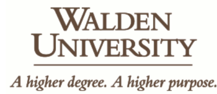
View metadata, citation and similar papers at core.ac.uk
brought to you by CORE
provided by Walden University



Walden University
ScholarWorks

Walden Dissertations and Doctoral Studies

Walden Dissertations and Doctoral Studies Collection

2019

Analysis of Nurses' Perceptions of Their Role in a Multidisciplinary Team

Jessica Ann Dempsey
Walden University

Follow this and additional works at: https://scholarworks.waldenu.edu/dissertations

Part of the Health and Medical Administration Commons, and the Nursing Commons

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Jessica A. Dempsey

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. David Anderson, Committee Chairperson, Health Services Faculty
Dr. Magdeline Aagard, Committee Member, Health Services Faculty
Dr. Daniel Okenu, University Reviewer, Health Services Faculty

The Office of the Provost

Walden University
2019

Abstract

Analysis of Nurses' Perceptions of Their Role in a Multidisciplinary Team

by

Jessica A. Dempsey

MSN, University of Phoenix, 2009

BSN, Ramapo College of NJ, 2004

Dissertation Submitted in Partial Fulfillment

Of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

November 2019

Abstract

A better understanding of task allocation for the registered nurse (RN) within the scope of the multidisciplinary care team model is required. Patients, healthcare staff, and medical facilities that utilize RNs in multidisciplinary care teams will benefit from improved role identification. A multidisciplinary care team consists of a variety of health care professionals and without role identification, confusion, miscommunication, and negative patient outcomes can occur. A literature review demonstrated that a gap in knowledge existed related to task allocation and role identification of RNs within a multidisciplinary care team. The purpose of this study was to evaluate RNs' scope of practice within a multidisciplinary care team of an acute care medical center and identify a new theory regarding RNs' perceptions of their role. A grounded theory approach was used to explore and reveal these perceived role identifications through the lens of the accountability theory. The research questions and the guided interview explored RNs' self-perceived role identifications that have shaped RNs' expectations of their scope within the multidisciplinary care team model. The results found nurses to be experts of patient care and that the nursing role has a 24/7 responsibility while being the closest, most personal role to the patient, thus, the RN feels accountable for all the needs to the patient, even if the needs or actions are outside of the nursing assigned role or tasks. From these results emerged a new theory, the perpetual accountability theory. Identified recommendations regarding RNs' roles and their utilization within the multidisciplinary care teams allow a positive social change of greater success at delivering best practices and optimum patient outcomes.

Analysis of Nurses' Perceptions of Their Role in a Multidisciplinary Team

by

Jessica A. Dempsey

MSN, University of Phoenix, 2009

BSN, Ramapo College of NJ, 2004

Dissertation Submitted in Partial Fulfillment

Of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

January 2019

Dedication

I dedicate this dissertation to all the healthcare colleagues who I have worked among and beside who have shared in the arduous work and passion for improving patients' and families' wellness both selflessly and generously. I also would like to dedicate the commitment and dedication necessary to complete this program to my children, who can learn from my mistakes as well as my successes. I want to share with them the goal of leaving the world a better place than we found it.

Acknowledgments

This dissertation and the desire to improve the inpatient experience is a product of many patient care contacts and comradery within multi-disciplinary care groups. There are too many to thank, each one paved the path of this journey. My employers, both Johns Hopkins Medicine and Maryland Department of Public Safety, have encouraged my growth and development and I am grateful to them. Complementing my career experiences and goals, including the discussions, projects, and guidance received within the coursework at Walden University, specifically the encouragement, support, and knowledge shared by my URR Daniel Okenu, and my Committee Member Dr. Magdeline Aagard and Chair Dr. David Anderson.

More than anything and anyone else, my family has supported me and gave me the courage to pursue that which initially seemed to be dauntingly unobtainable. My parents have molded my morals and ethics, birthing my passion for education and drive. My husband, Keith, had a parallel journey, one of support, frustrations, and sacrifice, which I never asked him to make, but one that he was given. Thank you.

Table of Contents

Chapter 1: Foundation of the Study 1

Introduction 1

Background 2

Historical Review 3

Case Studies 3

Qualitative Interviews 4

Problem Statement 5

Purpose of the Study 6

Purpose Statement 6

Definition of Central Phenomenon 7

Research Questions 7

Theoretical Framework for the Study 8

Accountability Theory 8

Nature of Study 8

Definitions 9

Assumptions 10

Scope and Delimitations 10

Limitations 11

Significance 12

Summary 12

Chapter 2: Literature Review 14

Introduction 14

Synopsis of Literature 14

Main Points 15

Literature Search Strategy..15

Library Databases 15

Search Terms 16

Search Process 16

Current Research... 16

Theoretical Foundation 17

Relating Theory to the Present Study 18

Central Phenomena Aligned to Theory... 19

Literature Review..20

Historical Review.. 20

Quantitative Approaches... 23

Qualitative Approaches... 25

Chapter 3: Research Method...29

Introduction 29

Research Design and Rationale 29

Research Questions... 29

Central Concepts and Phenomenon 30

Research Tradition 30

Role of the Researcher..30

Bias 31
Methodology 32
Participation Selection Logic 32
Criteria 32
Pilot Study 33
Sample Size 33
Saturation 34
Instrumentation 34
Sufficiency 34
Researcher-developer Instruments 35
Procedures for Recruitment, Participation, and Data Collection 36
Data Analysis Plan 37
Issues of Trustworthiness 38
Credibility 38
Transferability 39
Confirmability, Dependability, and Reflexivity 39
Intracoder Reliability 40
Ethical Procedures 40
Summary 41
Chapter 4: Data Collection 42
Introduction 42
Pilot Study 42

Setting 43

Demographics 43

Data Collection 44

Data Analysis 44

Evidence of Trustworthiness....49

Credibility 49

Transferability.... 50

Confirmability, Dependability, and Reflexivity 50

Results....51

RQ1 51

RQ2 53

RQ3 55

RQ4 57

Summary of the Theory 59

Summary....60

Chapter 5: Interpretation of Findings....61

Introduction....61

Interpretation of Findings 61

Limitations of the Study....64

Recommendations....65

Implications....65

Positive Social Change 65

Methodological, Theoretical, and Empirical Implications 66
Conclusion 67
Appendix A: Standards of Practice for RNs 76
(a) .01 Definitions.. 76
(b) .02 Standards of Care.. 80
(c) .03 Standards of Professional Performance. 84
(d) .04 Specialty Practice.. 89
Appendix B: Recruitment Flyer 92
Appendix C: Guided Interview Protocol 93
Appendix D: Coding Protocol 96
Appendix E: Consent Form 98
Appendix F: Participant Demographics Classification Sheet 102
Appendix G: Deidentified List of Participant Locations 103
Appendix H: Coding Steps 105
Appendix I: Hierarchy Charts 107
RQ1 107
RQ2 108
RQ3 109
RQ4 110

Chapter 1: Foundation of the Study

Introduction

Patients' and families' needs are at the center of healthcare, with an increasing number of expectations. These expectations are evaluated and monitored daily by the multidisciplinary care team. The concept of a multidisciplinary care team within an inpatient care setting offers patients and families the opportunity to draw information, experience, knowledge, and expertise from a team of varied professionals, working together from unique perspectives. The multidisciplinary care team consists of healthcare professionals that include but are not limited to: physicians, RNs, clinical support staff, pharmacists, respiratory therapists, rehabilitation staff, and unlicensed direct and indirect care staff (Epstein, 2014). Though there were different perspectives due to the variety of roles, one commonality is meeting patients' and families' needs. Epstein (2014) said that expanding and improving communication between the various levels of healthcare workers decreases morbidity and mortality and subsequently improves patient and staff satisfaction. A question arose regarding what the multidisciplinary care team acknowledged as their individual roles and respective responsibilities in the team during the inpatient care process. A problem was identified for a need for role identification and responsibility among team participants, specifically the role of RNs. Edwards et al. (2015) also identified the concern of role identification within the multidisciplinary care team model stating a better understanding of task allocation is needed.

The purpose of this study was to evaluate RNs' scope of practice and its use within a multidisciplinary care team. Also, the study aims to identify a new theory

regarding how and why perceptions of the RNs' role exist. To address this gap, a grounded theory study was used to explore and reveal perceived roles, as well as the scope and use of RNs within the acute care setting.

The study aimed to fill a gap in the literature regarding the utilization of RNs and the extent of their scope of practice and responsibility. This study was unique as it explores the under-researched area of the scope of nursing practice and RNs' role utilization among a team of professional experts. This study further explored the multidisciplinary care team, involving RNs' responses to interview questions regarding self-perceptions, team member perceptions, and approaching questions and answers through the lens of the accountability theory.

This chapter presents the background, problem statement, the purpose of the study, research questions, theoretical framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance of the research. Literature related to the scope of the study explored multidisciplinary care team processes and the role of RNs within that team. The literature review identified a gap regarding team members' roles and specifically that of RNs' roles and their responsibility.

Background

A literature review regarding the role of RNs within the multidisciplinary care team was conducted using Walden University's library and Google Scholar. The current role of RNs, a historical review of nursing roles, and observations of nursing roles within multidisciplinary care teams were explored. Retrospective reviews, analyses, interviews, and surveys provided a platform for evaluation.

Historical Review

A review of the literature found both team nursing and the concept of nursing involvement in multidisciplinary care teams have been evaluated by researchers. With the analyses, many previous nursing models were evaluated, including primary care nursing, team nursing, and task-focused nursing. The concept of multidisciplinary care teams was not new. Applying the team care approach in health settings faced challenges in terms of role identification, leadership perspectives, and understanding between interdisciplinary professionals and the team, making it difficult to implement (Nagi et al., 2012). Multidisciplinary team leaders perform as specified to their role responsibilities and performance standards (Nagi et al., 2012). Zoucha and Husted (2000) explained as a result of particular roles within multidisciplinary care teams; members develop values, beliefs, and choices to enable themselves or other members of the group to improve and enhance health and wellbeing. Role identification for members of the team is important to associate responsibility and accountability specific to that role. According to Nagi et al. (2012), teamwork within a multidisciplinary care model required an overall understanding of patient care among the team members.

Case Studies

Interview responses from multidisciplinary care members were explored and subsequently transcribed and coded results using qualitative analysis software. A case study was completed and concluded that the roles of RNs are complex and include interactions with patients, critical thinking, informed experiences, and a sense of autonomy (Mendes, da Cruz, & Angelo, 2015). One barrier involving multidisciplinary

team care was identified as not always having an established team leader (Weller et al., 2011; Mendes, da Cruz, & Angelo, 2015). Interview data from a different case study collected from doctors and RNs concluded that these roles were not successfully working. Appropriate leadership and role identification among multidisciplinary care teams were not always present (Weller et al., 2011). Physician staff and nursing staff are separate departments of individuals who need to collaborate as peers with a common goal to provide care and improve wellness for patients and families (Reeves, Nelson, & Zwarenstein, 2008). Weller et al. (2008) suggested strategies including education, building trust, and improving short and disjointed rotations of doctors on wards to work more cohesively and have role identification (Weller et al., 2011, p. 485). These studies similarly conclude that role identification of the members of the multidisciplinary care team is necessary.

Qualitative Interviews

Glogowska et al. (2015) completed an in-depth interview study that explored perceptions and experiences of healthcare clinicians working in multidisciplinary care specifically related to communication and information sharing between the team members. Interviews were completed among clinicians across primary, secondary, and community care in the Midlands, South Central, and South West of England (Glogowska et al., 2015). Clinicians in the community and hospital teams reported issues regarding communication between hospitals and primary care clinicians (Glogowska et al., 2015). Themes related to communication needs emerged. Glogowska et al. (2015) identified needs related to the multidisciplinary care teams which included identifying

responsibilities for members, more team involvement regarding drug regimen, and more education for clinicians regarding comorbidities and medications. RNs were identified as a pivotal role in ensuring continuity and quality of care while taking the lead in coordinating services (Glogowska et al., 2015).

The nursing role appeared to be defined by both the Licensing Board of Nursing and by members of the multidisciplinary teams. The RN Scope of Practice (Appendix A) identified the scope and role as it pertains to licensing requirements. The multidisciplinary care teams' nursing role appeared to be due to the individual teams' needs and expectations to meet patient care goals. It was necessary to explore the multidisciplinary care team and the perceptions of other team members.

Problem Statement

Consumers have access to healthcare professionals with a variety of roles and specialties when using healthcare services. Healthcare had changed and evolved to meet the needs of the public, and many services are available in one setting. Having these resources may lead to unintended consequences. Evidence demonstrated overlapping and unidentified responsibilities among three separate roles in a cross-sectional survey of primary care providers (PCPs), midlevel providers, and RNs (Edwards et al., 2015). All three roles had reported performing similar responsibilities, e.g., completing a head to toe assessment on a patient; and was unaware of who was responsible for other tasks, e.g., coordinating transport to another unit or facility. Hille (2015) suggested that RNs provide both cost and clinically-effective care but have been underappreciated in

healthcare settings. The literature review led me to identify that there is a problem with identifying the role and utilization of the RN among the multidisciplinary care team.

Shamian and Ellen (2016) said that there was an inadequate understanding in the healthcare setting regarding implications and the potential influence that the nursing role can provide to the realms of practice, policy, science, and the profession to the global health agenda. In a cross-sectional survey of PCPs, it was found that three separate and unique roles felt that they were responsible for the same clinical tasks required by the patient. This cross-sectional survey concluded that there was a need for role identification among the multidisciplinary care team. A deeper understanding of both self-perceived RN roles and how these roles are utilized in a multidisciplinary care team was needed. A research study was needed to explore the gap in the literature regarding RNs' roles among the multidisciplinary care team. Data from interviews measuring RNs' experiences and perceptions that emerged from this study will be meaningful for RNs, patients and families, other individuals within the multidisciplinary care team, and institutions that use multidisciplinary care teams in an acute care setting.

Purpose of the Study

Purpose Statement

It has been implied that RNs may not be used to the extent of their scope of practice. A qualitative grounded theory approach provided the methodology to explore the gap in the literature. This study explored the RNs' perceived roles, as well as the scope of practice and utilization of the RNs within the acute care setting in a multidisciplinary team.

Definition of Central Phenomenon

A need for role identification within multidisciplinary care teams was observed in the literature review. Hille (2015) argued that RNs have been proven to deliver both cost and clinically effective care and that there was a widespread failure to apply RNs appropriately in primary healthcare. There was an implication that RNs were not being utilized as well or as broadly as the nursing scope of practice permits. Edwards et al. (2015) identified that clear task delegation is missing among physicians and nursing staff. The primary care model included physicians and nursing staff, while the multidisciplinary care team involved physicians, RNs, and a variety of other experts. McNamara et al. (2011) identified the nursing role as one that has been blurred and diluted within the multidisciplinary care model. McNamara et al. (2011) explained that RNs offer clinical leadership and expertise to the multidisciplinary care team that shall benefit from leadership development. It was found that multidisciplinary care combined primary care with consulting, transitional, and long-term care processes within a hospital setting (Fennell et al., 2010). As a result of this study, the RNs' roles will be explored in the acute care medical center setting to determine its efficacy.

Research Questions

RQ1: What is the nature of self-perceived role identification as viewed by RNs in a multidisciplinary care team within an acute care inpatient medical center?

RQ2: How do these RNs feel their roles and responsibilities are perceived by their team members?

RQ3: What experiences may have shaped RNs' expectations regarding their role within the multidisciplinary care team?

RQ4: How do RNs view their scope of practice when applying the lens of accountability theory?

Theoretical Framework for the Study

Accountability Theory

I approached this study through the lens of the accountability theory. Vance, Lowry, and Eggett (2015) defined the accountability theory as to how one needs to rationalize one's behavior to another party and thus create the feeling of accountability in terms of how decisions, processes, and judgments have been reached. Tetlock and Lerner (1999) explained the accountability theory as having four core components: identifiability, the expectation of evaluation, awareness of monitoring, and social presence. Data were collected through interviewing RN participants regarding experiences and perceptions of their roles within multidisciplinary care teams . The data were analyzed for themes related to how and why decisions, processes, and judgments have led to roles and scope of the RNs within the multidisciplinary care teams while being mindful of the accountability components. The research questions addressed RNs' self-perceived role identification by exploring experiences. An analysis of the RN participants' experiences led to grounded theory identification.

