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Interdisciplinary Teams and Collaboration in a Long Term Care Facility

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INTERDISCIPLINARY TEAMS AND COLLABORATION IN A LONG TERM CARE FACILITY

by

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This thesis, submitted by Michelle Conley in partial fulfillment of the requirements for the Degree of Master of Science from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

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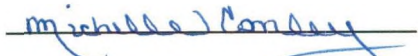
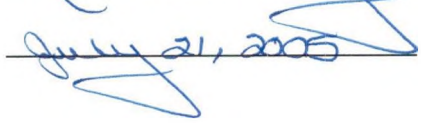
Signature 

Date 

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ABSTRACT

The purposes of this qualitative study were to discover what influences collaboration had on an interdisciplinary team practicing in a rural Midwestern long-term -care facility, to discover what factors influence collaboration, and to discover what barriers can hinder collaboration for the interdisciplinary team practicing in this facility. In this descriptive, qualitative study, eleven semi-structured in-depth interviews were completed, and a constant comparative method of data analysis was used.

The categories that emerged from the data analysis were (a) chronic health conditions, (b) collaboration, (c) communication, (d) expectations, (e) influences that enhance collaboration, and (f) influences that are barriers to collaboration. Influences that enhance collaboration fell into the following subcategories: (a) communion (sharing), (b) community (connectedness), (c) independence, (d) problem-solving, (e) responsibility, and (f) synergism. Barriers to collaboration had eight subcategories: (a) unresolved factors, (b) feelings of isolation, (c) interrelationships, (d) lack of understanding, (e) minimum data set (MDS) and Medicare, (f) physician's role, (g) unmet expectations, and (h) end-of-life. Themes related to the categories were then discussed.

Collaboration is an important and significant factor in a nurse practitioner's role. Effective collaboration can enhance the knowledge and skills of a nurse practitioner and

enhance the relationship of the nurse practitioner with all members of the interdisciplinary team, including the patient.

CHAPTER I

INTRODUCTION

The nurse practitioner's (NP's) practice is influenced by the NP's ability to collaborate with other members of an interdisciplinary team; that is, the NP's practice is influenced by how the NP works with others to achieve a common goal. A collaborative relationship can allow for an interchange of ideas which can assist the nurse practitioner in resolving problems. Collaboration can encourage networking and problem solving and generate support from interdisciplinary team members (ITMs) and colleagues.

However, little is understood regarding collaboration and the impact it has on the nurse practitioner's practice. Much of the information and knowledge obtained while attending nursing education programs will be outdated in three to five years. Thus, accessing needed information for practice issues can be challenging. Nurse practitioners need current information for quality patient care, policy writing, patient education, and research.

When the nurse practitioner recognizes limitations of his/her knowledge, experience, and time constraints, collaboration can be used to increase the experience of the nurse practitioner. Collaboration with other members of the interdisciplinary team can increase the team members' knowledge and experience to effectively enhance patient outcomes. The success of the nurse practitioner rests in the ability to demonstrate proficient clinical decision-making skills, assume accountability for his/her actions, and

work in an autonomous yet collaborative manner, while providing the best care possible to patients (Rudy et al., 1998).

Problem

The ability to work with others to achieve a common goal is an important aspect when working on the interdisciplinary health care team. ITMs do not always collaborate. Certain patient care decisions can be difficult. Patient outcomes can be affected by the decisions. The functioning of the interdisciplinary health care team can be improved by effective collaboration that provides the opportunity for dialogue among members of the interdisciplinary team.

Developing a collaborative relationship with other members of the interdisciplinary health care team can enhance the clinical decision-making of the nurse practitioner. Enhancement of nurse practitioner's decision-making will facilitate the achievement of optimal patient outcomes. Thus, collaboration is an important and significant entity in the nurse practitioner's role.

Health care costs can also rise when collaboration is not successfully utilized by ITMs. Additional research is needed with interdisciplinary health care team models regarding their impact on collaboration related to team functions and patient outcomes (Phillips, Harper, Wakefield, Green, & Fryer, 2002; Zwarenstein & Bryant, 2003; Zwarenstein, Stephenson, & Johnston, 2003).

Significance of the Study

Effective collaboration can enhance the interaction of knowledge and skills of the nurse practitioner. It can also impact the nurse practitioner's relationship with all members of the interdisciplinary team, resulting in and synergistically influencing patient

care. Collaboration is an under recognized, under utilized resource for the nurse practitioner.

In an effective collaborative practice, physicians and nurse practitioners "let go" of past differences to enhance collaboration in their practice (Baggs, Norton, Schmitt, & Sellers, 2004; Fontaine, 2003). By understanding collaboration and how to cognitively interact in the process of collaboration, the nurse practitioner can enhance utilization of colleagues and thus decision-making of the interdisciplinary team.

Purpose of the Study

The purpose of the study was to examine collaboration in an interdisciplinary team functioning in a rural midwestern long-term-care (LTC) facility. Specifically, this study examined the role of the nurse practitioner and collaboration within the interdisciplinary team.

The benefits of this study to society are an increased understanding regarding the impact of collaboration in the work setting and, possibly, planning effective interventions to increase collaboration. Such interventions could increase collaboration and thereby increase teamwork, cost containment, and patient outcomes.

Conceptual Framework: Synergy Model

In 1998, the Synergy model was developed by the certification board of the American Association of Critical Care Nurses (AACN) to explain critical care nursing practice. An explanation of what nursing does and its relationship with patients and families was needed to demonstrate what effect nursing practice has on patient outcomes. The model describes how patient needs drive a nurse's characteristics. When the two are

in synchrony, optimal patient outcomes result. The model describes the nurse-patient, nurse-nurse, and nurse-system relationships.

This model is important for today's health care delivery systems. Nurses need to be intelligent, competent, and caring. These evolving relationships (nurse, patient and health care system) are interdependent and intersubjective, each coming to know the other. When this relationship is coordinated, it is then synergistic and likely to lead to optimal patient outcomes. The Synergy Model allows for the description of nursing competence and for new practice and care delivery.

The Synergy Model describes how synergy between patients' characteristics and nurses' competencies optimize patient outcomes (American Association of Critical Care Nurses, 2004). With the advanced practice nurse (APN), this model can be used in different patient-nurse situations and is applicable across the patient's life span. The model describes personal characteristics that each patient can bring to a health care situation. The nurse assists the patient and family towards self-awareness, self-understanding, and competence in their health, through managing stressful events and a peaceful death. The whole person is considered as body, mind, and spirit. When patient characteristics and nurse competencies match and synergize, optimal patient outcomes result (American Association of Critical Care Nurses, 2004; Sigma Theta Tau International, 2004).

Synergy Model (Nurse)

When nurse-patient interaction occurs, each of their respective eight dimensions is affected. The nurse's dimensions are clinical judgment, clinical inquiry, caring practices, response to diversity, advocacy, facilities of learning, collaboration, and

systems thinking. The patient's dimensions are stability, complexity, vulnerability, resiliency, predictability, resource availability, participation in decision- making, and participation in care (American Association of Critical Care Nurses, 2004; Collopy, 1999; Czerwinski, Blastic, & Rice, 1999; Doble, Curley, Hession-Laband, Marino, & Shaw, 2000; Ecklund & Stamps, 2002; Hartigan, 2000; Moloney-Harmon, 1999; Pope, 2002; Saunderson Cohen, Crego, Cuming, & Smyth, 2002; Sigma Theta Tau International, 2004; Small, 1999). The patient, family, and community's developmental stage and biological, psychological, social, and spiritual characteristics are included in patient and nurse dimensions. The eight nurse dimensions in this model have a higher or lower degree of priority for each patient. The degree of priority changes along eight continuums over time, depending on the strength or weakness of each patient along each of the patient's dimensions. This model believes that patients' needs drive nurse priorities along each of the nurses' eight dimensions (or eight continuums).

The goal of this model is to restore the patient to an optimal level of wellness, defined by the patient and family. Death can be an outcome. The nurse-patient relationships are interdependent and intersubjective. When this relationship is coordinated, it is then synergistic and likely to lead to optimal patient outcomes.

While Benner's (2001) novice to expert nursing framework describes the "how" of nursing practice, the Synergy model, describes the "what" of nursing practice. APNs, clinical nurse specialist (CNS) or nurse practitioner (NP), from competent to expert, is considered in this model (Sigma Theta Tau International, 2004).

The eight nurse dimensions for the APN are the same as for the nurse, but are applied to responsibility to nursing staff, patient populations, and to the health care

system. The APN participates at an increased level in unit decision-making, care issues, and finding resources available for the nursing staff.

The nurse approaches the care of each patient differently. Caring practices are a collection of nursing activities that are responsive to the uniqueness of the patient and family, creating a compassionate and therapeutic environment with the aim of promoting comfort and preventing suffering (Hartigan, 2000; Moloney-Harmon, 1999; Rohde & Moloney-Harmon, 2001).

The importance of the APN in ensuring positive patient outcomes through the delivery of care is why the Synergy Model applies to this study. The competencies of the nurse reflect an integration of knowledge and skills, experience and attitudes, and the nurse's desire to meet the needs of the patient in optimizing their outcomes (Ecklund & Stamps, 2002). Competence in all these areas is necessary. Nurses with sub-specialties develop expertise within each area based on the needs of the typical patient population. The eight characteristics of the nurse are:

Clinical judgment - the ability to assess situations and draw sound conclusions is not dependent on years of experience, but experience gained from learning and applying knowledge gained from each similar experience (Ecklund & Stamps, 2002; Saunderson Cohen et al., 2002).

Clinical inquiry - evaluating and informing practice, creating practice changes through evidence based practice, finding the evidence, making practice changes, and utilizing research and experiential knowledge. The APN questions practice and searches for alternatives. The expert nurse builds changes in practice based on data.

Caring practices - activities that are responsive to the uniqueness of the patient and/or family which promote comfort and healing and prevent suffering.

Response to diversity - the nurse incorporates differences in care based on the sensitivity, individuality, culture, gender, race, ethnicity, family structure, lifestyle, socioeconomic status, spirituality, age, and values of the patient/family (Saunderson Cohen et al., 2002). The APN would inquire and consider how the above components impact care. The expert nurse would change the environment to meet the diverse needs of the patient and family.

Advocacy/moral agency - the process of the nurse working on the behalf of the patient and or family by serving as a moral agent. They help to resolve ethical and clinical problems (Saunderson Cohen et al., 2002).

Facilities of learning - patient, family, and staff learn from the nurse by using mentoring, and team development. The nurse takes responsibility for mentoring the next group of nurses and members of the interdisciplinary team (Saunderson Cohen et al., 2002).

Collaboration - the nurse works with patients, families, intra-disciplinary and inter-disciplinary team members, colleagues, and the community to promote optimal and realistic patient/family or unit/program goals. Collaboration involves the process of resolving conflict and negotiating, creating a caring environment, and acting in the best interest of the patient and family. Collaboration is essential to all levels of practice (Kaplow, 2003; Saunderson Cohen et al., 2002).

Systems thinking - the inter-relationships and intra-relationships that exist in the health care setting which allows the nurse to manage internal and external resources that support the patient's and family's care environment (Saunderson Cohen et al., 2002).

In competent nurses, thinking operates on a micro level. Expert nurses however, operate on a macro level, applying their strategies to facilitate change within the complex health care systems (Collopy, 1999; Czerwinski et al., 1999; Doble et al., 2000; Edwards, 1999; Hartigan, 2000; Moloney-Harmon, 1999; Pope, 2002; Rohde, & Moloney-Harmon, 2001; Small, 1999; Stannard, 1999).

Rohde and Moloney-Harmon (2001) described a condition of advocacy and moral agency, conforming to standards of what is right or just in behavior, where nurses work on another's behalf and represent the concerns of the patients, their families and community. Moral agency requires "knowing the patient" which creates trust that is basic to the nurse-patient relationship. This assists nurses in exploring their practice and developing organizational strategies that are driven by the needs of patients, families, and the interdisciplinary health care team.

Synergy Model (Patient)

In the Synergy model, the patients and their families are encouraged to be active participants in the patient/family/nurse interaction. Each patient has a unique environment, affecting the type of nursing care required. When care is tailored to fit the patient's needs, it will contribute to the patient's perception of being cared for.

As stated previously, patient characteristics are stability, complexity, vulnerability, resiliency, predictability, resource availability, participation in decision-making, and participation in care. These eight characteristics have changed to include

compensation, margin of error, risk of death, independence, self-determination, and engagement (Sigma Theta Tau International, 2004).

Stability - can be physiological, psychological, emotional, family, or social.

Complexity - can include multiple systems and therapies, body systems, family system, social system, and/or therapeutic interventions.

Vulnerability - considers the patient's risk, the assessment of an exposed patient's susceptibility to the effects of a particular hazard. Patients are susceptible to stress that can adversely affect patient outcomes.

Resiliency - the ability of the patient to return to a restorative level of functioning. As the patient participates in decision-making, they return to a stable state of health using compensatory and coping mechanisms.

Predictability - an illness has a usual course of events. Some patients do not respond in a typical sequence to events.

Resource availability – what the patient, family, and community can use or bring to the patient. This may include personal, physiological, social, technical, and financial resources.

Participation in decision-making - the patient/family assists in decision-making, engaging their capacity, desire, and level of decision-making. The level of decision-making involvement varies within the health care environment.

Participation in care - the patient/family assists in care activities. Their capacity, desire, and level of participation can vary. The nurse provides or assists the patient/family when giving care (Collopy, 1999; Czerwinski et al., 1999; Doble et al.,

2000; Hartigan, 2000; Moloney-Harmon, 1999; Pope, 2002; Rohde, & Moloney-Harmon, 2001; Small, 1999; Sigma Theta Tau International, 2004).

Synergy Model (Health Care System)

The health care system within the Synergy Model also has specific characteristics of stability, complexity, vulnerability, predictability, and resiliency. Each characteristic is considered by how it typically affects decision-making, issues related to patient care, and resources. The patient/nurse reciprocal knowing depends on the organization's attention to the model of care delivery, providing for continuity of care, allowing time for the nurse to spend with the patient and family.

This model takes into account not only the needs of the patients and families, but also those of the health care providers and the organization. The nurse practitioner can plan, effectively implement, and evaluate interventions appropriate to the complexity of the problems and resources of the system, showing clinical judgment and expertise. With the ever-changing health care system and challenging reimbursement systems, this would help with the aging population and the need to contain costs.

Synergy Model (Outcomes)

Outcomes need to be relevant to the patient and family. Optimal patient outcomes are a shared reponsibility between all members of the interdisciplinary team, individual patients, individual nurses, and health care systems. Outcomes can be patient, system, or population based. They may be long-term or short-term; with measurements being strategic in timing and importance (Sigma Theta Tau International, 2004).

The systems level may have recidivism, health care costs, and resource utilization. Patient outcomes include the patient's experiences in health and illness. The unique

APN's relationship with the patient and family can contribute to optimal patient outcomes.

> As the clinical nurse specialist role changes and the acute care nurse practitioner role emerge, it is imperative that advanced practice nurses describe their contribution to health care. Associating advanced practice nursing activities with outcomes will help further characterize these two advanced practice roles (Mick & Ackerman, 2000, p.210).

The importance of the APN in ensuring positive patient outcomes through the delivery of care is why the Synergy Model applies to this study. Researchers are providing evidence to support the role of the APN. The care delivery systems and the contributions of each nurse are influenced by the work environment and the resources available.

Collaborative relationships increase the APN's status and must be supported by administration and physicians. The collaborative exchange of information allows for an increase in skill enhancement. Having a collaborative relationship can enhance competency in taking care of a range of deviations of patients.

When collaborative relationships are formed, the experience and knowledge of the nurse practitioner will be enhanced, facilitating the nurse practitioner's advancement into an expert practitioner. "A limitation of both nursing process and decision analysis is that the task difficulty, relative importance, relational aspects, and outcomes of the skilled practice are not adequately captured without including the context, intentions and interpretations of the skilled practice" (Benner, 2001, p. 38).

The nurse practitioner's practice is influenced by the ability to collaborate with other members of the interdisciplinary team, supporting and enhancing their clinical decisions. This type of relationship allows for an interchange of ideas and resolution of

problems. Collaboration encourages networking, problem solving, and the generation of support from ITMs and colleagues. Huerta (2003) felt that "magnet forces" enabled a nurse to move more quickly from novice to expert when the organization fostered autonomy, professional growth, collaboration, and commitment to quality improvement.

Research Questions

The research questions for this study were:

1. What influences does collaboration have for an interdisciplinary team practicing in a rural Midwestern nursing home practice?
2. What are the barriers that hinder collaboration for an interdisciplinary team in a rural midwestern nursing home practice?

Definitions

The definitions that were used in this study include:

Barriers – a real or perceived obstacle that prevents something from occurring.

Collaboration – working with others including physicians, families, and other health care providers in a way that promotes and encourages each person's contributions toward achieving optimal, realistic patient goals. It involves intra- and inter-disciplinary work with colleagues (Kaplow, 2003) and joint decision-making with the goal that patient's wellness and illness needs are met, while respecting the unique qualities and abilites of each professional (Henneman, Lee, & Cohen, 1995).

Hinder – "to get in the way of someone or something, to make something difficult" (Lebaron & Lebaron, 2002, p. 212).

Influence – "to cause changes or have an effect on someone without using direct force" (Lebaron & Lebaron, 2002, p. 149). "A power affecting a person, thing, or course

of events, especially one that operates without any direct or apparent effort (Dictionary .com, 2005).

Interdisciplinary Team – a group of professionals working closely together towards a common purpose, establishing common goals and working towards assisting the patient in achieving their goals, a variety of disciplines may be represented with leadership varying according to situational needs (Roberts, 2000).

Nurse Practitioner – a registered nurse with a Master's degree and clinical expertise experience in the assessment, diagnosis, pharmacological and non-pharmacological treatment, and prevention of disease. The nurse practitioner's practice is regulated under the nursing licensure provisions of individual state nurse practice acts (Kaplow, 2003).

Long-Term-Care Facility – an agency that provides rehabilitative, restorative, and ongoing skilled nursing care to patients in need of assistance with activities of daily living. These can include nursing homes, rehabilitation facilities, inpatient behavioral health facilites and long-term chronic care hospitals (MedicineNet.com, 2003).

Midwestern - regions in the north central United States including areas around the Great Lakes, upper Mississippi Valley from Ohio, Kentucky, North Dakota, South Dakota, Nebraska, and Kansas.

Nursing Home Practice – providing services to residents and for residents such as nursing services, social services, food services, medical services, therapeutic recreational and activity programs, medical records services, pharmaceutical services, and rehabilitation programs.

Rural – areas that have low populations and the people have to travel distances for health care services.

Assumptions

For this study the following assumptions were made:

1. The nurse practitioner and ITMs will have an interest in and knowledge about the functions and workings of their interdisciplinary team.
2. The nurse practitioner, ITMs, and patients will provide their own honest thoughts, beliefs, and creative ideas regarding collaboration in their answers and assessments of their practices.

Limitations

For this study the following limitations were noted:

1. The study setting is rural, and findings related to this interdisciplinary team may not be applicable to urban settings.
2. Study participants may not openly disclose their thoughts and feelings about their team and its functioning.
3. The sample is small and purposive, and findings of this project are not generalizable to other teams where nurse practitioners are members.

CHAPTER II

REVIEW AND CRITIQUE OF RELATED STUDIES

This chapter will review past studies and findings that have been performed using nurses, nurse practitioners, physicians, and teams. Concepts of communication, networking, technology, patient outcomes, cost effectiveness, and the impacts on the heath care system and their relationship with collaboration will be explored.

Collaboration is a skill that is fundamental to every discipline in health care. To collaborate is to work together, acting jointly, cooperatively, and conspiring with one another (Roberts, 2000). Collaboration consists of mutual problem solving, task interdependence, shared record keeping, and accountability (Chaboyer & Patterson, 2001; Kuebler & Bruera, 2000). Professional collaboration is an important factor in improving quality and access to health care (Hamric, Spross, & Hanson, 2000; Lucena & Lesage, 2002; Roberts, 2000). Roberts (2000) defines collaboration as:

> An interpersonal process in which two or more individuals make a commitment to interact constructively to solve problems and accomplish identified goals, purposes, or outcomes. The individuals recognize and articulate the shared values that make this commitment possible. The definition implies shared values, commitment, and goals and yet allows for differences in opinions and approaches (p. 4).

Collaboration has been an elusive goal for many nurse practitioners (Hillier, 2001; Kleinpell, 1997; Whitcomb et al., 2002; Zwarenstein & Bryant, 2003). Communication games between nurse practitioners and physicians have delayed the development of

collaborative relationships (Coombs, 2003; Fagin, 1992; Larsen, 1999; Larson, Hamilton, Mitchell, & Eisenberg, 1998; Stichler, 1995).

Nurse Practitioner

Support or lack of support from other members of the interdisciplinary health care team and by administrators, physicians, and other nurses is a major influence for the successful performance of the nurse practitioner (Hupcey, 1993; Orme & Maggs, 1993). For the nurse practitioner, collaboration develops between them and another member of the interdisciplinary team. The nurse practitioner approaches the person for advice or information without feeling threatened or intimidated.

Collaboration can assist the nurse practitioner in differential nursing diagnosis. For example, if a patient presents with vague symptoms or is not amendable to treatment, the nurse practitioner can consult with another member of the interdisciplinary team to develop additional ideas on how to promote optimal patient outcomes. In this way, other disciplines are utilized for collaboration and assist in differential nursing diagnosis.

Nurses and Physicians

Collaboration allows both nurses and physicians to state their needs and resolve their problems (Saunderson Cohen et al., 2002). Thomson (1995) reported that there are certain specialties where nurses and physicians must work closely, making these areas most suited to begin the development of nurse/physician collaborative practice.

It has been reported in the literature that the nurse-physician relationship is the reason nurses and physicians are not working collaboratively (Coombs, 2003; Fagin, 1992; Larson et al., 1998; Lassen, Fosbinder, Minton, & Robins, 1997). A closer relationship between nurses and physicians may lead to improved patient care and protect

the best interests of patients, improving their ability to achieve patient well-being (Gianakos, 1997).

In 1985, Weiss and Davis found that nurses were not prepared for collaborative practice and had difficulty functioning in a collegial capacity. The Collaborative Practice Scales Survey was given to nurses and physicians. Five modes of interpersonal problem solving behaviors, avoidance, accommodation, compromise, competition, or collaboration, were measured. The reliability and validity of their collaborative practice scales was demonstrated. The discriminate validity of the instrument was $p<.001$; the reliability had an alpha coefficient of 0.82 and test-retest correlation of 0.77. The Collaborative Practice Scale was found to be an efficient method to determine the differences in interaction between nurses and physicians and the impact of collaboration on the delivery and outcome of care. The study found that nurses viewed physicians as more collaborative and physicians rated nurses as less collaborative.

Jenks (1993) used naturalistic inquiry to do a descriptive field study of 23 nurses in a 700 bed hospital. Jenks sought to explore the clinical decision-making of nurses by using focus groups and stories. Jenks found that enhanced interpersonal relationships decreased the nurse practitioners' conflicts with physicians. The nurses' perceptions and observations were respected by physicians, supporting the nurses' decision-making. The relationship between nurses and physicians was strained when nurses relied on intuition to guide their decisions. The physicians preferred to have a rational theoretical answer to why something was warranted or performed.

Patronis Jones (1994) studied nurse/physician collaboration with 59 nurses and 67 physicians through a random survey. Collaboration was measured using an adapted

Weiss and Davis Collaborative Practice Scale and consisted of indicators including power-control, practice spheres, concerns, and patient goals.

Power controls and concerns were the same between the groups; both groups were inconsistent in their perceptions of practice and goals. However, physicians perceived that they initiated a greater number of communications than nurses. Nurses and physicians in a demographic group who classified a goal or sphere as "nurse" or "physician" were considered less collaborative.

Studies have been done regarding nurse/physician collaborative practice. Thomson (1995), by questionnaire, studied physicians' perceptions of the nurse/physician collaborative practice. Neither nurses nor physicians reported high collaborative behavior, but nurses appeared to have higher perceptions of collaboration with the physicians.

Henneman (1995) explored the impact of nurses' knowledge in relationship to knowledge/power and its impact on nurse/physician collaboration. Barriers to collaboration were identified for nursing but not medicine, implying that work needing to be done within the nursing profession before collaboration could begin with physicians. According to these authors, much work needs to be done between the disciplines.

Most studies have been done using intensive care units. In a medical intensive care unit (MICU), Baggs and Schmitt (1997), interviewed 10 intensive care nurses and 10 medical residents regarding their perceptions of collaboration. Collaboration meant being available, being receptive, working together, and doing a better job. The major outcomes of collaborating were improved patient care and controlled costs. Both nurses and medical residents in intensive care units understood collaboration in the same way.

The differences in their interpretations of the same event might have them label interactions as less or more collaborative. Baggs et al. (2004) found core team members of physicians, nurses and patient/family members enhanced interdisciplinary collaboration. This improved care also enhanced the outcomes of the dying patient.

