

Navigating Relationships: Nursing Teamwork in the Care of Older Adults

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As people age there is increasing incidence of chronic illness and atypical presentations of acute illness. Although research suggests that the care of older adults is improved when there is collaboration between nursing staff and other health professionals, there is no clear understanding of how this might occur. This qualitative study describes how nursing staff work in teams to provide and manage the care of hospitalized older adults. Navigating relationships offers valuable insights into the perspectives of nursing staff working in teams with one another, with their operational leaders, and with other professionals. The language they used contributed to their perceptions of being undervalued within interprofessional teams, which in turn undermined their efforts to navigate relationships. Care for hospitalized older adults would be advanced through the provision of opportunities for interprofessional teams to learn the perspectives of nursing staff.

Keywords: older adults, interprofessional teams, nursing perceptions

Naviguer parmi les relations : le travail d'équipe du personnel infirmier dans la prestation des soins aux personnes âgées

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Le vieillissement de la population entraîne un accroissement de l'incidence des maladies chroniques et des tableaux cliniques atypiques de maladies aiguës. Bien que les recherches laissent entendre qu'une collaboration entre le personnel infirmier et les autres professionnels de la santé permet d'améliorer les soins aux personnes âgées, la façon dont cette amélioration se produit demeure incertaine. La présente étude qualitative décrit comment le personnel infirmier travaille en équipe pour assurer la prestation et la gestion des soins aux personnes âgées en milieu hospitalier. Naviguer parmi les relations offre un aperçu précieux du point de vue des infirmières et infirmiers travaillant en équipe les uns avec les autres, avec les responsables des opérations et avec les autres professionnels de la santé. Le langage utilisé dans le milieu contribue à accentuer la perception des infirmières et infirmiers de former un groupe sous-évalué au sein des équipes interprofessionnelles, ce qui en retour vient miner leurs efforts pour naviguer parmi les relations. Donner la possibilité aux équipes interprofessionnelles de mieux connaître le point de vue du personnel infirmier contribuerait à améliorer la prestation des soins aux personnes âgées en milieu hospitalier.

Mots-clés : personnes âgées, équipes interprofessionnelles, perception du personnel infirmier

Background

Adults aged 65 and older represent 40% of all in-patient hospital days (Canadian Institute for Health Information, 2011). Providing care for an older population is complex because of the atypical presentations of acute illness, underlying chronic diseases associated with reduced physical and cognitive function, and precarious health conditions subject to rapid deterioration (Fedarko, 2011). The complexity of their care calls for the expertise of multiple professionals (Arbaje et al., 2010; Hartgerink et al., 2013). Since nursing staff represent the largest workforce providing continuous bedside care to older adults (Institute of Medicine, 2008), they play a key role in organizing and coordinating older adults' care and communicating their needs to other health professionals (Dahlke, Phinney, Hall, Rodney, & Baumbusch, 2014; Harris & McGillis Hall, 2012). In providing care to older adults, nursing staff work in nursing teams comprising registered nurses (RNs), licensed practical nurses (LPNs), and patient-care/health-care aides (PCAs/HCAs), with varying levels of education, responsibility, and authority, and in interprofessional teams comprising physicians and allied health professionals (Barrow, McKimm, Gasquoine, & Rowe, 2015). Scholars who have studied nursing practice suggest that better teamwork is associated with less missed patient care because the weakness of one team member is compensated for by the strengths of another (Kalisch & Lee, 2010). Despite research findings suggesting that effective interprofessional teamwork can improve outcomes for older adults (Arbaje et al., 2010; Boulton et al., 2009), nursing staff have difficulty working effectively in interprofessional teams (Atwal & Caldwell, 2005) due to power issues, confusion over roles, and language that inhibits communication (Barrow et al., 2015; Fox & Reeves, 2015). It is unknown how nursing staff navigate these challenges in order to manage the care of older adults. Yet such knowledge could guide the development of initiatives to improve the ability of nursing staff to work in interprofessional teams and the development of research agendas in this area as well as improve outcomes for hospitalized older adults.