Nature of Study

Through a qualitative approach, I explored what experiences of RNs within a multidisciplinary care team can be applied to the scope and roles of RNs. I used a

grounded theory design. Similar research questions could be used in a narrative or case study; however, it would identify a smaller group of RNs' feelings, experiences, and beliefs versus a larger participant size that may represent the accurate size of the population that is found in grounded theory (Patton, 2015). By using phenomenology, I could explore what and how a person experiences that experience (Patton, 2015). I could use Ethnography to describe RNs' culture and ways of life, patterns, and beliefs (Patton, 2015). Through these approaches, I could explore the roles of RNs; however, grounded theory aligned with the goals of the study to define the roles of RNs within the multidisciplinary team given the overall literature gap.

I developed and used an interview guide following its approval by Walden's Institutional Review Board (IRB). The interview guide was prepared to ensure the same set of interview questions was asked of each participant. Participants were RNs who have experience within an acute care inpatient medical center and were involved in multidisciplinary care teams. Data collected through the interview process was uploaded into NVivo and used as a tool to assist me in organizing emerging themes and patterns I identified.

Definitions

Multidisciplinary care team: A team that consists of health care professionals that can include but are not limited to doctors, RNs, clinical support staff, pharmacists, respiratory therapists, rehabilitation staff, consult specialties, and unlicensed direct and indirect care staff. A multidisciplinary care team has been identified as a best practice for patients with comorbidities, which allows integration of patient preferences, customization of

disease-specific guideline recommendations, and bridges differences and conflicts amongst them (Ho, Caughey, & Shakib, 2014, p. 1-2).

Nurse: For the purposes of this study, RN refers to nurse, nursing, or registered nurse. A RN has passed the National Council Licensure Exam for RNs (NCLEX-RN)exam administered by the National Council of State Boards of Nursing (NCSBN) and has met all other licensing requirements mandated by their state's board of nursing. The scope of practice for RNs has been defined by the Code of Maryland Regulations (COMAR) (see Appendix A).

Assumptions

I identified assumptions of this study so that I may ask certain questions or use certain approaches to complete a systematic inquiry. An assumption of this study was that RN participants were expected to answer honestly. Participants consented to participate in this research and did not express feeling influenced. I assumed that the participants were committed to completing the study and provide truthful responses.

Scope and Delimitations

Patton (2015) explained that using a grounded theory design involved focusing on the process of generating theory rather than specific theoretical content. The literature gap I found led to my conclusion that RNs' roles among the multidisciplinary care team could be explored. I completed interviews to collect data and identify patterns and themes related to how and why there may be unidentified roles in the multidisciplinary care team. After many rounds of coding and analyzing, I was able to identify a new theory grounded in the data.

In my study, I explored the experiences and perceptions of RNs within a multidisciplinary care team in an acute care inpatient medical facility. RNs in other roles that do not have experience within a multidisciplinary care team in an acute care inpatient medical facility were excluded. Through the data analysis of this study, I was able to make recommendations regarding how to best use RNs within a multidisciplinary care team. Improving the utilization of RNs could optimize their scope of practice, which could improve both staff and patient satisfaction. Improving the utilization and optimization of the nursing role could improve patient outcomes. This study will lead to future implications for research and improved quality of care for patients and families.

Limitations

A limitation of this study was that the RN subset selected to explore does not represent the entire nursing population. This limitation can be corrected in future studies by comparing similar institutions of size and type once data have been collected and analyzed in this study. This study only represented a small population of healthcare consumers, which were acute care, medical-surgical, and progressive care populations. Additionally, I did not identify the number of institutions selected for sampling until participants qualified and consented to be in the study. Another limitation was my bias because I am a RN who has personal experience and beliefs regarding the role of RNs in a multidisciplinary care team. By visiting my bias regularly and reminding myself through journaling and reflection, I was able to reduce bias and prejudice. This included strategies not limited to developing interview protocols and nonprejudiced participant selection.

Significance

This study allowed me the chance to explore feelings, behaviors, and experiences of RNs within the multidisciplinary care team in acute care settings. The accountability theory was the lens that I used to view the design process. This lent an opportunity for me to explore the multidisciplinary care team in terms of experiences and perceptions paying particular attention to the concept of accountability. Through the data analysis ,I was able to make recommendations regarding how to best optimize RNs' scope of practice within the multidisciplinary care team. This study was important for RNs, patients, families, other roles within the multidisciplinary care team, and institutions that use multidisciplinary care teams.

Summary

Acute care medical inpatients' expectations of care during their stay are evaluated in many ways that vary from daily monitoring to post-discharge surveys. A question arose regarding what the multidisciplinary care team acknowledged as their role during this inpatient care process. A multidisciplinary care team model was identified as a best practice for patients with comorbidities which allows integration of patient preferences and customization of disease-specific guideline recommendations and bridges differences and conflicts (Ho, Caughey, & Shakib, 2014). A multidisciplinary care team consists of healthcare professionals that can include but are not limited to doctors, RNs, clinical support staff, pharmacists, respiratory therapists, rehabilitation staff, consult specialties, and unlicensed direct and indirect care staff. A problem was identified that RNs in acute

care medical centers among a multidisciplinary care team do not have identified roles or utilization of the role.

The qualitative grounded theory study I completed gave me the opportunity to explore and reveal the perceived RNs' roles shaped by the accountability theory, as well as the scope and capability of RNs' roles within the acute care setting of a multidisciplinary care team. Assessments in-depth interviews of RN participants were analyzed to explore the utilization and perceptions within a multidisciplinary care team. Chapter 2 provides a further exploration of literature and the theoretical foundation of this study.

Chapter 2: Literature Review

Introduction

The purpose of this study was to evaluate RNs' roles and their scope of use within a multidisciplinary care team at an acute care medical center. I used a qualitative grounded theory approach viewing the study through the lens of the accountability theory. The study involved identifying a new theory regarding why certain self-perceptions of RNs' roles exist.

Synopsis of Literature

Literature explored RNs' roles within multidisciplinary care teams through general historical reviews, qualitative concept analyses, and qualitative interviews. Also identified was a lack of RNs' roles recognizing leadership, overall frustration, miscommunication, and a need for improved collaboration to enhance positive patient care outcomes. Edwards et al. (2015) concluded that unclear role identification within multidisciplinary care teams is problematic and concluded that a better understanding of inter-professional task allocation is needed. Glogowska et al. (2015) determined that RNs were able to ensure coordination and continuity of care within the scope of the multidisciplinary care team. Lobo et al. (2015) concluded that RNs' roles among a multidisciplinary care team could coordinate effective patient treatment and care when supported by protocols and with access to medical specialists. Lacking role identification within a multidisciplinary care team presents a problem given the coordination and continuity of care RNs provide. A better understanding of perceived role identification within shared care services or multidisciplinary care teams was necessary to move

forward with improving collaboration between healthcare teams and improved patient care outcomes.

Main Points

Chapter 2 will analyze and summarize literature as it relates to the lack of identified RNs' roles within a multidisciplinary care team and the importance of role identification, leadership, and collaboration. The accountability theory defined that social judgments and choices combined with the approval and status-seeker image of human nature, are influential in decision-making environments (Tetlock & Lerner, 1999). The accountability theory will be evaluated regarding its origin, major assumptions, applications to previous similar studies, purpose, and the rationale for applying it to this study. Chapter 2 includes an exhaustive review of the current literature.

Literature Search Strategy

Library Databases

A literature review was necessary to explore the problem and potential gap in knowledge regarding RNs' roles within multidisciplinary care teams. The Walden Library was used for the literature review. Medline with Full Text, Ebscohost, and Google Scholar served as the search engines for the literature review. These search engines were useful as they provided information on medicine, nursing, and the healthcare system, which can be filtered in terms of the order of year published, the presence of full text, and that the information was peer reviewed.

Search Terms

Key search terms were used to find the most meaningful information. The following terms were used: accountability, accountability theory, acute care, advanced practice nurse approach, care coordination, communication, coordination, hospital, identified, interdisciplinary, interdisciplinary care team, interprofessional, interprofessional care team, management, medical, multidisciplinary, multidisciplinary care team, nurse, nursing, nursing scope of practice, registered nurse, responsibility, role, RN, scope of practice, shared care, team care, unidentified, and utilization. These key terms were useful in identifying articles, but the following search process was used to reduce the literature to a workable and meaningful set of supportive literature.

Search Process

MEDLINE, EBSCOhost, and Google Scholar were used to search for meaningful and relevant information and literature. These terms provided literature that was not specific to the problem involving the lack of RNs' roles identification and utilization within multidisciplinary care teams of an acute care medical center. I was able to customize the list adjusting the filter to include articles that were both peer reviewed and published within the previous five years. I was able to find literature that identified a gap in literature and research that would lead to a qualitative study exploring self- perceptions of RNs' roles among the multidisciplinary care team in an acute care medical center.

Current Research

Pertinent and current literature was limited. Shamian and Ellen (2016) concluded that there lacks current knowledge-base of the potential influence nursing applies to the

overall profession in healthcare. Hille (2015) also identified the need for role identification and responsibility, specifically the roles of RNs in healthcare. This lent the opportunity to explore a knowledge and research gap. I wanted to research a new theory as to why there is a lack of RNs' role identification. Many qualitative approaches aligned with the problem and purpose; however, an exploration of the problem through a grounded theory approach through the lens of the accountability theory was used.

Theoretical Foundation

The major theoretical proposition of the accountability theory is that that there is an expectation that one may be called to justify beliefs, feelings, or actions, and providing unsatisfactory actions would have negative consequences (Tetlock & Lerner, 1999). I have approached this study through the lens that members (RNs) of multidisciplinary care teams may feel accountable due to a need to justify their beliefs, feelings, or actions due to possible negative consequences if actions were unsatisfactory.

A gap in literature allowed me to identify the need to explore the perceptions of role identification and utilization of RNs within their multidisciplinary care teams and explored the themes that emerged from data collection related to the accountability theory. This exploration of a new theory supported a grounded theory approach. The licensing board of nursing for each state defines the role and scope of practice for RNs which identifies accountability and responsibility involved in RN and other patient care roles. I chose the accountability theory as the theoretical foundation for this study.

Relating Theory to the Present Study

I aligned the approach, research questions, and theoretical framework to develop a new theory that demonstrated why there is a problem of unidentified roles or tasks among RNs within the multidisciplinary care team as perceived by RNs. The accountability theory defined that people justify their feelings or actions to avoid negative consequences, and I used this as a framework to determine why RNs in multidisciplinary care teams in acute care hospitals made certain decisions or actions. The literature review identified that there was a role overlapping and unidentified task delegation that led to a lack of clear roles and responsibilities belonging to members of the multidisciplinary care team. The accountability theory provided a focus or lens for me to have explored if accountability and feelings, behaviors, and actions that exist for RNs were due to avoid unsatisfactory consequences. I have analyzed the data to explore if this accountability had confused their own role identification. The research questions for this study were:

RQ1: What is the nature of self-perceived role identification as viewed by RNs in a multidisciplinary care team within an acute care inpatient medical center?

RQ2: How do these RNs feel their roles and responsibilities are perceived by their team members?

RQ3: What experiences may have shaped RNs' expectations regarding their role within the multidisciplinary care team?

RQ4: How do RNs view their scope of practice when applying the lens of accountability theory?

I used the accountability theory as the lens while having approached the organization, coding, and categorizing of the RNs' interview data. The research questions grew into the development of interview questions, which was applied to interview participants to produce reported information about their past experiences, beliefs, and actions. This information was built upon the framework that people, healthcare providers, and RNs within a multidisciplinary care team of an acute care hospital made decisions that led to action dependent upon feeling accountable.

Central Phenomena Aligned to Theory

The major concept of this study was that there was a need for RNs' role identification within a multidisciplinary care team. Tetlock and Lerner's (1999) Theory of Accountability was a contributing factor to why RNs' roles compared to that of others remain clouded within the multidisciplinary care team. Though there was no previous research that approached these phenomena using the same theoretical framework, the writings of both Tetlock (1992) and Tetlock and Lerner (1999) was related to this study's central phenomena. Tetlock (1992) concluded that there was a sociological and anthropological theory regarding the essential circumstances of social order in hypothesizing accountability to be a general feature of natural decision settings. This concept provided the foundation for Tetlock and Lerner's (1999) accountability theory that explained the existence of a logical complex construct that intermingles with the features of decision makers and properties of the task environment to yield a range of effects. The current study benefitted from the accountability theory framework in exploring and categorizing interview data to explore why decisions were made that

clouded specific roles or tasks of RNs with that of a separate role within the multidisciplinary care team.

Literature Review

Completing a review of the current literature found that information retrieved could be categorized in the context of a historical review of the RNs' roles, quantitative approaches to the collaboration of health care professionals including that of the roles of RNs, and qualitative approaches that explored in-depth interviews or surveys of RNs exploring their roles. The literature reviewed demonstrated strengths in identifying the problem, a lack of role identification, but a weakness in generalizing the role or specialty. Approaches to research included a historical review of literature analysis, case studies with observations, and phenomenological interviews. The approaches provided a gap in information that each led to a need for more information in a follow-up study. The research specifically identified RNs' roles within specialties of cardiac, urology, community, and neurologic fields. The need to explore why RNs have an unidentified or clouded role and the application of the approach to a broader population justified the need for this study.

Historical Review

Through a retrospective audit, Ho, Caughey, and Shakib (2014) evaluated data between 2006 and 2011 to assess the impact of multidisciplinary care. 255 chart reviews for patients with congestive heart failure (CHF) who visited multidisciplinary clinics at Royal Adelaide Hospital were conducted. Ho et al. (2014) maintained an objective to assess the impact of multidisciplinary care in patients with CHF. The study met its

objective, determining median comorbidities and compliance with guidelines. The study also highlighted that having a dedicated RN to initiate lifestyle measures with the patients may bring better compliance (Ho et al., 2014). The study had several limitations, including being based on a clinical database, making it difficult to compare to other previous studies, and that the focus was specific to CHF patients, limiting if concepts found could be applied to other patient diagnosis populations.

Nagi et al. (2012) evaluated the role of the RN, stating the role makes up the largest part of the healthcare workforce. Nagi et al. (2012) found that many previous nursing models were evaluated, including primary care nursing, team nursing, and task-focused nursing within the United Kingdom. Though interdisciplinary, multidisciplinary, and team-care groups have not been a new concept, the realistic application of the diverse team-care group was challenging (Nagi et al., 2012). Also emphasized was the notion that many leaders across many disciplines providing care to a patient include barriers of coordinated teamwork extending to individual roles, leadership, clinical accountability, and agreement among professionals (Nagi et a., 2012). Each job disciplinary team leader within the multidisciplinary care team had a specified role dictated by its job description with performance standards defined by that role's job function (Nagi et al., 2012). Senior RNs as team leaders had proven to be successful (Nagi et al., 2012, p. 59). Nagi et al. (2012) explained that the critical analysis led the concept that teamwork within a multidisciplinary care model requires knowledge of patient goals, progress, and problems (Nagi et al., 2012). Though nursing had been observed successfully in the leadership role within the multidisciplinary care model, these RNs must possess leadership skills that

include being able to organize, lead a productive team, maintain close cohesion and morale among team members (Nagi et al., 2012). Nagi et al. (2012) made implications for future practice that identified RNs as a unique discipline among other disciplines. RNs were discovered to be capable of performing the leader-role of a multidisciplinary care team. This implication related the authors' research to the problem and purpose of this current study. Limitations of the study included the country of origin and a different health care delivery model than this study's setting.

Lillyman, Saxon, and Treml (2009) completed a review of the literature to a broad population using electronic databases in 2008. Papers were sourced from Medline, CINAHL, and Cochrane (Lillyman et al., 2009). Lillyman et al. (2009) had the objective of identifying the role of community matron, or case manager, and involved care models in the United Kingdom. A limitation of the review revealed that the evidence is limited to a literature review, needing evidence-based research (Lillyman et al., 2009).