Keenan, Cooke, and Hillis (1998) studied the keys to understanding nurse/physician collaboration by having nurses in 36 emergency departments complete a version of the Organizational Culture Inventory and respond to vignettes. From the vignettes, collaboration was the most agreed upon strategy for managing conflicts. From the analysis of the inventory, the nurses' strongest "conflict style" was in collaborating, obliging, and compromising. The "conflict style" nurses reported physicians as having been in being self-orientated or dominating. The nurses had intentions to collaborate, but conflicts were not conducive to nurse/physician collaboration. The major impediment to collaboration in this study was power struggles between the two professions.

With qualitative methods, Shuval (2002) studied the social situations in which complementary and conventional health care providers interacted by using four outpatient clinics in Israel. Interviews with 14 physicians and nurses working collaboratively with a variety of alternative health care specialists were done. Boundary and authority issues, authority and control issues, the relationships between practitioners, and their motivation patterns were explored. Shuval found that while physicians did collaborate with the qualified complementary practitioners in assuring quality care there was a strong pressure for conventional medical dominance in decision-making. The health care provider's proximity to the collaborating physician was also cited as a factor in the success of collaboration.

In three types of hospitals, the method of transferring patients was explored. Four hundred seventy three, 465, and 494 patients were moved out of critical care units onto a regular floor. Using questionnaires, Baggs, Schmitt, Eldredge, Oakes, and Hutson (1997) studied collaborative practice in the team environment, comparing levels of collaboration and satisfaction with decision-making processes by 150 critical care nurses, 74 residents, and 82 attending physicians. Nurse and resident perceptions and interactions during the transport process of patients from an intensive care unit (ICU) to a floor were assessed. Nurses reported less satisfaction with decision-making than the physicians, and collaboration was related to satisfaction with decision-making for all providers. Collaboration was a more important component of satisfaction with decision-making for nurses than for physicians.

Hojat et al. (1997) studied attitudes about collaboration by having 408 medical students and 149 nursing students complete a questionnaire. The reliability and validity of the original version of the questionnaire was alpha coefficient 0.84. Hojat et al. (1997) revised the questionnaire before completing the survey. Believing collaboration should start from day one, students reported collaboration should control costs, expand services to the underserved, and improve quality of care by using problem solving techniques to reach common goals. The medical students held the traditional view of physician authority and responsibility.

Chaboyer and Paterson (2001) investigated nurse perceptions of collaboration. Critical care nurses and general nurses were surveyed on how they perceived collaboration with physicians. Their findings supported other researchers; critical care nurses have greater collaboration with physicians than generalist nurses, even after

education and experience were taken into consideration. Chaboyer and Paterson (2001) felt critical care units would be areas to use for study to assist with understanding collaborative practice.

Coombs' (2003) ethnographic study found role definitions and power bases continue to exist. This study explored the decision-making between physicians and nurses in three ICUs. Over 14 months, 3 sites, 18 ethnographic interviews, 62 documents, and over 2000 hours of participant observation occurred in the analysis of this study. The findings indicate the nursing role has changed, but not in terms of how they make clinical decisions.

Mortality rates may be affected by collaboration. It has been proposed that mortality rates in the ICUs differ based on communication between nurses and physicians (Dracup & Bryan-Brown, 2003; Fagin 1992). Fagin discusses the importance of collaboration and coordination between nurses and physicians in contributing to lower mortality rates. Fagin's (1992) comments describe collaboration, why it should be promoted, barriers that exist, and strategies to promote change to enhance collaboration. Neither nurses nor physicians can function without the other; thus, they need to move to a broader, more shared perspective. Barriers between nurses and physicians have included (a).tension at the bedside between physicians and nurses; (b).slight differences in education, jurisdictions, practice, and territory for the two professions; (c). social class differences, nurses' dissatisfaction, sex role stereotypes; and (d) nursing actions that are not seen by the public, patient, or family - invisibility of the nurse's hands-on care. Strategies to improve collaboration include restructuring educational programs, new methods of issue resolution in the practice arenas, and organizational change. In

addition, faculty involvement in patient care should extend to collaborative practice and education.

In Kramer's study (2003), 279 nurses from magnet hospitals were interviewed. Results indicated nurses had less then a good relationship with physicians. One-fourth to one-third of the nurses reported having negative nurse/physician relationships. Inexperienced nurses had less of a relationship with physicians than ER or critical care nurses. Nurses felt knowledgeable, put the patient first, and knew the patients' response better than the physicians. Kramer concluded that the nurses' knowledge is different, but just as important as the physician's. Nurses felt they had little control over practice with physicians dictating everything. This was especially true when there was a new group of physicians.

Length of stay, costs per patient stay, and in-hospital mortality were less when there was better collaboration between nurses and physicians according to Zwarenstein and Bryant (2003). In their study involving 1945 people, interventions to promote collaboration between nurses and physicians were investigated. They found better collaboration improves patient care and staff satisfaction while lowering costs. Poor communication and unsatisfactory work practices produce conflict and less efficient patient care. Further research was recommended to identify the barriers to collaboration. They suggested that further studies should include multi-center studies directed at increasing collaboration and improving patient outcomes. The authors felt different types of interventions could enhance collaboration. These interventions could include (a) coordination of patient care, (b).smaller patient units, (c).patient centered care efforts, and

(d) team building workshops and training workshops in collaboration and communication skills.

Research by Spilsburgy and Meyer (2001) suggested that the roles of nursing need to be changed in new ways to make better use of the nurses' knowledge and skill mix. This would result in reduced lengths of stay, mortality, costs, and complications and increased patient satisfaction, patient recovery rate, quality of life, patient knowledge, and compliance. Communication gaps between nurses and physicians have impeded the development of the collaborative relationship (Campion, 1998; Crotty, 1998; Rice, 2000).

Nurse Practitioners and Physicians

A nurse practitioner's management style is interactive and inclusive of both patients and interdisciplinary team members (ITMs) (Cullen, 2000). A clear definition of the nurse practitioner role is difficult to describe. The work varies according to the health care needs of the population they serve (Maclaine, 1998; Torn, & McNichol, 1998).

The purpose of Kleinpell's (1997) study was to explore the acute-care nurse practitioner (ACNP) roles and practice profiles. The first NP certification exam was December of 1995. The study was conducted in January 1996. Of the 136 surveys, 126 were returned. Roles were identified as specialty based (23%), unit based (23%), or collaborative practice (31%). The key element of the acute-care nurse practitioner (ACNP) role varied depending on the setting and specific patient population. Collaboration was viewed as an essential element for success of the ACNP.

Six nurse practitioner/physician teams practicing in three primary care settings were interviewed by Lamb and Napodano (1984). They examined the problem-solving and collaborative efforts of primary care teams. They found little interaction between

practitioners and minimal physician-initiated exchange of information. Independent practice with occasional consultation and referral occurred with collaboration between members of the team being rare.

Norsen, Opladen, and Quinn (1995) discussed collaborative practice and the characteristics of the advanced-practice nurse (APN) in a collaborative practice. The critical attributes of collaborative practice are skills that require professional maturity, self-confidence, and motivation associated with graduate education. Flexibility and the ability to work in ambiguous situations are important to the collaborative practice. Many skills and competencies are shared between the physician and the APN.

According to Vance (2002), APNs felt challenged and opposed by medicine and were perceived as second-class health care providers. An e-mail survey explored the incidence of the imposter phenomenon in nurse practitioner students. The imposter phenomenon is often experienced by women in highly professional roles and is defined as a feeling of intellectual phoniness. People afflicted with this phenomenon often feel as if their accomplishments are due to luck or faulty test scores, even though they may have extensive documented successes to their credit. They feel they are not as intelligent as their peers give them credit for. Relationships between high imposter scores and role expectations, prior experiences, academic achievements, age, and level of family support existed. The imposter phenomenon was thought to be linked with new roles and experiences. Vance implied this would interfere with the collaborative process between the nurse and physician, with the APNs continually needing to have unrealistic achievement standards to prove their worth to the health care system.

In Stubblefield, Houston, and Haire-Joshu (1994), models of health-related behavior were used to promote interdisciplinary collaboration. Interactions focused on effective understanding of the roles of the different disciplines. Respect and value for the input of the other discipline in the decision-making process is essential to successful interdisciplinary collaboration. In their study, Stubblefield et al. (1994) showed a need for continued focus on the development and evaluation of teaching nurse practitioners' strategies to foster positive attitudes toward interdisciplinary collaboration.

Several studies have examined barriers to collaboration. Maclaine (1998) and Kleinpell (2003) felt barriers existed to measure outcomes of APN care. Through interviews, the value of collaboration was explored by Azzi (1998) in the nurse/physician collaborative practice. Communication, competence, and trust were key attributes mentioned in the study. Barriers which prevent collaboration between physicians and nurse practitioners were economic barriers, knowledge deficit, lack of collegial support, lack of autonomy, and the traditional hierarchy.

Campion (1998) felt successful collaboration depended on the nurse and physician finding a comfort level with the APN's level of autonomy determined between the professions. There is a need to educate each other on their practices. The obstacles to this relationship include unrealistic expectations, failing to follow a standard of practice, and the different practice styles.

Pan, Straub, and Geller (1997) analyzed 1738 nurse practitioners and the impact of certain variables on the nurse practitioners' practice environment and level of autonomy. The preference of the collaborating physician often determined the role the nurse practitioner had in patient care, and affected the level of autonomy. Those

affiliated with a physician on-site had more authority than those with a physician through telecommunication.

In the same study, Pan et al. (1997) found quality of care and patient outcomes were similar between a nurse practitioner and a physician, while costs for the same services were lower when given by a nurse practitioner. Similar results were found with Mundinger et al. (2000). In ambulatory care situations, patient outcomes were comparable between nurse practitioner and physician.

Rudy et al. (1998) found that among acute care nurse practitioners, physician assistants, and resident physicians, patient outcomes did not differ. The nurse practitioners and physician assistants were more likely than the residents to discuss and interact with patients and families. The care given by nurse practitioners was felt to be equivalent to that of physicians (Mundinger et al., 2000; Rudy et al., 1998). All three professions needed to work in a collaborative manner in providing the best care to the patients (Rudy et al., 1998).

Rural and urban nurse practitioners were studied by Sand (2000). Rural nurse practitioners felt less respect from collaborating physicians than urban nurse practitioners. For urban nurses, this was attributed to the ease of contact or accessibility of the collaborating physician, while rural nurses felt the need to prove themselves to other physicians and administration constantly.

Hillier (2001) did a cross-sectional descriptive study of 32 nurse practitioners' and clinical nurse specialists' roles in gastroenterology. The purpose of the study was to monitor activities of care provided by APNs to validate their use as cost effective health care providers. The results supported both the collaborative nature of the role and

entrepreneurial aspect of the APN. One of the recommendations from this study was increased support for the APN role from physicians, administration, and state boards of nursing. Hillier stated that APN care in collaborative partnerships would help build a knowledge base for payers, providers, and consumers when selecting health care providers.

Howie and Erickson (2002) examined inpatient medical management of patients with acute care nurse practitioners and hospitalists collaboratively managing patients. The outcomes by these two groups were measured. Their model process, development, and evaluation were described. The model's development and the process that lead to their framework of care were discussed. Collaboration between physicians and the nurse practitioner was the key component in their care delivery. This enhanced positive outcomes for the patients by improving communication which decreased costs to the health care system.

Showing decreased fragmented care, the nurse practitioner and hospitalists increased their interaction and enhanced their roles in the clinical evaluation and decision-making of patients. Similar results with clinical nurse specialists were found by Saunderson Cohen et al. (2002). The clinical nurse specialists' (CNSs') success was in the ability to communicate and collaborate with others, which influences the practice of each clinical nurse specialist, thereby providing positive outcomes for patients and facilitating change across the system. Saunderson Cohen et al. (2002) described how a group of CNSs applied the Synergy model to change from a unit-based to a multisystem practice in Florida. Similar results in LTC were found in studies that researched the

impact of APNs in LTC facilites (Krichbaum, Pearson, Savik, & Mueller, 2005; Ryden, Gross, et al., 2000; Ryden, Snyder, et al., 2000).

Some researchers feel more information on size, function, and deployment of nurse practitioners was needed to see how they function with other health professions (Phillips et al., 2002). Nurse practitioners were seen as a flexible workforce that could both collaborate and compete with physicians. Their analysis of nurse practitioner/physician collaborative practice showed that patients benefit from the combination of the complementary skill mix (Stichler, 1995).

Meyer (2002) studied the effect of collaboration in cardiovascular care using retrospective two-group comparison between adult patients for whom care was directed by either a cardiovascular surgeon alone or a cardiovascular surgeon in collaboration with an acute care nurse practitioner. Two nursing units with two hundred fifteen subjects were evaluated. Findings showed the cardiovascular surgeon in collaboration with acute care nurse practitioner did decrease length of stay by two days per patient, and thus, the total cost of care decreased.

Many studies compare nurse practitioners and physician assistants with resident physicians. Hoffman, Tasota, Scharfenberg, Zullo, and Donahoe (2003) examined the difference in practice between one acute care nurse practitioner and six physicians in training. They found the physicians spent more time than the nurse practitioner in non-unit activities and the nurse practitioner spent more time interacting and collaborating with patients, families, and health team members. The presence of the nurse practitioner focused on the coordination of care, enhancing the quality of care, and shortening the patient's length of stay.

When a physician and nurse practitioner have a collaborative relationship, both contribute their expertise and ideas to make the best management and effective treatments for the patient (Cullen, 2000; Hojat et al., 1997; Whitcomb et al., 2002). A common theme in all of these studies, in order for collaboration to be successful, was a mutual trust and respect for the other profession (Campion, 1998; Crotty, 1998; Gianakos, 1997; Henneman, 1995; Kuebler & Bruera, 2000; Norsen et al., 1995; Rice, 2000; Zillich, McDonough, Carter, & Doucette, 2004). Continued investigation, education, and communication about the role of the nurse practitioner are needed to facilitate role acceptance and interdisciplinary collaboration (Kleinpell, 1997).

Teams

"All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics" (Ehnfors & Grobe, 2004, p.45). Intraprofessional collaboration occurs between two or more professionals from the same discipline. Interprofessional collaboration occurs between two or more professionals from different disciplines. A multi-disciplinary team consists of a group of professionals from different disciplines working in cooperation, giving their input on ideas or tasks.

According to Roberts (2004), interdisciplinary collaborators work closely together, by providing multidimensional assessment and information from multiple perspectives. In multi-disciplinary collaboration practice, there is an awareness of the other disciplines, with each returning independence in making decisions regarding that sphere of influence and expertise and making recommendations in their respective areas (Rice, 2000; Roberts, 2004). Trans-disciplinary collaboration is where members are

multi-skilled, prepared to engage in skills learned from other disciplines, have equal status and power, and share all decisions while working towards a common goal (Rice, 2000; Roberts, 2004). Adequate appropriate collaboration is essential for members in all teams (Kallenborn, 2004; Lucena & Lesage, 2002; Rice, 2000; Roberts, 2000; Saunderson Cohen et al., 2002).

In health care, a team of professionals collaborating toward a common purpose can decrease costs, improve quality of care, and increase patient satisfaction. The ideal team would have a high level of collaboration; balancing power and providing integrated care of the patient (Rice 2000; Roberts, 2000; Saunderson Cohen et al., 2002; Stichler, 1995). Henneman et al. (1995) explored the model case, contrary case and related cases of collaboration to clarify the concept. They found individuals who are involved in collaboration benefit from the supportive and nurturing environment it can create. Collaboration can promote individual and team objectives.

Shuval (2001) found that accessibility of physicians and other practitioners provides a source of traditional knowledge, where each learns from the others and gains confidence. It takes increased time and energy to collaborate with other professionals. Knowledge of what other professions can offer the patient is helpful, as each profession can contribute a new perspective or possible solution. Each member would address issues within their domain, provide input when appropriate, and allow leadership and opinions from another (Roberts, 2000).

Teams that have effective collaboration do not treat situations with conflict or rivalry. Instead, they have an active process affecting their interpersonal relationships, which involves sharing common problems, perceptions, and thinking about the delivery

of patient care (Lucena & Lesage, 2002; Roberts, 2000). Roberts (2000) and Lucena et al. (2002) state that collaboration lies on a continuum with courtesy at one end and on-site collaboration and team work at the other end.

Lamb and Napodano (1984) found little interaction in communication exchanges between team members. The reasons a provider chose to communicate with another member were consistent within the teams. Interactions between nurse practitioners and other ITMs were higher than their interactions with physicians. There were minimal physician initiated communication interactions.

Lingard, Reznick, Espin, Regehr, and DeVito (2002) stated that no study in literature had addressed communication in the interdisciplinary team. Their study explored the nature of communication among operating room (OR) team members to identify common communication patterns using observation and interviews. They found the patterns of communication were complex and socially motivated. Team communication in the OR was influenced by recurrent themes, such as tension-affecting novices. Their behaviors intensified rather than resolved inter-professional conflicts among the team members, and more miscommunication took place.

Lucena et al. (2002), using interviews and focus groups, surveyed five general practitioners (GPs) and five psychiatrists in Montreal. They were trying to improve collaboration between these two groups. They identified demographic and practice characteristics as well as strategies to improve communication involving the organization of continuing educational activities concerning GPs in the psychiatry field. Strategies for collaboration with accessing physicians did require significant alterations to clinical routines and professional roles. Collaboration could be improved between the two

groups with more effective communication and organizing continuing medical education in psychiatry. In the same study, Lucena and Lesage (2002) interviewed 10 Family Practice physicians (FPs) and psychiatrists and had a focus group to understand collaboration and strategies to improve collaboration between the two groups. Three strategies were identified: communication; continuing medical education for family physicians (FPs); and access to consulting psychiatrists. The psychiatrists did not think access to psychiatric patients was feasible due to lack of time and remuneration for the activities.

Collaboration between ITMs enhances decision-making. The quality of decision-making is influenced by the environment in which it takes place. If the environment or the culture is not conducive to communication, it will be difficult for collaboration to occur within and among ITMs. Orme and Maggs (1993) felt that decision-making within teams who use collaboration could be enhanced by: (a) development of practitioner's confidence, (b) willingness to discuss or become involved in the process with peers, (c) support and approval of peers, (d) permission to take risks, (e) positive peer encouragement, (f) opportunity for reflection, (g) supportive management.

The expertise and unique abilites of all ITMs are valued in a collaborative practice. Team members work cohesively and strive for a common goal (Norsen et al., 1995; Coombs, 2003). The relationship between teamwork in intensive care units (ICUs) and patient outcomes was examined by Wheelan, Burchill, and Tilin, (2003). In 17 ICUs, 394 staff members completed a survey on team functioning. Each unit predicted mortality rates and actual mortality rates were recorded. Staff members who perceived their team as functioning at a higher stage had lower mortality rates. They perceived

their team members as less dependent, trusting, and being more structured and organized than did staff of lower-performing units. A link between teamwork and patient outcomes in ICUs was evident. Strategies to improve teamwork and collaboration among staff members were recommended.

Grap et al. (2003) described the implementation of a protocol for mechanical ventilation to reduce weaning time for patients, reducing costs and the length of stay in a twelve-bed medical respiratory intensive care unit (MRICU). Implementation of this type of protocol required a collaborative team effort. The need to provide efficient patient care required the collaboration of all disciplines involved in providing care, reducing costs for the hospital and the patients.

Zillich et al. (2004) studied collaboration in the physician/pharmacist team by examining variables that influence collaborative relationships. They surveyed 340 primary-care physicians in Iowa. They found the exchange characteristics - relationship initiation, trustworthiness and role specification - were the most influential in the relationship. Their exchange characteristics are characteristics that are important for fostering growth and development of a collaborative relationship. Pharmacists were found to be the initiators of the communication with physicians with role specification and trustworthiness influential in the relationship. Communication was found to flow in the direction from pharmacist to physician. Further research was recommended for the use of different communications and face-to-face communication.

An ethnographic study by Coombs (2003) examined decision-making between physicians and nurses in three ICUs to examine clinical roles. It was found that nursing roles had changed and that nurses have little impact on how decisions are made. During

the study both groups were aware of the power and conflict struggles when making decisions concerning patient management. Coombs (2003) stated that the future for effective teamwork is with physicians and nursing staff realizing their power through recognition of the complementary knowledge and roles of each discipline.

Around-Thomas (2003) found that phases of team development, membership in team operating norms, including communication on issues related to control, and team goals were the factors that influenced the degree of collaboration with the team. Lamb and Napodano (1984) recommended that diverse professionals are needed on interdisciplinary teams to treat patients with complex medical problems. These patients would be candidates for team care. The team members have expectations that are important considerations in the collaboration process. Team members shape the other team members behavior by the nonverbal and interpersonal communication they use as they talk with each other. By using and facilitating communication styles, they foster collaboration.

Communication

Communication problems have occurred between physicians and nurses because of issues such as role misunderstanding, real and perceived differentials in power, position and respect, and varying perceptions regarding decision-making and autonomy (Baggs & Schmitt, 1997; Coombs, 2003; Larson et al., 1998). Larson et al. (1998) did a descriptive survey and interviewed attending physicians, registered nurses (RNs), and medical residents on medical units in a 325 bed hospital to study collaboration and effective communication between these health care professionals. The physician/nurse communication scale developed by Jones (1994) was used. The results found that while

physicians and nurses have similar perceptions of the communication processes, they differed in the perceptions of the physician's and nurse's roles in giving information, orientating, and providing education. Both physicians and nurses had an interest in more interaction. Nurses expressed the need to feel listened to and respected. The researcher recommended that inter-professional and intra-professional communication be incorporated into curriculums; providing clinical experiences where positive role modeling is experienced.

Larson et al. (1998) felt delivery models that facilitate interdisciplinary teamwork should be tested. Interactive communication styles should continue to be developed and explored, seeing how they might be modified. Communication styles could be tracked over time, seeing the effect of organizational change and interactions between inter-disciplinary health care teams.

Van Ess Coeling and Cukr's (2000) conducted a study to identify specific behaviors that contribute to collaboration. The degree of interdisciplinary collaboration in the health care setting was limited. Communication styles that contributed to collaboration were identified as attentive, non-contentious, and non-dominant styles of communication. They felt collaboration skills needed to be taught to ITMs.

Saunderson Cohen et al. (2002) found communication is able to effect a change within the system, a group meets to network, and problem solve, generating ideas and support. In a study by the Board on Health Care Services and the Institiute of Medicine (2003), communication between departments was poor. Departments behaved as semi-autonomous units, evidencing little collaboration and shared decision-making.

Lack of communication is a concern of patients and families. Norton, Tilden, Tolle, Nelson, and Talamantes Eggman (2003) did a descriptive analysis of family members to describe communication difficulties between and among clinicians and families at the patient's end-of-life. Families described unmet communication needs such as: (a) the need for timely information, (b) the need for honesty, (c) the need for clinicians to be clear, (d) the need for clinicians to be informed, and (e) the need for clinicians to listen. Paying careful attention to communication needs could reduce the conflict between clinicians and patient's families and reduce the stress for all involved. The study found that over 30% of patients' families were dissatisfied with communication (Norton et al., 2003).

Enhanced communication between professionals can result in better decision-making between the disciplines and with the patients. Decisions and treatments can then best meet the needs of all involved in the decision-making process by sharing common values, perceptions, language, and thinking about the combined work to deliver optimum patient care. Communication and trust enhance the functioning of interdisciplinary health care teams (Roberts, 2000; Zillich et al., 2004).

Networking

In networking, a problem is reviewed with various members of the inter-disciplinary team. With a networking relationship, respect and trust have not been established or developed. It is often necessary to look outside of one's normal colleagues for information (Boswell & Cannon, 2005). The nurse practitioner may know individuals in different specialty areas, that they do not consider as mentors or as someone they can

run problems or ideas by (Zellinger, 2004). These individuals serve as a network relationship for the nurse practitioner.

Understanding the concept of collaboration can expedite the process of transforming networking into collaboration, thus enhancing clinical decision-making and patient outcomes. Bringing the right team members together at the right time through networking can help to solve problems. Over time, these relationships may become strong and collaborative (Boswell & Cannon, 2005). Collaboration occurs when the nurse practitioner develops a relationship with another member of the interdisciplinary team, approaching that person for advice or information without feeling threatened or intimidated. Collaboration consists of mutual problem solving, task interdependence, shared record keeping and accountability (Chaboyer & Patterson, 2001; Kuebler & Bruera, 2000).

Kerfoot (2002), in Boswell and Cannon (2005), had observed the development of a complementary and synergistic group of team members was essential to the success of collaborative efforts. It was often necessary to look outside of one's normal colleagues to find the right individual for a given partnership network.

Technology

Technology can enhance or disturb the collaborative ability of a team. Technology can enhance the teaching, professional growth, and communication with other colleagues. Telephone calls and inappropriate, unreturned or frequent, pages can disrupt the communication between team members, leading to conflict and unsuccessful collaboration (Coombs, 2003; Kallenborn, 2004). Strategies should be used to enhance

the use of technology between disciplines so that obtaining members for collaboration can occur between ITMs (Kallenborn, 2004).