Literature Review

Literature examining interprofessional practice and how to manage some of the challenges to interprofessional collaboration does not adequately represent the perspectives of nursing staff working with others in managing the care of older adults. Studies examining the involvement of nursing staff in interprofessional teams report that nurses play a minimal role in team meetings yet are often sought out by other professionals for their patient-related information (Atwal & Caldwell, 2005, 2006; Miller

et al., 2008). Atwal and Caldwell (2005) found that nursing staff were disinclined to voice their opinions and attended team meetings principally to relay information about their patients. When questioned regarding their perceptions about working in an interprofessional team, nursing staff described it as a myth — suggesting that just because professionals meet, it does not mean they are a team (Atwal & Caldwell, 2006). The studies cited above focused on the challenges of interprofessional teamwork but not on how nursing staff manage such challenges. Furthermore, they did not identify the type of nursing staff (e.g., RNs, LPNs) involved in the study, nor did they explore how nursing staff functioned within the nursing team. Because of varying levels of education, responsibility, and authority among nursing staff, they can experience challenges associated with power issues and confusion about roles within both nursing and interprofessional teams (Dahlke, Hall, & Phinney, 2015).

Scholars who examined the emotional work of nursing staff in terms of interprofessional collaboration found that their feelings of group belonging, obligation, and loyalty to one another were derived from a belief in their subordinate position among professionals (Miller et al., 2008). This suggests that working in nursing teams may be different from working in interprofessional teams. In the study by Miller et al. (2008), nursing staff experienced negative group belonging within interprofessional teams, describing the relationship as “the RN against everyone else,” leading them to disengage from structured interprofessional collaboration (p. 336). Voyer and Reader (2013) found preliminary evidence that nurses view themselves as subordinate to other professionals. Although both of these studies offer insights into the perceptions of nursing staff about their place within interprofessional teams, it is not well understood how nursing staff work with other health professionals to manage the care of older patients.

The first author’s doctoral study examined nursing practice with hospitalized older adults. One of the findings was the importance of working with others when caring for an aging population (Dahlke et al., 2014). Although this initial study identified some of the challenges nurses faced in collaborating with other professionals, data on the topic were not explored fully. The first author ruminated on nurses’ confessions of feeling less valuable than other professionals and how negative perceptions of themselves in relation to other professionals could erode patient care. Further reading about interprofessional teams and reflection on the gaps in our understanding of how nursing staff (RNs, LPNs, PCAs) function in these teams prompted the present study. An understanding of how nursing staff perceive and work within interprofessional teams can form the foundation for initiatives that support the ability of nursing staff to

collaborate with other professionals and ultimately provide more effective care to hospitalized older adults.

Methods

Design

This study was a thematic analysis of data collected for the first author's doctoral dissertation (Dahlke et al., 2014). The dissertation reported on a grounded theory exploration of nursing practice with hospitalized older adults. Although relationships with others was found to be important in that study, these relationships were not explored in relation to nursing staff's perspectives with regard to interprofessional teams. In the present study we explored the data for the perspectives of nursing staff with regard to interprofessional teams and how nursing staff engaged with other professionals.

The study was guided by the following research question: *What contributes to the perceptions of nursing teams about their place within inter-professional teams?*

Participants and Data Collection

Data collection for the grounded theory study took place between July 2010 and May 2011. It included 375 hours of participant observation (PO) on two different hospital units; 35 interviews with 24 nursing staff — RNs, LPNs, and PCAs; and a review of selected documents. The two units were located in hospitals managed by two different health authorities. The first author engaged in active PO by assisting participants with bed-making or retrieving needed supplies, gaining participants' trust and experiencing some of the challenges faced by nursing staff (Dahlke, 2015; Mulhall, 2003; Polit & Beck, 2010). In addition, previously developed observation questions guided the researcher in examining the layout of the units, activity levels, and how staff interacted. Both units identified their population as almost exclusively older adult, defined as over 65 years. Sites were chosen to provide variation in type of hospital setting, thus one was a geriatric unit in a tertiary-care hospital and the other a medical unit in a community hospital.

There were 24 participants: 18 RNs, 3 LPNs, and 3 PCAs. Participants ranged in age from 25 to 58 years. Their level of education varied by job category: PCAs had 4 to 6 months' health-care education, LPNs had 12 months' health-care education, and RNs held either a 2-year diploma or a or 4-year baccalaureate degree. As data collection unfolded it became evident that the sample did not include experienced RNs, whose perspective was considered important from the point of view of both less experienced RNs and PO, thus theoretically relevant.