The historic review of the literature revealed that the roles of RNs were important, yet not clearly defined. This information supported the need for further evaluation of the roles. Limitations of these studies aligning with the current need to explore the problem included that the data found was specific to a patient population or to a country that has different health care models. Ho et al. (2014) identified the importance of and the need for an identified nursing role among CHF patients only. Lillyman et al. (2009) identified the positive impact an identified nursing role could have on patients discharged from hospitals with long-term conditions in the United Kingdom. Both literature reviews

supported the need for consistent and identified RNs' roles among the multidisciplinary care team.

Quantitative Approaches

Shamian (2016) presented a meta-analysis study evaluating the significance and potential contribution that RNs can make to the multidisciplinary and global health agenda through statistical methods. Shamian (2016) presented evidence implicating the return on investment of nursing care related to RN-staff-ratios, education and training, and RNs in leadership positions. Shamian (2016) emphasized the clinical, social, and economic benefits that health care systems should include in the planning of the nursing workforce. Shamian (2016) concluded that RN leaders and nursing organizations need to identify important committees to address issues and that leaders themselves need to gain policy-making, decision-making, communication, and advocacy skills. Though Shamian's (2016) study did not identify that the nursing role was limited due to its unidentified role, it did support the importance and impact nursing can provide to multidisciplinary health, making the exploration of the nursing role pertinent.

Edward et al. (2015) performed a cross-sectional survey of Veterans Affairs primary care providers and staff, including physicians, RNs, licensed practical nurses, and medical assistants. Edward et al. (2015) explored the perceived task allocation and unclear roles in interdisciplinary primary care teams. The data collected demonstrated that most physicians perceived they were solely responsible for most clinical tasks, while the RNs felt they were relied on for the same tasks. Edwards et al. (2015) concluded that there is a need for better inter-professional team task allocation. Edwards et al. (2015)

provided data that supported performing an additional study to perceive not only task allocation but the need for role identification within the multidisciplinary care team. The limitation included the setting specific to Veterans Affairs primary care, rather than that of an acute-care hospital.

In a quasi-experimental approach, Popejoy et al. (2015) acknowledged care coordination as a priority to improve the health care system. Care coordination, as explained by Popejoy et al. (2015), was delivered in a variety of ways, including that of hospital transition to home, discharge, and beyond (Popejoy et al., 2015). Popejoy et al. (2015) compared the utilization and cost outcomes of patients who received long term care coordination. Home healthcare had been a way to deliver community-based care, and its coordination was identified as the roles and responsibilities of professional RNs (Popejoy et al., 2015). Popejoy et al. (2015) demonstrated that the coordination of care was the responsibility RNs which proved to have reduced cost and time. Popejoy et al. (2015) also concluded that RNs improved the delivery of care while working with a variety of medical professionals. This study supported the responsibility and leadership the roles of RNs can provide in long term care.

These quantitative approach studies have provided data and support for the responsibility, skill, and care RNs can provide in leadership positions. These studies also found that unclear task allocation of interprofessional teams existed. This supported the need for RNs' role identification in an acute care hospital multidisciplinary care team important.

Qualitative Approaches

Rozmovits, Mior, and Book (2016) explored the current safety culture of spinal manipulation therapy (SMT) by health professionals in Canada regarding perceptions of readiness to track adverse events. 56 semi-structured interviews with inter-professional leaders were conducted to explore the culture of patient safety. Rozmovits et al. (2016) reported that collaboration across the inter-professional disciplines clouded patient safety and may have created a high-risk industry. Though this research did not identify RNs' role perception as a problem, it did present the need for inter-disciplines to collaborate and communicate effectively to promote patient safety and reduce unintended outcomes. This study aimed to explore that role identification is part of the communication and collaboration process, and unidentified role identification is a lack there-of. Without communication and collaboration, patient safety was at risk (Rozmovits et al., 2016).

Lobo, Masacrenhas, Worthington, Bevan, and Mak (2015) utilized qualitative interviews to collect data from health professionals involved in managing the care of patients living with Hepatitis C and from patients engaged in Hepatitis C RN-supported shared care services in Australia. Lobo et al. (2015) interviewed 16 health professionals and 47 patients. Professionals were queried as to their perception of which programs worked well and what areas needed improvement (Lobo et al., 2015). Patients were surveyed exploring patterns of accessing health services, reasons for commencing treatment, the types of professionals responsible for the treatment, perceptions of quality of care, and overall impressions of the shared care initiative (Lobo et al., 2015). Lobo et al. (2015) concluded that RN-supported shared care services reduced costs, accelerated

access to treatment, and compliance with those treatments as scheduled while also demonstrating that patients expressed high satisfaction. Lobo et al. (2015) demonstrated that RNs in regional areas could coordinate effective patient treatment when supported by protocols and access to medical specialists. This qualitative research demonstrated that nursing could model a leadership role with defined protocols, policies, and task responsibilities. The limitation was that the patient population is specific, and the setting is in a healthcare delivery model specific to Australia.

Glogowska et al. (2015) used to explore perceptions and experiences of health care clinicians working in multidisciplinary teams that included heart failure RNs when caring for the management of heart failure patients. 24 clinicians were interviewed across primary, secondary, and community care in three different regions of England (Glogowska et al., 2015). The study results identified challenges when working with heart failure patients, specifically communication within the multidisciplinary care team (Glogowska et al., 2015). Glogowska et al. (2015) believed that RNs may facilitate team communication and that this communication and multidisciplinary input is needed due to the complexity of patients. Glowgoska et al. (2015) concluded that there is a need for communication, and it strengthened the multidisciplinary care team when RNs are facilitating team communication. The limiting factor included the setting of England and its health care delivery model(s).

Weller, Barrow, and Gasquoine (2011) interviewed 25 doctors and RNs and explored their experiences of working together. Weller et al. (2011) explored the concept that doctors and RNs do not always work collaboratively in health care settings, which

contributed to suboptimal patient care. Interviews were transcribed and entered into a qualitative analysis software package, data coded against a theoretical framework for health care team function (Weller et al., 2011). Results included mutual respect but limited professional relationships (Weller et al., 2011). Though Weller et al. (2011) discovered sharing information and agreeing goals were fundamental to good decision making, the working environment and differing perspective made this difficult to achieve. Weller et al. (2011) concluded that the inter-professional team did not have consistent leadership or an environment open to communication and that both were important for patient safety. Weller et al. (2011) provided a similar study to that of this current study to compare the approach and its alignment to all aspects of the study. This study provided a platform for my study. My study has expanded Weller et al.'s (2011), having built upon working relationships and clear communication, but first, role identification is needed. The limitation was that this study is specific to one group of clinicians working together rather than a mix of similar roles amongst a larger setting.

The literature review explored task allocation among multidisciplinary care teams and its roles, perceptions of teamwork and collaboration, and the importance of leadership skills that RNs can provide for an inter-professional or multidisciplinary care team that supports the purpose of this study. The literature review was limited to exploring particular countries, health care settings or delivery models, and particular patient populations, but the current study elaborated upon these boundaries. The research questions for this study provided similar alignment related to roles and self-perceptions of RNs and enhanced the literature review data collection to meet this study's purpose by

having explored past experiences and RNs within the multidisciplinary care team and their perception of the accountability theory related to their actions and decisions. Chapter 3 will discuss the research design and rationale involving the gap in the literature.

Chapter 3: Research Method

Introduction

A qualitative grounded theory approach allowed me to explore perceived roles as well as the scope of practice and utilization of the nursing role within the acute care setting for a multidisciplinary team. The accountability theory allowed me to view the study through a lens focused on accountability. This chapter will explore this study's research design, methodology, data collection instrument, procedures for recruitment and participation, and trustworthiness.

Research Design and Rationale

Research Questions

I aligned the problem statement and purpose with the following research questions:

RQ1: What is the nature of self-perceived role identification as viewed by RNs in a multidisciplinary care team within an acute care inpatient medical center?

RQ2: How do these RNs feel their roles and responsibilities are perceived by their team members?

RQ3: What experiences may have shaped RNs' expectations regarding their role within the multidisciplinary care team?

RQ4: How do RNs view their scope of practice when applying the lens of accountability theory?

Central Concepts and Phenomenon

The central concepts and phenomena were varied role utilization and role identification of RNs among a multidisciplinary care team. This was demonstrated in the RNs' interview responses. These responses were analyzed, organized, and coded by exploring nursing experiences and perceptions.

Research Tradition

The grounded theory emerged from American sociologists Glaser and Strauss as they were describing a new qualitative research method. Glaser and Strauss (1967) said that this theory had no preconceived hypothesis and used continually comparative analysis of data. According to Creswell (2009), grounded theory was a strategy in which the researcher originated a general theory grounded in the views of the participants of the study.

Through the study, I explored the scope of nursing practice and utilization of RNs within a multidisciplinary care team and identified a new theory regarding why self-perceptions of RNs' roles exist. A grounded theory study design was completed to explore and reveal the perceived role, as well as the scope and utilization of RNs within the acute care setting. There was limited literature on this topic, and there was no documented preconceived hypothesis.

Role of the Researcher

I approached participants' experiences and perceptions through the lens of the accountability theory by analyzing data looking for themes related to accountability and similar patterns among information collected that led to theme generation. While

analyzing data from the interviewed participants, I looked for themes and similarities among their responses as well as demographic similarities as it related to themes and patterns.

As the researcher, I recruited participants who had experience in an acute care inpatient medical center setting. As a RN myself who still has connections to previous hospital communities that I have worked in, I had access to many health professional circles and potential participants who have experience in acute care inpatient medical centers. Some participants I may have had previous professional relationships with but have not been in this status for many years. Due to conflicts of interest and ethical issues related to interviewing subordinates, I did not interview participants with whom I have a current professional relationship.

Bias

I am a current RN with previous experience in the healthcare setting. I have previous firsthand experiences in multidisciplinary care teams in acute care medical centers. My experience assisted in identifying the problem for this study. I eliminated bias by using a structured interview process via phone, Skype, or Facebook. I did not discuss or concur with RNs' interview responses related to perceptions. No leading questions or prompting were used during the interview process.

This study was analyzed and evaluated on a continuous basis. I continued to address bias through reflection and journaling. I had no conflicts of interest. RN participants did not include employees that I have authority over. I offered a $5.00 gift card from Starbucks as an incentive and token of appreciation.

Methodology

Participation Selection Logic

The participants that were the focus of this research study were RNs who had experience working in an acute care inpatient medical centers with multidisciplinary care teams. The purposeful sampling strategy was criterion sampling, followed by snowball or chain sampling. Creswell (2007) said that criterion sampling is useful for quality assurance in that all cases meet some criteria. The criteria that qualified RN participants aligned the participants with the problem. Following with snowball or chain sampling allowed cases of interest to emerge from people who know people from the criterion selected sample.

Criteria

There were three specific criteria for participants to qualify for this study. Participants must have been a RN (see Appendix A). Participants also needed to have had experience in an acute care inpatient medical center as RNs. As RNs, the participants must report having participated in a multidisciplinary care team. Participants were able to demonstrate meeting the criteria via the licensee database of the State Board of Nursing. Prior to meeting participant criteria, potential participants reviewed definitions of acute care inpatient medical center and multidisciplinary care team and confirmed their experiences in medical centers and units, which remained anonymous in this study.

Pilot Study

A pilot study was necessary to validate the guided interview instrument. The guided interview instrument lists interview questions to be asked to each participant. This pilot included three participants who met the same criteria and recruitment procedures as the main study. The RN participants provided responses to the interview questions, during which I took notes and used an audio recording. The RNs' interview responses were analyzed. The results of the pilot were evaluated to assure that interview questions were valid and involved relevant data. If any changes were needed regarding the guided interview protocol (see Appendix C), the data collected could not be used in the final data analysis. The guided interview pilot measured RN interview responses, which allowed me to explore the research problems without altering the instrument. The pilot study demonstrated that the interview questions were valid.

Sample Size

The target sample size had a goal range from 20 to 30 participants. Creswell (2007) suggested that 20 to 30 participants support a grounded theory study to develop a well-saturated theory but may increase in number. Participants were identified and recruited by posting the criteria on the Walden University Research Pool as well as advertising via Social Media forums attracting candidates that meet the criteria noted above (See Appendix B). Initial contact with participants included virtual via social media or email. In person, video, telephone, or email interviewing followed initial contact. Interviews occurred in person, or virtually via Skype or Facetime. From this recruitment and identification, snowball and chain sampling were invited to occur.

Saturation

There was a direct relationship between saturation and sample size. Though there was a target sample size, recruitment for participants, and collection of data proceeded until saturation was met. Saturation was met when as many incidents, events, or activities as possible provided support for categories (Creswell, 2007). Creswell (2007) also explained that with grounded theory research, the investigator went through multiple stages of coding data, reducing information into categories and properties that represented perspectives. If saturation was not met, data collection was intended to proceed until it was met.

Instrumentation

The data collection instrument included a guided interview protocol (Appendix C) developed by the researcher and approved by Walden's IRB. I identified interview questions and created the tool to collect data through interview responses from each participant. The interview questions explored the information needed to answer the central research questions of the study. The source included the interviewed participants' responses, whether it be in person and audiotaped, virtually and audiotaped via Skype for Business, over the phone, and audio taped, as well as via email, where all shared words were captured in text.

Sufficiency

The sufficiency of the data collection instrument and source(s) were explored and approved by a Committee to include the Chair and the Methodology Expert, as well as the Department Head designee, the URR, and the IRB. Walden University's approval

number for this study is 1220-18-0532281, and it expires on December 19th, 2019. Each interview question was developed having aligned to exploring a central research question to the study. To establish validity, I completed a pilot study to ensure the interview questions explored the research questions as intended and allowed me to practice interview techniques.

Researcher-developer Instruments

The basis for a researcher-developed interview protocol stemmed from completing a grounded theory study. To establish a new theory from explored perspectives, aligning research questions to interview questions resulted was to develop a researcher-initiated interview. Current supportive literature also used qualitative interviews to explore health care roles within the multidisciplinary care team, specifically the in-depth interviews Glogowska et al. (2015). The interviews determined that RNs were able to ensure coordination and continuity of care within the scope of the multidisciplinary care team. Lobo et al. (2015) also drew conclusions from interviews that identified nursing roles among shared care services can coordinate effective patient treatment and care when supported by protocols.

Content validity and sufficiency of data gained by the guided interview questions were established by directly aligning the interview questions to explore the central research questions. A pilot study took place to ensure that the interview questions explored data that aligned to answering the research questions.

There were four central research questions that explored the nature of RNs' self-perceptions, how RNs feel others perceive them, experiences that led to these

perceptions, and how RNs perceived the accountability theory to self-perceived roles were related. The interview questions were aligned directly to the research questions.

Procedures for Recruitment, Participation, and Data Collection

I collected data by interviewing RNs who met the criteria through a guided interview protocol. I collected data for as long as it took to meet saturation, having expected to interview 20 to 30 participants. Over a period of 8 weeks, a target of completing four interviews each week was scheduled and conducted. Each interview was planned to take an hour, including introductions, consent, and the actual interview. RNs' interview responses were recorded via audio-tape recorder. Recruitment and scheduling of interviews were intended to be concluded when saturation had been met, or 30 interviews have been scheduled, and data collected. I had evaluated the need for additional recruitment after 24 interviews were completed. Since no new data had been revealed in the most recent five interviews, my committee and I determined saturation had been met.

Participants exited the study when their data had been collected and transcribed. Prior to analyzing data, participants were given the opportunity to review the transcribed responses for the opportunity to correct, elaborate, remove or confirm their responses. Participants received an explanation of the intention for using the results of the interview process and subsequently offered a copy of the report (Creswell, 2007).

The data collection method was an interview by means of a designed interview protocol. The interview protocol included open-ended questions intended to explore the research problem and research questions. If necessary, after initial data analysis, I may

have needed to contact them for clarification or additional explanations. This need for clarification would have been by phone or email and completed in person or virtually on Skype or Facetime. Though there was a plan in case it was deemed necessary, however, there was no need for clarification from the participants. The data was stored on a USB drive in a locked file cabinet.