Technology can enhance communication between team members or between patients and their health care provider. Patients can be monitored on their status and compliance of therapy. High-tech monitoring devices can transmit information via the Internet or wireless communication systems providing telehealth services. Patients can be monitored on their status and compliance with therapy. Teams can access information via e-mail, chat rooms, discussion boards, or bulletin/message boards. The Internet and telephone provides human interaction, and thus communication. Technology has made life-saving critical care possible and accessible.

Technology can reduce the nurse practitioners' need for collaboration. Lamond and Thompson (2000) indicated that using decision analysis or decision trees to aid decisions has improved both the accuracy of diagnoses and the ability for novice nurses to reach decisions similar to expert nurses. They discuss the need for more analytical ways of examining the process and outcomes to delivering care to patients using professional decision-making based on the best research evidence. Chumbler, Geller, and Weier (2000) found nurse practitioners who treated patients according to clinical guidelines had higher levels of clinical decision-making authority, helping direct the clinical activities of the patient. Clinical guidelines are intended to inform decisions for practice (Cusick & McCluskey, 2000). Many personal data assistant devices (PDAs) provide these guidelines for clinical practice.

Tunnel vision, where physicians and nurses do not see the changes in the patient may develop with the overuse of technology (Benner & Shobe, 2003). Benchmarks in

treatment patterns can help, but they cannot replace the clinical judgement of interdisciplinary team members to help the specific patient.

A study of 108 nurses using interviews, observation, and audits in three acute hospitals in England was conducted (McCaughan, Thompson, Cullum, Sheldon, & Thompson, 2002; Thompson et al., 2001a; and Thompson et al., 2002). The purpose of their study was to find what sources of information was actually used by nurses versus what they said they used for arriving at clinical decisions in the ICU setting. Nurses found collaborating with colleagues and physicians more useful than obtaining research information (Thompson, 2003). The order resources were used for obtaining information were: (a) first, human resources; (b) then, local information; and (c) last, technology was seen as the least accessible form of information. Nurses who spent more time in a role or clinical specialty, perceived human sources of information as more accessible than other sources of information. Human sources of information were overwhelmingly perceived as reducing the clinical uncertainty in decision-making and in assisting with the nurses clinical decisions (McCaughan, Thompson, Cullum, et al., 2002; McCaughan, Thompson, Phil, et al., 2002; Thompson et al., 2001a; Thompson et al., 2001b).

Cusick and McCluskey (2000) explored strategies to use for continuing professional development in becoming evidence-based practitioners. Collaboration may need to occur in order to relate research finding to clinical situations. There was a need to know what the evidence was, how to use it in daily practice, and how to implement it as part of decision making.

Thompson et al. (2001a) thought nurses needed to be given the skills and knowledge to find, evaluate, and implement research knowledge in their work or else

accessibility would be as much as a problem as physical inaccessibility. They recommended giving the nurses the skills, resources, and motivation to make technology more useful. They suggested other ways of getting quality research information might best be done using a clinical specialist or nurse consultant. Evaluation of the clinical nurse specialist's or nurse consultant's impact on clinical decisions, in both process and the quality of the outcome, was recommended by Thompson et al. (2001a).

Patient Outcomes

The importance of consulting patients is apparent as health care professionals and patients do not always share the same views on what is a successful or a desirable treatment outcome. Kaplow (2003) states that outcomes are whatever the patient says they are. Patients should be consulted by healthcare providers when planning and providing care; the outcome for the patient is what is important. Involving the patient can lead to a holistic approach to care. In an effective collaborative practice, patients will feel more important, more respected and receive better care (Thomson, 1995).

Baggs, Ryan, Phelps, Richeson, and Johnson (1992) studied collaboration and patient outcomes in a medical intensive care unit. Fifty-six registered nurses and thirty-one residents were studied. As collaboration between the two groups increased, negative outcomes with patients decreased, and nurses' satisfaction increased. Patients' negative outcomes decreased from 16% to 5% when the process was fully collaborative versus no collaboration in decision-making. The major outcomes from the nurses and residents working together were improved patient care, feeling better in the job, and controlling costs. It was recommended if further research identification of patient outcomes that were more sensitive than mortality or readmission to the ICU needs to be established.

Collaboration was associated with improved outcomes for patients as reported in Baggs et al. (1997). It was recommended that to fully implement collaboration, a way to increase physician interest and efforts needed to be found. Support form both medicine and nursing was needed to make this change.

The outcomes of patients cared for by 16 matched groups of acute care nurse practitioners, physician assistants, and resident physicians in an acute care setting were compared by Rudy et al. (1998). Nurse practitioners and physician assistants were found to be more open to discussion and interaction with patients and families. Outcomes did not differ between the groups.

Larson (1999) reviewed the literature on perceptions of physicians and nurses regarding the components of collaboration and communication. Larson (1999) stressed it would be important to identify respective professional and interprofessional roles, suggesting that organizational and cultural changes need to occur to improve the quality of care and patient outcomes.

Mundinger et al. (2000) studied the outcomes for 1316 patients that were cared for by a nurse practitioner or physician in five primary care clinics functioning as an emergency room. No significant differences were found in health status, health service utilization, or satisfaction ratings. The patient outcomes were comparable. Collaboration was used when admitting patients into the hospital by both the physician and the nurse practitioner.

Shuval (2001) studied the integrated services of traditional and complementary medicine using collaboration between qualified practitioners assuring high quality care. For example, certain types of medical problems were relieved with complementary

medicine when conventional medicine had failed. Collaboration with a complementary provider was necessary for recommended treatment strategies.

Ingersoll, McIntosh, and Williams (2000) measured the APNs impact on health care outcomes with a survey of 66 APNs. Twenty outcome indicators were measured and ranked. The 10 highest ranked indicators were - satisfaction with care delivery, symptom resolution, perception of being well-cared for, compliance with treatment plan, knowledge of patients and family, trust of care provider, collaboration among care providers, frequency and type of procedures ordered, and quality of life. The researchers felt that collaboration was an indicator of the care delivery process rather than an outcome, resulting in improved care delivery outcomes for patients. The researchers had a return rate of 15% on the survey. Because of the low return rate, the ability to generalize findings of the survey was limited.

Rice (2000) analyzed the literature on interdisciplinary collaboration in health care in the areas of practice, education, and research in an effort to show the effectiveness of interdisciplinary practice. The benefits of interdisciplinary care are not easy to measure. The team treatment, variations in outcome variables, variations in the types of patients, problems, providers and settings, make this complicated and difficult to generalize to others. Additional research in these areas was indicated.

Ferrand et al. (2003) used a questionnaire to study the perceptions of 3,156 nursing staff and 521 physicians in 133 French ICUs. Ninety percent of those interviewed believed that decision-making should be collaborative, 50% of the physicians and 27% of the nursing staff members believed that the nursing staff was actually

involved in decision-making. Staff satisfaction with the decision-making process was significantly related to patient outcomes.

Grossman and Bautista (2002) studied how evidence based practice and joint decision-making between disciplines can improve patient outcomes. Using the Pin Site Quality Improvement Tool to evaluate the effectiveness of a practice change, they found collaborating with others generated ideas and resources in facilitating research and cost effective evidence based protocols for pin site care on an orthopedic unit. The combining of resources, competencies and contributions of all disciplines provided the highest quality of care. Similar results were found in Grap et al. (2003); when using collaborative practice and a weaning protocol, patients receiving mechanical ventilation had shorter hospital stays and lowers hospital costs. Burns (2003) discussed the long-term mechanical ventilator patient program and the successful attainment of positive program outcomes, attributing its success to collaboration. Burns found that collaboration helped to ensure positive patient outcomes.

Hoffman et al. (2003) examined outcomes between one acute care nurse practitioner and six physicians in training in an ICU; both NP and physician spent half of their time directly related to management of patients. The nurse practitioner spent more time in activities related to coordination of care, interacting with patients and families, and collaborating with ITMs. This coordination of care was felt to enhance the quality of care and shorten the patient's length of stay in the ICU.

In 17 ICUs, Wheelan et al. (2003) examined 394 staff. They examined the relationship between teamwork and patient outcomes in the intensive care unit. They found that there was a link between teamwork and patient outcomes. Implementing

strategies to improve teamwork and collaboration among ITMs was recommended. Similar findings were found by Spilsbury and Meyer (2001) and Rudy et al. (1998), between nurses and physicians and between residents, physician assistants and nurse practitioners. Increased collaboration and cooperation between disciplines can improve the ability to achieve patient outcomes and wellbeing (Henneman, 1995; Rice, 2000; Rudy et al., 1998).

Dechairo-Marino, Jordan-Marsh, Traiger, and Saulo (2004) performed their research on nurses working in three medical surgical units and two intensive care units. They used the Baggs Collaboration and Satisfaction about Care Decisions Survey, measuring collaboration before and after several interventions to investigate improved nurse/physician collaboration. Registered nurses, 87 nurses pre-test and 65 nurses post-tests, completed an action research pre- and post-test survey. There was not a significant difference in either type of nurse scores.

These studies indicate that the effective use of collaboration in making a clinical decision will result in better outcomes for patients. Having effective changes throughout the health care system will result from enhanced collaboration.

Cost Effectiveness

Van Ess Coeling and Cukr (2000), Monarch (2001) and Huerta (2003) believe that health care organizations are looking for ways to improve patient outcomes as well as the work enviornment. APNs had an average cost savings of $50,000 per month, with improvement seen in length of stay, wound care interventions, and equipment utilization (Whitcomb et al., 2002). In addition, retention of nurses increased by eight percent.

Kleinpell (2003) stated there are barriers that exist for collaboration that can make it difficult to measure outcomes of APN care.

Grap et al. (2003) examined protocols with weaning of ventilated patients in an ICU. Implementing these protocols was not easy without a consistent collaborative effort. This collaborative effort reduced the duration of mechanical ventilation and the length of stay. The authors felt multidisciplinary collaboration was critical to this study's success.

Impacts – Health Care System

The power of a healthy work environment is evident in studies where mutual respect and effective communication between nurses, physicians, and ITMs prevents errors and improves patient outcomes. A healthy work environment can be achieved by a collaborative practice (Baggs et al., 1992; Fontaine, 2003; Fontaine, Irwin, & Buchman, 2004; Hojat et al., 1997; Stichler, 1995). For the health care system, health care outcomes include recidivism, costs, and resource utilization (Kaplow, 2003). Enhancing collaboration could improve patient care, staff satisfaction, and lower costs. Better patient outcomes could result in using more efficient work patterns and fewer costs for the patient and health care system (Hojat et al., 1997; Lassen et al., 1997; Zwarenstein & Bryant, 2003).

Time and energy are required for interdisciplinary collaboration and refinement of projects. A unified relationship between disciplines leads to improved patient care. The support of management for collaboration is a vital component to its success (Jones, 1997). Role definitions and power bases with traditional and historical boundaries

continue to exist. Differences in interpretation of events and differences in power could lead to labeling the same events as collaborative or not (Baggs et al., 1997).

Stickler (1995) and Giacomini (2004) felt organizations should support and improve their treatment of interdisciplinary work by encouraging communication, recognizing the productivity from collaboration and making allowances. The expertise and unique abilites of all care providers is required in a collaborative practice, implying that team members work cohesively and strive for a common goal (Norsen et al., 1995).

Factors that can influence the development of collaboration are an organization's culture and professional competence (Baggs et al., 1992; Baggs et al., 1997; Stichler, 1995; Thomson, 1995). To interpret an organization's culture, the organization's beliefs and values need to be examined. Culture is not something that can be managed; it is an inherent part of an organization having social behaviors, and institutional processes (Hewison & Stanton, 2003). A strong culture will have an influence on performance, as the amount and degree of collaboration varies in the organization. Collaboration can draw strengths from each discipline and optimizes care for patients (Wakefield, 2003). In a health care organization, collaboration makes a difference in the functioning of teams.

Norsen et al. (1995) stress the importance of administration providing financial support to establish and maintain a collaborative team. Fitzgerald and Teal (2003) found a difference in cultural ambiguity, where occupational groups adapt to organizational change in different ways, possibly limiting the development of collaboration, teamwork and interprofessional practice, complicating the implementation of change in organizations. McCaughan, Thompson, Phil, et al. (2002) found cultural resistance characterized by apathy and inaction rather than in overt or active resistance. All

members of the team did not always welcome information-seeking behavior to find the answer to a clinical question in practice.

Hewison and Stanton (2003) found that collaborative and co-operative approaches to the provision of health care have occurred. They examined the complexity of the situation between nursing and management, hoping to remove the barriers between these two groups. Cassidy (1998) thought collaboration was essential in creating an environment where power is shared. It strengthens the organization, fostering the growth of those involved in the process and developing a sense of pride and ownership that supports a permanent change.

Organizational values, which support collaboration, include participation, support systems, nurturance, autonomy, freedom and equality, freedom of expression and interdependence (Henneman, 1995). The focus of attention should not be on systems and structures, but on people and understanding people's interpretation of processes and events.

Organizational culture is the general climate or feeling within an organization, the beliefs, attitudes and values that exist (Cassidy, 1998; Hewison & Stanton, 2003). Management methods were examined by Hewison and Stanton (2003) focusing on the conflict between management and nursing. In some management cultures, new values or assumptions and ways of working are imposed on the employees. Difficulties arose when attempts were made to change the culture of an organization. ITMs often acted in the opposite direction when this was imposed upon the members (Hewison & Stanton, 2003).

Summary

The results of these studies established a link between collaboration, teamwork, and patient outcomes. This evidence is sufficient to warrant the investigation of strategies designed to improve interdisciplinary teams and collaboration among staff members. The functioning of the interdisciplinary health care team can be improved by effective collaboration. The role of the nurse practitioner can be important in modeling collaboration to other ITMs. By understanding collaboration and how to interact in the process, the nurse practitioner can enhance the utilization of colleagues of the interdisciplinary team. Continued investigation, education and communication about collaboration are needed to facilitate interdisciplinary collaboration.

CHAPTER III

METHODOLOGY

Introduction

This chapter describes the research method used to investigate collaboration between members of an interdisciplinary team. Sections of this chapter include the design of the study, population sample, setting, data collection techniques and analysis techniques for interpreting the data collected.

Design

The student investigator interviewed eleven consenting ITMs practicing in a Midwestern long-term care (LTC) facility. Sampling was purposive. Team members were recruited based on referral from the facility and on team members' willingness to participate. They were invited to participate through personal invitation, letter, phone call or e-mail sent by the investigator. Interviews included open-ended questions evaluating interactions and relationships between ITMs. Information gathered allowed the researcher to evaluate the effect collaboration had on the practices of team members when collaborating with the interdisciplinary team.

Grounded theory was used in this study. According to the tenets of grounded theory, "The goal of grounded theory is not to tell people what to find or to force, but what to do to allow the emergence of what is going on" (Boychuk, Duchscher, & Morgan, 2004, p.4). Grounded theory was used to explore how ITMs define reality and

how these beliefs are related to their actions. Reality is created by the meanings that the ITMs attach to certain situations. These meanings are different for each ITM, being the basis for the ITM's actions and interactions. Grounded theory method was used to seek ways to understand the ITMs' ways of living, believing, and adapting to situations in their life.

Grounded theory employs different modes of inquiry to discover the meanings of given situations to individual ITMs. These modes of inquiry include a descriptive mode, discovery mode, emergent fit mode, and intervention mode. The descriptive mode provides a rich detail of the situation. The discovery mode provides patterns of life experiences of ITMs. The emergent fit mode allows for a focus on previous work around a certain social process. The intervention mode tests the relationships, involving interventions of the researcher. This study will use the discovery mode. The discovery mode develops a picture of the wholeness of the culture of the ITMs (DeSantis & Ugarriza, 2000; Gillis & Jackson, 2002; Strauss & Corbin, 1990; Strauss & Corbin, 1998; Werner & Schoepfle, 1987).

Sample

Purposive sampling was used. The sample for this project included ITMs from a rural Midwestern LTC setting. Criteria for inclusion in this study were that the participants needed to be a member or a patient from the identified LTC facility of an interdisciplinary team working in a rural LTC setting. This study intended to discover the unique experiences of ITMs. The researcher had the Director of Nursing (DON) contact ITMs within the facility to ask for their permission to be in the study. ITMs who were interviewed included people in the following positions: (a) nurse practitioner; (b)

medical director of a nursing home, who was the nurse practitioner's supervising physician; (c) charge nurse; (d) physical therapy aide; (e) certified nursing assistant (CNA); (f) DON; (g) social worker; (h) pharmacist; (i) dietitian; and (j) two residents. The interviews were conducted over a one-month period in either the LTC facility or a location chosen by the interviewee. The purpose of the study and a consent form were given to participants at the time of their interviews (Appendix A and Appendix B). Interviewees were given permission to withdraw at any time during an interview and did not have to answer questions that made them feel uncomfortable. The student researcher was not a member of this interdisciplinary team.

Setting

The ITMs were employees of a rural midwestern LTC facility. This LTC facility was a skilled bed nursing facility, proving 24 hour care by licensed nursing staff that were trained in sub-acute needs. Forty eight rooms were semi private and one hundred and two rooms were private. There were residents with various levels of care. It was Medicare/Medicaid certified. One goal of this LTC facility was to maximize the life of all who lived there. Physical, occupational and speech therapies were available for residents. Recreation therapy provided a variety of activities.

The health care delivery model used at this facility was team nursing, with nursing care given by a team that had registered nurses, licensed practical nurses and certified nursing assistants. In this nursing model, most direct bedside care was given by the CNAs, while the RNs spent most of their time at the nurse's station in other nursing activities. For confidentiality purposes, further description of the LTC facility will not be included in the thesis.

Methodology of Project

After the study was approved by the Institutional Review Board (IRB) at the University of North Dakota and by the health system affected by the study, potential study participants were contacted by the LTC facility's Director of Nursing. A letter of support for this study was obtained from the Director of Nursing. After the Director of Nursing contacted the ITMs for possible participation, they were then invited to participate through a phone call or in person by the student investigator.

Interviews were arranged with each participant at a time of their choosing. Interviews were held in a place inside or outside the work environment, chosen by the participant, accessible to persons with mobility impairments, and conducive to the sharing of stories. The location supported privacy and confidentiality for the participants. Some were performed in lounges and meeting rooms of the LTC facility, another in a hospital lobby and one at a coffee house with rooms for privacy.

Interviews included open-ended questions, observing the interaction and relationship of the participant with other ITMs, observing the effect and significance collaboration has on their practice, and observing problem-solving within the team.

Pre-field work involved determining what was to be studied and what the significant variables might be. A literature review to establish the construct for the phenomenon to be studied was completed. Interview questions were prepared with the assistance of the researcher's graduate committee.

During the fieldwork phase, information was obtained from ITMs. The fieldwork method of in-depth interviews was used. Information was written from an emic perspective. The process of data analysis was concurrent with sampling, guiding the

direction of the study, looking for saturation of the data. Data were gathered, major themes were identified; data was rechecked, looking for relationships, refining themes and looking at how the findings illustrated perceptions of interviewees. Strauss and Corbin (1990, 1998) described three elements to theory building: (a) initial and advanced coding, theoretical coding; (b) memo writing; and (c) theoretical sampling. Inital coding involves examining each line of data and naming the actions or events found, a microanalysis. Advanced coding is the process of organizing or grouping the previously coded concepts and then abstractly conceptualizing the theories or patterns that emerge from the data. Memo writing is the writing of ideas before, during and throughout data analysis, separate from the data. Theoretical sampling is the process of ongoing data collection, analyzing the data to develop the theory as it emerges, and building on emerging concepts. This process was continued until the relationships between the categories were well established.

Warm-up questions were asked in the beginning of the interview. For example, "Tell me how your day is going?" was used. The interviewee was then asked general background questions that pertained to their perspective on the impact of collaboration in their work. Each interview was expected to be about an hour in length and utilized the qualitative interview process.

Questions for participants included:

1. Tell me about your position as a _____ at this agency.

   Prompt: How long have you worked here?

   Prompt: What lead you to take your current position?

   Prompt: Why do you stay?

Prompt: Tell me about your practice, working arrangements, expectations, and responsibilities.

2. You work with other professionals at this agency. Tell me about that.

3. Tell me about a problem at work that you had? How did you solve the problem?

Prompt: Which group of individuals would you confide in or discuss a problem with?

Prompt: What resources do you commonly use?

Questions for the Director of Nursing:

1. Tell me about your health care facility.

Prompt: Do you use a particular healthcare delivery model?

Prompt: What kinds of staff do you need at your facility?

Prompt: What roles, expectations, and responsibilities do you have of the various staff?

2. What type of patient concerns do you deal with?

Prompt: Give an example. How did you solve that problem?

Prompt: What resources or individuals would you access to solve patient problems?

3. If both you and the staff are solving patient problems, tell me how that works?

Prompt: What is the difference in your role versus the staff's role?

Prompt: At what point do you usually get involved? Informational resource, to take action, to evaluate what happened, etc.

Questions for a patient:

1. Tell me about your self.

   Prompt: How long have you been at this facility?

   Prompt: Where are you from originally?

2. What is it like living here at _____?

   Prompt: What do you like about living here?

   Prompt: If you could change one thing about living here, what would it be?

3. Tell me about your healthcare.

   Prompt: Is there anyone here at this facility that helps you with your healthcare concerns?

   Prompt: How often do you see someone about your health? MD? NP?

   Prompt: Would you change anything about your health care?

   Prompt: What role do you play in your healthcare? Do you make you own healthcare decisions?

Data Collection – Methods and Procedures

At the beginning of the qualitative interview, each participant was reminded that the interview would be taped, and the regulations regarding confidentiality that would be followed. The student investigator conducted all the interviews in a private setting. The semi-structured interview was intended to be collaborative in nature and was designed to capture the essence of each participant's perception of their experience with collaboration in their work setting.

Data from interviews have been maintained in a locked cabinet in a locked room in the researcher's college and will be kept for a period of three years then destroyed. After three years, paper transcripts will be shredded. Audiotapes of the interviews will be erased magnetically, three years after the interviews. Consent forms have been stored separately from other forms in another locked cabinet within the department. They will be shredded after three years of storage. Only the research team will have access to the data.

There was no monetary benefit for participants in this study. A potential benefit of participating in this study for the participants may be the opportunity to be involved in research. The benefit to the individual may be the opportunity to talk to a caring professional about their life and work experiences. The benefits also include contributing information that may help future research. Information gained for this study could formulate nursing questions or problems and develop hypotheses for further testing. Benefits may also include potential improvements in collaboration systems for LTC facilities, improvements based upon findings of this research.

There were no anticipated risks associated with participation in this project. It is possible that concerns may have arisen regarding confidentiality of statements made by participants. Each participant's information has been kept confidential and only themes that arose from the data as a whole were reported. This aggregate form of reporting qualitative data ensured that comments could be identified back to the person who made them. There was a small chance that some of the information requested would cause psychological discomfort. Some psychological discomfort was experienced by two participants. At the time participants became uncomfortable, the interview was stopped,

the researcher gave verbal support, and each participant was given the opportunity to quit the interview. Both chose to continue the interview, neither wanted the option of seeking additional counseling services at their own expense. No injuries occurred as a result of this study.

Protection of Human Subjects

This researcher completed required educative modules and HIPPA as directed by the Institutional Review Board at the University of North Dakota. Participants were provided a copy of the consent form at the time of the initial interview. Before the interview, participants were asked to read and sign the consent form. A separate consent form was made for ITMs and for the residents. If a person chose not to sign their consent form, they were not interviewed. Informed consents were collected and stored separately in a locked file to be destroyed after at least three years.

All information gained in this study was held confidential. No individuals were identified. Each qualitative interview was audiotaped, ensuring that the interview was properly recorded. In addition to the steps identified above to protect confidentiality, all identifying information was removed from the transcripts and from audiotapes (e.g. place of work, names, and any other specific details that might identify the participant). There is no way to link subject response and/or transcription sheets to consent forms, and no names appear on any form except the consent form.

In summary, there were three precautions used to minimize the risk of a breach of confidentiality: (a) the name of participants or their job titles were not used on any tapes or transcripts, (b) the interview was conducted in a private setting, and (c) the results

were summarized from all the ITMs interviewed (with no identifying details of any one person) in the final report. That is, data was reported in summary form across interviews.

It is a practice with qualitative research to quote participants experiences. The participants were protected by using only direct quotes that could no way identify the individual, using common themes across cases. Tapes were transcribed by the student and transcriptionists. Transcriptionists signed a form stating they would maintain all data as confidential. All material generated by the transcriptionist, including computer files, was turned over to the student researcher after transcribtion was completed. Subsequent data relating to this research were deleted from the transcriptionist's computer, in the presence of the student researcher.