Participants	Years of Experience (mean)	Years Working on Unit (mean)	Work Location Unit
RNs <i>N</i> = 18	1.5–8 (4.2)	1.5–2 (1.8)	Geriatric <i>n</i> = 11 Medical <i>n</i> = 7
LPNs <i>N</i> = 3	1.5–8 (4.2)	1.5–2 (1.8)	Geriatric <i>n</i> = 2 Medical <i>n</i> = 1
PCAs <i>N</i> = 3	2–20 (8)	2–8 (4)	Geriatric <i>n</i> = 3

The first author attributed this lack of experienced RNs to participants encouraging their experienced co-workers to take part in the study.

Data collection proceeded after ethical approval had been obtained from two different health authorities in western Canada and informed consent had been secured from the participants. Initially the first author buddied with a nurse to familiarize herself with the unit. During the first PO shift several nurses volunteered to participate. During subsequent PO shifts other nursing staff volunteered to participate. The first author, who was known to participants as a doctoral student, conducted all of the data collection for the grounded theory study. Nursing staff were interviewed using semi-structured questions following PO, to allow for clarification of events that occurred during observation. Questions included the following: “What is important about caring for hospitalized older adults?” The interviewer also inquired about events that had occurred during PO.

During PO, participants interacted with physicians, other nursing staff, occupational therapists, physical therapists, social workers, rehabilitation aides, pharmacists, unit clerks, and a variety of other health-care providers and offered their perspectives on these relationships. Interactions were included as data whenever informed consent had been obtained from the primary participant — that is, the person who was the focus of observation.

Data Analysis

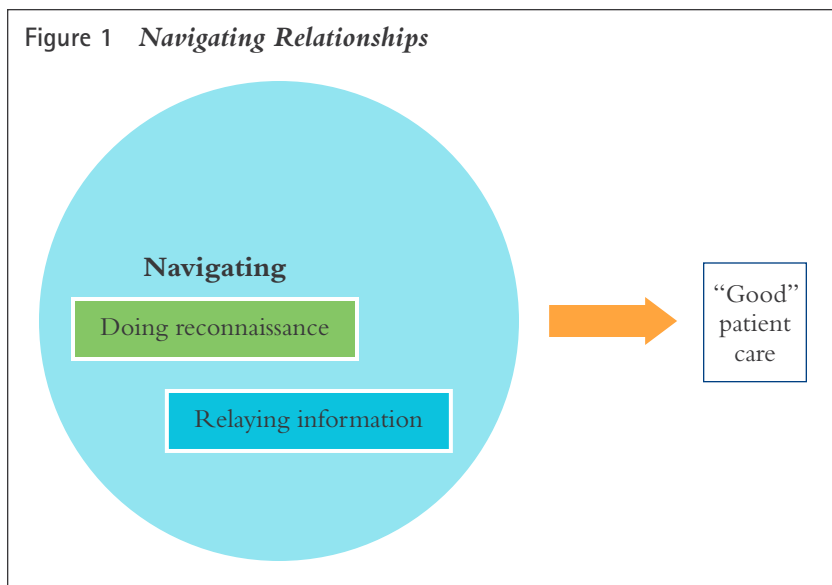
Data analysis, initially conducted by the first author, entailed reviewing data using thematic analysis with regard to the nursing team’s actions or interpretations of their actions in relation to working in various teams (Loiselle & Profetto-McGrath, 2011). The second author provided feedback on the first author’s analysis. An iterative process took place as the two authors debated their interpretations of the data until they reached consensus on the themes developed to describe the perspectives of

nursing staff working in interprofessional teams within the social context of acute-care hospital units. Both authors were experienced in conducting thematic analyses.

Trustworthiness of the data was enhanced through the ensuring of credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). Credibility was supported by triangulation of data collection and analysis. Ways in which nurses responded to working in interprofessional teams and how they articulated their actions were found to be important in the grounded theory study (Dahlke et al., 2014). The present study provided an opportunity to examine this phenomenon in detail. Dependability was supported by the use of data from two sites collected over the course of a year. Confirmability was promoted through support to the first author from her doctoral committee during data collection and through the iterative process employed in the present study. Transferability was enhanced by the thick description provided in the findings and in explanations of the research process as well as the participant demographic information provided.