Data Analysis Plan

Data analysis included grounded theory coding. Grounded theory coding is a constant comparison data analysis and will include substantive and theoretical coding (Holton, 2007). Open coding began during note taking and journaling during the interviews of the participants and was followed by additional coding in electronic software.

The coding that occurred following the interview was within QSR NVivo qualitative software. NVivo software was designed to help manage and organize data that is not easily reduced to numbers. Using NVivo, one can create a project to store documents; organize documents; attach ideas to text and find patterns among one's ideas. Bazeley (2002) explained that using NVivo impacts both the convenience of the software and the capacity of interpretive analysis by the researcher.

Within NVivo Software, coding began with open coding, coding for major categories of information (Creswell, 2007). Following open coding, axial coding proceeded by going back to the data and reviewing for sub-categories of these 'core' phenomena (Creswell, 2007). This coding was referred to as axial coding by creating related categories to the core categories (Creswell, 2007). In the next step, selective

coding, I made propositions that related categories and created a story, or theory (Creswell, 2007). Straus and Corbin (1998) explained an additional step which enhanced the selective coding by developing a conditional matrix in grounded theory and that made connections between the macro and micro conditions that influenced the phenomena.

Once data had been analyzed and coded, discrepant cases were evaluated. If needed, by contacting and consulting participants, one may be able to determine the reasons for the discrepancy (Creswell, 2007). There were no discrepancies; this step was not needed.

Issues of Trustworthiness

Credibility

As defined by Lincoln and Guba (1985), credibility was the confidence that can be placed in the research findings; it established the plausibility of information drawn and interpreted from participants' original views. There were multiple strategies to confirm credibility. Lincoln and Guba (1985) listed a variety of strategies to ensure credibility; in this study, prolonged engagement and persistent observation. Engagement included the time spent with the participants during long interviews. Persistent observation involved a constant review of the literature and relevant previously published findings that discussed RN roles within a multidisciplinary care team. Interviewing was not limited until data saturation had occurred. Data were evaluated in an ongoing method to determine if saturation had been met and if no other additional information had emerged.

Transferability

Thick description was utilized to allow readers to determine whether the findings can be transferred to other settings (Creswell, 2007). Thick description was not limited to behavior and experiences but included context so that the behavior and experiences were meaningful to the outsider (Lincoln and Guba, 1985). The participants included a variation in selection, meaning that though the participants must have had qualifying criteria to be eligible to participate, it was emphasized that the participants were to be in varied demographics not limited to age, years of experience, gender, and care centers of employment.

Confirmability, Dependability, and Reflexivity

Confirmability was to be observed through dependability and reflexivity. As defined by Lincoln and Guba (1985), dependability was the stability of findings over time, involving participants' evaluation of the findings, interpretations, and recommendations. Transparently describing the research steps through an audit trail was captured by recording stages to the research process in memos entered into the QSR NVivo Software.

To confirm reflexivity, the process of self-reflection was noted within the text of the analysis of what biases, experiences, and values I came to the research with. Lincoln and Guba (1985) stated that reflexivity could be captured via recordings in a diary. I stated that I balanced my experience, values, and bias with the objectivity of approaching the data through the lens of the theoretical framework aligned with the research questions.

Intracoder Reliability

Intracoder reliability referred to the consistent process that the researcher coded and depends on the researcher becoming wholly familiar with the transcribed text (Given, 2008). As evidence in the coding protocol (Appendix D), there was evidence of consistent coding to demonstrate intracoder reliability. The coding protocol included aligning the problem statement to the research questions, and subsequently to the interview questions. The coding process was completed by viewing the data through the lens of the accountability theory. This coding was to be evident in higher level nodes and subnodes. This process was planned to be captured in the audit trail.

Ethical Procedures

There were many ethical procedures that will be in place. Research participants' understanding of the study and willingness to engage in research must be documented. The consent form (Appendix E) was completed by each RN participant and documented their willingness and understanding of the study.

As there were no specific hospitals being used to recruit participants, Institutional permissions will not be needed. Ethical concerns were avoided by abiding by the role of the researcher within the boundaries of this study, by recruiting participants per the indications and criterion stated, and by having remained objective during the data collection process. The recruitment process included criterion selection and a snowball or chain sampling. Recruitment was initiated via social media and through the Walden Research Participant Pool. Ethical selection was maintained as participants were not to be selected as a result of a power relationship or place of employment with peers.

Participants were introduced to the purpose of the study, consented to participate and were to be made aware of the opportunity to review data as it was reported. There were no predictable adverse events that could attribute to participants exiting the process prior to the completion of data collection. Since data were collected until 20-30 participants and saturation had been met, the ethical process for participation included continuing to recruit participants until enough data were collected.

The treatment of data was confidential. While organizing data, information collected was identified by confidential title, e.g., Participant 1. While only having discussed data collection with committee or Walden faculty, a Confidentiality Agreement form was not needed to be reviewed and signed.

Data was be stored on one device, within the boundaries of the QSR NVivo Software, and analyzed within the dissertation process. Participants were made aware during the introduction and the consent process of confidentiality. Participants were also notified within the consent that the confidential data, as evidence in transcribed interviews, would be destroyed at the completion of the dissertation process.

Summary

The research design, methodology, data collection instruments, procedure and participation, and trustworthiness have been explored and stated. In efforts to collect data, interview questions were aligned to research questions through the lens of the accountability theory addressed in a qualitative grounded theory study. This study was devoted to exploring and revealing the perceived role of RNs and their scope of practice and utilization within the acute care setting in a multidisciplinary team.

Chapter 4: Data Collection

Introduction

The qualitative grounded theory approach was applied to this study. The RNs' self-perceptions of their scope of practice and utilization of their role within the acute care setting in a multidisciplinary team was explored through their interview responses. This chapter will explore the pilot study, setting, demographics, data collection, data analysis, evidence of trustworthiness, and results.

Pilot Study

A pilot study was necessary to validate the researcher-developed guided interview instrument (see Appendix C). The pilot included three participants who met the same criteria and recruitment procedures as the main study. The pilot participants completed the consent form and interviews were scheduled. The interviews were completed through IRB-approved methods, using the guided interview completed in person, via Facetime, or phone. Notes were taken during all interviews, and they were audio-recorded. Journaling experiences took place during interviews through note-taking as well as during transcribing audio after each interview was completed. Transcripts of each interview were sent to participants for review and approval. After receiving approval, the transcripts were loaded into NVIVO and coded for major categories of information. Upon reviewing notes, audio, and open coding, patterns were demonstrated and discussed with the chair. Approval was gained for using the pilot results in the final data analysis and proceeding with the main study.

Setting

There were no personal or organizational conditions that influenced participants or their experiences at the time of the study that could influence the interpretation of the study results. No personnel, budget cuts, or other trauma were noted or observed in my or the participants' setting. I analyzed the shared experiences of each participant. Though personal and organizational conditions existed sometime in their life that led them to choose their career path as a RN, these conditions did not exist during the time of the study that could influence the interpretation of the data. I have history practicing as a RN in an acute care medical center working with multidisciplinary care teams, which could pose as potential bias for approaching the study. Through journaling, a guided interview protocol, and iterative reflection, I committed to separating personal bias from the study.

Demographics

Participant demographics collected included acute care medical center names and location, age, gender, marriage, children, years practicing as a RN, years practicing with multidisciplinary care teams, previous career, and current academic status in nursing. All demographics, except location and specialty, were presented in the Participant Demographics Classification Sheet (see Appendix F). In order to protect the participants' identities, the location and specialty had been de-identified and listed in alphabetic order (see Appendix G). Due to the snowball method of recruitment, there were four participants that were referred from previous participants. These participants were recruited through the snowball method by other participants at Hospital University in

Pennsylvania, Paoli Hospital, and the University of Utah. 24 participants spanned 20 different acute care medical centers. 23 participants practiced in the United States, and one practiced in Italy.

Data Collection

My study indicated a need to interview 20-30 participants, or until saturation was met. Data were collected via a guided interview with 24 participants. Recruited participants were given the choice of in person, virtual, or telephone methods of interviewing. One interview was completed in person, two via Facetime, two via Skype, and 20 via phone. Each interview ranged from 14-30 minutes. Interview data were recorded via a smartphone application called Voice Recorder. There was no deviation from the data collection method as stated in Chapter 3. One unusual circumstance presented during data collection. Participant 16 scheduled an interview and kept rescheduling agreed upon times to complete the process. Once the interview took place, P16 was only able to complete half the interview. P16 was unable to follow up with additional scheduled times. P16 was removed from the final data analysis.

Data Analysis

Data analysis involved an iterative process following the grounded theory coding procedure (See Appendix H). Both substantive and theoretical coding proceeded through constant data analysis. Coding occurred using NVivo qualitative software. Notes were taken during the interviews and reflected within journaling. As I transcribed the interviews and received approval to use the transcripts from participants, they were uploaded into NVivo and coded for open coding, major categories, and concepts

identified in notes and journaling. The data were then reviewed for subcategories, also called core phenomena (Creswell, 2007). Open coding, coding for major categories, and axial coding continued during the interview data collection period and for months following. The next stage of coding included identifying propositions that related categories to a new theory. Straus and Corbin (1998) said selective coding was enhanced by a conditional matrix that makes connections between the macro and micro conditions influencing the phenomena. Notes from the interview and journaling led to open coding that identified major concepts that were indirectly related to the research questions. These concepts were: day or night shift assignment, experiences that explained why participants chose nursing as a career, which roles were utilized in multidisciplinary care teams, and how RNs labeled their role as it related to the entire multidisciplinary care team.

Participants explained why they chose nursing or whether they wanted to care for people. Some participants stated nursing as a career was due to salary and job stability observed when Participant 19 stated, “Salary was a factor based on careers I was looking at, being cognizant of having a family.” Other participants chose nursing due to personal experiences observed when Participant 13 stated, “The RNs were fantastic, how they made him feel, how they made us feel. He was there all summer, and he ended up dying. But all the RNs were amazing, made me want to be like them, purely emotional.” Some RNs identified choosing nursing as a career because it was familiar in their family observed when Participant 12 said, “I grew up in a family of RNs. Nursing was a perfect fit.” Other RNs identified their personal need to care for people seen when Participant 4

said, “I always wanted to do something that I could interact with people and help people.”

Open coding also identified how participants labeled themselves among their multidisciplinary team colleagues. Guided interviews involved inquiries regarding participants’ feelings and experiences in terms of how they perceived their role. The participants identified labels that they identified themselves as. Participant 21 said, “cog in the wheel.” Participant 13 reported, “coraller.” Participant 8, Participant 13, and Participant 18 all stated, “gatekeeper.” Another label was stated by Participant 3, “Jack of all trades.” A most frequently reported label was stated by Participant 1, Participant 3, Participant 7, Participant 8, Participant 11, Participant 13, and Participant 22, “patient and family advocate.” Participant 17, Participant 20, and Participant 21 stated the label, “patient-care expert.”

The major categories were then identified by reviewing the research questions and its’ related interview questions. The major categories are: whether RNs were active or passive in multidisciplinary care team rounds, the role of RNs in rounds, how RNs felt his/her role was perceived by the multidisciplinary care team and examples of experience that led this belief, what RNs believed his/or her role should be if different than their current practice, and lived experience and examples of what responsibilities the RNs were accountable for and why. Following major category identification and coding, subcategory identification proceeded. This stage of coding required going through the transcripts line by line, looking for patterns in the responses that could be grouped into sub-categories to the major categories.

There were 8 major categories identified. A second review line by line led to subcategory identification and sub-sub categories to further explore the sub categories where necessary. The first major category identified was RNs' involvement in the multidisciplinary care team. The subcategories identified for the multidisciplinary care team's major category was whether RNs participated in multidisciplinary care teams, observed multidisciplinary care teams, or both. A second major category identified was the perceived roles of RNs within the multidisciplinary care team. The subcategories identified were whether RNs directly or indirectly participated. A sub-subcategory identified the varied identified roles of RNs during direct participation. This included RNs review of meeting daily patient goals, RNs' role of being the fact checker, or RNs having presented the holistic picture of the patient to the multidisciplinary care team. The third major category identified was the RNs' perceptions of how the other colleagues in the multidisciplinary care team perceived the RNs. The subcategories were other roles perceived RNs as needing improvement in their role or that the other colleagues were appreciative of the roles that RNs performed.

The fourth major category included situations that the RNs shared regarding the RNs' perception of how their role was utilized. The subcategories were the RNs being utilized as experts, fact checkers, goal planners, or that there was a perceived lack of value or respect demonstrated by physicians. The fifth major category was the RNs' perception of what the RNs' role should be if different than what their current roles were. The subcategories were either the RNs felt that their roles should be different or should stay the same. Sub-subcategories identified for when RNs felt their roles should be

different included being the expert during rounds, flexing to the needs of the team, or leading rounds. The sub-subcategories for when RN felt their roles should stay the same included having participated in rounds as needed or having presented the patient to the team. The sixth major category was the shared experiences of the RNs that led to other team members' perceptions of RNs utilization within the multidisciplinary care team. The subcategories included the RNs perceived utilization by the team as being critical or life-threatening to patients' well-being, closest to patients than other roles, the roles that followed through on all needs related to patient care, or the role that led the team rounds. The seventh major category included the RNs' perceptions of what roles or tasks RNs were also being held accountable for. The subcategories that the RNs identified as being accountable for were other roles within the hospital, general patient care related accountability, or that RNs did not report being accountable for any other responsibility outside the scope of the RN role. The sub-subcategories for roles that the RNs reported also feeling accountable for were responsibilities of case management, dietary/nutrition, family responsibility, hospital coordinator, housekeeping, social work, maintenance, patient care technician, pharmacy, physician, respiratory, secretary, telemetry staff, and wound care.

The eight major categories identified were the RNs having explored the accountability theory and its application to the RNs' roles. The subcategories identified included whether the accountability was perceived by the RNs as applicable to their practices. The RNs provided statements related to the accountability theory as it was perceived applicable to their practices. Participant 12 stated, "Often, if the RN doesn't do

it, it doesn't get done." Participant 1 stated, "Because the RNs are so close to the patient, there is a feeling of accountability, from the patient, from the family, from the charge RN, colleagues, RN manager, etc. I don't see this accountability in other roles of the multidisciplinary team." Participant 10 stated, "I do what's needed. Ideally, we would have other roles to complete those tasks, but I do as much as I can." Participant 11 stated, "Ultimately, I am accountable, it's my license. Other roles we delegate too may not have the license piece, at the end of the day, it's my license I make sure it gets done. Patient success is my success, the best outcome that could be achieved." Participant 12 stated, "When these other roles are absent, we do it because we can't stop the flow of patient care."

The overarching theme, the macro condition supported by micro details and conditions, is that RNs perceive feeling accountable for all needs of the patient due to having the closest, most personal, and 24/7 responsibility for the patient unique only to the nursing role. This theme was identified in open coding through self-perceived labels, through major concepts and their sub and subcategories. There were no discrepant cases to factor into the analysis.

Evidence of Trustworthiness

Credibility

Multiple strategies ensued to confirm credibility. To ensure credibility, I verified the participants' responses by member checks. I ensured that the participants agreed to their words to ground the data. Persistent observation, as recommended by Lincoln and Guba (1985), ensured credibility. Prolonged engagement included the time spent with

the participants during the guided interviews. Persistent observation included a constant review of the literature and pertinent published findings that discussed nursing roles within a multidisciplinary care team.

Transferability

Thick description as evidence by quotes from identified major concepts and categories are being utilized. This allowed readers to determine whether the findings can be transferred to other settings (Creswell, 2007). There are a variety of participants that both meet the qualifying criteria to be eligible to participate, and have varied demographics not limited to age, years of experience, gender, and care centers of employment.

Confirmability, Dependability, and Reflexivity

Confirmability was observed through dependability and reflexivity. As recommended by Lincoln and Guba (1985), dependability is the stability of findings over time, assuring that another researcher can replicate a study. The research steps were described earlier as stages in memos entered into the QSR NVivo Software as well as captured in an audit trail within the autogenerated reports of the software.