Data Analysis

The researcher used in depth participant interviews to collect data for this research. Data analysis was conducted concurrently with the interviews in the tradition of grounded theory. Grounded theory was used to collect and analyze the data. Grounded theory seeks to utilize a systematic approach to the collection and analysis of data to allow the emergence of theory "grounded" in the focal context of the research.

Data were gathered and major themes identified; both data and themes were rechecked for meanings. Themes were refined and findings representing the team, identified. The process of data analysis or "coding" in grounded theory aims to establish "categories" from the data, together with the interplay between these categories in relation to a guiding research question. One of these categories is usually designated as a "core category" as it links the other categories in a meaningful way, pertaining directly to the research question.

Transcribed text was coded and themes and patterns with regularities and inconsistencies identified. Analysis began with initial data collection and continued throughout the data collection process. Once saturation of the data had occurred, data were interpreted. Analysis of the content and the results were presented in a written format and given to the ITMs requesting the results.

A record of the researchers' written perceptions, the verbatim text from the interviews with the ITMs, and pertinent documents obtained in relation to the data collected were kept. Separate files of the researcher's journal, field notes, and interviews were manually transcribed, and written records were kept on a stored computer disc.

Triangulation of the data was completed to ensure credibility of the data. Triangulation is the use of multiple procedures or sources to check and establish validity of the study. This was then compared to the literature for similarities and differences.

Participants were under no obligation to submit to a second interview, and the lack of a second interview would not take away from the validity of the study. No second interview was required of any of the interviewees.

A detailed record of research methods and procedures used throughout the study process was documented to ensure dependability and confirmability. Descriptions of the characteristics to the settings, the ITMs, and the processes used by the researcher were given to assist in transferability, characteristics to the settings of the ITMs to other interdisciplinary teams in other LTC facilities.

CHAPTER IV

RESULTS

Introduction

The purpose of this qualitative study was to examine how collaboration influenced an interdisciplinary team functioning in a rural Midwestern long-term-care facility. Specifically, this study examined the role of the nurse practitioner and collaboration within the interdisciplinary team. This chapter will focus on the results of this qualitative study. Categories that emerged while grouping the data from the interviews are described. Influences and barriers to collaboration are discussed. As with most interviews, participants in this study opened up more and more as the interview progressed. They more openly discussed issues at the end of the interview, sometimes after the recorder was turned off, often saying things they might not have otherwise included in the interview.

This was a qualitative study, using a constant comparative method of data analysis. Coding occurred throughout the interviews. The data from each of the interview questions were examined for codes, categories, subcategories, patterns and themes (See Appendix C).

Analyzing data to determine categories and themes began after the first interview and continued until the relationships between the categories were well established. There

were seven themes that emerged from the data. They will be discussed in detail in Chapter V.

Theme One	All staff (including CNAs, PT Aides, housekeepers, etc.) should have the opportunity to collaborate.
Theme Two	The LTC facility should regularly schedule training workshops on enhancing teamwork, communicating effectively, coping with stress, and building support networks.
Theme Three	The quality of life and well-being of the residents could be enhanced by providing an environment that is more like home and by providing activities that give a sense of belonging to residents.
Theme Four	In a LTC facility, all interdisciplinary team members need to communicate openly with families and residents concerning diagnoses and treatments and the implications these hold for the resident's future.
Theme Five	Physicians are not sufficiently active in the collaboration process with patients and families.
Theme Six	The increasing cost of long-term care is a concern for the aging population and their increased co-morbidity of chronic diseases.
Theme Seven	LTC facilities need a support network to assist staff and residents with grieving when death occurs on a unit.

The research questions for this study were:

1. What influences does collaboration have for an interdisciplinary team practicing in a rural Midwestern nursing home practice?

2. What are the barriers that hinder collaboration for an interdisciplinary team in a rural Midwestern nursing home practice?

Categories Based on Responses to Questions

Data were gathered and major categories identified; findings representing the interdisciplinary team were listed. Six main categories that were inherent in the data are listed below. In the first part of Chapter IV, data were analyzed based on the actual questions presented to study participants. Four categories emerged from this data. They were: Chronic Health Conditions, Collaboration, Communication, and Expectations. In the second half of Chapter IV, data were again analyzed according to how the data influenced collaboration (research question number one). Influences to collaboration fell into two additional categories: Influences that Enhance Collaboration and Influences that are Barriers to Collaboration.

Chronic Health Conditions

Many of the problems mentioned by both ITMs and residents related to dealing with chronic health conditions of the residents. Many health problems accumulate as a person ages, creating co-morbidity for the residents. A few ITMs mentioned that residents coming into the LTC facility are younger than they used to be. They also mentioned that the co-morbidity of obesity with other chronic health conditions is going to be a problem in the future.

Chronic health problems in this category encompassed: (a) increased aging of the residents; (b) increased dementia, requiring increased referrals for psychiatric intervention; (c) increased need for depression surveys and mini-mental exams for residents; (d) increased prevalence of co-morbid chronic diseases in LTC; (e) as co-

morbidity problems increase, so does the need for a greater variety of disciplines that need to be involved in caring for residents; (f) increased injuries; (g) lack of understanding – resident, family and some staff do not understand or know what to expect with some disease processes; (h) increased fragility of the resident as the resident ages; (i) residents who become ill faster; (j) residents who have a harder time recovering from illnesses; (k) residents who have used illegal drugs (such as methamphetamine) and the dilemma associated with drug use.

One of the interviewees felt the two main medical conditions associated with chronic health conditions in an aging population that required collaboration were when residents developed skin problems and exhibited weight loss:

> ..., there is always weight loss and ... skin [issues] are probably some big ones that we deal with ... so we all do ... I think we all have our own audits that we do, but I might talk to 'em about [issues] ... I guess weight loss is ... would be a common [problem], ...

Another person interviewed commented on changes in residents over time:

> ... a lot of them are here, maybe just during their Medicare covered days and then they're gone and so, shorter stays, sicker people, and very complex, for a nursing home, I think. We've got some really specialized, individualized diets. The people that, the residents that are here, have also gotten a lot more vocal than they used to...

A couple of subgroupings or subcategories became apparent while analyzing the data. These were: Medical Conditions and Medications. ITMs "knowing the patient" were essential to the clinical reasoning and collaboration process. The patients' knowledge and beliefs about their condition and attitude towards past and future treatments was important.

One resident made the following statement about medical choice:

> I make a lot of my own, because I've either seen it before or I've read it before or it's acting on a certain thing, like my gallbladder. I've had gallbladder trouble for years and so they ... I say, "Give me some 77s, you know." "What do you want them for?" "Well, I'm having a gallbladder attack...." I know if I eat strawberries or tomatoes or something with seeds, I know that I'm going to have one and I don't need them to tell me and so I know what they are and so there's a lot of things that I just know, like I said from reading about them or knowing somebody that [it] happened to and I kind of compare notes on what it felt like or what it, how it made you feel and all that, and then I'd go from there, ...

Collaboration

Lucena and Lesage (2002) describe collaborative care as a continuum ranging from occasional courtesy (networking) to on-site collaboration and teamwork where the team shares common values, perceptions, language and thinking about their joint work to provide effective patient care. A typical example of a response which illustrated this category was, "I believe that our team can resolve anything, sit down and talk it over, we probably don't even realize that you're asking somebody else or that you're ... you're calling out for help."

This category could be further subdivided into four subcategories including: Interdisciplinary Team Members, Relationships, Teams, and Resources. For a complete listing of categories, subcategories, and codes, see Appendix C.

Interdisciplinary Team Members

This subcategory consisted of all data which characterized the interactions between ITMs, such as: (a) talking; (b) sharing; (c) comparing; (d) being appreciative of feedback from others; (e) being available; (f) being reliable; (g) being competent; (h) being honest; (i) being creative; (j) getting a perspective; (k) being open to hearing about the issues at hand; (l) giving updates and cues to each other about important things; (m)

meeting, when shifts change, to talk about what has gone on while staff coming to work was absent; (n) answering "What do you think?" with different ITMs; (o) confiding in each other; (p) being supportive of each other; (q) utilizing multiple disciplines, elevating the level of care; and (r) having high expectations of certain ITMs.

One ITM commented on the multi-disciplinary nature of staff in a LTC facility. "In the LTC, it is very multi-disciplinary, working with dietary, physical therapy, occupational therapy, all sorts of different disciplines". A feeling echoed by a separate participant regarded being a member of the team was: "I might put in my two cents. You know ... 'I'm the ... Here's what I'm seeing, can you help me with this?' I've asked for consults. I've talked with Dr. .... We've worked together to get them to eat orally."

Relationships

Data that characterized the subcategory, relationships, included: (a) trust between a nurse practitioner and certain nurses; (b) intimidation between coworkers; (c) guidance as a role model; (d) respect between physicians and nurse practitioners; (e) how the social worker interacts with everyone; (f) support for family and staff; (g) lack of communication between family and physicians; (h) families' being unaware of "What's going to happen?"; (i) the social worker as mediator for residents, family, and staff; (j) stressed relationships when dealing with the dilemma of taking a resident off therapies; (k) disrespect between residents and families; (l) disrespect between families and staff; or (m) disrespect between residents and staff.

As one interviewee reported regarding staff relationships:

> You know, there's some pretty strong relationships amongst the staff. You know, a lot of these people have worked together for a very long time.

> It's physical work. It's emotional work and you're not always looked ... you know, you're not always treated the best .... and they have a ... they have a strong bond ... and they work well together and they anticipate each other's, you know, moods and ... for somebody to come in from the outside and fit in, it's difficult ... very difficult. Their work has to be up to par; they have to, you know, ... the personality has to be right and ... You have to be well organized and do a good job and it's tough.

Teams

Throughout the interviews, the subcategory, Teams, involved the following characteristics: (a) lack of trust between new ITMs and ITMs that have tenure; (b) needing competent staff that can take care of most issues, and provide quality care; (c) individual unique disciplines working together as a team unit, involving a team effort; (d) a bunch of staff interacting; (e) some ITMs caring, some listening, some not caring or listening, and ... "they just don't care" (if you're going to work as a team, you need to care about each other); (f) if they work as a team, resolving anything if they sit down; (g) in an emergency situation, the team coming together.

As one interviewee commented on their contribution to the team, in caring for the residents:

> Gosh. I know, we've had several, ... people that come in, you know, they're tube fed for whatever reason and we've worked together to get them to eat orally, ... I don't know, stroke ... a stroke resident, you know, that came, tube fed and you deal with moods, you know, the ... the depression and all that kind of stuff, but ... a-and speech pathology, that's another, discipline I work pretty closely with. Um, you know, they'll help with texture modifications, you know, how ... when are they ready to eat and what textures are they safest at, and then my part is, you know, calorie counts and how are they eating and can we wean that tube feeding off and get them to eat more and, again you've got nursing and the care coordinators that are a big part of that as far as, monitoring, you know, the tolerance to that. CNAs are the feeding aspect of things. So, we've gotten, we've had several residents that we've been able to successfully get off the tube feeding and back to eating orally and so those are always fun to see.

A different participant picks up this theme: "Yeah, but internally, I think we've ... we've got every... everybody that we need and that sounds a little pompous, but, we do ... we really do have a good team." This feeling was echoed by another participant:

> Ho, boy, we ... we do a lot of brainstorming together. I don't know who else we would call if we didn't deal with each other. Pretty much, I believe, that our team can resolve anything if we just sit down and talk it over. I don't know that we'd have to call extra. We have dealt with personal, ministers. Maybe we'll talk to psychologists. We'll deal with psychiatry, either from ... or ... if we feel that we can't get things resolved and the physician.

Resources

The subcategory of Resources was built upon the following sources: (a) books; (b) internet; (c) practice groups, i.e. American Dietetic Association; (d) different list-serves; (e) human resources, i.e. care plan coordinator; (f) members of an inter-disciplinary team; (g) staff support – "Who can I call?"; (h) on call support – safety net available for the ITM; and (i) administrative support – never feel alone when dealing with problems.

One interviewee commented on support of other ITMs:

> ... and so ... it's my position to say, "Have you thought of this?" "Is this possible?" "Maybe we should do this." "We need a Round Table. Let's all get together and discuss." I mean those are the things, the resources ... that might ... maybe the individual might not think that they have.

The following quote illustrates a good example of effective collaboration:

> I think the biggest relationship and the most important, for me, is with the nurses, though. Those are the people that I work with every day, and we have established a trust, I think, with one another. They know what I expect of them and I know what, ... they know the patients the best and are really the ones that are able to find, you know, changes in conditions. They may know that, you know, for example, that if a person want to go down to play bingo, or something, that that's really a change for them and,

you know, they're obviously not feeling well if they're not able to express that ...

A number of attitudes and behaviors can change as a result of increased collaboration. These may include changes in: communication (of information, opinions and feelings); sharing (of tasks, decision-making, and goals); power dynamics (visible expressions of power, such as more equal verbal participation in decisions); mutual respect; and comprehension of effective therapies.

An example of a collaborative effort in solving a problem by the interdisciplinary team is given in this scenario.

> Yeah, hmm. Gosh, we have a resident here that, fairly young, you know, in her 60s, some developmental delays, obsessed with food. There's a lot of behavior issues, so, we have all worked very closely. ... she's very manipulative with food and staff and all the times think ... so we all had to come together and, um, figure out how to deal with her. Ah, from every angle, I mean, 'cause she's all over the building, so activities has had to figure out how to deal with her. We have a very important piece because she's been ... she was morbidly obese when she came, diabetics, open areas, all that kind of stuff.
>
> ... and then the behavior issue ... [the] social worker had to get together ... so we've all[nursing, social worker, dietitian, (therapy aides), nurse practitioner] ... she's going to be here long term. She's not going anywhere. So we kind of got together and we came up with a ... we can't restrict her food all the time with ... Because she lives here, she needs to go to activities, but what she would ... um, throw major fits in there because she couldn't have the snacks that they were having ...
>
> ... so we've kind of devised a system where she's got five tickets a month and she can choose however she wants to use these tickets for food, type of thing ... and so it's just been a very joint effort. I mean, that ... that's probably the one big example that comes to my mind and as a result of everybody working together; she's lost at least 150 pounds. She's no longer on insulin. Her skin healed. She's walking, but it's ... it's a daily issue that we all, you know, ... We don't always talk about her every day, but it's, you know, how staff deal with her is a daily occurrence, so she's probably the biggest example that comes to mind immediately, but we've got several mood issues, you know, how are we going to get them to eat?

Communication

This category was grouped based on topics about which the staff, families, and/or residents might communicate. For example: (a) plan of care, (b) education of the family and staff, (c) methods of effective communication, (d) patterns of communication in "Chain of Command" were elicited from the participants. The data that supported this category appeared highly interlinked with data from other categories, which suggested strong links between other categories and this one.

Communication and collaboration became easier as the ITMs worked longer at the LTC facility, and when they were in a higher position. Even though all ITMs were invited to participate in care conferences and be involved, only day shift ITMs attended. The residents were encouraged to be involved in these processes, too, but they lacked experience and know-how within the system.

Communication, like collaboration, was also a large category with a multitude a data. Communication could be subdivided into the following subcategories.

1. Directives
2. Goals
3. Safety

The subcategory, Directives, included the following characteristics: (a) the Ethics Committee helping to look at issues with an open mind, (b) developing a Plan of Care, (c) planning coordination of care, (d) educating family and staff on what is going to happen and when, (e) End-of-Life programming to give assistance to families and staff, (f) ITMs notifying appropriate disciplines to let them know what is going on, (g) physician's levels on what to expect.

The following statement illustrates how communication with the family can assist in collaborating and reaching goals with the resident:

> Oh, yeah, crazy Fridays, but, yeah, we had one come last week from Boston. He was tube fed; ... He has a history of rectal cancer and chemo and ... all that kind of stuff, but he's able to take his pills orally without problems. So, you know, I mean, it's a Friday afternoon and blah, he's got these goofy orders, um, like a 25cc water flush every hour while the tube feeding's running and it's a Friday afternoon, you know, so you're not going to ... you don't want to really change anything for the weekend, and there was questions about tube feeding intolerance and loose stools and all this kind of stuff so, I'm like ... so we just, I talked to him and he's alert, but, you know, why does he need the tube feeding? There really was no physical problem that prevented him from swallowing because he could take his pills without a problem, orally. Um, but it turns out he's got bipolar ... disease and I think that's the biggest hurdle with him eating. So, I talked to him and just going to try and establish an a ... a rapport with him. Um, and kind of got his feelings about eating and is it something you want to try again and, that following Monday, which was his ... Monday, he agreed to drink two cans of ... a day ... and so we cut down the tube feeding a little bit. ... and now, today, he said, "Okay, I'll drink three cans a day." ... so we're going to cut it down a little bit more.
>
> Yeah, so I ... and his wife is really happy. He's a young guy ..., you know, 60s. ...very alert and oriented, but I think the bipolar issue's been his ... that's his biggest hurdle, so working again with the social worker, on that one and ... and the wife really close ... and then I also work with him. I'm trying to get him as much control over what and when and how much as I can, 'cause I don't want to ...I would love to get him off his tube feeding. So that's ... that's usually a Friday (laughing).

One interviewee commented on how difficult it could be to respond to recommendations by "experts" that don't do the work, but they are the experts.

> Cause they ... sometimes they'll say, "Oh, we got to do this", "You got to do that", "You got to do that," but you do it and you tell them, "It doesn't work because ..." ... you know, they ... it's easy for them to say, "You got to do this, you got to do that," because they're not doing it, but if you go in there and you.... They want to physically do it ... doing what they want you to do and tell them it doesn't work ... "Oh, but you have to do it this way." Like when the lady comes from PT. "Oh, you need to do this" and "Do that" and "Do this ..." You know you try it and it ... Oh, but it works this one time that you're doing it ... you know, and it takes ten minutes to do it. We don't have that time.

> Oh, like if the PT person brings them in and says you need to do it this way... and the PT person has the ... the 10 minutes to do it ... where you guys don't ... because you've got to get everybody up and that kind of thing.

The subcategory, Goals, included the following: (a) decisions made by residents (residents are more interested in meeting goals if they are involved in making goals), (b) residents being more vocal than in the past, (c) residents compliance with therapies, (d) residents noncompliance with food restrictions, (e) staff knowing it's a lot of work helping residents meet their goals, (f) several disciplines needing to help residents achieve their goals, (g) educating residents on self care and health care decisions to assist them in obtaining their goals.

One interviewee reported a common problem that requires round table discussion to resolve the problem, as being, "I think ... when the staff feels that they are not on goal with the resident or the family."

The subcategory, Safety, included the following characteristics: (a) residents' illegal activities; (b) screening of residents for dementia, depression, and other health risks; (c) safety using drugs (safe for person / safe for facility); (d) residents hitting staff being a danger to be around; and (e) resident safety, bed alarm sounding when a resident was climbing out of bed.

One participant described some safety issues the LTC staff had to deal with when a resident has dementia:

> They don't have a dementia unit there, so when people ... ah, when they open the dementia unit over at ... built up immediately. But, the patients who are there are usually only there for a short term because as the dementia progresses, they become total nursing home care patients...
> ... and behavioral issues become a problem with people who are and have dementia becoming confused. Sometimes you become, ah,

> disruptive with behavior ... they can't be ... and then, many of them are ... when they're ... when they're demented, they want to get up and walk. They don't realize they can't stand up anymore .... So, you can't restrain people with ... physical restraints anymore. You're not supposed to use chemical restraints on people ... but, they do, often have to receive some kind of sedative to ... to ... just to keep them from being ... disruptive, for their own safety as well as the safety of others. ... and then of course, documentation is a major thing, too, and ... whenever there's a ... an issue like that, patients have ... the doctors and those other caregivers have to document very clearly on the record, why patients are being given these psychotropic drugs, for example.

Expectations

This category covers staff and how they view each other's roles. Staff at a LTC facility are dependent upon each other. They expect certain things from each other. If expectations are not met, problems can result. This category also covers what family and residents expect from staff and what staff expect of residents and family. This category included conflict and how it influenced collaboration. Some of the characteristics in this category are listed below:

1. Expectations of level of care of families and residents were often beyond what the LTC facility could provide
2. Expectations of family were in contrast with reality
3. Expectations of family, government, etc. tend to increase over time; they tend to be higher than a LTC facility is capable of providing

One interviewee commented:

> It's ... nursing home care is increasingly important to people. ..of the family members, and patients, ... you know, they ... if we tell them up front, when they first come into the home, ... this is what we can do for you, ... then, here's your obligation, too, you have to tell us what you expect of us.

The category, Expectations, could also be subdivided. Subcategories under the category, Expectations, were as follows:

1. Visions
2. Home
3. Long Term Care Facilities
4. Factors in the Nursing Home

Visions

The subcategory, Visions, included the following concepts: (a) what would the ideal situation be under these circumstances, (b) actual possibilities for the resident with limited resources, (c) anticipation of coworkers, (d) having big expectations of CNAs, (e) guaranteed work behaviors from coworkers in knowing what to expect, (f) assurances for family expectations, (g) family and the resident needing to tell ITMs what they want, (h) family and residents making demands beyond what they can get from the delivery system, (i) staff-provisions to give staff what they need to provide care for the residents.

As one interviewee commented on their vision for a new coworker coming in to the department:

> Yeah. It's like, you're not in the routine and yeah, the ... the new person doesn't know, you know, if they should ... you know, to clean ..., you know after the day is over, you know, they clean the department, you know, if there's this dirty cushions that come then, you know, we have to give them clean ones, ...

Sometimes a family or resident will expect life in a LTC facility to be a certain way and when it is not, the disappointment that follows is hard to deal with.

> The only time we get into trouble is when the patients are ... have expectations or more than likely the families have expectations that are beyond what the nursing home can give ... or if they are led to believe that

> the services should be greater than what they are ... and, that ... has to be dealt with, ah, very quickly, otherwise, ...unhappiness.

Home

The subcategory, Home, refers to a goal, the goal of getting residents back home; helping them improve their health to the point where they can go home. It includes the following ideas: (a) hope for discharge (residents want to go home), (b) increased quality of life at home by enhancing home with programs (i.e., physical therapy, occupational therapy), (c) lifestyle changes such as following a perspective of health, i.e. quitting smoking. As one interviewee commented:

> I mean, ... nobody wants to be in a nursing home. They all like to be staying in their own home, independent, driving their own car. So right off the bat, you have to get people to understand that this is their home, now. It's a nursing home. It's where they're going to live. They only have a room and a bed and a chair and a bathroom and that's it, but that's they're home and they're there for an indefinite period of time, maybe for the rest of their lives.

Long Term Care Facilities

Another subcategory, Long Term Care Facilities, included characteristics that described the environment of a LTC facility. Characteristics in this subcategory included: (a) nursing home as community rather than repository; (b) state surveys the ITMs worked with, an archaic method of surveying; (c) Medicare reimbursements; (d) Per Diem revenue from the nurse's assessment; (e) LTC cost of co-morbidity increasing; (f) cost increasing for LTC and the residents; (g) nursing home activities – i.e. PT helped bake cookies, pen-pals, plays; (h) insurance as an on-going problem – costs, very expensive drugs, $1000 for 5 days. One interviewee mentioned:

> Well, and the other part of it is the ... the, ... challenges that ... the families come with, in terms of trying to procure or to try to figure out what to do

> with their loved ones. ... frequently, skilled nursing facilities are not the first choices ... that, other options have either not been available to them or failed them ... and so then they come to us in some ... desperation or whatever you would want to call it, ... end of the line, or "... what do we do now?" ... and so those are ... those are part of the mission ... and part of why we're there.

Factors in the Nursing Home

The subcategory, Factors in the Nursing Home, described problems in the LTC facility. These factors occurred when expectations of family or staff were not met. Characteristics included: (a) nothing being done to make the residents' situation better (paying $6,000 a month); (b) reimbursement to the LTC facility for care of residents was an issue because many expensive drugs and expensive nursing costs exceeded the per diem allotment given by insurance companies for resident care; (c) many of the residents did not like change (facility remodeling, residents would be moving twice within the facility).

Categories Based on Influences to Collaboration

The purpose of this section was to present data that influenced collaboration, that is, that answered research question number one. Through the DON's, residents', and ITM's responses, comments related to how they perceived their circumstances while interacting with each other were explored. Answers to the interviews were re-analyzed for statements relating to the concept of collaboration. These answers revealed that influences to collaboration could be divided into two major groupings, influences that enhance collaboration and influences that are barriers to collaboration (Appendix C). Barriers to collaboration answered research question number two.

In the following sections, two categories revealed in the data are listed, "Influences that Enhance Collaboration" and "Influences that are Barriers to Collaboration." Along with these categories, some of the major groupings (or subcategories) that make up each category are listed. For a more complete listing of categories, subcategories and codes please see Appendix C. Figure 1 depicts the relationships between the research topics of the categories revealed in the data, and the influences and barriers that can affect collaboration.