Findings

Navigating relationships describes how nursing staff work in teams to provide older adults with good care, which participants defined as safe, individualized, enhancing function, and ensuring comfort. Navigating



relationships describes how nursing staff negotiated expectations for working with each other and with other professionals. Participants needed to navigate relationships in order to gather and share information related to care. The complexity and physical challenges associated with caring for older adults within resource-deficient and hierarchical work environments underpinned why nursing staff engaged in navigating relationships. The relationships that nursing staff were able to develop brought them opportunities to provide better care than they could offer on their own, such as getting assistance with moving a heavy patient or collectively managing an older patient's breathing problems. Navigating relationships underpinned how nursing staff assessed their environment (doing reconnaissance) and how they passed information to others. Doing reconnaissance describes the ongoing assessments performed by nursing staff as they gather information about patient states, staffing levels, the physical environment of the hospital unit, and available resources. Relaying information involves passing information to nursing and inter-professional team members in order to leverage better care.

Navigating Relationships

Navigating relationships describes how nursing staff negotiated spoken and unspoken expectations for working in nursing and interprofessional teams encompassing a variety of roles and levels of experience. RNs possessed knowledge and skills that allowed them to care for patients in a highly acute and unstable state. As a result, RNs were ultimately responsible for the overall care of the patients on the unit. If a patient assigned to an LPN or a PCA became acutely ill, the RN had to step in to manage the situation. RNs were

. . . fully responsible. You have to be in control of the situation. But you can still be responsible and delegate. You have to trust that the person you're delegating to will do their job. (PCA 3, site 1)

This need to trust one another in order to collectively provide good care influenced how nursing staff navigated relationships with one another. They purposefully developed relationships with each other over time and over food shared in the break room. Participants shared information and learned about each other's values, practice challenges, and effective and ineffective strategies. They learned whom they could trust to help them leverage better care for their patients. There was a shared understanding about the importance of everyone being a team player. One participant described the importance of helping when you are new on a unit in order to make personal connections and to be accepted by the nursing team:

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If you're not really a team player your life is going to be miserable. And then you've got nobody to talk to. Nobody to answer your call bells. (RN 11, site 2)

Another participant described the importance of being a team player: “It’s give and take” (LPN 3, site 2). Nursing staff who helped others were more likely to receive help when they needed it. Participants valued nursing team members who were “good helpers” — defined as those who could anticipate when help was needed and offer it without being asked (field note, July 2, site 2). Thus helping others was an essential element of navigating relationships within the nursing team.

Although helping one another was valued and expected in the nursing team, it was not expected in the interprofessional team. Participants discerned a helping hierarchy among health professionals, with doctors at the top and nursing staff at the bottom:

There's horizontal accommodating, like patients, other nurses, PT [physical therapist], OT [occupational therapist], all accommodating each other; we accommodate and help the doctor. It's the hierarchy and it just has to be. (field note, July 16, site 1)

Although this participant viewed relationships with other professionals (with the exception of the doctor) as horizontal, others believed that interprofessional team members managed their workload pressures by “getting us [RNs] to do their jobs” (RN 2, interview 2, site 1). As evidence of hierarchical rather than reciprocal relationships, participants explained that physiotherapists were “delegating [walking patients] to us” (RN 2, interview 2, site 1). Ironically, participants also indicated that walking patients was part of their own goals of good care — enhancing the function of older patients. The perceptions of nursing staff of their position within interprofessional teams influenced communication patterns and ultimately the relationships they were able to develop with other professionals. For example, during a PO one RN who had a positive perception of other professionals demonstrated one of the ways in which she navigated relationships with the various levels of doctors and medical students on her unit:

The doctor had told the medical student it was okay for the patient to eat but didn't write it. The RN explains, “I'll ask the doctor to write an order.” She goes to the desk, where a third-year medical student is looking at charts. The RN asks him, “Do you want us to give the essentials? Could you write the order, please?” She smiles, then she goes and finds the chart and hands it to him. (field note, July 19; RN 3, site 1)

This nurse navigated relationships with other professionals by politely and clearly articulating what she would like them to do for the patient.

Opportunities for nursing staff to develop trusting relationships with interprofessional team members were limited because of differing work schedules. Nursing staff reported being excluded from interprofessional team decisions:

Someone had to fight just to get us to be able to attend care rounds. We weren't even included in the beginning. (RN 9, site 1)

Such experiences contributed to their lack of trust and their unwillingness to engage in open communication with other interprofessional team members.