To confirm reflexivity, the process of self-reflection was noted within the text of the analysis of what biases, experiences, and values I come to the research with. Through the use of journaling, I was able to keep myself aware of my previous career and any biases or experiences that could be relevant. I balanced my experience, values, and bias with the objectivity of approaching the data through the lens of the theoretical framework aligned with the research questions.

Results

RQ1

RQ*1*. What is the nature of the self-perceived role identification as viewed by RNs in the multidisciplinary care team within an acute care inpatient medical center? The major concepts and subcategories can be demonstrated visually (see Appendix H, RQ1).

The major categories included RNs' involvement in multidisciplinary care teams and the roles of the RNs in multidisciplinary care teams. The first major category was the participation status of RNs in the multidisciplinary care teams. The subcategories included the RNs having participated or observed in the multidisciplinary care teams. *2*3 (96%) of respondents had experience actively participating in multidisciplinary care rounds, with only two participants observing colleagues and peers participate. This was identified by statements that included the words participated, presence, or observed. The statements indicated either an active or inactive role. Participant 1 stated, “I participated.” Participant 2 stated, “I participated as both the assigned RN and as a Charge RN.” Participant 3 stated, “I was expected to be present and participate.

The second major category related to RQ1 included RNs identifying their roles in multidisciplinary care teams. 20 (83%) of the participants identified RNs in multidisciplinary care teams as directly involved in the team by fact checking the patient status and his/her needs, by updating the team to identified daily goals, or presenting the holistic picture of the patient to the team to evaluate patient status. 20 (83%) of the participants referenced direct participation. Participant 2 stated, “The bedside RN was

mainly responsible for identifying infectious lines that could be removed, daily goals that were or weren't being met, the ins and outs, and vital signs. Participant 14 stated, "When I was primary care, it was knowing your patient, the plan of care, test results, lab results." Participant 19 stated, "The RN is the center of the wheel, patient care. Yes, we take orders, but we advocate for the patient's transport, communicate with other RNs, departments, the RN has one of the most important roles of the MDR, they have the most 1:1 time with the patient."

5 (21%) of the participants stated that RNs often indirectly provided facts electronically or by completing a form that could be reviewed at rounds while RNs were not present, often as a result of RNs being busy with patient care and the rounds began without RNs' presence. This was interpreted by words that grounded the concept of passive or observation type of involvement. This can be observed in the statements the participants made. Participant 1 stated, "The RN in rounds was expected to attend rounds and discussion by the unit. However, the rounds often began without consideration to when the RN was available and often did not include direct participation." Participant 10 stated, "I work nights, and I do updates on the computer." Participant 21 stated, "I think they read our notes."

I assessed RQ1 and its related interview responses provided by the RNs for the development of a new theory. The theory that began to emerge included the personal and direct care that the participants shared in their interview responses. 20 (96%) of the participants had made statements identifying their active, direct, center of providing care, and personal involvement with the patients.

RQ2

RQ2. How do these RNs feel their roles responsibilities are perceived by their team members? The major concepts and sub-categories can be demonstrated visually (see Appendix H, RQ2).

The major categories identified in the interview responses from the RNs included the perceptions of the RNs roles by team colleagues and experiences shared that demonstrated why the team members' perceptions existed. The participants provided statements that could be placed in subcategories of a nursing role that needs improvement or team colleagues were appreciative. 19 (79%) of the participants reported perceptions that indicated their interdisciplinary colleagues demonstrated appreciation for the roles of RNs. Statements provided by the participants included positive words like value, respect, and appreciated. These words assisted in interpreting the responses to associate to this category and subcategory. Participant 10 stated, "I feel very highly respected; the team looks to us for identifying needs for the patient." Participant 12 stated, "RNs are perceived in the positive. Input really mattered. Charge and bedside were well received." Participant 13 stated, "We were shown respect, and they realize and value our opinion."

Nine (38%) of the participants shared perceptions of feeling like their role identification needed improvement. The participants' statements were interpreted to fit into this category due to negative words or statements, including the words valued, and not utilized. Participant 1 stated, "The RN was not utilized, which would lead me to believe that the RN was not considered a valuable part of rounds from other's

perspectives." Participant 14 stated, "Physicians can have a tendency to not take into account what primary (nursing) care knows." Participant 15 stated, "I think it's very important that they wait for RNs; if the bedside isn't ready, then the charge RN should be present for the RN." Participant 18 stated, "I have been dismissed.

The second major category for RQ2 included the experiences shared by the RNs that demonstrated why team members perceptions existed. Subcategories included the participants being perceived as experts, fact checkers, and goal planners or perceiving having a lack of value. 22 (92%) of the participants referenced experiences and examples of being utilized by team members as experts, fact checkers, and goal planners. The statements shared by the participants were interpreted to fit into this category by identifying words or statements that indicated expertise, being aware of minute-to-minute patient changes, or related to goals. Participant 10 stated, "There is a lot of interaction we have with the patient that the team does not. We can identify their needs." Participant 18 stated, "We were there if anything changed." Participant 1 stated, "the RN was asked questions related to the patient that was necessary for planning discharge." Five (21%) of the participants stated they perceived a lack of the nursing role being valued. Responses that fit into this category included words or expressions that demonstrated not being necessary or being overlooked. Participant 21 stated, "Nurses are in the periphery." Participant 6, "Sometimes no one recognizes they (RNs) are there."

As coding the data from RQ2 to major categories and subcategories, the pattern followed that indicated the emergence of a new theory. RQ1's data analysis identified the personal and direct care that RNs explored through their responses. RQ2's data

analysis related to either personal or direct care that expanded this new theory that RNs perceive themselves as the expert. RNs perceive themselves as a unique role that is in the center of patient care, able to see the minute-to-minute changes unlike any other role.

RQ3

RQ3. What experiences may have shaped the RNs' expectations of the RN's role within the multidisciplinary care team? The major concepts and sub-categories can be demonstrated visually (see Appendix H, RQ3).

The major categories included the RNs' perceptions of how their roles should be and their experiences that led to why their perceptions or self-perceived roles existed. Subcategories included the concept of needing to change or not needing to change. 15 (63%) of the respondents stated that their role in the multidisciplinary care team should be better utilized as a patient-care expert, flex to the needs of the team, or lead rounds. These responses indicated a need to change. These statements were identified by words like needs, to be followed by patient care expert or flexible tasks or duties. Participant 14 stated, "The RN knows the needs, condition, and barriers; and the main goal becomes discharge planning. I think the RN needs to be more involved in planning and focused more on the condition and plan of care, not the plan of discharge." Participant 8 stated, "The RN should grow into the role that the multidisciplinary care team needs." Participant 7 stated, "I am the messenger. I would like to know the factors and intentions; our role should be expanded."

Nine (38%) of the participants identified that RNs were well utilized within the multidisciplinary care team rounds and did not need to change. Participant 10 stated, "No

change. Well, I find that RNs' role is identifying the needs, order consults, and directly give to the multidisciplinary care team input." Participant 23 stated, "When I think of the multidisciplinary care rounds, it's what I experienced is what it should be. I felt my voice was heard. For the plan, or advice on the plan and for discharge home, it was heard and valued."

The second major category for RQ3 included the experiences shared by the RNs that led to why perceptions or self-perceived roles existed. The participants provided lived experiences that led to their perception of RNs utilization within the team being critically responsible, being the patient care expert, providing any needs to the team, or leading rounds. The statements that fit into this category included real-life examples of how they perceived their role being utilized. 15 (60%) of the respondents stated that their role in the multidisciplinary care team should be better utilized as a patient-care expert, flex to the needs of the team, or lead rounds. Participant 12 stated, "Probably any critical care experience. The RN is pivotal, with the psych patient, the elderly, critical trauma. The RN gathers the most information and shares. Other roles are more singular; we have the bigger picture." Participant 13 stated, "I think being at the center and taking an active role makes the RN the best advocate. By doing so and working with the same team, they realize that and utilize nursing as such; it's so important." Participant 3 stated, "The RN like I said really is a Jack of All trades, being able to be all roles. The RN's ability to be personal, a people person, is invaluable. RNs are checking all other roles, because the RN makes sure it's (care, treatment, plan) is actually best for the patient, because no one else will. The RN advocates when others fall short. The RN needs to know a little about

a lot." Participant 6 stated, "Other roles, the Case Manager always come to RNs with question or information related to plan of care. Social Work and Pharmacy too, even more than the medical providers, they all seem to value nursing."

RQ1 and RQ2's theory emergence allowed me to assess RQ3 for further theory development. RQ3 and its related interview responses were analyzed for a growing theme related to RNs' active roles within the multidisciplinary care team. I found that data were categorized and organized in such a way that portrayed the RNs' perceptions as being pivotal to patient care, as the expert or advocated and should be utilized in such a way. The emerging theory is grounded in RNs' self-perceptions being that of the expert and pivotal within patient care.

RQ4

RQ4: How do RNs view their scope of practice, applying the lens of the accountability theory? The major concepts and sub-categories can be demonstrated visually and can be seen in Appendix H, RQ4.

The major categories listed in RQ4 data results are the perception of accountability and applying the lens of the accountability theory in practice. Respondents' statements were categorized into subcategories of feeling accountable for other roles or not having additional accountability. 22 (92%) of the participants identified being accountable for other role's responsibilities. As stated previously, other roles or tasks RNs perceive being accountable for are management, dietary/nutrition, family responsibility, hospital coordinator, housekeeping, social work, maintenance, patient care technician, pharmacy, physician, respiratory, secretary, telemetry staff, and

wound care. These roles were identified by those titles/labels and coded into those subcategories. Participant 15 stated, "I would say short staffing, missing components to the team, nursing ends up doing it, because there is no one else." Participant 19 stated, "There are always tasks left undone, so you have to." Participant 25 stated, "Everything falls back on the RN." Participant 8 stated, "It's a constant discussion. They want me to do tasks outside of my scope because I am capable, but it's not my responsibility."

Two(8%) participants shared experiences that supported only being accountable for nursing responsibilities and no other. Participant 22 stated, "No, I only work in my scope of practice." Participant 4 stated, "Personally, no. Our team is so expansive, I never really felt that way."

RQ4's second major category was identified as RNs applying the lens of the accountability theory in practice. This major category was identified by participants confirming or denying the use of the theory after being read the definition. 24 (100%) of the participants identified that the accountability theory applies to the nursing profession. Participant 13 stated, "I definitely feel I am accountable to the patient and the family. When I go above-and-beyond, it's because I am accountable to that person, so they can leave and hopefully not come back. We wear so many hats for that, act as occupational therapy, physical therapy, respiratory therapy, everyone else, nursing cares that is the 100% reason why we go above and beyond." Participant 20 stated, "RNs are accountable all day every day to peers, managers, patients, families. If you breakdown the day of the RN, charging, assessing, accountability is a large part of the day." Participant 21 stated, "Yeah, it applies, to everyday, even the little things – with pump changes, I go through

why with the patient, and it helps the patient learn. I think patients view RNs as far more important than physicians; they are the lifeguard (the RN). The physicians just float in and out. The relationship with the patient/RN is like a mother and child."

The emergency of a new theory was evident in the responses provided by RNs that were coded into major categories and subcategories within RQ4's data. RQ4 data were organized into categories of responses that demonstrated the participants' perspectives of their accountability to patients. All the participants felt accountable to the patients, and all but two participants felt accountable for other roles outside of nursing. The new theory is grounded in the all-day every day accountability statements the respondents vocalized in their 24/7 roles, perceived by the RNs to be unique to only their roles as RNs.

Summary of the Theory

The overarching theme is that RNs perceive feeling accountable for all needs of the patient due to having the closest, most personal, and 24/7 responsibility for the patient. This 24/7 responsibility is perceived by the participants as unique, only to the nursing role. This theme was identified in open coding through self-perceived labels, through major concepts and their sub and subcategories. This study has demonstrated the emergence of a new theory that can be identified as the perpetual accountability theory. Due to the 24/7, minute to minute, ongoing and continuous accountability that the respondents shared.

Summary

A qualitative grounded theory framework was used to explore the perceived role, as well as the scope of practice and utilization of the nursing role within the acute care setting in a multidisciplinary team. Guided interviews of participants provided data that shares the lived experience of 24 RNs from a variety of demographic statuses, locations, medical centers, and specialties. Analyzing the answers from interview questions as they aligned with the research questions allowed the results to show that most participants actively participate in multidisciplinary care rounds and are perceived or needed to be clinical experts. While few participants feel that their role is well acknowledged and does not need to be better utilized, most share that that role could be better utilized as the patient-care expert since their role is closest to the patient with 24/7 responsibility and accountability. Most RNs also share that they are accountable for the patient and complete tasks other roles are assigned to as it meets the patients' needs. Unanimously, all participants feel that the accountability theory can be applied to their practice. Chapter 5 will explore the interpretation of the results.

Chapter 5: Interpretation of Findings

Introduction

Through a grounded theory approach, the self-perceived role and utilization of RNs among multidisciplinary care teams within the acute care setting have been explored. This chapter will interpret the findings, review the limitations of the study, and provide recommendations and implications following the study. Guided interviews were completed that collected the lived experience of 24 RNs with varied demographics. Most participants actively participate in multidisciplinary care teams and are often perceived or needed to be clinical experts. Most participants said their role was closer to the patient than any other role and required 24/7 responsibility and accountability. Participants shared that their accountability in terms of patient needs extended into other tasks that many times are completed by the RN due to their 24/7 accountability. Unanimously, participants said that the accountability theory applies to their daily practice.

Interpretation of Findings

The literature review for this study related identified key points regarding the nursing role and its utilization with the multidisciplinary care team. As described in Chapter 4, the overall findings from the results of the data collection revealed that in addition to members of the multidisciplinary care team, most RNs perceived themselves as clinical experts. This concept that participants identify as clinical experts was found during open coding and interviews. Through open coding, the participants identified themselves with specific labels, including that as clinical experts. Also, the participants stated they felt they were the cog in the wheel, the coraller, the gatekeeper, the Jack of

all trades, the patient and family advocate, and the patient-care expert". This study focused on nursing self-perceptions only and did not include the physician or midlevel provider perceptions, except in terms of perceived experiences of RNs.

The concept of accountability was also noticed repeatedly through open coding and through identifying major categories and subcategories during the analysis. Many participants reported being accountable and responsible for tasks assigned to other roles (physicians, case managers, patient care technicians, etc.). Edwards et al. (2015) said that unclear role identification within multidisciplinary care teams is problematic and concluded that a better understanding of interprofessional task allocation is needed. The perceptions of respondents in this study completing non-role specific tasks may lead other members of the multidisciplinary care team to not have a clear understanding of the assigned role and task delineation.

Both Glogowska et al. (2015) and Lobo et al. (2015) concluded that RNs were able to coordinate effective care and ensure continuity of care within the scope of the multidisciplinary care team. Participant 12 stated, "The RN knows the whole picture and shares with everybody." Participant 3 stated, "The RN is a Jack of all trades, being able to be all roles. The RN's ability to be personal, a people person, is invaluable. RNs are checking all other roles because the RN makes sure the care and treatment-plan are actually best for the patient because no one else will. The RN advocates when others fall short. The RN needs to know a little about a lot."

The findings of this study aligned with the propositions of the accountability theory. The major theoretical propositions included that there was an expectation that

one (RNs) may be called to justify beliefs, feelings, or actions and that producing unsatisfactory actions (e.g., errors, not meeting patient or family needs) will have negative consequences (Tetlock & Lerner, 1999). Through open coding of the participants' responses and through major category coding, the concept of accountability was explored. RNs shared that if they did not hold themselves accountable, there would be negative consequences. Participant 10 stated, "I do what's needed. Ideally, we would have other roles to complete those tasks, but I do as much as I could." Participant 3 stated, "The patient needs us to do it, and we just need to get it done." Participant 11 stated, "Ultimately, I am accountable, it's my license. Other roles we delegate too may not have the license piece, at the end of the day, it's my license, I make sure it gets done. Patient success is my success, the best outcome that could be achieved." Participant 12 stated, "When these other roles are absent, we do it because we can't stop the flow of patient care."