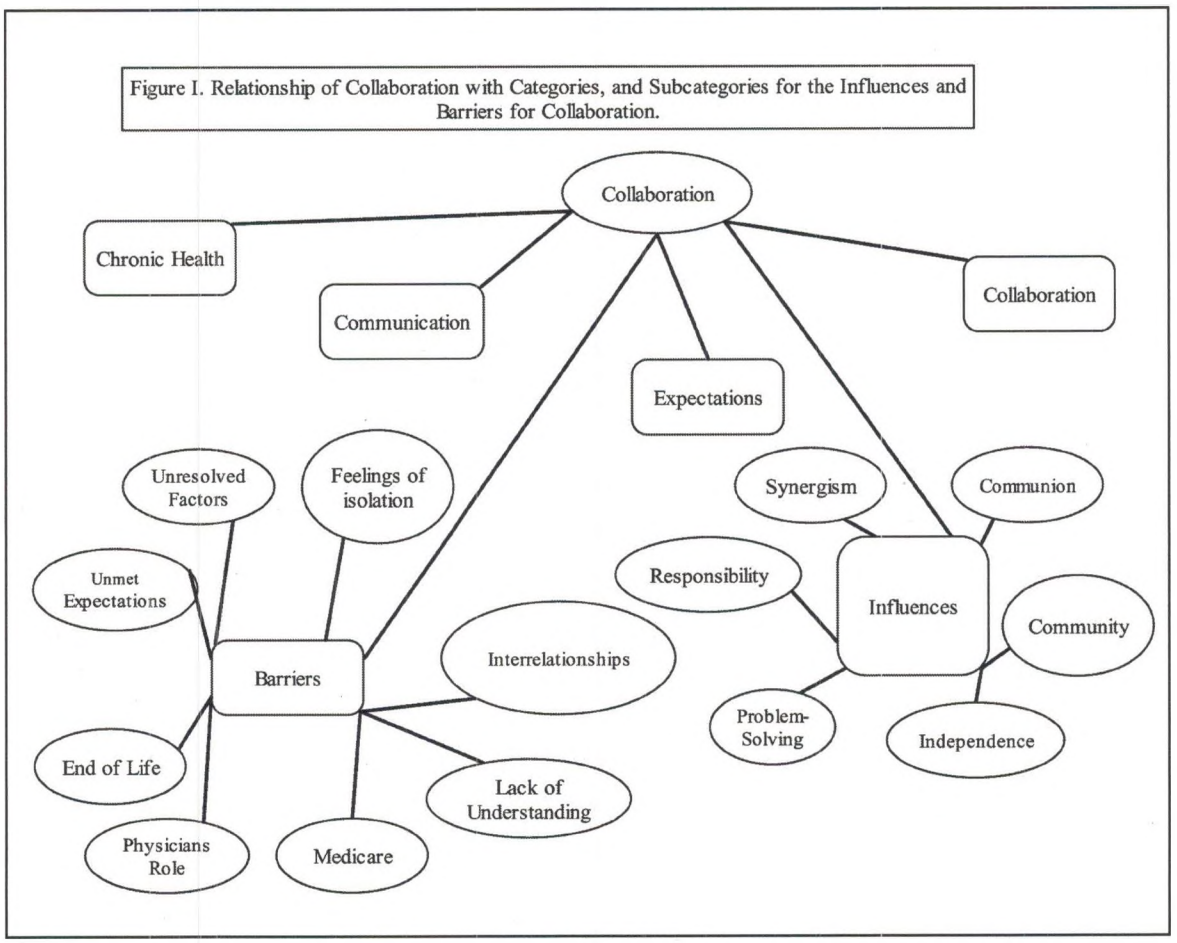

Figure 1. Model Relating Collaboration to Categories Developed from Research Data

Influences that Enhance Collaboration

Influences that enhance collaboration fell into the following six subcategories: (a) communion (Sharing), (b) community (Connectedness), (c) independence, (d) problem – solving, (e) responsibility, and (f) synergism.

Communion (Sharing)

Communion refers to influences that characterize positive means of communication. Good communication was expressed by all ITMs interviewed as the most important variable that enhances communion. Other variables included sharing information about a problem or issue in order to receive feedback rather than keeping the information to oneself or ignoring little problems until they became big problems. The category of communion included some of the following characteristics: (a) ITMs sharing information with one another; (b) ITMs being willing to consult one another for recommendations; (c) ITMs listening to each other; (d) ITMs having good communication with the family; (e) ITMs having care conferences to resolve issues and problems; (f) ITMs trusting other ITMs; (g) ITMs respecting one another, their abilities, their differences, and their positions; and (h) ITMS not being afraid to point out problems when they occur.

"We're going to be talking about these things altogether, all the time," commented one interviewee. Another comment that elaborated on the concept of communion included, "So we just talked about what the family thought and how they felt of us and I think everybody just kind of put their heads together to say, 'What should we do differently?'"

> ... we've got several mood issues, you know, "how are we going to get 'em to eat?" "What medications can we try?" ... and all that kind of thing. ... or, you know, we just, you know, I've noticed this with .... "Have you guys seen anything and ..." and um, we all just all kind of compare.

One ITM spoke about sharing and comparing with other ITMs.

> Well, for sure, social services, ... the nurse, ... the dietician and the activities and therapeutic recreation are more part of life enhancement rather than getting to those tough decisions ... the administrator is ... assistant director of nursing, the director, … the physician,... if we can't get the physician on board with us, we need a physician in conference call with us, ... or we need the nurse to call the physician and say, "Hey, this is where we're at."
>
> Ah, the tough talk with the family, ... involving the family and saying, "Hey, this is ... this is what's going on." ... and this is a problem for us in the ... in the setting whether that's a daughter, a son, or a spouse. ... I guess I think that, um, the family needs to be always on board, initially, ... because they know the life history. They know what that person's life has been. They know what to expect. They've ... they know way more than we do.

The following comments illustrate how ITMs shared with each other, items that they felt were important to know.

> …we do work with the dietician a lot. We have a lot of, … renal patients here, ah, we have peritoneal dialysis here and we have a lot of people on hemodialysis, so their diets include restrictions, and things like that become important. We also have some tube feeders here that require certain, you know, biggest, you know a little bit more ..... complicated, yeah, diets. ... and especially if they have diabetes and, you know, that kind of thing, so ...
>
> She's really good about letting me know, you know, so also hasn't had a ... you know, and I've even drawn, do ... do you think that would be important to draw? ... so she's really good about kind of cueing me into what she feels is important.

Community (Connectedness)

Community refers to a person's sense of belonging, a sense of being comfortable in their surroundings. Community was enhanced when staff and residents, alike, felt

comfortable with each other and their surroundings. Collaboration was enhanced when the ITMs showed respect and a common interest in each other.

The category of community included some of the following characteristics: (a) ITMs were treated as an extended family member; (b) ITMs were family oriented; (c) ITMs took the time to educate families in normal progression of chronic disease, and other issues in a LTC facility; (d) families trusted ITMs; (e) staff had strong positive relationships with each other (they got along); (f) ITMs were comfortable communicating with doctors and nurse practitioners; (g) ITMs had good leadership; (h) ITMs felt their job was important (they felt they could make a difference); (i) people in the LTC facility showed compassion for each other (they were interested in each other); and (j) ITMs enjoyed their jobs.

One ITM mentioned it was, "... beneficial if teams work together for a long time." The longer staff members worked in a facility, the easier it was for them to feel a sense of belonging and acceptance within the interdisciplinary team. For example, one person stated, "You know, a lot of these people have worked together for a very long time. They have a strong bond, and they work well together and they anticipate each other's moods, know all of the patients very well." Another ITM commented on their sense of belonging to the community.

> ... they're, like they're extended family, you know, ... about their kids and about what goes on, you know, you come back, if you get a weekend off, they ask you how, you know, how your family is, what you did ... you talk about the weather and everything ...

Independence

When speaking of residents, independence referred to their ability to have some control over their lives and their situations. When speaking of staff, independence referred to ITMs wanting freedom to perform their work as they deemed necessary. Also, if resources were available that ITMs needed to solve problems; this would enhance independence by giving the ITMs the ability to choose wisely when making decisions. Responsibility was closely related to independence. The more responsibility a person was willing to accept, the more independent they tended to be. Independence was important because it helped staff develop from novice to expert. The category of independence included some of the following characteristics: (a) residents felt knowledgeable about their body; (b) resident's were involved in making decisions regarding their situations; (c) ITMs were given as much responsibility as they were capable of and willing to accept; (d) ITMs were allowed to look up information, i.e. PDAs, to solve problems; (e) ITMs responsibilities were individualized according to discipline (ITMs were focusing on their own jobs, not doing somebody else's tasks); (f) ITMs were supported in their decisions by their superiors; (g) ITMs could see that their interventions were helping residents and each other; (h) ITMs could be objective rather than emotional when problem solving; and (i) ITMs were allowed freedom of choice on how to solve problems. Independence was important for residents and they needed to be given as much independence as they were capable of. However, there were occasions where a resident's independence caused problems. The following quote illustrated this point.

> ... I think that just recently we had a situation where an individual in our nursing facility did something that ..., not only was something that we couldn't ... accept, but also something that was ... probably not legal and ... the social worker and the care coordinator really said and asked, "Are we going to get backing on this?"

Most of the time, however, the more independence a resident had, the better it was for that resident. One resident explained how they tried to stay as independent as possible by doing as much as possible. Residents chose whether to participate in therapies or not.

One ITM related how important it was to the staff in a LTC facility for residents to maintain their independence as much as possible, "Well we just do the best ... I mean, well, care for the residents, you know, the best care you can give, you know, give them without them losing their independence and that's basically our role is here and it ..."

Independence in the work environment could also help staff members feel better about themselves and their work. One interviewee commented on how having some independence during decision-making allowed them some leeway in caring for the residents of a LTC facility.

> I tend to be more focused on comfort care here, making them comfortable instead of doing a lot of things, aggressive things that, in the end probably aren't going to make a whole bit of difference. You know, I'm not one to put a 95-year old through a colonoscopy or a bunch of tests that really isn't going to change the outcome of their demise or quality of life. I try to really do things that are going to make a difference for that person, and kind of keep that in the back of my mind, and to some people that just isn't aggressive enough, and so, you know, you may have different points of view, however, I think that's good, ...

Independence appeared related to responsibility. The more responsibility a person was willing to accept, the more independence their role acquired in a community.

> ...I think I, oh you kind of, ah, develop the role as you work at a job and ... the role changes as you may either accept or refuse to accept more responsibility ...

Problem - Solving

When problems were solved efficiently, they did not accumulate. So, an efficient method of solving problems would enhance collaboration by minimizing the number of problems that had to be dealt with at one time. When analyzing the data from the perspective of influences to collaboration, problem-solving re-emerged as a category that enhanced collaboration. Some of the characteristics that described factors that enhanced problem solving included the following: (a) ITMs encouraged individuals that were having problems to report them; (b) ITMs and family members developed realistic advance directives with the residents; (c) ITMs were willing to talk to the nurse practitioner, the nurse, or to call the doctor, as needed; (d) ITMs would identify little problems before they became big problems; (e) ITMs were able to figure out what to do when solving a problem; (f) ITMs respected and followed the "chain of command" in a LTC facility (for example, CNAs approached the care coordinator, first, and then the charge nurse when trying to solve a problem-they did not go over their supervisor's head); (g) ITMs believed it was important to be willing to try several methods for solving a problem rather than focusing on one option alone; and (h) ITMs were willing to discuss a problem with all persons involved to determine what everyone's perspective was, as opposed to one person's perspective. Problem solving was enhanced by experience. The longer a staff member worked in a facility, the better they knew who could help them solve problems. Problem solving was enhanced by creativity.

One of the first steps to solving a problem was identifying the problem and reporting it to staff that could help solve the problem. For example, when it came to prescriptions, staff needed to be sure residents were getting the correct prescription. One interviewee noted:

> …. 'cause sometimes they'll write something and they don't mean to write it. But ... but we'll question it. I find ... some nurses don't like to question doctors. ... and I'm sure some pharmacists are the same way too, but, you gotta. I mean, you just... because I'll call a nurse up and say, "That doesn't sound right." "Well that's what he wants," ... "Well I don't care, that ... that doesn't sound right." ... and they'll check, eventually.

Once a problem was identified, staff had to be creative and look for ways to solve the problem. The next quote displays a good example of how staff identified a problem and used their creativity to develop a couple different options to solve the problem.

> I know just recently, we ... had a lady on a unit that ... very distracted, she's got Alzheimer's ... very distractible, overwhelmed, panicky, anxious and they'd noticed that she wasn't eating well at meals, so they wanted to try just giving her one item at a time, at meals, so we tried that, and it still wasn't working well, but the nurses, realized that she would give anything that you gave her out by the nurses desk, but once you got her in the parlor, she wouldn't eat. ... and I think it was just too many people, so then we started, giving her tray after all the other residents had left the parlor, so she was basically alone with some supervision and ... and she's been doing really well. So stuff like that ... identifying problems and trying to come up with a solution, and that's ... that's a very common one is ... is where to put people at meals and how are we going to feed this person…

One person commented on how helpful it was when a fellow ITM was willing to take the time to explain how to solve a problem, "He is willing to teach when you have any questions or problems." Solving problems was easier when you could gain several different perspectives on a situation as shown by this

statement, "We all have different personalities, so we all will attack a problem a little bit different and it helps sometimes to bounce back if there's a problem."

Responsibility

Responsibility referred to accountability. Data revealed that in order for collaboration to be effective, it was important for ITMs to be accountable, and to be responsible for what the team expected of them. Team members, residents, and families all had certain things that were expected of them in a LTC facility. The category of responsibility included some of the following characteristics: (a) family and residents had a role in predicting disease processes; (b) everybody involved was willing to follow the policies in place; (c) ITMs followed accepted standards of care; (d) ITMs complied with guidelines for resident care; (e) ITMs were well versed in their area; (f) ITMs were receptive to discussing problems; (g) accountability was enhanced, and therefore, responsibility was enhanced when ITMs were assigned the same resident every time they were on duty; (h) ITMs completed their assigned tasks while on duty (rather than leaving some things for the next shift); (i) ITMs conscientiously recorded changes in residents' conditions and reported any concerns in those conditions; (j) ITMs were honest when giving information to other ITMs; (k) ITMs were reliable about coming to work and about helping each other; (l) ITMs were courteous to the people around them; (m) ITMs kept themselves in good condition, emotionally and physically; and (n) ITMs were accessible by phone or email, etc., to other ITMs.

In order for collaboration to be effective, a responsible person would keep the lines of communication open as demonstrated by this comment, "What I think is an

acceptable behavior might not be acceptable to nursing or to the nurse aide, and we'll have to sit down and talk about that."

ITMs were expected to be responsible for their own specific tasks. They were expected to act respectfully to each other. One person explains:

> I have a high respect for the nurse aids and their job is extremely hard and they have to do the... the... heavy work. They have to do the personal care for the residents and they have to be the one that ... maybe isn't always ... respected from the residents either.
>
> ... but I expect them to always act professionally and I'm reminded sometimes by our DON that they're not professionals, so, that's the hard part for me to talk team work is I do expect them to act the same as I would ... and we have to teach and train them how to act as I would, so I do get involved in the classroom training too, but... that's... the hardest one for me. I always expect the staff to be professional and I always expect people to ... not take criticism personally when it comes from the residents ... and that's hard for staff too.
>
> ... other expectations, I think that it's just the general professional thing. We know what the nurse's job is - you know, the medications, the assessments, being able to deal with the critical happenings that go on with the residents and they ... pretty much always do that. I expect the same from an RPN as an LPN ... or an LPN as I do as an RN and that's not always fair either.

Staff members needed to be responsible for keeping each other informed of residents' conditions. Staff needed to work together to care for the residents. One person interviewed described how they did this.

> ... we have a notebook of, you know, big things that we've done during the day, changes that we want each other to know about, diet changes, all that kind of stuff, so we try to keep each other informed as much as you can, but you don't know everything, you know, and that tends to drive me crazy ...

One person interviewed enthusiastically described their responsibility toward the residents:

> ... well, you just care for them. You're basically their, you know, you're their eyes and ears and stuff, you know like if you go outside and they ask

> you how outside is, you're their eyes and ears out there. You know, if ... they can't see, you can see for them. If they can't reach something, you reach it for them. You know, you do what they can not do. ... and then I..., sometimes they can do it, but you just, you know, help them and encourage them, you know, so you're ... you know, to get them to try and accomplish their goal better.

Resident's, themselves, could be responsible for their own condition. One resident described what they did to help themselves.

> ... and I do that every day and then I maybe take a two minutes rest or something. Then I get in my, ah ... I grab my walker and I walk up and down. I'm not sure they ... and I think I'm doing pretty good. You know, some don't even try. The way I look at it, some's worse ...

Synergism

Synergism emerged as a final category, when the data were re-analyzed for this section, Influences that Enhance Collaboration. Synergism referred to a situation where two (or more) people worked together to achieve a result that neither was capable of achieving on their own. The category of synergism was supported with some of the following characteristics: (a) the presence of "Hands on Care" – refers to the physical aspect of caring for a resident, "being done without being seen", this intimacy created a bond between caregiver and resident, it was a deeply personal warming experience and gave a sense of peace; (b) during collaboration "credible connections" developed, a credible connection refers to the enhanced connection that occurs when two people work together to solve a problem; (c) family and resident had good rapport; (d) ITMs that worked well together, that communicated well, that knew each others moods and supported each other, had a synergistic relationship; (e) when residents and ITMs took the time to get to know one another, and they liked each other, you had a synergistic relationship; (f) when an ITM respected colleagues' efforts to help them with difficult

times or situations, and when the situation was reversed, they reciprocated, this demonstrated a synergistic relationship; and (g) when ITMs knew each others' expectations and were willing to fill those expectations, synergism was present.

Synergism is a type of relationship that would abound in a LTC facility, because of the nature of the facility. One interviewee said it best, when they stated, "I can't think of anything that would just be me." People in this type of work relied heavily on each other. Reliance led to synergistic relationships. Another interviewee expounded on this, "Each one of them is important, to the residents overall health, it is important to communicate well with all of these different disciplines and work together as a team."

An ITM described their "credible connection" with a social worker when residents were first admitted to the LTC facility. This ITM felt they worked well with their social worker. The two ITMs had a good system.

> I frequently touch bases with the social workers, especially like day of admit, you know, ... they get a very detailed history and ... if she goes in there before I do, she'll often give me a heads up as to, "Here's what they said. Here's kind of what they were doing at home. Maybe you want to ask them about this." ... or if I get to them first and they comment that they just don't feel like it's worth it anymore, I'll just pass that on to the social worker, too, before she goes in there, ...

One ITM described their synergistic relationship with restorative aides:

> I'd said you give a lot of credit to the ... our restorative aides here, that you do hear different stories from the therapists that go from here to ..., you know, comparing, ... I wish that I could give them more credit here, because you know, they're so efficient and stuff, too, and I don't have to hardly ... Yeah. I don't have to hardly even supervise them or ... and you know, they just kind of look up to me for, you know, questions and problems that come up, you know, little problems, but like, they do ... they respect me a lot and I like that ...

Sometimes a synergistic relationship will develop between a resident and one or more of the staff at a LTC facility. One resident described such a relationship. "I, got to know my workers and I enjoyed 'em. They'd give me a shower and we'd giggle in the shower, you know. They were all a bunch of nice girls that I had ..."

Another person described their relationship with a nurse practitioner fondly.

> Well, we're in ... contact all the time. If she has any problems, she can't resolve, then she calls me on them so, anyway, ... is wonderful, and been just great to work with and she's elevated the level of care over there, immensely since she's been there. I don't know how we'd get along without her now.

One ITM described how they felt their role compared to other ITM's roles during collaboration.

> Um, gosh, I see my role as just being a piece of the puzzle. Um, when you look at a ... a resident, you ... I look at the nutrition piece, and then the others just kind of fill in the other parts of the puzzle and ... I think we don't get together very often during the day, 'cause we've all got different things to do, so when we're actually at the care conference, all sitting around the table, we do a lot of talking and sharing and comparing and ... all that kind of stuff, so I see just my piece of the puzzle being nutrition.

Influences that are Barriers to Collaboration

Barriers to collaboration fell into eight subcategories (a) unresolved factors, (b) feelings of isolation, (c) interrelationships, (d) lack of understanding, (e) minimum data set (MDS) and Medicare, (f) physician's role, (g) unmet expectations, (h) end-of-life.

Many variables existed that hindered collaboration. Some were a result of personality traits among staff members, whereas others were more related to policies, procedures, or rules followed by the facility. Comments made during the interviews that implied that barriers to collaboration existed were noted.

Unresolved Factors

While analyzing the data, the category, Unresolved Factors, became apparent. Some of these factors had been in existence for a long time and would continue to be a problem for the LTC facility. Unresolved factors in the nursing home included some of the following characteristics: (a) complaints about the cost of LTC; (b) complaints about residents being on so many medications; (c) complications to a resident's overall health that could arise from being in an institution (i.e., pressure sores, skin breakdown, depression); (d) residents not liking the choice of food; (e) residents complaining about a lack of privacy; (f) residents and staff not agreeing on the perspective of health (refers to an overall regimen for keeping residents healthy – residents are not allowed to smoke, drink, do drugs, etc. and some residents want to do these things); (g) complications to a resident's health resulting from a hospital stay; and (h) residents and staff resisting changes to a LTC facility, changes which are necessary to maintain or enhance the facility or the LTC environment.

One comment from an ITM who detailed the concept of unresolved factors in the nursing home included, "This nursing home cannot afford to do those things and they don't have the staff to provide that level of intensity like they do in the hospitals." Another team member elaborated on the problem of costs associated with LTC.

> You know ... and ... $1000 for five days, I mean, there ... are worse things ... and I know that they'll ... call me and ask me, "Well how much does this cost?" ... because they're thinking about admitting somebody into the nursing home and I'll tell them, I'll ... whatever. So when they decide whether or not they're going to take this person. If it's just ... you know ... when you're getting paid $300 a day, you don't want to be spending $400 a day, 'cause that ... the bottom line, you gotta ... if you don't make a dollar, even though you're non-profit, you still got to ...You got to show a profit ...

Feelings of Isolation

Feelings of isolation arose when a person felt they were not accepted as part of a team or group. They did not feel support from the people around them. Analysis of the data revealed several characteristics that supported this category. These characteristics were (a) staff did not inform supervisors/administrators of problems, (b) supervisors were overzealous about monitoring staff to prevent deficiencies, (c) family did not contact the institution or resident frequently enough for adequate consulting, (d) family members behaved inappropriately towards the resident, (e) residents behaved inappropriately towards ITMs or family, (f) residents did not wish to live at a LTC facility, (g) ITMs forgot to include physicians in interdisciplinary team discussions, (h) residents refused to stop participating in illegal activities, (i) certain ITMs felt as if their opinions or knowledge were more effective than other disciplines (social pecking order was in effect), and (j) ITMs felt isolated because their opinions were not considered valuable.

A LTC facility is a closed environment that develops from persons being together for extended time periods. New residents and staff may sometimes feel isolated if they are not included in conversations or other community activities (or in collaboration).

One staff member commented on the difficulties they encountered when they first started working at a LTC facility.

> I had a hard time working with a certain therapist, I don't know why ... I think we kind of clashed ... I remember going home a couple times at lunch and I'd just cry 'cause I just did not want to go back to working ...

Another ITM commented on the difficulty of working with other disciplines when they did not listen to what you were saying, "... intimidating shall we say, and so a lot of

people will be scared to confront them about a question, but I'm sure that's always been like that, too." When a staff member felt afraid to consult someone that they should be able to consult, the staff member may have felt isolated and that made solving a problem more difficult.

One resident commented on how they would have preferred to be home. This resident was confined to bed and felt isolated when they could not participate in the LTC facility's activities:

> ... you get like you always want to go home. ... and they have them ... a world of there own and I kind of, still, I'm too young to be here, you know, but I have to be here 'cause my husband can't handle me.

Interrelationships

If interrelationships between ITMs are of a negative nature, communication becomes more difficult. How do you collaborate with someone with whom you can not communicate? Characteristics that created barriers to interrelationships among staff and residents at a LTC facility were discovered while analyzing the data. The category relating to interrelationships of ITMs was based upon these characteristics: (a) social "clicks" among ITMs prevented the development of good interrelationships between some team members, (b) when some ITMs were not willing to consult others, or were intimidated by other disciplines, relationships would not develop (You can't have a relationship without communication; (c) bad attitudes interfered with interrelationships; (d) interruptions (phone calls, pagers, and people breaking into conversations) made it difficult to collaborate, collaboration in a private setting to avoid these interruptions was more conducive to problem solving; (e) ITMs were not on goal with the residents; (f) skewed communication or even lying to avoid unpleasantness could interfere with

relationships (ITMs valued honesty); (g) staff and residents showing a lack of courtesy could interfere with good interrelationships; (h) overlooking a team member during a round table discussion could lead to the development of bad feelings and therefore bad relationships; and (i) redoing another person's work would create bad feelings.