Participants believed that interprofessional team members were misinformed about challenges faced by nursing staff. They observed that many interprofessional team members were unwilling to work collaboratively with or help nursing staff. Consequently, nursing staff were cautious in their interactions with interprofessional team members. This resulted in nursing staff relaying less information about patients. For example, during an observation an RN did not pass specific information to a resident about a patient. She explained: "I try to step back because . . . they [might] know what to do" (field note, October 25, site 1). Nonetheless, participants agreed that when all members of the interprofessional team communicated and contributed their expertise to problem-solving it was easier to achieve good care for older patients:

[When] everybody within the team knows their job and knows their responsibilities, the nurses are going to do the nursing and the care aides are going to do the care-aide-ing and the physios are going to do the physio-ing and the dietitian is going to do the dietition-ing. Nice and smooth — everybody's happy. (PCA 3, site 1)

Doing Reconnaissance

Doing reconnaissance represents the ongoing assessments performed by nursing staff as they gathered information about the status of their patients, staffing levels, the physical environment of the unit, and available resources. This information would then be strategically passed on to obtain assistance from other team members or to influence them in the provision of good care. Participants explained that constant assessments were necessary because everything around them, particularly the health status of older patients, was constantly changing: "Things change from hour to hour" (RN 7, site 1). RNs constantly assessed the environment and their patients as a means of protecting patients from harm:

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Every time I go in the room, I'm looking at the patients, checking that they're safe. (RN 5, site 1)

Their constant vigilance required accurate assessments of patients' status and knowledge about when to call for the assistance of nursing and interprofessional team members, because it was their responsibility to know when to engage other professionals and what to say in order to leverage their assistance.

Doing reconnaissance included gathering information about all patients on the unit as well as which nursing staff members were working a particular shift. The following field note from an observation shift includes an example of reconnaissance:

. . . across the unit, two other experienced RNs nurses are watching this RN nurse as she goes about her work. (field note, November 7, site 2)

As the day unfolded, the researcher learned that these two experienced RNs were assessing not only patients but the unit as well, watching and evaluating how other RNs and LPNs (in particular, new nurses) were managing their patient assignments. Their attention to these types of detail allowed them to intervene if assistance was needed. They considered it part of their shared responsibility to keep patients safe.

Nursing staff were also doing reconnaissance as they interacted with members of the interprofessional team: "I'll ask [the physiotherapist] [about] the mobility of the patient, so we get help" (LPN 2, site 1). Frequently, nursing staff were able to gather information about patients' mobility or share information with interprofessional team members because of previously developed relationships. For example, during POs, occupational and physical therapists were observed responding more quickly to the requests of RNs who, they explained, were experienced and to those whose practice they trusted (July 19, site 1; August 23, site 1).

Nursing staff also included patients' families in their reconnaissance activities. They asked family members about patients' pre-hospital baseline cognitive and mobility states. If a patient did not speak English, family members could aid the nurse in her reconnaissance activities as well as in passing information to the patient. For example, during one observation the family of a non-English-speaking patient was encouraged to remain at the bedside as long as they could. When the RN and the first author came to the patient's bedside "his daughter-in-law translates and the RN learns that the patient wants a glass jar to pee in" (field note, July 16, site 1). In these ways families could serve as an extra pair of eyes and ears to monitor patients' needs. The extent to which families could assist in gathering information about patients' needs and promoting com-

pliance with the plan of care, they were considered part of a team. Nursing staff were able to engage families as part of the team only to the extent that they had developed a relationship with them. During POs, the time that nurses took to explain tests and medical plans to families demonstrated how they were navigating these relationships. For example:

As the RN goes into an older woman's room, she greets the patient and her daughter. She explains the test [that] the patient is waiting [for] to the daughter. (field note, July 18, site 1)

Relaying Information

Part of leveraging good care involved passing along information that nursing staff had gathered while doing reconnaissance. They passed pertinent information to each other, patients and families, interprofessional team members, and leaders. Communicating patient care plans to families was observed to increase their cooperation with the plans and their participation in care. Relaying information helped nursing staff to develop and navigate relationships with patients and families. It was vital to navigating relationships: "Everybody knows what's going on. Everybody communicates" (PCA 3, interview 2, site 1).

Nursing staff used descriptive terms to rapidly communicate patient care information to each other, clinical leaders, and interprofessional team members. They used the word "acute" to convey the complexity of older patients' medical conditions with potential for rapid deterioration. They used the word "heavy" to describe patients who, while medically stable, were dependent on nursing staff for assistance with activities of daily living and who needed physical assistance to improve their function so they could be discharged. The use of these terms by nursing staff was an efficient way to communicate with and summon help from each other.