All participants concluded that there is an expectation that actions must be done, and otherwise, patient care is compromised with negative consequences. 22 (92%) of the participants identified other roles and responsibilities they felt accountable for as it related to having unsatisfactory consequences if otherwise. These other roles or responsibilities were discussed in Chapter 4 and can be reviewed as subcategories (see Appendix H) not limited to physician, case management, and patient care technician responsibilities. The scope of this study did not explore other roles or their perceptions to compare perceptions or responsibilities.

Limitations of the Study

The study analyzed data shared primarily via phone communications. In a future or repeat study, in-person interviews may elicit details not revealed electronically. Body language and intonation could not be assessed. Thick description confirmed transferability results but was limited to mostly electronic interviews and did not include body language or intonation. This study analyzed data shared by participants with different demographics but could have been more conclusive. These participants were recruited primarily from the United States and spanned many states (see Appendices G and H) but could have been expanded to other countries. There were very few male participants. Eighty-four percent of participants were women, and the other 16% were men or identified as nonbinary. There were few non-Caucasians. Eighty-four percent of participants identified themselves as Caucasian. 12% of the participants identified themselves as Black. Four percent identified themselves as Asian. The U.S. Department of Labor (2003) said that 92.1% of RNs were women. This study matches the country demographics for the profession, increasing the number of non-women participants may have elicited different data. The U.S. Department of Labor (2003) said that 81.9% of RNs were Caucasian, 9.9% were Black, and seven percent were Asian. Increasing the number of minority participants may have elicited different data. Hispanics represented 3.9% of the country's demographics (U.S. Department of Labor, 2003) and were underrepresented. As revealed during the literature review in Chapter 1, this study was limited to the perceptions of nursing roles among the multidisciplinary care team and did not explore perceptions regarding other roles on the team. The RNs shared their

perspective of the perceptions of the other roles on the team, limiting responses to the participants' experiences and bias.

Recommendations

As demonstrated in the limitations, further research that includes increasing elicited interview responses in-person rather than electronically may provide further exploration of the problem. Body language and intonation are not observable during electronic communications and may elicit follow up questions and further explanations that would enhance the interview. Future studies should include an increase in under-represented demographics like men and minorities.

This study explored the feelings and experiences of 24 RNs as it related to their role in the multidisciplinary care team. Future studies should explore the perceptions of other members of the multidisciplinary care team. The perceptions of the other roles, including but not limited to physicians, case managers, and patient care technicians, would expand the exploration of perceptions that was limited to only RNs in this study.

Combining the recommendations of in-person data collection and expanding the participant pool to include other roles, a future study could approach the data through a small group interview or a case-study. This recommendation would increase the data sources to include observations in the role's real-time setting.

Implications

Positive Social Change

RNs and nursing leadership within institutions that utilize multidisciplinary care teams may benefit from reviewing the data revealed in this study and apply it to current

practices. This study implies that RNs perceive themselves as clinical experts as well as perceive that others utilize them as such. The data revealed that care is completed and/or coordinated through the nursing role, implying that those institutions that are not utilizing nursing in such a way may have room for implementing social change. This may increase the utilization and accountability of RNs to ensure that patient care tasks are completed in a timely manner, to benefit the patients. The findings of this study can drive decision makers of acute care medical centers to utilize the RNs' within the multidisciplinary care team to coordinate and complete patient care. The findings indicate that RNs' perspectives have identified that RNs are accountable to complete patient care goals and the RNs' roles should be clearly identified as the coordinator or leader of multidisciplinary care teams. The data will drive decision makers to clearly identify roles and task delineation of multidisciplinary care teams, beginning with RNs, to avoid miscommunication or miscoordination. This positive social change can lead to an increase in positive patient care outcomes, increase in patients' satisfaction, and an increase in RNs' satisfaction.

Methodological, Theoretical, and Empirical Implications

The accountability theory was the lens was used to approach all pieces of the design process. Tavallaei and Abutalib (2010) said that the theory could shape or enhance a study. The nursing participants in this study revealed that accountability is a driving force for many of their decisions made. The implications and recommendations found from this study may be applied to other roles, like the nursing role that provides care. Other roles or professions can review this research to determine applicable to their

profession, e.g., teachers, police, fire-fighters. If this research applies to other professions, positive social change may be applied to fields outside of nursing as a result of this study.

The overarching theme, the macro condition supported by micro details and conditions of this study, reveals that RNs perceive feeling accountable for all needs of the patient due to having the closest, most personal, and 24/7 responsibility for the patient unique only to the nursing role. This study applied a grounded theory approach to all aspects of the design, and the theme revealed indicates a new theory. This new theory implies that, due to the nursing role having a 24/7 responsibility while being the closest, most personal role to the patient, allows the RN to perceive feeling accountable for all needs to the patient, even if the needs or actions are outside of the nursing assigned role or tasks. This current study and implications for future research to explore the identified gaps demonstrate intentions for increased patient satisfaction and improved patient outcomes.

Conclusion

Through a literature review and the subsequently identified gaps of knowledge, a qualitative grounded theory study was performed exploring and revealing the perceived role and the perception of the utilization of scope of practice within the multidisciplinary care team. Through data collection and analysis, it was revealed that RNs perceive themselves as being utilized as an expert and being accountable for all aspects related to patient care. The study determined the emergence of a new theory, one that implies that the nursing role has a 24/7 responsibility while being the closest, most personal role to

the patient which allows the RN to perceive feeling accountable for all the needs to the patient, even if the needs or actions are outside of the nursing assigned role or tasks. There are recommendations and implications for future studies to apply positive social change in the nursing profession, acute care medical centers that utilize multidisciplinary care teams, and possibly other professions that provide care. The current literature review in Chapter 2 exposes the nursing role in the multidisciplinary care team to have a perceived unidentified role and misutilization. This study's results will require publication and future studies to proceed in order to alter the current perception that the nursing role is misidentified or underutilized. The positive social change includes changing the perception of peers and society with research and best practices.

References

Banning, M. (2006). Medication review: The role of RN prescribers and community matrons. *RN Prescribing*, *4*(5), 198-204.

Bazeley, P. (2002). The evolution of a project involving an integrated of structured qualitative and quantitative data: From N3 to NVivo. *International Journal of Social Research Methodology, 5,* 229-243.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park, CA: Addison-Wesley.

Carter, N., Bryant-Lukosius, D., Dicenso, A., D., Blythe, J., & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum, 41*(5), 545-547. doi:10.1188/14.ONF.545-547

Chamberlain-Salaun, J., Mills, J., & Usher, K. (2013). Terminology used to describe health care teams: An integrative review of the literature. *Journal of Multidisciplinary Healthcare*, *6*, 65–74. doi:10.2147/JMDH.S40676

Conn, V. S., Zerwic, J., Rawl, S., Wyman, J. F., Larson, J. L., Anderson, C. M., Markis, N. E. (2014). Strategies for a successful Ph.D. program: Words of wisdom from the WJNR Editorial Board. *Western Journal of Nursing Research, 36*(1), 6-30.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage Publications, Inc.

Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Edwards, S. T., Rubenstein, L. V., Meredith, L. S., Schmidt Hackbarth, N., Stockdale, S. E., Cordasco, K. M. ... Yano, E. M. (2015). Who is responsible for what tasks within primary care: Perceived task allocation among primary care providers and interdisciplinary team members. *Healthcare (Amsterdam, Netherlands)*, *3*(3), 142-149. doi:10.1016/j.hjdsi.2015.05.002.

Epstein, N. (2014). Multidisciplinary in-hospital teams improve patient outcomes: A review. *Surgical Neurology Int., 5* (7), 295-303. doi:10.4103/2152-7806.139612

Fennell, M., Das, I.P., Clauser, S., Petrelli, N., & Salner, A. (2010). The organization of multidisciplinary care teams: Modeling internal and external influences on cancer care quality. *JNCI Monographs, VOL. #?*(40), 72-80. doi:10.1093/jncimonographs/lgq010

Given, L.M. (2008). Inter- and intracoder reliability. *The Sage encyclopedia of qualitative research methods*. Thousand Oaks, CA: Sage Publications, Inc

Glaser. B.G. & Strauss, A.L. (1967). The discovery of grounded theory. City, State: NAME OF PUBLISHER (accurate spelling and capitalization).

Glogowska, M., Simmonds, R., McLachlan, S., Cramer, H., Sanders, T., Johnson, R. Purdy, S. (2015). Managing patients with heart failure: A qualitative study of multidisciplinary teams with specialist heart failure RNs. *Annals of Family Medicine*, *13*(5), 466-471. doi:10.1370/afm.1845

Hakanson, C., Douglas, C., Robertson, J., & Lester, L. (2014). Evaluation of a rural RN-led clinic for female sexual dysfunction. *The Australian Journal of Rural Health*, *22*(1), 33-39. doi:10.1111/ajr.12076

Hille, S. (2014). RN professionals viable in mental health care. *Australian Nursing & Midwifery Journal*, *21*(11), 50.

Ho, T. H., Caughey, G. E., & Shakib, S. (2014). Guideline compliance in chronic heart failure patients with multiple comorbid diseases: evaluation of an individualized multidisciplinary model of care. Plus One, 9(4), e93129. doi:10.1371/journal.pone.0093129

Holton, J. A. (2007). *The Sage handbook of grounded theory.* Thousand Oaks, CA: SAGE Publications.

Kocher, R., Adashi, E. (2011). Hospital Readmissions and the Affordable Care Act Paying for Coordinated Quality Care. *Jama*, *306* (16), 1794-1795. doi:10.1001/jama.2011.1561

Lincoln, Y., & Guba, E. (1985). Naturalistic Inquiry. Sage Publications.

Maryland Department of Health Board of Nursing Standards of Practice for RNs, COMAR, Title 10 Subtitle 27 Chapter 09 (10.27.09), 1989, retrieved 3/21/18 from

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 11*(3). Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/1428/3027

Maxwell, J. A. (2005). *Applied Social Research Methods Series: Vol. 41. Qualitative research design: An interactive approach* (2nd ed.). Thousand Oaks, CA: Sage Publications.

McNamara, M. S., Fealy, G. M., Casey, M., Geraghty, R., Johnson, M., Halligan, P., & ... Butler, M. (2011). Boundary matters: clinical leadership and the distinctive disciplinary contribution of nursing to multidisciplinary care. *Journal of Clinical Nursing*, *20*(23/24), 3502-3512. doi:10.1111/j.1365-2702.2011.03719.x

Mendes, M. A., da Cruz, D. A., & Angelo, M. (2015). Clinical role of the RN: a concept analysis. *Journal of Clinical Nursing*, *24*(3-4), 318-331. doi:10.1111/jocn.12545

Miles, M. B., Huberman, A. M. & Saldana, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Morse, Janice M. (1994). Designing funded qualitative research. In Norman K. Denzin & Yvonna S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp.220-35). Thousand Oaks, CA: Sage.

Nagi, C., Davies, J., Williams, M., Roberts, C., & Lewis, R. (2012). A multidisciplinary approach to team nursing within a low secure service: the team leader role. *Perspectives In Psychiatric Care*, *48*(1), 56-61. doi:10.1111/j.1744-6163.2011.00310.

NVivo. (n.d.). Retrieved April 15, 2018, from http://www.qsrinternational.com/nvivo/what-is-nvivo.

Pannucci, C., Wilkins, E. (2010). Identifying and Avoiding Bias in Research. *Plastic and Reconstructive Surgery, 126* (2), 619-625. doi: 10.1097/PRS.0b013e3181de24bc

Patton, M. Q. (2015). *Qualitative research & evaluation methods* (4th ed.). Thousand Oaks, CA: Sage Publications.

Pew Research Center: The generations defined. (2018, April11). Retrieved from https://www.pewresearch.org/fact-tank/2018/04/11/millennials-largest-generation-us-labor-force/ft_18-04-02_generationsdefined2017_working-age/

Popejoy, L. L., Galambos, C., Stetzer, F., Popescu, M., Hicks, L., Khalilia, M. A., & ... Marek, K. D. (2015). Comparing Aging in Place to Home Health Care: Impact of RN Care Coordination on Utilization and Costs. *Nursing Economics*, *33*(6), 306-313.

Reeves, S., Nelson, S., & Zwarenstein, M. (2008). The Doctor-RN Game in the Age of Interprofessional Care. *Nursing Inquiry, 15* (1), 1-2.

Reimanis, C., Cohen, E., Redman, R. (2001). RN Case Manager Role Attributes: Fifteen Years of Evidence-based Literature. *Professional Case Management, 6*(6), 230-239.

Rozmovits, L., Mior, S., & Boon, H. (2016). Exploring approaches to patient safety: the case of spinal manipulation therapy. *BMC Complementary and Alternative Medicine*, *16*(1), 164. doi:10.1186/s12906-016-1149-2

Shah, S. P., Huang, Y., Xu, T., Yuen, M. S., Ling, J., & Ouellette, B. F. (2005). Atlas - a data warehouse for integrative bioinformatics. *BMC Bioinformatics*, *6*34.

Shamian, J., & Ellen, M. E. (2016). The role of nurses and nurse leaders on realizing the clinical, social, and economic return on investment of nursing care. *Healthcare Management Forum / Canadian College of Health Service Executives = Forum Gestion Des Soins De Santé / Collège Canadien Des Directeurs De Services De Santé*, *29*(3), 99-103. doi:10.1177/0840470416629163.

Straus, A. & Corbin, J. (1998) *Basics of qualitative research; Grounded theory procedures and techniques* (2nd ed.). Newbury Park, CA:Sage.

Tavallaei, M., & Abutalib, M. (2010) A general perspective on the role of theory in qualitative research. *The Journal of International Social Research*, *3*(11), 570-577.

Tetlock, P. E., & Lerner, J. S. (1999) Accounting for the effects of accountability. *Psychological Bulletin, 125*(2), 255-275.

United States Department of Labor. (2003). Statistics on RNs. Retrieved from https://www.dol.gov/wb/factsheets/qf-nursing.htm

Vance, A., Lowry, P., & Eggett, D.L. (2015) A new approach to the problem of access policy violations: Increasing perceptions of accountability through the user interface. *MIS Quarterly, 3*(11), 345-366.

Walden University. (n.d.-i). Office of Student Research Administration: Ph.D. Dissertation Program. Retrieved December 18, 2014, from http://academicguides.waldenu.edu/researchcenter/osra/phd

Weller, J. M., Barrow, M., & Gasquoine, S. (2011). Interprofessional collaboration among junior doctors and RNs in the hospital setting. *Medical Education*, *45*(5), 478-487. doi:10.1111/j.1365-2923.2010.03919.x

(What is a registered nurse? (n.d.)Retrieved January 3, 2018, from https://www.graduatenursingedu.org/what-is-a-registered-nurse/

Zamawe, F. C. (2015). The implication of using NVivo Software in qualitative data analysis: evidence-based reflections. *Malawi Medical Journal: The Journal of Medical Association of Malawi*, *27*(1), 13-15.

Zoucha, R., & Husted, G. L. (2000). The ethical dimensions of delivering culturally congruent nursing and health care. *Issues In Mental Health Nursing*, *21*(3), 325-340.

Appendix A: Standards of Practice for RNs

Title 10 MARYLAND DEPARTMENT OF HEALTH
Subtitle 27 BOARD OF NURSING
Chapter 09 Standards of Practice for RNs
Authority: Health Occupations Article, §§8-205 and 8-316, Annotated Code of Maryland

(a) .01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Accountability" means being answerable for the actions of self and others.

(2) "Aggregate" means the sum total of nursing care the client received.

(3) "Assessment" means a systematic, dynamic process by which the RN, through interaction with the client, family, significant others, and other health care providers, collects and analyzes data.

(4) "Assign" means the transfer of responsibility from one RN to another with each RN having the legal authority to perform the function as permitted by the licensee's scope of practice.

(5) "Client" means an individual, family, group, or community under the licensee's direct or indirect care.

(6) "Continuity of care" means an interdisciplinary process that:

(a) Includes the client, family, and significant other in the development and communication of a coordinated plan of care; and

(b) Based on changing needs and available resources, facilitates the client's:

(i) Care within a setting, and

(ii) Transition between settings.

(7) "Criteria" means relevant, measurable indicators of the standards of RN practice.