Comments by ITMs elaborated on the difficulties that could arise to the development of good interrelationships. One person stated, "For somebody to come in from the outside and fit in, it's difficult, terrible turnover rate. If they do not catch on right away, they do not last, either." A couple of staff members agreed, and referred to this problem of long term staff members treating new staff members poorly as, "eating their young," or putting the new staff member, "out to dry a lot."

This example shows how lack of courtesy could damage the interrelationship between ITMs.

> ... so we just sit there and just say, "Okay, whatever." Yeah, she's ... she's the ... like the treatment nurse, I mean, you know ... yeah, so she gives them the medicine and stuff and like the cups and put this on so-and-so and, "Okay, what's ...," you know, if we're in with a resident, say getting them ready for bed, she'll walk right in and give them their medicine and not even ask, you know, we're in ... in the middle ... getting them into bed and she just walks right in, you know, "Here take this here, oh, I'm sorry I'm in your way?"... trying to get her job done. I just walk out and say, "Okay, I'll come back," so, I'm like, okay. Yeah. ... and yet, you still got to work with that person, ... so you've got [to] watch what you say ... or they'll make your day miserable. Yeah, so I just leave. She's going to do everything and I just go ... go on to somebody else.

Lack of Understanding

Following analysis of the data, the subcategory, Lack of Understanding, emerged. This subcategory included some of the following characteristics: (a) residents sometimes displayed disruptive behaviors as a result of disease; (b) many staff did not have an

understanding of the behavior issues of some residents; (c) when staff displayed unprofessional behavior, this contributed to a lack of understanding, unprofessional behavior could contribute to problems with interrelationships, and feelings of isolation; (d) when staff were not knowledgeable about standard rules and did not follow the rules (i.e., someone didn't follow a doctor's orders), a big problem with understanding between staff members could develop and the viability of the facility could be in jeopardy; (e) lack of understanding could arise when communications were misinterpreted; (f) many new ITMs were not prepared for the emotional aspect of working in LTC facility; (g) many new ITMs were not prepared for the physical aspect of working in LTC; (h) some ITMs, residents, and family members lacked knowledge of chronic disease and its processes; (i) some ITMs did not understand the importance of evaluations (e.g. what is implied when a facility receives a Level G deficiency – a facility rated with a Level G deficiency can lose revenue and lose admissions); and (j) residents refused to comply with decisions made by providers because the resident didn't understand the importance of the providers' decisions in regards to the resident's health.

A good example of a situation where lack of understanding could arise occurred when ITMs were excluded from a Round Table, not intentionally, but because they were simply forgotten. "... we forget that because we operate under physicians' orders, we always need to bring in the primary physician and the nurse practitioner, ..." Forgetfulness contributed to lack of understanding.

Some families expected their loved ones to improve in a LTC facility. They did not understand that improvement may have been impossible because of the nature of the resident's disease. "They're not understanding the expectation of what happen[s] when

somebody has dementia, Parkinson's, ... the chronic diseases that are so prevalent in the population...."

This next quote showed how lack of understanding could develop when some staff did not have access to information on a resident's needs or conditions. "They ... don't read through the charts. ... they don't have ... full access to the charts ... don't really understand what each medicine is for or each tube is for ... a lot of it is education and sometimes it's, ... interpreting policy ...." One person explained, "So I really don't know the patients, shall we say. You know, we'll see the prescription, we know what drugs they take and ... we might know some disease states and stuff like that, but it just, you know, we're not that in tune to who they are exactly."

Minimum Data Set (MDS) and Medicare

Minimum Data Set (MDS) refers to a tool, or instrument, which is used to assess LTC facilities and the condition of residents in the facilities. Much of the revenue a facility receives is based on these MDS assessments. Medicare payments are based upon MDS assessments. MDS assessments can be positive in that they help identify problems in the LTC facilities that need to be solved and they help generate revenue. They can be negative when they: (a) over focus on finding problems and don't help look for solutions to those problems; (b) over scrutinize the nurses doing the MDS assessments, contributing to the stress on the nurses; and (c) create extra paperwork that takes time away from caring for the residents.

This category, Minimum Data Set (MDS) and Medicare, included some of the following characteristics (a) nurses who performed MDS assessments were always under investigation, (b) state teams of assessors created problems by always criticizing, never

complimenting when things were done right (lowered employee morale), (c) the time and paperwork required to perform MDS assessments often interfered with other tasks such as Round Table discussions and caring for residents, (d) paperwork generated by "Prior authorizations" for medications or treatments stole time from other tasks, and (e) methods of reimbursement for medications could interfere with decisions regarding residents and regarding facilities involved in collaboration. One example of funding interfering with facilities that collaborated and the decisions they made regarding resident outcomes was portrayed in the following quote:

> ... let's say we get an admit by the nursing home. They come out of the hospital and they're on a bunch of drugs. One of them is, ah, PPI, right ... Protonics, that's all we have over there is Protonics. So ... well, if they're on Medicare, fine, we'll fill Protonics. Um, then a week later, they go off Medicare and they're on ... Medicaid. ... Medicaid won't pay for Protonics, not without a prior authorization and the only way they'll prior authorize it is if they have tried the Prilosec OTC. Well, of course, our system of doing nursing homes, we don't bill until the end of the month. So if you don't ... catch it, you end up sending ... through a month's worth. ... $100, whatever it is. More than that. Gone.

One interviewee commented on the stress that could arise from all the assessments LTC facilities must undergo to stay open and receive their funding. "... it's a very archaic method of surveying nursing homes ... there needs to be ... rethought and revamped, rather than being punitive, it should be more of a quality improvement type of an approach." This person went on to say, "State, ah, survey teams, they come in, they're looking for problems. They ... want to find problems. They don't want to find things that are right and when they find problems, they want to punish the organization."

Nurses were hired specifically to perform MDS assessments. These nurses were under a great deal of stress to perform accurately. One person explained what could

happen to a nurse who made a mistake or intentionally reported false information on an assessment, "The nurses that do assessments ... are subject to fine if they falsify that ..."

Having to fill out MDS assessments was not only time consuming, but it could interfere with a person's personal time, vacation time, when only one person knew how to complete the assessment.

> That has been an issue. Um, because I am ... I was the only dietician here for many ... many years, thirteen years, and there was a ... a good span of 10 years where I didn't get a vacation that was longer than, maybe a Thursday through a Monday, because you've got ... you've got MDSs and you can't work ahead, 'cause you've got to set assessment periods ... and you have to do it every 90 days or, yeah ... there's a whole set schedule, but you can't work ahead and you can't backdate, so I mean you've got this window of time where ... and there's nobody else that does my section ...

Sometimes what Medicare would or would not pay for interfered with prescriptions. One pharmacist explained.

> No, there's a few of them. ...They pay for most things, but there are certain things. They'll only pay for one a day of certain things because it's cheaper to take, you know, instead of taking two a day. ... but ...Well, kind of, what ... what he does is, um, he decides ... like, ... this is kind of ... provisional. According to the manufacturer, it doesn't do any good to take more than 200 milligrams a day. Well, everybody's different and ... and ... and even if it doesn't, if they think it works, 'cause you know, whatever, but he ... they won't pay for more than one a day, period, end of discussion. So-o-o, you get this person that comes in, they want twice a day. They won't pay for it. What do you do? Well, you call up the doctor. "Well, they need it." Well, they aren't going to pay for it. "You want to pay for it?"

Physician's Role

After synthesis of the data, the category, Physician's Role, in the LTC facility emerged. Physician's played an important role in the care of residents at a LTC facility. When a physician did not fulfill all aspects of his role as a collaborator, problems could

develop. The following characteristics describe barriers to collaboration that fall into the category, Physician's Role: (a) physicians did not agree on a plan of care for residents, (b) staff was frustrated with the physician not communicating with families (i.e., family was not informed when a resident was defined as "end-of-life"), (c) ITMs forgot they operated under physicians orders because a physician may have rarely been around, (d) physicians sometimes missed visits with residents (a LTC facility requires a physician visit each resident at least 3 times a year), (e) physicians' prescriptions were hindered by insurance requirements, (f) some physicians did not want to be on call, (g) sometimes ITMs could not get ahold of a physician, and (h) some residents had more faith in TV and the National Enquirer than with physician recommendations.

One comment from an ITM elaborated on how physicians were sometimes perceived. "You have certain doctors that are hard to talk to, intimidating shall we say a- and so a lot of people will be scared to confront them about a question."

> ... I guess ... we have, we do have good communications with the doctors and to ... and with our nurse practitioner. Um, it ... it wasn't always that way. I remember starting and it would be nothing to be screamed at, you know, by a physician, angry over something and maybe it was an on call situation and they weren't the doctor. You know, you ... really don't run into that much, now. Every once in a while, but not much. ... so there seems to be more respect.

ITMs often became frustrated with doctors who refused to speak openly with families of residents.

> ... and the family was just pushing pushing pushing for a lot of things that the nursing home couldn't provide and the nursing home felt very frustrated with this, frustrated with the doctor not stepping in like they thought. I thought like my hands were sort of tied, because you can only say so much, you know, and when there's ... when there is discrepancy between some of the doctors, what they think, and it's really hard for the nursing home to get a good plan of care going ...

One staff member spoke about their frustration at a physician's absence.

> Other times, we've had meetings on, ... family expectation of the resident. Maybe they weren't going to recover, as they thought, and everybody knew it, except the family, and so we talk about how do we ... how do we get this accomplished without, you know, ... it's got to be the doctor's role, but how do we ... how do we get the doctor to come over and ... or at least facilitate some kind of a deal, so we've got conferences with that. Most of the time, the dilemma, the resident dilemmas, are dealt with with the nurse and the social worker.

Another person referred to physicians as invisible.

> Personally, no, it's usually the nurses, but when the doctors come; when the psychiatrists come, we're probably more involved than ... than the medical physician, ... but we do talk with them. We can't take orders, so we, you know, usually talk with the nurse and then they call the doctor. So that's usually it. Um, the physicians, you know, all the ... long term care, ah, information always talks about the physician as part of the team and um, they ... probably are a part of the team, but I don't buy it as much. ... they're very invisible. That's a good way to say it. Yeah. They're there; they need to be aware, but they're not in the decisions ... the problem solving..... of the decisions. They're there more to be told what's happening or to tell us what the parameters are and then we do the work.

Unmet Expectations

When data were evaluated, the category of "Unmet Expectations" emerged. Staff, families, and residents often had certain expectations of LTC facilities. When expectations were not realized, the resulting frustrations could cause barriers to communication and therefore collaboration. Common characteristics in this subcategory were as follows: (a) facilities were expected to provide an increased level of care for less money, this was driven by insurance companies, government and consumers; (b) resident conditions were deteriorating and the family was not informed, therefore, the family did not expect to see the decline; (c) residents expected to be able to do what they wanted to do, but what they wanted to do may have been against LTC policies (i.e., smoking was

not allowed); (d) expectations of families were sometimes in contrast to reality as the interdisciplinary team saw reality; (e) expectations of staff were unmet; (f) families were given false impressions about what a LTC facility was capable of providing and preventing (as in the case of falls); (g) ITMs were not as assertive in educating families about what to expect as they needed to be, when residents were admitted to a LTC facility; and (h) when a resident's condition changed and the family was not expecting it, anger that resulted could interfere with collaboration.

One comment from an ITM that detailed the concept of unmet expectations included: "Kind of clashed in a way 'cause, she was very, she wanted to be right, she's sometimes difficult to work with, doesn't seem very happy, like she just shouldn't bring it to work kind of thing." Sometimes new staff members did not understand how difficult it could be to work in a LTC facility. One staff member commented on new ITMs and their perception of the job. "... it's not as easy as people think it is. I mean that it's a lot of independent work ... and, we've had night nurses come in who ... will work one night as an orientee and they'll never come back."

Sometimes a family or resident would expect life in a LTC facility to be a certain way and when it was not, the disappointment that followed would be hard to deal with.

> The only time we get into trouble is when the patients are ... have expectations or more than likely the families have expectations that are beyond what the nursing home can give ... or if they are led to believe that the services should be greater than what they are ... and, that ... has to be dealt with, ah, very quickly, otherwise, ...unhappiness.

One person explained how they could minimize the occurrence of unmet expectations.

> ... if an individual is admitted with a pressure ulcer; their expectation that they will get another one is clearly there and predictable, yet it becomes the fault of the facility when that happens and ... and so, I think that we are ... we are frequently, acting ... from a victim behavior/perspective. We need to be more assertive in our education of families, on admission, with realistic expectations of what we can do and the potential of the kinds of things that we will fail at ... and I don't think we do that very well.

Sometimes one staff member may have expected another staff member to have knowledge they did not have.

> And I also expect people to tell me too, "I didn't know that," or "I don't know what to do," and then I'll help with anything but otherwise, I kinda expect them to know what to do in all circumstances and that's not always fair.

End-of-Life

Many people have difficulty talking about End-of-Life issues. This made it very difficult to collaborate, when people were unwilling to talk or were in denial. This subcategory included the following issues: (a) maintaining realistic advanced directives and code status for residents (Code I – everything done, Code II – drugs and/or defibrillation only, Code III – nothing but supportive care), (b) preparing advance directives with residents and their family; (c) realistic expectations of residents and ITMs; and (d) family support, death support. One participant commented on how they dealt with death when it occurred.

> Um, there ... it's ... I hold up pretty good, I think. 'Cause I know that, you know, we're all going to die, you know, and you're in a better place, you know ... so it's ... it's okay for me. I had a son that passed away, when he was a year ... a year old.

This feeling was echoed by another comment, "So, when they ... when they do pass away, then they're just ... they're free. Doing all the stories they told you, just, you know, ... do all that stuff."

Summary

The concept of collaboration was examined for an interdisciplinary team functioning in a rural Midwestern long-term-care facility. The role of the nurse practitioner was fundamental for collaboration to occur within the interdisciplinary team. The results of this qualitative study indicated that much work needs yet to be done with ITMs, specifically nursing, in order to fully encompass collaboration within the health care setting of the LTC facility. Categories were described that emerged while grouping the data from the interviews. These categories may indicate areas in which to start implementing interventions to enhance collaboration. Influences and barriers to collaboration were discussed. These indicated areas to focus intervention efforts on, in order to enhance team building and collaboration between ITMs in the LTC facility.

Good collaboration is very important. When collaboration and communication break down, the results can be depressing. One person who was interviewed explained what could happen when a physician did not speak openly with a resident's family. This chapter concludes with a quote that describes one case that resulted from poor collaboration.

> Well, we talk to the care plan coordinator. She helps us a lot and we kind of ... she kind of decides, "Well, maybe we need to talk to Dr. So-and-so," and, "Is this appropriate?" "What is our goal?" ... kind of thing and if she's at risk, if we're doing the tilt table and she's at risk for ... heels breaking down, toes, you know, opening, sores, then we have to talk to ... we have to see if we can, you know, dc [discontinue]the order which is another kind of chore to do, sometimes with this case, it's been kind of difficult. We've been seeing her probably for a couple of years now, off and on, in formal therapies and she is just maintenance, right now, and ... She had tendon releases. She's all contractured ... in her knees, too. ... and, now her legs are stuck straight out. ... and they've been wanting us to, you know, work on bending her knees, bending her knees, 'cause ... well, we don't know why, but ... they don't bend and she's in pain when

we're trying to meet ... we put 14-20 pounds on the ankles and they don't bend and we've been doing tilt table a little bit and stuff, too, but she's kind of comfortable doing, ... but before we were doing tilt table, she was all bent up. Her knees were bent and I mean, she's probably better off this way, but her ... her toes, I mean, when she's standing ... she's always ... she's had skin issues, breakdown, her heels and stuff and she, I don't ... we're ... I kind of say, "Why are we trying to bend her knees?" You know, what our goal here is and someone ... she did go to the rehab for a little bit, again, came back and someone ... this one therapist thought they could put her onto a s... from a sta... to a standing lift. She's like …, right now, but, there's no way you could get her up standing, on a standing lift, 'cause your knees need to bend, you know, they're not bending. It's kind of been a big issue. The husband just thinks she's going to get up and walk, again or something, but ... kind of sad and I don't think doctors really talk to these families, you know, about, you know, what's going to happen, what ... what can you expect and stuff ... kind of sad, so then they leave it up to us. Then we're caught in a bind, but, ... yeah ... He's like, "Oh, how's the tilt table doing?" and, "How's she doing?" ... and she, you know, like he'll tell us, "She ... she was talking a little bit yesterday," 'Cause she doesn't talk a whole lot, but she can if she wants to, but she just ... I think she's angry, you know and she's always just ... I think it's a lot of him that ... telling the doctors he wants the tilt table. He thinks that's going to make her stronger, again and if she keeps standing, well she can't move her legs at all. She can only move one arm, you know, and that's it which is sad, but, ... yeah ... I don't ... when we're going to come to an end with this case, but it's been a few years and it's sad, but ...

CHAPTER V

DISCUSSION AND RECOMMENDATIONS

The purposes of this qualitative study were to discover what influences collaboration had on an interdisciplinary team practicing in a rural Midwestern long-term-care facility, to discover what factors influence collaboration, and to discover what barriers can hinder collaboration. Since this was a descriptive, qualitative study, using grounded theory, semi-structured, in-depth interviews were used to collect the data. Results were obtained using a constant comparative method of data analysis.

Research Questions

The research questions for this study were:

1. What influences does collaboration have for an interdisciplinary team practicing in a rural Midwestern nursing home practice?
2. What are the barriers that hinder collaboration for an interdisciplinary team in a rural Midwestern nursing home practice?

Data were analyzed and themes relating to the data developed. Themes were subdivided into specific assertions and recommendations for improving conditions for efficient collaboration in a LTC facility. In the remaining pages of this chapter, themes and assertions will be discussed as they relate to the research questions. Literature will

also be presented that relates to the themes developed from this study. Study findings in relation to the current literature on collaboration, on what influence collaboration has in a LTC facility, and what are the barriers that hinder collaboration for an interdisciplinary team practicing in a rural Midwestern nursing home practice will be discussed.

During this study, data were gathered and major themes identified; themes were refined and findings representing the interdisciplinary team were listed. Seven main themes, inherent in the data, are listed below. How these themes relate to the research questions will be discussed.

Theme One	All staff (including CNAs, PT Aides, housekeepers, etc.) should have the opportunity to collaborate.
Theme Two	The LTC facility should regularly schedule training workshops on enhancing teamwork, communicating effectively, coping with stress, and building support networks.
Theme Three	The quality of life and well-being of the residents could be enhanced by providing an environment that is more like home and by providing activities that give a sense of belonging to residents.
Theme Four	In a LTC facility, all interdisciplinary team members need to communicate openly with families and residents concerning diagnoses and treatments and the implications these hold for the resident's future.
Theme Five	Physicians are not sufficiently active in the collaboration process with patients and families.
Theme Six	The increasing cost of long-term care is a concern for the aging population and their increased co-morbidity of chronic diseases.

Theme Seven LTC facilities need a support network to assist staff and residents with grieving when death occurs on a unit.

Research Question Number One

What influences does collaboration have for an interdisciplinary team practicing in a rural Midwestern nursing home practice?

Theme One
All staff (including CNAs, PT Aides, housekeepers, etc.) should have the opportunity to collaborate

Assertion One. Everyone has something to contribute to the team.

Assertion Two. It is important that nonprofessional staff are treated and respected as important members of the team.

Assertion Three. It is important for all staff to report problems immediately when they are discovered.

Assertion Four. It is important to solve problems as they are identified, rather than letting them build into larger problems.

It was mentioned in the interviews that many of the CNAs knew the residents better than other ITMs. All staff should be able to participate in collaboration, including CNAs, PT aides, housekeepers, etc. Having the opportunity to collaborate allows everyone involved to feel like an important member of the team. One participant thought that it was important that the CNAs be present at round table discussions. "... certified nursing assistants ... are very much the direct care-givers of our residents and so ... they need to be at the table saying, 'Well this is ... this is how this resident responds to the program.'"

Chronic health conditions require collaboration and communication. Aides and housekeepers were not invited to provide input into at the Round Table. They mainly go to professional ITMs if complications or problems with the residents were noticed. This relates to Assertion One and Assertion Two.

Communication occurred between the residents, aides and housekeepers. Sometimes staff members knew the residents better than professional team members. Many aides, housekeepers, etc. became like family to the residents, often knowing what was occurring within the residents' families. This knowledge is excellent information to bring to Round Table discussions and may help with resident care. This finding can interrelate to all four assertions.

When effective communication occurs, information can identify problems before they become issues. This relates to Assertion Three and Four, reporting problems and dealing with them immediately.

Expectations of the residents were that their caregivers knew what to do and why they were doing it. Expectations of the staff were that professionals provide collaboration and communication. Assertion one is for all, professionals and non-professionals, to have expectations of being able to contribute to the team.

Good collaboration with aides and housekeepers was established when other staff members had established an effective relationship with them. The staff. were appreciated for what they did, receiving positive feedback for a job well done. When staff were provided with education and guidance, collaboration was enhanced. Some of the influences for enhanced collaboration included the following: (a) CNAs being assertive with physicians and families appeared to lead to enhanced collaboration; (b) CNAs

having good communication with nurses helped collaboration; (c) if the CNA was an effective communicator with other ITMs, this also enhanced collaboration; (d) CNAs were more collaborative, when they felt they made a difference; (e) CNAs appreciated other ITMs that had more compassion and were more interested in them as a person; (f) When the ITMs and residents perceived other CNAs and aides as competent, this also was effective; (g) when ITMs and residents respected and trusted the CNAs abilities and knowledge, communication and education was enhanced, and this relates to Assertion Two since problems could be described or explained; (h) when CNAs had good leadership; (i) when CNAs asked questions of businesses and other people who were resources for information, collaboration was enhanced; (j) all ITMs needed to hear the same thing at the same time; and (k) when CNAs knew that the other ITMs were always there for them, this enhanced collaboration.

Aides could influence collaboration amongst themselves and with nurses. This pertains to Assertion One, everyone has something to contribute. This seemed to be where a majority of the conflicts occurred, between the nurses and nurse aides. If barriers to collaboration such as personality conflicts among team members were minimized, more effective teamwork could occur. For example, nurse aides might be more willing to report problems to nurses if they feel nurses would be willing to listen. This addresses Assertion Three and Assertion Four; it is important to identify, report, and solve problems as they occur. This will be further addressed in research question number two.

Pertinent Literature

Lindeke and Sieckert (2005) and Boal, Burke, and Flaherty (2005) recommend using a variety of disciplines to enhance the creativity of problem-solving. Baggs (2005) recommended that leaders need to consider how to support collaborative behaviors for better patient outcomes and to recruit and retain providers. Baggs et al. (2004) thought collaboration was closely tied to satisfaction with the decision-making process for nurses. CNA education has been identified as being insufficient to equip CNAs with the ability to collaborate with ITMs. Arford (2005) mentioned that to manage conflict using collaboration, all the involved members must be interested in and willing to collaborate. The aides in this study were willing to collaborate but not always given the opportunity. All of these variables needed to be considered with this study.

Theme Two

The LTC facility should regularly schedule training workshops on enhancing teamwork, communicating effectively, coping with stress, and building support networks

Assertion One. All employees should attend team-building sessions to enhance the work environment.

Assertion Two. It is important to have a safe environment for residents, families and staff.

Assertion Three. It is important for staff to have resources they can consult for solving problems.

Assertion Four. It is important to have accurate and through assessments on the residents.

Assertion Five. It is important to have qualified capable staff to care for the residents.

Assertion Six. It is important to staff that they enjoy their job and the people they work with.

Chronic health conditions are not easy disorders. Managing a chronic health problem requires continuing education on the part of the ITM to provide competent care for residents. This pertains to Assertion Five, it is important to have qualified staff. Collaboration with others is necessary because the wealth of information on LTC has become large, requiring expertise and direction from each discipline. Assertion Three on the importance of having good resources relates to this. Communication skills would enhance interpersonal relationships amongst the staff, leading to a more productive work group and a content staff. This applies to Assertion One; all staff should attend team building workshops to enhance communication skills, Assertion Six; it is important staff enjoy their job. Having staff attend workshops that address topics like chronic health conditions and communication skills could lead to fewer turnovers in staff, less sick calls, and more effective work practices. This is applicable to Assertion Six.

The LTC facility presently has a nurse practitioner providing in-services on a monthly basis for the CNAs. End-of-life, infectious disease, and chronic health issues are addressed. Motivating techniques maybe needed to encourage staff to attend, especially if the in-services or workshops are provided on their days off. This pertains to Assertions Four and Five that addresses accurate assessments on residents and having qualified staff.

Having staff participate in the in-services or workshops could enhance collaboration within a group. With further skill development, ITMs could apply their skills communicating with other disciplines with greater success and confidence. This applies to Assertions Six, it is important staff enjoy their job.

Expectations staff members held for themselves and for other staff members were for the other ITMs to know their field of expertise and be available as a resource. Assertion Three, having adequate available resources, deals with this. This cannot occur if the staff do not feel education is important. Residents expectations expressed in the interviews were that ITMs should know what things were for and how to use them. This relates to Assertion Five having qualified capable staff. Team building workshops would enhance the variables that influence collaboration and could decrease barriers to collaboration. It would give the ITMs skills to communicate their needs to each other, providing a synergy in caring for the residents. This is applicable to Assertions One, Two, Three, and Six.