Nursing staff used the word "heavy" in conversations with their leaders as part of their rationale for requesting more staff. However, use of this word did not necessarily result in help. Rather, it reinforced general nursing beliefs about care of older adults as custodial, "consisting of bedpans and pills" (RN 4, site 1), "not very acute" (RN 9, site 1), or lacking in complexity. This could explain why RNs reported, "You'll really have to put a good case forward" (RN 11, site 2) "because it's going to be looked at, like, why can't you do it yourselves?" (RN 12, site 2). When nursing staff were unable to make the case for what they considered sufficient staffing, the acute needs of older patients who had been labelled "heavy" were easily overlooked:

They don't get better. They get bedsores, they get infections, and they actually get worse in the hospital and [end up] staying for quite a while. (LPN 3, site 2)

Use of the word “heavy” could be a disadvantage in their ultimate goal of providing good care to older patients.

Nursing staff did not use the word “heavy” within the interprofessional team. Rather, they used “acute” when seeking prompt attention for their patient-related concerns. Observing RNs relaying information within the interprofessional team made their knowledge base evident and highlighted their strategic ways of sharing information. In the following PO note, an RN realizes the significance of laboratory results for the condition of her patient, an older adult, and responds:

The RN checks her patients’ blood work and says her patient’s white count is elevated. She explains that she will flag the doctors to see if they want to order an antibiotic. She puts a note to the doctor on the front of the chart and explains that if the doctor doesn’t come in a couple of hours, she will page him. Later, she pages him. (field note, July 16, site 1)

As this example shows, conveying information effectively required synthesis of information such as laboratory values and the patient’s medical condition, and its significance, to determine which interprofessional team member to contact and how to most effectively relay the information. Nursing staff also considered the unit routines and the patterns of a particular interprofessional team member’s visits to the unit to aid them in communicating with them:

RNs demonstrated a particular style of passing information to physicians, especially novice physicians. During one observation shift, a novice physician was reviewing the care of a patient who had pulled out his intravenous. The physician was considering restarting the intravenous in order to give medications. The RN told [the researcher]: “I don’t want him tortured with another intravenous and then he dies anyway. The doctor has not had the courage to tell the family that the wisest course of action is comfort care.” (field note, October 25, site 1)

Starting intravenous lines or conducting invasive procedures was not included in the RNs’ goals of comfort care. Yet, even after expressing strong feelings to the researcher about the requisite care, nursing staff would not openly discuss their opinions with the physician. Rather, they would present selected information in such a way that the physician would be “naturally led” to the “right conclusion.” Nursing staff tailored their communication strategies to perceptions of their low status in the health-care team, indicative of relationships that had been established, to obtain the patient care they believed to be most appropriate.

Nursing staff were engaged in doing reconnaissance and relaying information constantly and concurrently within the relationships they were building and navigating in order to ensure better care for their

patients than they could provide on their own. Although there were individual variations in how these processes were enacted by the three different groups of nursing staff, all three were agreed on the importance of constantly being aware of what was transpiring in their environment and relaying important information to various professional team members. Moreover, all groups saw the importance of nurturing relationships to support interprofessional teamwork.

Discussion

Navigating relationships provides novel insights into how the use of particular language by nursing staff influenced the responses they received from managers and interprofessional team members. The responses reinforced the self-perception of nursing staff as lower in status than other professionals. Consistent with the results of previous research, how nursing staff communicated was pivotal to the right patient information reaching the right health professional (Buljac-Samardzic, Dekker-van Doorn, Wijngaarden, & Wijk, 2010; Edwards & Donner, 2007; O'Brien, Martin, Heyworth, & Meyer, 2009; Orchard, 2010). Use of the word “heavy” to describe their older patients undermined the ability of nursing staff to communicate their staffing requirements to nursing leaders and patient care needs to the interprofessional team. “Heavy” is often associated with older adult care that is physically strenuous and requires little thinking (Deschodt, Dierckx de Casterle, & Milisent, 2010; Kjørven, Rush, & Holt, 2011). Although further research is needed, it is possible that managers and other professionals interpreted “heavy” as describing older adults’ functional status, such as immobility. While functional changes in older patients can be a symptom of acute illness (Fedarko, 2011), the word “heavy” did not convey the need for assessment and acute intervention. Previous research has suggested that language can undermine communication in interprofessional teams (Barrow et al., 2015; Fox & Reeves, 2015). Use of the word “heavy” by nursing staff in this study shows how communication about older patients can be misinterpreted by other professionals. There is a need for interprofessional teams to dialogue about the underlying meanings of language used in describing older patients. In particular, nursing teams need to clarify what they mean by “heavy” in their communication with other professionals.