(8) "Delegate" means the RN:

(a) Invests authority to act on behalf of the RN to an unlicensed person;

(b) Authorizes the unlicensed person to augment and supplement the care the RN provides; and

(c) Retains the accountability and responsibility for the delegated act.

(9) "Evaluation" means the review and analysis of the extent to which the assessment, nursing diagnosis, planning, and implementation is effective in resolving the client's health problems or progress toward the attainment of expected outcomes.

(10) Health Care Providers.

(a) "Health care provider" means an individual with special expertise who provides health care services or assistance to clients.

(b) "Health care provider" includes:

(i) RNs;

(ii) Physicians;

(iii) Psychologists;

(iv) Social workers;

(v) Nutritionists/dietitians; and

(vi) Various therapists.

(11) "Health care team" means a group of individuals, which includes health care providers and unlicensed personnel, working in collaboration with the client, family, and significant others to achieve identified outcomes.

(12) Health Status Data.

(a) "Health status data" means information obtained through nursing assessment of the client.

(b) "Health status data" includes but is not limited to:

(i) Growth and development;

(ii) Biophysical status;

(iii) Emotional status;

(iv) Cultural, religious, and socioeconomic background;

(v) Activities of daily living and instrumental activities of daily living;

(vi) Patterns of coping;

(vii) Interaction patterns;

(viii) Client perception of and degree of satisfaction with health status;

(ix) Client health goals;

(x) Physical, social, emotional, and ecological environments; and

(xi) Access to and availability of human and material resources.

(13) "Implementation" means the process of performing, delegating, assigning, supervising, and coordinating interventions.

(14) "Instrumental activities of daily living" means home management skills such as shopping for food and personal items, preparing meals, or handling money.

(15) "Nursing diagnosis" means a description of the actual or potential, overt or covert health problems which RNs are licensed to treat.

(16) "Outcomes" means measurable, expected, client-focused goals which translate into observable behaviors.

(17) "Plan of care" means designing methods to solve identified problems and to attain outcomes by means of establishing priorities, setting goals, and defining interventions.

(18) "Process" means the delivery of care and the fulfillment of the practice standards.

(19) "Quality of care" means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

(20) "Recipients of nursing care" means individuals, families, groups, communities, or populations.

(21) "RN" means a RN as defined in Health Occupations Article, §8-301, Annotated Code of Maryland.

(22) "Responsibility" means the obligation and duty to perform.

(23) "Scientific principles" means a fundamental belief or reason for action derived from an organized system of study.

(24) "Standards of care" means a minimum level of competent nursing practice demonstrated through assessment, analysis, formulation of nursing diagnosis, outcome identification, planning, implementation, and evaluation.

(25) Standards of RN Practice.

(a) "Standards of RN practice" means the minimum criteria the RN shall adhere to in the practice of registered nursing.

(b) "Standards of RN practice" includes both standards of care and standards of professional performance.

(26) Standards of Professional Performance.

(a) "Standards of professional performance" means a competent level of behavior in the professional role.

(b) "Standards of professional performance" includes activities related to:

(i) Quality of care;

(ii) Performance appraisal;

(iii) Education;

(iv) Collegiality;

(v) Ethics;

(vi) Collaboration;

(vii) Research;

(viii) Resource utilization;

(ix) Assignment;

(x) Delegation and supervision; and

(xi) Refusal.

(27) "Structure" means:

(a) The environment in which care is provided; and

(b) Resources available to provide care including but not limited to finances, staffing, supplies, equipment, and medical records.

(28) "Technology assessment" means a review of drugs, devices, procedures, and systems in relationship to their safety, effectiveness, and economic and social impact.

(b) .02 Standards of Care.

A. Assessment.

(1) The RN shall collect client health data.

(2) Measurement Criteria.

(a) Data collection shall involve the client, family, significant others, other members of the health care team, and the health record, when appropriate.

(b) Data may include the following dimensions:

(i) Physical;

(ii) Psychological;

(iii) Sociocultural;

(iv) Spiritual;

(v) Cognitive;

(vi) Functional abilities;

(vii) Developmental;

(viii) Economic;

(ix) Technology; and

(x) Life-style.

(3) Priority of data collection is determined by the client's immediate condition or needs, health status, and setting.

(4) Pertinent data shall be collected using appropriate assessment techniques.

(5) Data collection shall include a technology assessment.

(6) The data collection process shall be comprehensive, systematic, and ongoing.

(7) Relevant health status data, including changes, shall be documented in an authorized record which is accessible and in a retrievable form.

B. Analysis and Nursing Diagnosis.

(1) The RN shall analyze the assessment data in determining nursing diagnoses.

(2) Measurement Criteria.

(a) The RN shall analyze the data, consider the options, including technology, and make a determination as to whether the selected options are appropriate for the needs of the client.

(b) Nursing diagnoses shall be:

(i) Derived in a complete, systematic, and ongoing manner from the assessment data;

(ii) Validated with the client, family, significant others, and other members of the health care team, when possible; and

(iii) Documented in a manner that facilitates the determination of expected outcomes and plan of care.

(c) Nursing diagnoses shall identify the nature and extent of the client's health status, capabilities, and limitations.

C. Outcome Identification.

(1) The RN shall identify expected outcomes individualized to the client.

(2) Measurement Criteria.

(a) Outcomes shall be:

(i) Derived in a comprehensive, systematic, and ongoing manner from the diagnoses;

(ii) Directed toward management of the client's health problems;

(iii) Formulated with the client, family, significant other, or other members of the health care team, when possible and appropriate;

(iv) Culturally appropriate and realistic in relation to the client's present and potential capabilities;

(v) Attainable in relation to the resources available to the client;

(vi) Documented as measurable goals with time estimates for attainment as appropriate; and

(vii) Documented in an authorized record which is accessible and in a retrievable form.

(b) Outcomes provide direction for continuity of care.

D. Planning.

(1) The RN shall develop a plan of care that prescribes interventions to attain expected outcomes.

(2) Measurement Criteria.

(a) The plan shall be:

(i) Individualized in a comprehensive, systematic and ongoing manner;

(ii) Developed utilizing available data;

(iii) Prioritized to meet the client's condition or needs;

(iv) Developed, coordinated, and communicated with the client, family, significant other, and other members of the health care team as appropriate;

(v) Congruent with the client's therapeutic regime; and

(vi) Documented.

(b) The plan shall:

(i) Reflect current nursing practice;

(ii) Provide for continuity of care; and

(iii) Include identification, coordination, and utilization of available resources.

E. Implementation.

(1) The RN shall implement the interventions identified in the plan of care.

(2) Measurement Criteria.

(a) Interventions shall be:

(i) Implemented recognizing the rights of the client, the family, and significant others;

(ii) Consistent with the established plan of care;

(iii) Implemented in a competent, safe, and appropriate manner consistent with knowledge of scientific principles; and

(iv) Documented.

(b) Interventions may include, but are not limited to:

(i) Patient teaching;

(ii) Counseling;

(iii) Implementing clinical practice guidelines, protocols, and pathways; and

(iv) Independent nursing functions.

(c) Selected interventions may be assigned and delegated to other personnel participating in delivering care.

(d) When assignment or delegation occurs, supervision is provided.

(e) A safe and therapeutic environment is provided for the delivery of nursing care.

(f) Relevant information which may be needed to carry out the nursing plan is provided to the client, family, significant others, and other members of the health care team without violating the client's confidentiality.

F. Evaluation.

(1) The RN shall evaluate the client's progress toward attainment of outcomes.

(2) Measurement Criteria.

(a) Evaluation shall be systematic, ongoing, and criterion-based.

(b) The client, family, significant other, and other members of the health care team shall be involved in the evaluation process, when appropriate.

(c) Ongoing assessment data shall be used to evaluate the process of care and to revise the nursing diagnosis, outcomes, and the plan of care.

(d) Revisions of diagnoses, outcomes, and the plan of care shall be documented.

(e) The effectiveness of interventions shall be evaluated in relation to outcomes.

(f) The responses to interventions shall be documented and communicated to the client and other members of the health care team.

(g) The RN charged with the documentation of the client's discharge shall make the final nursing evaluation.

(c) .03 Standards of Professional Performance.

A. Quality of Care.

(1) The RN systematically shall evaluate the quality and effectiveness of nursing practice in the aggregate.

(2) Measurement Criteria. The RN shall:

(a) Participate in activities to evaluate quality of care including, but not limited to, monitoring the structure, process, and outcome of nursing practice, with consideration for access and cost;

(b) Use quality monitoring data to identify opportunities for improving care; and

(c) Participate in activities related to implementing changes designed to improve care.

B. Performance Appraisal.

(1) The RN shall be accountable for evaluating the RN's own nursing practice on a regular basis in relation to professional practice standards and relevant statutes and regulations.

(2) Measurement Criteria.

(a) The RN shall:

(i) Participate in peer review as appropriate; and

(ii) Seek guidance, support, education, and supervision as necessary.

(b) The RN shall demonstrate knowledge of and shall comply with:

(i) Relevant professional practice standards;

(ii) Statutes and regulations governing nursing; and

(iii) The policies and procedures of the practice setting.

C. Education.

(1) The RN shall acquire and maintain current knowledge and competency in nursing practice.

(2) Measurement Criteria. The RN shall:

(a) Participate in educational opportunities and experiences to maintain professional competence; and

(b) Obtain knowledge and skills appropriate to the practice setting.

D. Collegiality.

(1) The RN shall contribute to the professional development of peers, colleagues, and others.

(2) Measurement Criteria.

(a) The RN shall share knowledge and skills with peers, colleagues, and others.

(b) The RN shall contribute to a supportive and healthy work environment.

E. Ethics.

(1) The RN's decisions and actions shall reflect ethical principles.

(2) Measurement Criteria. The RN shall:

(a) Comply with the Code of Ethics in COMAR 10.27.19;

(b) Maintain client confidentiality within legal and regulatory standards;

(c) Act as a client advocate and assist clients to advocate for themselves;

(d) Deliver care in a nonjudgmental and nondiscriminatory manner that is sensitive to client diversity;

(e) Deliver care in a manner that preserves client autonomy, dignity, and rights; and

(f) Seek available resources to help formulate ethical decisions.

F. Collaboration.

(1) The RN shall collaborate with the client, family, significant others, and other health care providers in providing care.

(2) Measurement Criteria. The RN shall:

(a) Collaborate with the client, family, significant others, and other health care providers in the formulation of overall goals, the plan of care, and decisions related to care and the delivery of services; and

(b) Consult with health care providers for client care.

G. Research.

(1) The RN shall participate in research activities appropriate to the licensee's position, education, and practice environment.

(2) Measurement Criteria. The RN shall:

(a) Support the client's rights related to research;

(b) Participate in data collection;

(c) Participate in identification of clinical problems suitable for nursing research; and

(d) Utilize established facility-approved research protocols.

H. Resource Utilization.

(1) The RN shall consider factors related to safety, effectiveness, and cost in planning and delivering client care.

(2) Measurement Criteria. The RN:

(a) Shall assist the client, family, and significant others in identifying services and options available to address health-related needs;

(b) Shall evaluate factors related to safety, effectiveness, and cost when performing, assigning, delegating, and supervising nursing care, and teaching the client, family, and significant others; and

(c) As a case manager, may identify and facilitate options and services for meeting individual health needs by enhancing quality, cost-effective clinical outcomes while decreasing fragmentation and duplication of care.

I. Assignment, Delegation, and Supervision.

(1) The RN may assign nursing acts or delegate nursing tasks to individuals who are competent to perform those acts or tasks, when the assignment or delegation does not jeopardize the client's welfare.

(2) Measurement Criteria.

(a) When delegating a nursing task to an unlicensed person, the RN shall assess the client and determine that the delegation is consistent with COMAR 10.27.11.

(b) When delegating a nursing task to an unlicensed person, the RN shall:

(i) Instruct;

(ii) Direct;

(iii) Regularly evaluate the performance of nursing tasks by the unlicensed person;

(iv) Rectify a situation in which the unlicensed person under the licensee's supervision is performing nursing tasks incorrectly; and

(v) Prohibit the continued performance of an unlicensed person who is performing the delegated nursing task or tasks incompetently.

(c) When the RN is assigning a nursing act to another licensed RN, the RN shall:

(i) Verify that the nursing act is within the licensed RN's legal scope of practice;

(ii) Verify that the licensed RN has the knowledge, skills and clinical competency to perform the assigned act;

(iii) Verify that the assigned act is consistent with the facility's policies and procedures;

(iv) Regularly evaluate the licensed RN who is performing the assigned nursing act;

(v) Rectify a situation in which the licensed RN assigned to perform the nursing act has performed the nursing act incorrectly; and

(vi) Prohibit the continued performance of the assigned nursing act by a licensed RN who is performing the assigned nursing act or acts incompetently.

J. Refusal.

(1) The RN has the right and the responsibility to refuse to perform, assign, or delegate nursing acts.

(2) Measurement Criteria.

(a) The RN has the right and responsibility to refuse to perform a nursing act which is beyond the parameters of the RN's education, capabilities, and clinical competency.

(b) The RN shall obtain appropriate education, training, and supervision as required to perform nursing functions which are beyond the parameters of the RN's education and clinical competence.

(c) The RN has the right to refuse to accept responsibility and accountability for supervising, monitoring, instructing, or evaluating an unlicensed person performing a nursing task that has not been delegated by that RN.

(d) .04 Specialty Practice.

A. A RN functioning in a specialty practice shall have additional education, training, and experience. Specialty practice does not include advanced practice nursing.

B. Definitions.

(1) In this regulation, the following terms have the meanings indicated.

(2) Terms Defined.

(a) "Critically ill client" means a client who:

(i) Has developed or is at high risk for developing life threatening problems;

(ii) Requires constant intensive multidisciplinary assessment and intervention to restore stability and prevent complications; and

(iii) Needs restoration or maintenance of physiologic stability.

(b) "Interfacility specialty care transport" means the movement of a critically ill client by transport vehicle when the client's level of care requires the care of a RN during transport.

(c) On-Line Medical Direction.

(i) "On-line medical direction" means oversight and orders by licensed physicians at base stations to EMS providers or members of the transport team providing patient care at an Advanced Life Support (ALS) or Basic Life Support (BLS) level.

(ii) "On-line medical direction" includes medical orders and oversight by a licensed practitioner at a specialty care unit at a hospital to a RN during a specialty care transport, provided the licensed practitioner is permitted by the facility to provide these services and the services are within the scope of the individual's license.

(d) Licensed Practitioner.

(i) "Licensed practitioner" means a dentist, physician, RN practitioner, RN anesthetist, or RN midwife or any other individual permitted by law and the facility to provide care and services within the scope of the individual's license.

(ii) "Licensed practitioner" does not include a student in a graduate education program whose practice requires supervision and whose orders must be countersigned.

(e) “Specialty care transport” means transport for all ages of critically ill clients in accordance with the definitions under COMAR 30.09.01.02.

C. Practice Specialty Care Transport.

(1) Education, Training, and Experience Requirements. Except for the provisions under §C(2) and (4) of this regulation, a RN who provides interfacility specialty care transport shall meet the education, training, and experience requirements for staffing an interfacility specialty care transport mission in accordance with COMAR 30.09.14.02G(1)—(3).

(2) When a specialty care transport ambulance is not available within a clinically reasonable time, a RN who has not completed a program of study in accordance with COMAR 30.09.14.02G(1)—(3) for the transport of patients by ambulance can provide interfacility specialty care, if:

(a) The RN has education, training, and experience in the critical care area required by the mission as determined by the referring physician;

(b) The RN is accompanied by an individual who is currently licensed as a Maryland ALS provider, in accordance with COMAR 30.02.02, to support the RN with the transport; and

(c) On-line medical direction is available to the RN.

(3) A RN providing specialty care transport who does not have national certification for working with the client population to be transported shall have at least:

(a) 2 years of clinical nursing experience in critical or specialty care within the last 5 years;

(b) Age appropriate advanced life support training; and

(c) Nursing expertise in the specialty care area required by the client’s age and diagnosis.

(4) This regulation does not apply to, restrict, or limit:

(a) Other health care practitioners who are authorized to perform these duties under their respective laws; or

(b) A RN providing care to a critically ill patient during a declared natural disaster or emergency.