ITMs reported they were now seeing older and more demented residents than ever before; thus compromising the safety of other residents and staff. It was important for the social worker to obtain psychiatric referrals, when necessary, for the residents since the incidence of dementia had increased. These expectations assisted the ITMs in planning and maintaining a higher level of care for the residents. This relates to Assertion Two.

Getting ITMs to attend workshops and in-services would influence collaboration because the ITMs would better understand how to intervene in resident care. CNAs would feel more capable, more comfortable, and would perhaps share information more readily. Such a situation would encourage individuals that were having problems to report the problems. This relates to Assertion Three. Because ITMs would be communicating more effectively, they would be utilizing other disciplines more effectively and would be more willing to work with different disciplines. In this study, ITMs had favorite colleagues; they preferred to deal with as they were viewed as more

approachable. In this study, ITMs preferred to hear suggestions from other ITMs; when perhaps they needed input from other team members.

In this study, some ITMs felt they knew the residents the best. Some ITMs knew the expectations of the other ITMs. ITMs could see the efforts put forth by other disciplines and appreciate those efforts. When ITMs would know the expectations of other ITMs and respond, this would enhance collaboration.

One person expressed frustration over situations where team members were not communicating with each other.

> So ... and then you deal with so many different doctors and then, we get orders from a certain doctor for this and then another doctor says, "No, you shouldn't be doing that, because she'll get sores on her heels," you know and then, this doctor wants range of motion like three times a day and so it's ... it's tricky when there's like three or four doctors involved and then the husband, too, and they just don't ... I don't think they realize, you know, all these orders.

Pertinent Literature

The LTC facility regularly schedules in-services. Workshops on enhancing teamwork, communicating effectively, coping with stress, and building support networks could be performed a variety of ways. Henneman et al. (1995) cited organization values that were supportive of collaboration as being participation, support systems, nurturance, autonomy, freedom and equality, freedom of expression, and interdependence. This win-win attitude promoted success and accomplishment in meeting individual as well as team objectives, reinforcing the feeling of competence, self worth and importance in the individuals. These qualities were seen in the more senior ITMs in this study.

Fitzgerald and Teal (2004) thought multidisciplinary commitment to organizational development was dependent on the discipline's perception of status, the

history of their profession, their own educational experiences, and the reverence they gave to their professional managers. Administrative support was recommended in Norsen et al. (1995) providing an environment where constructive debate was encouraged, professional growth was expected, and shared decision-making could occur. This occurred in this study during Round Table and other informal discussions.

As in McCaughan, Thompson, Phil, et al. (2002), cultural resistance was apparent in apathy and in-action rather than in resistance by the ITMs. Cultural resistance was seen more in this facility by the examples given by the PT aide and certified nurse assistants (CNAs); ITMs did not want to deal with dysfunctional staff and chose to ignore the situation instead of fixing the problem or notifying the appropriate manager.

In the culture of teams there needs to be four values: mutual respect; accountability; trust; and excellence (Fagin, 1992; Terry, 2000). During the interviews, these values were expressed. The relationship with the aides and CNAs was lacking in one or more of these areas.

Brykczynski (1989) found NPs reported dissatisfaction with the lack of cooperation from other nurses, RNs and LPNs. This was not seen in the current study. Norsen et al. (1995) found successful collaboration in a team's commitment to the mission and goals of the team. Few ITMs had mentioned collaboration as a goal for the team in this study.

During collaboration, the roles and responsibilities of each team member should be defined. The roles were defined for the ITMs in this study. Problem-solving processes enhanced collaboration as in Norsen et al. (1995). Surgenor, Blike, and Corwin (2003) found that in addition to being of value, effective teamwork and

collaboration was associated with a lower risk-adjusted length of stay, lower nurse turnover, higher quality of care, and a better ability to meet the needs of families. Good collaboration was also associated with better outcomes after transfer, as measured by readmission or death after discharge from the ICU. These were not measured in this study, but would be recommended for further studies.

Toner, Miller, and Gurland (1994) discovered that team development, management and maintance could increase a team's effectiveness and efficiency. This could also be done with this study.

Gianakos (1997) found that increased communication, empathy, cooperation, and collaboration between nurses and physicians improved patient well-being. This was somewhat apparent in the resident interviews. Branowicki, Shermont, Rogers, and Melchiono (2001) used interdisciplinary team forums instead of committees and found it strengthened collaboration and the collective knowledge of all members. Their core membership did not include CNAs as in this study. Their team approach changed the culture. This type of forum could be implemented at the LTC facility.

Lingard et al. (2002) found communication patterns to be complex and socially motivated. The dominant communication themes found were time, safety, sterility, resources, roles, and the situation. Safety, resources, roles and the situation could be the same characteristics found within this study.

Thompson and Dowding (2002) believed that there is a collaborative nature to decision- making. Decisions were rarely made alone. In this study, ITMs sought advice from colleagues and other professionals on how to act when they were faced with clinical uncertainty. Thompson et al. (2001a) and Thompson et al. (2001b) found human sources

of information were seen as most accessible, especially the CNS, clinical experience being a key factor. The more time an ITM spent in a specialty area, the more probable the ITM perceived human sources of information as most accessible (Rycroft-Malone, Harvey, & Kitson, 2002). Results of this study agree. Most ITMs relied on other ITMs for information; few used the internet or books as resources. Some ITMs did not feel comfortable looking up information.

In Philips et al. (2002) and Stickler (1995), NPs were seen as a flexible workforce who could collaborate and compete with physicians, with the residents benefiting from the combination. A similar situation was also apparent in this study. The physicians relied on a nurse practitioner to care for their residents on a daily basis; the NPs, then, were able to bill for their services and provide care. A NP often saved the residents from having to go to the emergency room for care.

The results of studies by Wheelan et al. (2003), Baggs et al. (2004), and others have established a link between teamwork and patients' outcomes in intensive care units. This evidence was sufficient to warrant the implementation of strategies designed to improve the level of teamwork and collaboration among staff members in intensive care units. Such strategies could also be implemented at this LTC facility.

Rice (2000) found that a lack of clearly stated, shared and measurable purposes lead to ineffective teamwork. Rice also found a lack of clearly defined roles for group members, and a lack of a mechanism for the timely exchange of information contributed to ineffective team work. Buckingham and Adams (2000) found disciplines were similar in making decisions, transcending disciplines and domains, linking different theoretical approaches together and hopefully enhancing the nurse's status as an equal professional

partner. In this study, the nurses were already considered equal partners to other disciplines. Many felt that there was not a traditional hierarchy. The more experience and professional the nurse was in the organization, the higher their level of autonomy and decision making within the team. Lingard et al. (2002) described tension levels varying across ITMs and how these moves were learned, refined, challenged and discarded, creating a complicated "dance." More interviews under different conditions would need to be conducted to determine the type of "dance" being performed between ITMs in this study.

Lindeke and Siekert (2005) recommended fostering self-awareness and preventing burnout in teams, with the team focusing their attention on issues of importance. Several strategies for enhancing collaboration were given. These could be implemented in this facility to prevent burnout.

Barr and Threlkeld (2000) found the patient-centered approach was used by expert practitioners who believed that teaching and guiding patients was more effective than "doing" for them. Cusick and McCluskey (2000) found each practitioner needed to use research findings differently, based on their own understanding and experience of clinical reasoning. Guidelines were a substitute for clinical decision-making, and they needed to include professional judgement, bringing together clinical experience, expert opinion and research evidence in those guidelines. In this study, guidelines were used by all the ITMs. ITMs had a patient-centered approach to methods of care, using guidelines specific to their discipline in providing that care.

Thompson et al. (2002) found a good clinical decision balanced research, patient preferences, and resource awareness with clinical experience. Currey and Botti (2003),

as cited in Chase (1995), stated that a hierarchy of nurses helped solve problems, and provided support for less experienced staff. Experienced nurses made decisions faster and more accurately. This was also apparent in this study. ITMs with more expertise and years of experience provided support to other less experienced ITMs. Dracup and Bryan-Brown (2003) found so many of the decisions made were based on intuition and judgement. This apparently occurred with some of the ITMs in this study, as well. Some ITMs reported they just knew what to do. Some ITMs relied on past experiences, and others, their feelings regarding the situation, to make decisions.

Several of the ITMs were effective collaborators. This included the social worker, the dietician, and the DON. These individuals had longevity working in LTC; years of experience ranged from 14 to 29 years. The NP, on the other hand, had been there less than 10 years. As in Hoffman et al. (2003), the NP in this study spent more time in activities related to coordination of care, interacting with residents, collaborating with ITMs, and interacting with other ITMs.

A mutual trust and respect for the other professions is needed for collaboration to be successful (Crotty, 1998; Gianakos, 1997; Henneman, 1995; Kuebler & Bruera, 2000; Norsen et al., 1995). This assertion was also evident in this study. Those that reported enhanced collaboration and effective teamwork conveyed a sense of trust and respect towards the other ITMs they worked with. Those that did not trust and respect their colleagues reported less collaboration and effective teamwork in their case scenarios.

Like Baggs and Schmitt (1997), the DON reported collaboration improved the care of the residents, with ITMs being better at controlling costs. The DON also reiterated Hojat et al. (1997) by reporting that collaboration not only assisted in

controlling costs, but in expanding services, improving quality of care, and using problem solving techniques toward common goals.

In Roberts (2000) and Shuval (2001), the ITMs learned from each other and gained confidence. This was evident in the LTC facility by having various committees, and several ITMs collaborating, when necessary, regarding residents. Keenan et al. (1998) stated collaboration was the most agreed upon strategy by the ITMs for managing conflicts. Unlike this study, the major impediment to collaboration was power between nurses and nurse aides, not nurses and physicians. In this study, administration had power but had a high degree of collaboration with other ITMs. As in Shuval (2001), the medical director stated that the provider's proximity to the collaborating physician was a factor in the success of collaboration.

Baggs et al. (1997) indicated that nurses reported less satisfaction with decision-making than physicians. This finding was not apparent in this study, since the physicians were seen by other ITMs as invisible members of the team. Established standards of care and guidelines allowed ITMs to have a great deal of opportunity for decision-making.

Lipman and Deatrick (1997) found nurses with more experience were more likely to intervene without consultation than less experienced nurses. Burman, Stepans, Jansa, and Steiner (2002) mentioned the importance of the NP responding to the patients' needs, providing symptomatic treatment and reassurance. Cashman, Reidy, Cody, and Lemay (2004) found that skilled team members value an increased ability to share potentially critical observations and information with fellow team members. Similarly in this study, ITMs found value in being more assertive in communicating, having an ability to understand how personality and personal attributes shaped an individual's actions, having

an understanding of team development, and being able to gain perspective and remain objective. Expectations of the institution were flexibility, empowerment, respect, pride, enthusiasm, and workforce development opportunities for teams to perform well and maintain a higher level of teamwork (Cashman et al., 2004). These expectations were also expressed by administration in this study.

As recommended in Orme and Maggs (1993), effective decision-making in teams could be enhanced by peer support, approval with positive peer encouragement, and by providing the opportunity for reflection. In the LTC facility, ITMs had the characteristics of development of a practitioner's confidence, had peers who were willing to discuss or become involved in the process, had supportive management, and had permission to take risks. Residents were consulted by the NP, social worker, and dietitian, but rarely by the primary providers or consulting physicians.

Disciplines involved in direct care cannot do their work without cooperating with each other. Wheelan et al. (2003) found strategies promoting teamwork and collaboration resulted in better patient outcomes in ICUs. In this study, some ITMs were not sufficient in teamwork and teamwork skills. Finding assistance or backup with team problems was not readily available. Social workers were the main back-up system in this study. Wheelan et al. (2003) felt implementing these teamwork and collaboration skills would enhance the quality of work life for ITMs, provide better patient outcomes, and provide goals for the industry.

Arford (2005) cited Gitell et al. (2000), who found the frequency of interaction between teams, increased shared goals, shared knowledge, and mutual respect. They recommended practices to strengthen communication and the relationships among key

caregivers. These team skills were supported by leadership. Strategies to enhance collaboration and communication included using unit based APNs to manage interdisciplinary teams. Similar results were found in Hoffman et al. (2003). In the present study, a higher frequency of interactions between ITMs did strengthen collaboration and communication; practices were still needed to strengthen relationships among the aides and nurses. The DON was supportive of enhancing team skills.

Baggs (2005) thought strategies that enhanced collaboration focused on team development and communicating in fast-paced situations. Baggs et al. (1997) had a participant comment that it actually takes less time to work as a team. If everyone was clear about the goals, where they needed to go and how to get there, the team could get there faster and more efficiently. This theme was expressed by several of the ITMs interviewed, when utilizing the round table and collaborating when problem–solving.

Manley (2000) studied an intensive care unit (ICU) and the influence of workplace and organizational culture to understand quality of services. In this study, Manley discussed the role of leadership in facilitating cultural change and patient outcomes. Manley discussed change, itself, as a way of life that empowered staff to meet their objectives and influenced the development of medical practice. There was a considerable difference between adopted culture and the culture in practice. Manley (2000) stated the focus should be on understanding people's interpretations of process and events, which is more important than attempting to formulate social science laws. After performing the interviews in this study, this researcher agrees with Manley's interpretation. If the ITMs perspective is taken into consideration when planning change, it may assist those involved in planning to determine the best methods for incorporating

changes into the culture of the workplace; it may also empower staff to assist in planning change and incorporating change into the society of the workplace. One ITM had expressed that it did not make a difference ... with an attitude like that, it would be difficult to get that staff member to be enthusiastic and supportive about incorporating change into the workplace.

Coombs (2003) thought that all members of the interdisciplinary team were crucial to patient care and outcomes. Coombs (2003) and Wakefield (2003) thought effective teamwork lay in the power of complementary knowledge and roles held by each group on the interdisciplinary team. As in Rice (2000), the benefits of ITM care in this study were not easy to measure. The treatments, variation in outcome variables, variations in types of residents, problems, providers and settings were also difficult to measure. It was not the purpose of this study to measure contributions of each discipline to patient care and outcomes.

As shown through the interviews, developing a collaborative relationship with other members of the interdisciplinary health care team could enhance the clinical decision-making of the NP. As expressed by several ITMs, enhancement of decision-making by the NP facilitated the achievement of increased optimal patient outcomes. Thus, collaboration was an important and significant entity in the nurse practitioner's role. In this study, the social worker and dietitian had more interaction and collaboration than other ITMs.

Theme Three

The quality of life and well-being of the residents could be enhanced by providing an environment that is more like home and by providing activities that give a sense of belonging to residents

Assertion One. It is important for a LTC facility to have a variety of activities for residents to help maintain a positive attitude.

Assertion Two. It is important that residents participate in various activities in order to maintain quality of life.

Assertion Three. It is important to residents that they are allowed to bring more personal belongings into their rooms to make the LTC facility feel like a home.

Usually, if a resident is in a LTC facility, they have a deficiency in one or more activities of daily living and/or a health related illness which hinders them from participating in some activities. Limited mobility, limited senses, and limited communication can affect to what degree they can participate in activities. This relates to Assertion Two. When residents are able to participate in the activities around them, they develop a sense of purpose, giving them a feeling of well-being enhancement. This also gives them a sense of belonging to the society of the LTC facility. This pertains to Assertion One.

When residents feel a sense of community, there is an increase in the amount of communication and the willingness to participate in decision-making regarding their health and a higher degree of compliance with medical therapy. This pertains to Assertion Two. Also, if they have a sense of purpose, there is a decrease in the amount

of depression and other stress related diseases. This relates to Assertion One. When the resident is less depressed, it is easier to communicate and collaborate with them.

Societies need communication. Many residents in the LTC facility enjoy talking about other residents and the events/activities of the facility. This is related to Assertion One and is all one of the interviewees wanted to discuss. For this person, knowing things that other residents did not seemed to make this individual feel important. Residents were not concerned about their health care as much as they were about their ability to go play bingo or to other scheduled events. This relates to Assertion Two. Residents expected a home-like atmosphere. This pertains to Assertion Three.

When residents were given freedom of choice, when they assisted in goal setting, and where they were informed about their choices, it enhanced their ability to collaborate. Giving positive feedback, being honest with them, and clarifying situations assisted in collaboration. There were certain ITMs the residents enjoyed working with, especially those that enjoyed their job, and those that had more compassion and more interest in the residents as people. Certain ITMs knew the residents better and were able to follow the changes in the residents that signified needing a change in their care or environment. ITMs were able to enhance collaboration with the residents by providing education and guidance.

Pertinent Literature

Roach (2004) found positive interactions between the resident and others led to the forming of interpersonal relationships and increased fulfillment in life, resulting in improved health status and a sense of well-being. The basic human rights of freedom of choice and having a measure of control over one's own life gave some level of autonomy

and thus increased self-esteem and improved sense of fulfillment in the resident's lives. Acknowledging these rights and facilitating shared and common interests between the residents was encouraged. This was also repeated in the ITMs' interviews but seemed to be discussed to a lesser extent than by residents in this study.

According to Smith (2004), being a younger person in an LTC facility affected emotional well-being, relationships with others, and activities, such as recreation. This was also evident in this study especially with the younger residents. Many residents who were older had multiple sensory deficits became significant, limiting the resident's means for gathering information and having social interaction. Without sensory functions the world becomes inaccessible. It is extremely important to maximize the quality-of-life among the residents through environmental means. This will offset the perception that most elderly are cognitively impaired when attention to their sensory loss through adaptive environmental design can maximize their well-being. Total wellness is dependent upon this. Perhaps this could be enhanced with pet therapy and other newer technology in adaptive equipment, when the facility is remodeled.

Redfern et al. (2002) found quality of life and morale was lower when there was less of a home-like atmosphere. The LTC facility does appear home-like upon first entering into the hallways, with living room furniture and dining room chairs and tables in the lounges. This researcher feels that actual resident rooms could be larger with more home-like space. The facility is presently scheduling remodeling to accommodate these needs.

The residents commented on what it was like living at the LTC facility.

> Oh, we could bake cookies and sometimes you'll make ... oh, different things. I-I-It's really interesting. Now, this year, we'd ... we'd probably make an Easter bunny. I think I had a picture of that someplace ... and then the ... then the next week, your pen pals ... we had them, too.

Another resident commented on the frustration of bedrest and not being able to go to activities.

> ... on my below and um ... so they're trying to keep me off of it, because it's getting more ... and so she come in and gave the order, "Stay off of it." Well, I like to go bingo ... playing bingo and do different things and I get stuck here ... laying in bed.

As one ITM interviewee commented:

> ... and they have activities for people that, ... they probably never used to have. They take them ... take them out to ... now and then. There's physical therapy and occupational therapy and church services, group meetings and things, so there's more ... more of a community, now, then repository.

Theme Four

In a LTC facility, all interdisciplinary team members need to communicate openly with families and residents concerning diagnoses and treatments and the implications these hold for the resident's future.

Assertion One. Health conditions and the consequences of those conditions should be described or explained to patients immediately when a patient receives a diagnosis.

Assertion Two. It is important that residents and the family feel knowledgeable enough about their conditions to be involved in decisions related to treating their conditions.

Assertion Three. Family, staff, and residents need to have common realistic goals for the residents.

Chronic health conditions are increasing because the age of the population at LTC facilities is increasing. Currently and in the future, many residents are going to be ill for longer periods of time and complications will arise from having chronic health conditions. If families and residents are informed as to the likely outcome of the resident's illnesses, they are more likely to make informed choices regarding the care of the residents; they are more likely to make healthy decisions regarding the resident's lifestyle. This could lead to the resident being more compliant with the plan of care, keeping co-morbidities to a minimum, enhancing their well-being, and utilizing the interdisciplinary team in efficient and effective ways to maintain and increase quality of life until discharge or death occurs. It could also decrease the impact of the cost of care, since it does cost more when co-morbidities arise. This is related to Assertion One since realistic expectations can occur from families and the residents if care providers level with families about probable consequences of health conditions. This is related to Assertion Two in that the residents and their families will feel knowledgeable about their conditions and make expert decisions according to their wishes.

When collaboration occurs, expectations of the resident and family members will be realistic and congruent with the ITMs. This will lead to enhanced resident care, more effective communication, and the needs for both groups will be met. This is related to Assertion One when realistic expectations are met. A level of comfort for ITMs could occur, since they would not need to avoid what the family does not know, or for which one is unprepared. This could also enhance the working relationship between ITMs, raising the level of cooperation and collaboration between the groups. If goals have been

made, Assertion Four can be met since the resident will have expectations in reaching their goals.

In research question number one, some of the influences for enhanced collaboration included the following: (a) ITMs being assertive with physicians and families; (b) ITMs having good communication with doctors and nurse practitioners, (c) ITMs were more collaborative when they felt their efforts made a difference; (d) ITMs appreciated other ITMs that had compassion and were interested in them as a person; (e) when the ITMs and residents perceived other ITMs as competent, (f) when ITMs and residents respected and trusted each other's abilities and knowledge, (g) good leadership by ITMs; (h) when ITMs asked questions of businesses and other people who were resources, (i) all ITMs hearing the same thing at the same time; and (j) feeling that the other ITMs were always there for them.

It is essential to have collaboration with ITMs. Residents and families need to discuss issues and information so that all individuals involved make informed decisions regarding residents' plan of care. The more complex the care for the residents; the more complex the decisions that are needed, thus increasing the need for effective collaboration between ITMs. This needs to occur in order to realize all of the assertions. In Assertion three the family, staff and residents will express their needs and achieve a plan to reach their goals to provide the most optimal level of care for the resident.

In the LTC facility, ITMs expressed that it was essential that all ITMs need to communicate. Some were able to talk more openly with families and residents regarding diagnoses and treatments. Many residents did not recognize the implications their conditions held for their (the resident's) future.

Several ITMs interviewed had expressed the same feelings as this participant:

> Well, when you're 75, or even 55, and you have no kidney function and ... someone's telling you ... we don't let you smoke here, those become crises and ... and those things, ... physicians don't like to sit down and do the clear table talk. I think it's getting better. I see younger physicians being more honest. I think it has to do very much with what can we do and what can't we do and how we get through that communication in that first 30 days.

Pertinent Literature

Kaplow (2003) described the Synergy model and how families liked to be involved in the patient's care, helping to make the situation more tolerable for them. The family is part of the team, and part of the patient. Transitions to different levels of care were smoother if the family was involved in the process.

Brykczynski (1989) found that collaborative relationships between a patient and a NP contained the following elements: open acknowledgment of clinical uncertainty; a personal approach to the patient; individualized self-care teaching; and a willingness to share responsibility for planning interventions. The NP in this study exhibited these qualities. Barr and Threlkeld (2000) found there was a need to learn the patient beliefs and behaviors related to their condition. A process of mutual goal setting with negotiation in choosing interventions that patients were likely to follow needs to be performed. Tickle-Degnen (2001) found the practitioner does not replace clinical expertise and wisdom with research results, using it more to supplement their individualized experiences, such as self and family report, clinical observation, expert opinion, and past experiences about the patient. This was also incorporated by the NP in this study.

Mentioned in the medical director interview, as in Lamond and Thompson (2000), decision analysis of ITMs was enhanced when guidelines were used. In Chumbler et al. (2000) and Cusick and McCluskey (2000), NPs directing the clinical activity of the residents had a higher level of clinical decision-making authority when guidelines were used. Thompson et al. (2001a) found nurses perceived that documents which were developed with medical staff were merited higher in the nurse's decision-making process. This was also the case in this study. The nurse practitioner used guidelines and had a high level of decision-making; and the staff used guidelines.

Dracup and Bryan-Brown (2003) cited Knaus, Draper, Wagner, and Zimmerman (1986) as noting mortality rates differed based on communication between the nurses and doctors. Baggs et al. (2004) felt collaboration improved communication among the patient, families and the doctor, valuing the nurse's experience, expertise and commitment to caring. This was expressed by the DON, medical director, NP and social worker. Baggs et al. (2004) also mentioned that an interaction that was helpful was when there was agreement among patients, families, and physicians about care goals, such as having prognoses that were accepted by the family and allowing patients to die with dignity. Communication and trust issues between providers and families still occurred even though the family was involved in the decision-making process. This LTC facility had communication and trust issues as evidenced by the reports in the interviews by the aides and other ITMs.

Research Question Number Two

What are the barriers that hinder collaboration for an interdisciplinary team in a rural Midwestern nursing home practice?

Theme One
All staff (including CNAs, PT Aides, Housekeepers, Etc.) should have the opportunity to collaborate

Assertion One. Everyone has something to contribute to the team.

Assertion Two. It is important that nonprofessional staff are treated and respected as important members of the team.

Assertion Three. It is important for all staff to report problems immediately when they are discovered.

Assertion Four. It is important to solve problems as they are identified, rather than letting them build into larger problems.

