadership competence of nurse managers was an important facilitator of delegation. Participants emphasized that managerial competence, supportive and empowering leadership, and confidence gained through experience improved delegation practices. Previous studies similarly show that leadership style and

managerial decision-making competence influence delegation effectiveness and staff empowerment (17, 39). In Iranian nursing management settings, supportive leadership and continuous managerial involvement have also strengthened professional performance and safe clinical practice (27). These findings suggest that leadership competence extends beyond technical delegation skills to include ongoing guidance and support, with coaching and supervision fostering trust, staff confidence, and sustained participation in delegation.

A supportive organizational climate facilitated delegation by promoting trust, communication, collaboration, and shared responsibility. Participants reported that supportive structures and positive professional relationships increased confidence in delegation. These findings align with evidence that positive work environments improve teamwork, engagement, and leadership effectiveness (16, 40) and with findings from Iranian hospitals showing that collaborative relationships, managerial support, and positive professional interactions strengthen nursing management and staff engagement (27). Together, these findings suggest that organizational climate extends beyond formal policies to encompass everyday relationships and mutual respect, thereby creating conditions for supportive leadership and effective delegation.

The findings have practical implications for nurse managers and hospital leaders. Delegation should be supported through leadership development and organizational strategies that foster trust, clarify roles, and strengthen team communication. Hospital leaders can facilitate delegation by establishing fair recognition systems, providing leadership development opportunities, and promoting cultures of shared responsibility rather than blame. These strategies may strengthen delegation, staff development, teamwork, and sustainable nursing leadership.

This study has several limitations. First, the hierarchical clinical setting may have influenced participants' openness, and social desirability bias cannot be ruled out, as participants described their own practices and weaknesses. Although non-leading questions, flexible probing, and confidentiality assurances encouraged openness, some participants may have presented their practices favorably or withheld undesirable experiences. Second, the findings are context-dependent and may have limited transferability to other clinical settings. No formal pilot interview or external expert review was conducted; however, the interview guide was reviewed by the research team and refined during initial interviews to improve clarity and sequencing without changing the study focus. Finally, despite member checking, peer debriefing, and

audit trails, qualitative interpretation involves researcher subjectivity.

5.1. Conclusions

This study showed that delegation among clinical nurse managers is a multidimensional process shaped by interconnected managerial, organizational, operational, and professional factors. Key barriers included a culture of control and distrust, restrictive managerial beliefs, operational and coordination challenges, and inadequate reward and recognition, whereas the professional competence of delegated staff, leadership competence of nurse managers, and a supportive organizational climate facilitated delegation. *Effective delegation* therefore requires competent and confident managers and delegated staff, supported by organizational conditions that foster trust, shared responsibility, professional relationships, and appropriate recognition.

Footnotes

AI Use Disclosure: ChatGPT (OpenAI) was used for translation in the introduction section at a Minor level.

Authors' Contribution: Study Concept and Design, Data Acquisition, and Data Analysis and Interpretation: T. G., M. F. K., H. K., and A. E.; Manuscript Drafting and Critical Revision for Important Intellectual Content: T. G. and M. F. K.; Study Supervision: M. F. K.; All authors reviewed and approved the final manuscript.

Conflict of Interests Statement: The authors do not declare any conflicts of interests for this study.

Data Availability: The dataset is available from the corresponding author upon reasonable request. It is not publicly available due to participant privacy and confidentiality.

Ethical Approval: This study is part of a PhD dissertation in Nursing at the University of Social Welfare and Rehabilitation Sciences, Tehran, and was approved by the university's Research Ethics Committee under approval code IR.USWR.REC.1403.067. (<https://ethics.research.ac.ir/EthicsProposalView.php?&code=IR.USWR.REC.1403.067>).

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