Use of the word “heavy” by nursing staff in their conversations with other professionals did not result in the actions they desired and as a result contributed to their perceptions that their contributions to the interprofessional team were of lesser value than those of other professionals. Previous studies have noted nurses’ perception that their power status is lower than that of other professionals (Miller et al., 2008; Speedy,

2009). The present study provides novel insights into how the perception of nursing staff that they were “just a pair of hands” influenced how they viewed their relationships and how they communicated with individuals outside of the nursing team. In communicating with other professionals, nursing staff did not articulate what they believed to be the most appropriate course of action for their older patients, but, rather, pointed to details of the patients’ conditions — hoping that the other professionals would determine what was best (in the nurses’ eyes) for the patients. This finding is congruent with other research findings concerning RNs’ indirect communication with other health professionals (Barrow et al., 2015; Edwards & Donner, 2007). This study extends these findings by revealing the reticence of nursing staff in communicating with interprofessional team members and disclosing their perceived value to the interprofessional team. Such perceptions have a historical context. The economic and philosophical models developed during the Industrial Revolution have contributed to health professionals’ sociological development, which is characterized by controlling their occupations and defining their identity, values, and sphere of practice in ways that protect their unique contributions to patient care (Hall, 2005). These historical forces help to explain why collaboration among professionals is often challenged by power issues (Barrow et al., 2015; Fox & Reeves, 2015) despite the stated need for interprofessional teams to improve the quality, safety, and efficiency of care (Reeves et al., 2009; World Health Organization, 2010).

This historical context also helps to explain why relationships were navigated differently within nursing teams compared to interprofessional teams. Since caring for hospitalized older patients frequently required the assistance of others, nursing team members valued one another as possible resources; they helped one another as a means of developing goodwill (also known as social capital) that could be mobilized strategically in managing the care of older patients (Adler & Kwon, 2003). The limited opportunities of nursing staff to develop relationships with interprofessional team members (due to differing work hours and because other professionals worked throughout the hospital) helped to entrench the nursing staff perspective that they were at the bottom of the hierarchy. The language used by nursing staff (e.g., “heavy”) in describing older patients did not reflect the significance of their observations. The lack of response to their language reinforced historical power structures and nurses’ low professional ranking. It also prohibited the exchange of professional opinions about patients’ conditions and obscured the complexity of nursing work from the view of other professionals.

There is a need for common conceptualizations about the role of each professional (Barrow et al., 2015; Pereault & Careau, 2012) and how professionals communicate with each other. Interprofessional teams need

to be aware of how hierarchy restricts communication and affects perceptions of self-worth and patient care. Nurse leaders and educators have a role to play in helping nursing staff to inform interprofessional teams about their knowledge, skills, and roles (Orchard, 2010; Sommerfeldt, 2013). Health-care leaders need to provide opportunities for interprofessional teams to have frank conversations about roles and communication strategies that foster positive relationships. A good way to start would be to unpack the meaning of the term “heavy” to each profession, in relation to older adult care.

Although this study was limited in size, representing only one geographical region and the perspective of only one professional group, it offers insights into how the language and perceptions of nursing staff limit their communication and collaboration within interprofessional teams. Further research is needed to explore the meanings attributed by each professional group to language such as “heavy.” Moreover, leaders and educators can help to optimize the ability of interprofessional teams to improve outcomes for hospitalized older patients by instituting interprofessional team training (Montagnini et al., 2014) and processes for professionals to have regular dialogue (Fox & Reeves, 2015) on such issues as language usage. Finally, we need more research on the processes and structures that facilitate interprofessional team collaboration in the care of older patients.

Conclusions

Navigating relationships illuminates the importance of the perceptions of nursing staff concerning their place among professionals and influences how they communicate and collaborate with others to leverage better care for older patients. The efforts of nursing staff to provide good care are hampered by the language they use and their perception of being undervalued in interprofessional teams. An important step in increasing the ability of nursing staff to collaborate in the care of older adults would be the initiation of regular dialogue among interprofessional team members so that they can establish common language and equitable relationships. Further research is needed to identify structures and processes that facilitate communication and collaboration within interprofessional teams.

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