(5) A RN is prohibited from accepting a transport assignment that exceeds the RN's knowledge and expertise.

Effective date: February 20, 1989 (16:3 Md. R. 343)
Regulation .03 amended effective October 25, 1993 (20:21 Md. R. 1654)

Regulations .01—.03 repealed and new Regulations .01—.03 adopted effective April 3, 2000 (27:6 Md. R. 642)

Regulation .04 adopted effective March 17, 2014 (41:5 Md. R. 346)

Appendix B: Recruitment Flyer

Eligibility: RNs that have experience working in an Acute Care Inpatient Medical Center working with multidisciplinary care teams

Compensation: $5.00 gift card to Starbucks will be provided to every participant at the beginning of the interview process.

Study Name: The Role of the RN in Multidisciplinary Care Team

Study Type: This study will require an interview either in person or virtually via Skype for

Business or Facetime

Duration: Estimated 30 – 60 minutes. The interview includes nine open ended questions.

Abstract: A brief interview to explore the perceptions and experiences of RNs and their

role within a multidisciplinary care team.

Description: The purpose of this study is to explore and reveal the perceived nursing role, as

well as the scope of practice and utilization of the nursing role within the acute

care setting in a multidisciplinary team.

Researcher: Jessica Dempsey, RN, MSN

Appendix C: Guided Interview Protocol

This study is being conducted by a researcher named Jessica Dempsey, who is a doctoral student at Walden University.

Background Information:

The purpose of this study is to explore and reveal the perceived nursing role, as well as the scope of practice and utilization of the nursing role within the acute care setting in a multidisciplinary team.

Procedures:

- You will be asked to complete an interview in person or via Skype for Business.
- If necessary, you will be asked to clarify responses once transcribed.
- After transcription, you will be asked to review your responses and confirm that you consent for your information to be evaluated and analyzed.

Demographic Information

1. What acute care medical center(s) do you have experience with multidisciplinary care teams. (This information will be kept anonymous and separate from you name. The information is needed to confirm your qualifications in this study.)
2. How many years of experience do you have as a RN?
3. How many years have you experienced multidisciplinary care rounds?
4. What is the highest level of education you have received?
5. List previous careers, if any.
6. Age.
7. Marital Status.

8. Do you have any children?
9. Ethnicity.
10. What made you decided on nursing as a career path. Please be as honest as possible; if the salary is/was a factor please indicate it here.

Interview Questions

1. Describe whether you have participated in a multidisciplinary care team or observed peers participate in the multidisciplinary care team.
2. Describe your role as the RN within the multidisciplinary care team.
3. How do you feel your role and its responsibilities are perceived by the other members of the multidisciplinary care team?
4. Describe situations or scenarios that demonstrate how other roles utilize or perceive the nursing role within the multidisciplinary care team.
5. If different than your experience in a multidisciplinary care team, what do you think the role of the RN within the multidisciplinary care team should be, and why?
6. What experiences, situations, and/or events have shaped your perception of the utilization of nursing within the multidisciplinary care team?
7. Please describe if you have experienced feeling accountable for roles or tasks that were not within the responsibility of the RN and why (this question is not asking about tasks that are outside of the scope of practice, but specific to outside of the RNs' responsibility).

8. The accountability theory (Vance, Lowry, and Eggett, 2015) explained how one needs to rationalize one's behavior to another party and creates a feeling of accountability for how decisions, processes and judgements have been reached. Keeping the accountability theory in mind, how can it be applied to your overall scope of practice?

Appendix D: Coding Protocol

The analysis of the data begins when the researcher becomes wholly familiar with the information obtained (Given, 2008). Through an in-depth interview, the researcher will collect data by audio recording each participant's interview and subsequently transcribing. Once transcribed, the information will be entered into NVivo Qualitative Software to be organized into categories and themes (NVivo 10, 2018). These themes and categories will be created by coding the participants' information and attaching them to themes and categories as observed as nodes within NVivo Qualitative Software (NVivo 10, 2018). I will be completing open and axial coding within NVivo (Creswell, 2007).

Protocol

1. The Primary Nodes will be labeled as the Research Questions of the study.
2. The Secondary Nodes will be labeled as the interview questions that align with the specific research questions.
3. The Tertiary Nodes will be labeled to match the type of responses to the interview question beginning.

The Primary and Secondary Nodes are identified prior to data collection. I will not be able to identify the Tertiary Nodes until data is reviewed, and themes or patterns emerge.

Each transcribed interview will be reviewed line by line coding information relevant to the protocol as defined above.

References

Creswell, J. W. (2007). Qualitative inquiry & research design: Choosing among five approaches (2nd ed.). Thousand Oaks, CA: Sage Publications.

Given, L. (2008). Inter- and Intracoder Reliability. *The Sage Encyclopedia of Qualitative Research Methods.*

NVivo 10, QSR International. http://www.qsrinternational.com/nvivo/home. Accessed August 8, 2018.

Appendix E: Consent Form

You are invited to take part in a research study about identifying the experiences and self-perceptions of RNs. The researcher is inviting RNs who currently or previously participated in or observed RNs participate in multidisciplinary rounds at an acute care medical center to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Jessica Dempsey, who is a doctoral student at Walden University.

Background Information:

The purpose of this study is to explore and reveal the perceived nursing role, as well as the scope of practice and utilization of the nursing role within the acute care setting in a multidisciplinary team.

Procedures:

If you agree to be in this study, you will be asked to:

- You will be asked to provide a phone number or email to initiate communication and to schedule an interview time.
- You will be asked to complete an interview in person or via Skype for Business.
- If necessary, you will be asked to clarify responses once transcribed.
- After transcription you will be asked to review your responses and confirm that you consent for your information to be evaluated and analyzed.

Here are some sample questions:

- Explain whether you have participated in a multidisciplinary care team or observed peers participate in the multidisciplinary care team.
- Explain the role of the RN within the multidisciplinary care team as experienced by you or if you have observed peers participate in a multidisciplinary care team.
- How do you feel your role and its responsibilities are perceived by the other members of the multidisciplinary care team?
- Why do you think or with what experiences do you believe have given you the impression that other members of the multidisciplinary care team perceive that of the nursing role?

Voluntary Nature of the Study:

This study is voluntary. You are free to accept or turn down the invitation. No one at Walden University will treat you differently if you decide not to be in the study. If you decide to be in the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as the time sacrificed for the study. Being in this study would not pose a risk to your safety or wellbeing.

Though there are no direct benefits to participants, the benefits are to the larger community. The benefits may include a better understanding of how the RN is perceived within the multidisciplinary care team and may provide an indication for a future study to

build upon team roles and utilization. Optimally, the benefit will be to improve or enhance patient care and patient outcomes.

Payment:

There are no payments being provided. If participants share an address, a thank you note will be provided via postal service.

Privacy:

Reports coming out of this study will not share the identities of individual participants. Details that might identify participants, such as the location of the study, also will not be shared. The researcher will not use your personal information for any purpose outside of this research project. Data will be kept secure by password protection and use of codes in place of names. Names will be stored separately from data, also password protection. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:

You may ask any questions you have now. Or if you have questions later, you may contact the researcher via email at Jessica.Dempsey@waldenu.edu or phone number at 443-504-8492. If you want to talk privately about your rights as a participant, you can call the Research Participant Advocate at my university at 612-312-1210. Walden University's approval number for this study is **1220-18-0532281,** and it expires on **December 19th, 2019.**

Please print or save this consent form for your records.

Obtaining Your Consent

If you feel you understand the study well enough to make a decision about it, please indicate your consent by replying to this email with the words, “I consent.”

Printed Name of Participant ______________________________

Date of consent ______________________________

Appendix F: Participant Demographics Classification Sheet

	A	B	C	D	E	F	G	H	I	J
1	Part.	Children	Ethnicity	Gender	Generation	Highest LOE	Married	Nursing Years	MDCT Years	
2	1	No	Caucasian	Female	Gen Y	BSN	No	3-10 (Proficient)	2-3 (Competent)	
3	2	Yes	Caucasian	Female	Baby Boomers	BSN	Yes	10+ (Expert)	10+ (Expert)	
4	3	No	Caucasian	Female	Gen Y	MSN	No	3-10 (Proficient)	3-10 (Proficient)	
5	4	No	Caucasian	Female	Gen Y	BSN	Yes	3-10 (Proficient)	3-10 (Proficient)	
6	5	No	Asian	Male	Generation X	DNP*	No	3-10 (Proficient)	2-3 (Competent)	
7	6	No	Caucasian	Non-binary	Gen Y	BSN	Yes	1-2 (Advanced Begi	1-2 (Advanced Beginner)	
8	7	Yes	Black	Female	Baby Boomers	PhD*	Yes	10+ (Expert)	10+ (Expert)	
9	8	Yes	Caucasian	Female	Generation X	PhD*	Yes	10+ (Expert)	10+ (Expert)	
10	9	No	Asian	Female	Gen Y	BSN	No	3-10 (Proficient)	3-10 (Proficient)	
11	10	Yes	Caucasian	Female	Baby Boomers	ASN	Yes	10+ (Expert)	10+ (Expert)	
12	11	Yes	Caucasian	Female	Baby Boomers	MSN	Yes	10+ (Expert)	10+ (Expert)	
13	12	Yes	Caucasian	Female	Generation X	PhD*	Yes	10+ (Expert)	3-10 (Proficient)	
14	13	No	Caucasian	Female	Gen Y	BSN	No	3-10 (Proficient)	3-10 (Proficient)	
15	14	No	Caucasian	Female	Generation X	DNP*	No	10+ (Expert)	10+ (Expert)	
16	15	Yes	Caucasian	Female	Gen Y	DNP*	Yes	10+ (Expert)	10+ (Expert)	
17	16	Yes	Caucasian	Female	Generation X	BSN	No	10+ (Expert)	10+ (Expert)	
18	17	Yes	Caucasian	Female	Generation X	BSN	Yes	10+ (Expert)	3-10 (Proficient)	
19	18	No	Caucasian	Male	Gen Y	PhD*	No	10+ (Expert)	10+ (Expert)	
20	19	Yes	Caucasian	Female	Gen Y	DNP	Yes	10+ (Expert)	10+ (Expert)	
21	20	Yes	Caucasian	Female	Gen Y	MSN	Yes	10+ (Expert)	10+ (Expert)	
22	21	Yes	Caucasian	Female	Baby Boomers	MSN	No	10+ (Expert)	10+ (Expert)	
23	22	Yes	Black	Male	Generation X	PhD*	No	3-10 (Proficient)	3-10 (Proficient)	
24	23	Yes	Caucasian	Female	Generation X	BSN	No	10+ (Expert)	10+ (Expert)	
25	24	No	Caucasian	Female	Generation X	MSN	No	10+ (Expert)	10+ (Expert)	
26	25	Yes	Caucasian	Female	Gen Y	ASN	No	10+ (Expert)	10+ (Expert)	
27						* Candidate				
28										
29										
30										

Participant Demographics

Appendix G: Deidentified List of Participant Locations

Abingdon Hospital, PA Orthopedic

Barnes St. Louise Hospital, Utah, MICU

Beth Israel Deaconess Medical Center, MA,
RN Education

Bryn Mawr, PA Orthopedic

Fort Washington, Maryland, ICU

Franklin Square Hospital, MD, Telemetry

Hospital University, PA Ortho

Hospital University, PA, Lactation

Johns Hopkins Bayview, MD, Med Surge,
Educator, and Ass. Manager

Johns Hopkins Cardiology, MD, Cardiology

Johns Hopkins Children's Center, MD,
NICU

Johns Hopkins Hospital, MD, IMC

Lourdes, KY wound, med surge, and ER

Lutheran Medical Center, CO, ICU

Naval Hospital of Sigonella, Sicily Italy, ER

Our Lady of Lourdes, NJ, Med Surg

Paoli Hospital, PA, ER (2)

Psychiatry Hospital, GA, Med Surg

Scripps Mercy Hospital, CA

University of Maryland, MD, MICU

University of Maryland, MD, SICU

University of Utah, UT Med Surg, Flight

University of Utah, UT, Educator, Pediatrics

University of Utah, UT, ER, Med Surg

Appendix H: Coding Steps

1. Open Coding	2. Major Categories	3. Sub Categories to Major Categories	4.Sub-sub Categories to Major Categories	5. Selective Coding – Major Theme connecting micro to macro
Shift Assignment affecting MDR	RN involvement in MDR	1. Participated 2. Observed		Feeling accountable for everything due to closeness and round the clock care
The reason why participants entered the nursing career.	Role of the RN in MDR	1. Direct participation 2. Indirect participation	1a. Daily goal review 1b. Fact Checker 1c. Presents a holistic picture to the team	
Roles Utilized in MDR	Perception of the nursing role by team colleagues	1. Role needs improvement 2. team colleagues are appreciative		
Labels RNs identified with	Experiences shared demonstrating why team members perception existed	1. Expert 2. Fact Checker 3. Goal Planner 4. Physicians lack respect or value for the nursing role		
	Perception of how the role should be	1. Needs to change 2. Does not need to change	1a. Expert during rounds 1b. Flex to the needs of the team 1c. Leads rounds 2a. Participates in rounds as needed 2c. Presents Patient-leads	
	Experiences that led to why perception	1. Critical or life threatening 2. Closest to patient		

	or self-perceived role existed	3. Follow through on everything 4. Leading Rounds		
	Perception of accountability	1. Additional Roles Accountable for 2. General Accountability 2. No additional Roles	1a. Case Management 1b. Dietary/Nutrition 1c. Family Responsibility 1d. Hospital coordinator 1e. Housekeeping 1f. Social Work 1g. Maintenance 1h. Patient Care Technician 1i. Pharmacy 1j. Physician 1k. Respiratory 1l. Secretary 1m. Telemetry Staff 1n. Wound Care	
	Applying the lens of the accountability theory in practice	The theory is applicable to practice.		

Appendix I: Hierarchy Charts

RQ1

2. Role of Nurse
Direct Participation
Fact Checker _ Advocate
Daily Goals_Infectious Lines_VSS_Ins ...
Presents Ho...
Indirect P...
Began ...
1. MDR involvement
Participated
Both
Observed
Specific Roles Identified in MDR
Nurse
Physician
Case Man...
Pharmacist
Social Wo...
MDR teams
many disciplines
Primarily Doc and Nurse
Titles Nurses referred to themse...
Pat and Familyl Advocate
Fact Checker
Coordinator
Coraller
Center of Mu...
Shift Assignment
Rotated shifts
Day...
24_7 Presence

RQ2

3. How do you feel MRD was perceived
The Staff Are appreciative
Need Imptovement
Not utilized to ability
Neutral
4. examples of perceived role
expert
fact checker
phyisicans lack respect,value
goal planning
Specific Roles Identified in M...
Nurse
Charge Nurse
Social Worker
Case...
Physician
6. Experiences that shaped ...
Nurses are personal, closes...
Nurses Leading and Presen...
MDR teams
many disci...
5. If different...
Not Diffe...
24_7 Presence
Titles...
Jack...

RQ3

6. Experiences that shaped perception of nurse utilization in MDR
- Nurses are personal, closest to patient
- Nurses do everyth...
- Critical Responsiblii...
- Nurses Leading and Presenting Patient

5. If different than your experience... what should be the role of the nurse in MDR
- Different - Closest to Patient
  - Act as Expert during rounds or pati...
  - Lead Rounds
  - Flex to the nee...
- Not Different
  - Presents Patient
  - Participates...

4. examples of perceived ...
- expert
- goal planning
- phyis...

Specific Roles Identified ...
- Nurse
- Tech
- Physician
- Charge N...

24_7 Presence

MDR t...
- many...

RQ4

7. Experience with Accountbailty
Areas accountbale for
Physician
PCT
Pharmacy
Housekeeping
General
Respiratory
Does not feel...
Dietary_Nutri...
Insurance Correct...
Paying for...
Tele...
Secre...
Case Management
Hospital_Shift Coo...
Wound Care
Maintenance
Quotes
8. Accountabilty Theory Applies
Yes
24_7 Presence
Shift Assi...
Night ...