Under research question number two, barriers to collaboration included when a co-worker had a poor attitude towards a CNAs work ethic or practice; barriers included a situation where a co-worker's behavior was not conducive to collaboration because the worker was too busy to be interrupted. When staff failed to recognize the CNAs' contributions to the care of the residents or the CNAs' knowledge regarding the residents, a barrier to collaboration could develop. Not all CNAs felt invited to contribute to the Round Table discussions. This related to Assertions One and Two.

A hierarchy existed among the nurses based on experience and social "clicks." CNAs were not allowed to discuss issues with families or residents, since CNAs did not have the education to explain all situations. Some medical conditions, or plans of care, were not discussed fully with the residents, leading to barriers to collaboration between

residents and staff. Practice styles of certain physicians increased the ITMs frustrations when caring for the residents. Also, one ITM discussed their treatment by the nurses when suggesting important concerns to the nurses:

> To ... some ... nurses do listen, some that don't. Some just ... you know, they don't care. Well, I don... I don't know if they don't ... they probably care, but they probably just say, "Oh what ...," you know, like ... "what do you know?"

Potential barriers to collaboration were aggressive attitudes by co-workers, co-workers having non-cohesive work behaviors, co-workers being disrespectful, poor interrelationships among coworkers, co-workers not being receptive to change, staff not being able to socialize or interact with other ITMs, and the varying practice styles of other ITMs. One participant stated, "I think probably the most interesting is ... observing how individuals work together. Sometimes how they don't work together." Another staff member described an interaction with an ITM that is difficult to work with:

> ... she'll walk right in and give them their medicine and not even ask, you know, we're in ... in the middle ... getting them into bed and she just walks right in, you know, "Here take this here, ... oh, I'm sorry. I'm in your way?"... trying to get her job done.

When problems with staff occur and are not reported or dealt with, it can have serious repercussions on teamwork and employee morale. For example, one staff member commented:

> ... and sometimes it's just so frustrating, you know you feel like you're ... you're the only one doing all the work and they just sit up like ... they could sit at the desk and talk forever about stuff that doesn't even make any ... you know, has nothing to do with work. They'll say, 'Oh, what did you do last night?' 'Oh, I did, you know, I did this and we did this and went out and got drunk,' and you know, and that has nothing to do with work and they'd be sitting there and there's lights [resident call lights] going off and they're just sitting there talking.

> ... and some of the nurses, too, they, ... they think like once they get their ... their RN, you know, that they ... like if there's a bed alarm going off, 'Oh, will you get that ...,' and they're just sitting there or you're busy doing something and like, 'Oh, what's that?' We have a nurse that she's ... oh, we don't care for her very much, let's say ... and that's the way she is. They just, 'What's that?' You know, a bed alarm, somebody might be crawling out of bed on the floor and then they complain about all the paperwork they have to do, when it, you know, it could have been prevented.

For research question number two, unmet and unrealistic expectations of the resident and families were expressed by many ITMs as a barriers to collaboration. This is related to all assertions when expectations need to be explained and met. CNAs were not allowed to discuss issues with families or residents. They were perceived as not having the education to explain all situations. Some medical conditions, or plans of care, were not discussed fully with the residents, leading to barriers to collaboration occurring. Practice styles of certain physicians increased the ITMs frustrations when caring for the residents.

Some of the barriers that hindered the relationship between the CNAs and the residents included (a) being on too many medications, (b) not feeling heard, (c) being challenged by an ITM on what they saw in the resident's environment, (d) complications from various therapies, (e) unmet food expectations, (f) feeling forced to participate in certain activities, (g) some residents did not appreciate the caregivers perspective of health, (h) institutionalization created a barrier to collaboration since many residents were unknown to a new resident, and (i) small rooms were not conducive to their home environment. Sometimes, residents were too young to be in the LTC facility. Many of the residents did not like change, so whenever change occurred (remodeling, death of a resident), the change was a potential barrier to effective collaboration.

Pertinent Literature

Weiss and Davis (1985) found that nurses were not prepared for collaborative practice. This was found within the non-professional staff in the LTC facility, leading to difficulty functioning in a collegial capacity. Jenks (1993) found enhanced interpersonal relationships decreased the conflicts with physicians. This was also evident in this study between NPs and physicians, and between a few other ITMs. The NP's perceptions and observations were respected by the physicians, thus supporting the NPs decision-making ability. As in Thomson (1995), nurses had a higher perception of collaboration with physicians. In the present study, barriers to collaboration occurred among non-professional nursing staff, not with medical staff. Several authors, Rice (2000), Roberts (2000), Lucena and Lesage (2002), Saunderson Cohen et al. (2002), and Kallenborn, (2004) reported that adequate appropriate collaboration was essential for all members in all teams; this was not evident with the CNAs and aides in this study.

Efforts to improve the care of the residents were dependent on effective teamwork; this would not occur if communication and collaboration barriers existed. Henneman (1995) felt collaboration could not occur unless all people involved understood their contribution to the decision-making process. Each ITM in this study, shared their expertise and understanding of their contribution to the "whole", to collaboration. Some ITMs understood their role and the impact it had for collaboration in this study. Henneman et al. (1995) stated distrust and disrespect served as barriers to collaboration; failing to recognize the contributions of other disciplines, and failing to recognize the synergism that resulted when disciplines with varying perspectives worked together were also noted. Similar findings emerged throughout the interviews from this

study. Those that were familiar with the effects of collaboration like the DON, dietitian and social worker worked together to create a synergism. Those that did not recognize or understand collaboration, like the aides, did not attempt to work with other ITMs in achieving a synergistic relationship.

Azzi (1998) felt barriers that prevented collaboration between physicians and NPs were economical barriers, competition for the same market, traditional hierarchy, lack of collegial support, lack of autonomy, and knowledge deficit as to the lack of the public awareness of the NPs role. None of these were found in this study.

Fagin (1992) felt education was one of the barriers in achieving collaboration. Fagin (1992) reported educational differences, social class differences, and nurse dissatisfaction as barriers to collaboration. These barriers were seen in this study. Fagin's (1992) strategies for change involved using educational programs. Some of this had been incorporated into the LTC facility. The educational programs could also be expanded in the LTC facility by having a collaborative practice, and providing education of new methods of collaboration between ITMs, which could include organizational change. The administration at this facility was very supportive of collaboration and improving the functioning of ITMs.

A responsive organizational culture protects staff and residents with advice and support. This was seen in this study. The DON permits staff and residents to come to the Round Table discussions. Rice (2000) felt the effects of collaboration were limited to groups of higher status professionals with lower status professionals feeling alienated from work and left out of the decision-making process. The data from this study

supported Rice's conclusions in this area, as aides and housekeepers were often excluded from Round Table discussions.

This study supported Zwarenstein and Bryant's (2000) findings in that poor communication and unsatisfactory work practices produce conflict and less efficient patient care. This was observed during interviews with the aides and their conflicts with the nurses. Through the discussions, as in Ingersoll et al. (2000), collaboration was seen as an indicator of care delivery rather than an outcome, resulting in improved care delivery outcomes for the residents. This was expressed by the dietician and the social worker in that they felt collaboration enhanced the care of the residents.

Chaboyer and Patterson (2001) thought having bedside-level versus managerial-level positions could alter perceptions of collaboration. In this study nurses at times "played games", having true open conflict and arguments, as evidenced by some of the statements made by nurses in the interviews. Ferrand et al. (2003) found the nurse's satisfaction was dependent on the amount of collaboration within the caregiver staff. This was also apparent in this study, with those involved in collaboration expressing greater satisfaction with their jobs than those left out of the collaboration process.

Croenwett (2001) identified the barriers to collaboration as factors related to knowledge, attitudes and behavior, which could be applicable to all health care personnel. Barriers, according to Roberts (2000), involve the categories of tradition, excessive self interest, lack of knowledge, and system barriers, including inadequate personal and social systems. Barriers to implementation of a collaborative practice included the professions isolated evidence bases, creating different frameworks of decision-making and communication strategies (Spain, DeCristofaro, & Smith, 2004).

Cashman et al. (2004) found barriers on unfriendly teams were likely to appear individually centered rather than team centered. There was no heterogeneity of team composition, role conflict, constraints placed on members by the larger organizational structure, or knowledge about the process of team development. In this study, these barriers seemed to be inherent in the relationship between some of the aides and Licensed Practical Nurses (LPNs) or medication nurses within this study.

Unlike in Currey and Botti (2003), experienced nurses at the LTC facility did not help inexperienced nurses solve problems. Some, but not all ITMs, seemed to help the inexperienced ITMs. As in Zwarenstein and Bryant (2003), poor communication and unsatisfactory work practices produced conflict and less efficient care of residents. As in Coomb's (2003) study, power bases and role definitions continued to exist between some ITMs at this facility. Consistent with Stubblefield et al. (1994) effective understanding of the roles of the different disciplines provided more effective interactions between ITMs. Respect and value for the other ITMs was essential to collaboration.

The ability to work with others to achieve a common goal was an important aspect when working in this interdisciplinary health care team. ITMs did not always collaborate. As expressed by some of the ITMs, certain patient care decisions could be difficult; patient outcomes could be affected by their decisions. The functioning of the interdisciplinary health care team could be improved by consistent effective collaboration that provides the opportunity for dialogue among members of the interdisciplinary team. Some ITMs were more collaborative in nature than others. Other ITMs felt their thoughts and opinions did not count.

Theme Four

In a LTC facility, all interdisciplinary team members need to communicate openly with families and residents concerning diagnoses and treatments and the implications these hold for the resident's future

Assertion One. It is important to educate families and residents on rules, regulations, and policies of a LTC facility.

Assertion Two. All health conditions and the consequences of those conditions should be described or explained to patients immediately when a patient receives a diagnosis. It is important that family and staff have realistic expectations in regards to prognoses of the residents.

Assertion Three. It is important that residents feel knowledgeable enough about their conditions to be involved in decisions related to treating their conditions.

Assertion Four. Family, staff and residents need to have common goals.

Providers and some ITMs are not effective at communicating the issues to the residents and families. It could be a combination of lack of education or a lack of experience. This was not an easy subject to approach with residents and families. Assertion Two describes the importance of open communication between providers and families regarding diagnoses and prognoses. If more open communication could occur between providers and families, the stage would be set for allowing all staff at a LTC facility to be more open with families and residents when educating and informing them about changes in condition of the resident, e.g. end-of-life. If neither staff nor residents are properly informed about changes in condition of the residents, they will lose trust in each other, which could lead to an increase in barriers to collaboration. Most ITMs in

this study could not inform or educate the family about medical conditions of the residents unless the physician had informed the family first. If staff discussed diagnoses and prognoses with families and residents before a physician, the LTC facility could face liability issues, as the ITMs operate under physician's orders.

Under research question number one, Theme Four describes some of the influences for enhanced collaboration. These relate to Assertion Two since consequences to these influences can be described or explained. If these consequences of health conditions are not described are not explained, to residents and their families because of individual or group dynamics, collaboration could be seriously hampered. It may not occur at all.

Only certain ITMs could ask questions of business and other people who are resources for information. Not all ITMs were able to hear the same thing at the same time, which sometimes is not feasible since nurses need to work shifts. When an ITM was new or inexperienced, the new ITM did not know or feel that the other ITMs were always there for them.

Pertinent Literature

This study supports the premise that residents and their families need to be educated, need to be informed, need to be communicated with from day one in the LTC facility. The impact of collaboration on the delivery and outcome of care was also supported by other ITMs interviewed. As in Kramer (2003) and in Baggs et al. (1992), this study supported the ideas that inexperienced nurses have less of a relationship with residents and other staff than more experienced personnel and nurses know the patients

better than the physicians. With the nurse's knowledge was different, it was just as important as the physician's.

Roberts (2000) felt patients faced many quality care issues, not receiving important health care information, preventative care, or achieving maximum control of their chronic health condition problems. This was not evident at the LTC facility visited in this study.

While Ferrand et al. (2003) found that 90% of caregivers thought decision-making should be collaborative, only 50% of physicians and 27% of nurses thought that they were actually involved. High quality decision-making involved a collection of opinions and proposals by all those involved, whenever possible from patients, families and caregivers. This was also expressed by participants during the interviews of this study.

Baggs et al. (2004) described a study by Lilly, DeMeo, Sonna, Haley, Massaro, Wallace, et al. (2000), where weekly meetings with the ITMs and family resulted in reducing the length of stay without increasing mortality. Baggs et al. (2004) recommended more work needed to be done with family members through the decision making process and assessing the long and short term effects of this interaction. Orme and Maggs (1993) found when the philosophy of the practitioner differed from the philosophy of the resident or the resident's relatives, tension and conflicts occurred. Jacobs et al. (2002) and Baggs et al. (2004) found that the physicians identified the social worker as a key member of the team in approaching families and in structuring meetings. This study found that some families had inadequate communication with physicians. The social worker was the key member when collaborating with other ITMs. In the literature

and in this study, physicians continue to have the most significant impact on health care decisions.

Theme Five

Physicians are not active sufficiently in the collaboration process with patients and families

Assertion One. Physicians need to be more active during collaboration.

When chronic health conditions was an issue, the experience and education a physician had was necessary to explain the situation to residents and family. Complex issues required complex decisions, which required more than one ITM in choosing the most appropriate treatment for the resident, making it inevitable that collaboration among ITMs needed to occur. Collaboration could decrease the amount of guessing the ITMs would need to do as to what physicians preferred, and could assist the ITMs in educating the resident and families on the physician's plan of care.

Many of the ITMs expressed having effective communication with the physicians. Many discussed how there were standards of care and guidelines to follow, so less time was required of the physician in establishing a plan of care. Standards of care and guidelines also helped alleviate questions as to which treatment regimens to follow. Since over half of the required physician's visits were performed by a nurse practitioner, physicians only needed to come to the LTC facility three times a year, making it less likely a staff member would interact with physicians. Many decisions were made without the input of the physician. Many of the ITMs expressed that information needed first to be from the physician, and elaborated on by ITMs. Physicians did not appear to communicate amongst themselves, as the attending physician often had an entirely

different perspective than the consulting physicians. This lead to confusion for the resident, family, and ITMs.

In this study, some physicians were perceived as difficult to approach. Not all physicians were comfortable with LTC patients; some were too busy, so they may have avoided interactions with the LTC facility. This could make communications with the physicians difficult. Newer staff members reported more difficulty with physician communication than did experienced staff. The medical director was highly rated by most of the ITMs in terms of being accessible for the ITMs when needed and being at their level.

In an ideal situation, where good collaboration would occur, the physicians would be accessible to the ITMs by phone and by pager, with the ITMs feeling comfortable in calling them. A good relationship with physicians would then occur with each profession appreciating the other. Physicians would act interested in the LTC facility's activities and the care of residents. Physicians would be more honest with ITMs and families. ITMs would feel capable of caring for the residents if a discussion of the goals occurred with the physician present. ITMs and residents would have confidence in the provider decisions.

Expectations by the staff was that the physicians should come and see the residents and that they should communicate more with the residents and families. The residents felt they were followed by providers appropriately. Some additional information into their medical conditions would have been more helpful and less stressful for both the ITMs and residents. ITM members felt it was important that the physician became more visible as a team member. All of the ITM members could not proceed with

the plan of care without a specific physician order; they expected the physicians to give the orders.

Standards of care had been developed, increasing the level of care at the LTC. The medical director had become more involved with the policies that affected the level of care of the residents. ITMs expected the medical director to maintain this level of activity with the staff where his predecessors had not. Despite these improvements, ITMs reported that the physician was an invisible member of the team. Specifically, ITMs thought the family needed to be told by a physician what the prognosis was of the resident.

A barrier for collaboration was an aggressive attitude by certain physicians. These physicians' behaviors were not conducive to collaboration. This type of physician was perceived as being too busy to care for the residents, too busy to handle staff concerns, not being receptive to the staff's requests, and being disrespectful to ITMs. Physicians perceived as being sometimes overly optimistic. Economic interests for the same resident and the physician having their self interests were barriers. Some physicians were perceived as having unprofessional interactions with families.

Physicians need to be more active during collaboration. Some physicians were better than others in attending Round Table discussions. When the physician did not attend, it made it difficult for ITMs to communicate with residents and their families.

Most of the medical director's responsibilities were with physicians, getting the other physicians to do their rounds and provide care for the residents. One participant thought the physicians would appreciate having the ITMs discuss issues with the family:

[Do you see other disciplines filling in that role of telling the family?] "I think that there are some physicians, who would be happy for us to do that."

One ITM spoke about the role of the physician:

> …you know, it's got to be the doctor's role, but how do we ... get the doctor to come over and ... or at least facilitate some kind of a deal, so we've got conferences with that. Most of the time, the dilemma, the resident dilemmas, are dealt with … the nurse and the social worker.

One ITM discussed their feelings about having an invisible team member:

> …usually talk with the nurse and then they call the doctor. So that's usually it. The physicians, you know, all the ... all the long term care, information always talks about the physician as part of the team and they ... they probably are a part of the team, but I don't buy it as much. Yeah, they're very invisible. That's a good way to say it. Yeah. They're there; they need to be aware, but they're not in the decisions the… the problem solving ... of the decisions. They're there more to be told what's happening or to tell us what the parameters are and then we do the work. So, yeah, you're right, they're an invisible team member.

Another ITM described how they went through a nurse, and used protocols to avoid speaking to a physician for clarifications:

> … sometimes we just don't understand it, so we'll call over there and talk to, like, the nurse, you know, his nurse or something, but we directly ... don't directly work with them or really communicate a whole lot with them. If they want like, Dr. ..., some of those doctors have their ... own protocols, you know, for the shoulder and stuff, you know. We'll make sure we have copies of, you know, the exercises, the protocols that we need to go by.

Pertinent Literature

Baggs et al. (1997) thought there needed to be a way to increase physician interest and participation in collaboration if collaboration was to be fully implemented. Baggs et al. (1997) stated several authors had expressed the need for nurses' clinical knowledge to increase to promote the physician interest in collaboration. The nurses at this facility

seemed knowledgeable.

Literature speaks to the level of care being comparable between physicians and NPs (Mundinger et al., 2000; Rudy et al., 1998) and that the NP interacts more with residents and families. These ideas were also found in this study. Unlike Sand (2000) and Hillier (2001), the NP in this study did not need to prove themselves constantly to administration and physicians. As in Cullen (2000), Hojat et al. (1997), and Whitcomb et al. (2002), the NP and physicians contributed their ideas to resident care resulting in improved management of the residents. The residents in this study commented, as in Ingersoll et al. (2000), on indicators that were ranked high, such as: (a) satisfaction with care delivery, (b) symptom resolution, (c) perception of being well-cared for, (d) compliance with treatment plan, (e) knowledge of residents and family, (f) trust of care provider, (g) collaboration with care providers, and (h) quality of life.

Rudy et al. (1998) found that NPs were more proficient than physicians at providing services that depended on communication with patients and preventative action. This was also seen in this study. Van Ess Coeling and Cukr (2000) found three communication styles that enhanced collaboration attentive style, non-contentious style, and non-dominant style. Failure to use these styles could hinder collaboration. These seemed to be the styles adopted by the NP in this study. Rice (2000) felt effective team functioning and communication were associated with better outcomes.

Collaboration between nurses and physicians could improve patient care, staff satisfaction, and lower costs (Philips et al., 2002). It was believed that poor communication and unsatisfactory work practices between nurses and physicians could produce conflict and less efficient patient care. This was not seen between NPs and

physicians in this study but between nurses and some therapy aides. Zwarenstein and Bryant (2000) found increased collaboration between nurses and physicians reduced costs without any apparent harm to the patients. It also improved staff satisfaction and their understanding of patient care. Their trials did not assess patient satisfaction (Zwarenstein & Bryant, 2000).

Using the Synergy Model, Ecklund and Stamps (2002) stated that collaboration was a competency that senior nurses would possess at level 3 and 5 (1-5 levels) of the Synergy Model practice scale. Kramer and Schmalenberg (2003) suggested that there was a relationship between unit worked on, years of experience, and the kind of nurse-physician relationships. This was seen in this study, with the increased years of experience and the enhanced relationship between ITMs. Creating a productive collaborative practice included establishing an effective interdisciplinary team, assuring a system to promote collaboration and encouraging characteristics consistent with collaboration (Norsen et al., 1995). This was being implemented in the LTC facility.

Studies had shown that using APNs in hospitals had improved retention, patient outcomes, and were cost effective (Whitcomb et al., 2002). Studies were found that had investigated the impact of APNs in LTC facilites. Ryden, Gross, et al. (2000), Ryden, Snyder, et al. (2000), and Krichbaum et al. (2005) all showed marked positive results in using APNs in LTC.

Lassen et al. (1997) found a collaborative relationship between physicians and nurses was in the best interests of the patient. Philips et al. (2002) found patients benefited from the complementary skill mix of NPs and physicians in a collaborative practice. This benefit was also seen in this study. Hoffman's et al. (2003) results were

supported in this study; nurse practitioners spend more time interacting and collaborating with patients, families and health team members. This study also supported Campion's (1998) study; successful collaboration depended on the nurse and physician finding a comfortable level, with the nurse practitioners level of autonomy, and ability to follow standards of care. The following statement reflects the enhanced level of care provided by the nurse practitioner. "So, anyway, ... is wonderful, and been just great to work with and she's elevated the level of care over there, immensely since she's been there. I don't know how we'd get along without her now."

Theme Six

The increasing cost of long-term care is a concern for the aging population and their increased co-morbidity of chronic diseases

Assertion One. All should pay for co-morbidity and its complications.

Assertion Two. It is important to find home services to help residents stay in their homes as long as possible.

Chronic health conditions do not come without a price tag. The more conditions a resident has, the higher the cost of care. The more complications a resident has, the longer the time needed to care for that resident, the greater the number of medications needed and the more costly the technology required to treat the condition. The more lifesaving measures needed, the greater the costs in caring for the resident. It is not easy to keep someone in a LTC facility when the reimbursement is preset. In addition, the expectations of the residents and family require the best or the same treatment as other residents in the facility. This is related to Assertion One in who should pay for chronic

health conditions and its costs. For those who pay taxes are participating in the expenses of co-morbidities in LTC.

Collaboration needs to occur so the most effective interactions of ITMs can occur and resident care is maximized and so health care dollars are most effectively utilized. Collaboration can lead to better outcomes. If the outcome is to discharge the resident, collaboration can enhance this goal by all providing a synergy in all working disciplines towards reaching that goal for the residents. This is related to Assertion Two in that if the residents were discharged it could be less expensive for the resident but not always the best situation for the resident. This would require collaboration to determine what would be in the best interest of the resident and their families.

Communication with all internal and external providers needs to occur so the game does not happen where those without the income do not get the placement required, care required, or the medication that could enhance their quality of life. This pertains to Assertion One. Communication between ITMs regarding medications and technologies related to their discipline is important to provide the most effective care with the least expenditures. Who should pay for this relates to Assertion One. If the care can be provided at home, it then relates to Assertion Two.

Expectations of the resident and families were that they had been paying all these years for the reimbursement to occur but it is now not sufficient to meet their required needs. This is related to Assertion One. The expectation was if a certain medication or treatment was available, they should be able to obtain it. With the increase in marketing, more residents and families were becoming more vocal with their wishes and needs. This

relates to Assertion One. When residents want and expect to return home this would relate to Assertion Two.

Competition by other LTC facility's for paying residents and insured residents, as well as paying minimal costs for medications and treatments could be barriers to collaboration. This applied to Assertion One. Reimbursement issues could cause the LTC facility to lose income. Insurance issues, such as a change in a policy causing a change in reimbursement practices; could cause a disruption and hardship to the LTC facility's financial system. The unresolved factors of who pays in a LTC facility could create financial stress on the LTC.

Poor family interactions with LTC staff could occur if care was not provided to the family's expectations. Self interest of ITMs can cause a barrier to collaboration. The unmet or unrealistic expectations of staff or residents for wanting the best and newest in technology can hinder collaboration.

The increasing cost of long term care is a concern for the aging population and the increased cost of the co-morbidity of chronic diseases is also important. ITMs commented on the escalation of care costs. One ITM stated, "... with individuals who are overweight and obese, ... the dilemma for our company in terms of cost to care for individuals that weigh over 300 pounds are clearly ... a future concern." Another addressed escalating costs of long term care:

> It will never get less; it will always be more and as the cost of care in skilled nursing facility escalates, the expectations of state governments and federal governments and what they're paying for will increase. They're not going to pay for shoddy care; they're not going to be accepting of situations that they might find in the newspaper. I also think that the image of the industry is a huge problem.

One of the interviewees commented on the cost of care and reimbursement practices:

> You've got somebody in the nursing home. They want ... want this person on a very expensive drug. Five days of therapy would be over $1000.00. ... and nursing home ... this person in the nursing home on Medicare. Um ... and Medicare pays the nursing home a per diem, period, that's it. You get $300.00 a day. ow, I don't know what the numbers are, it depends on what their problems are, but ... and this cost is going to cost over a five day period, what, $200 a day. So, you know, what do we do? Well, as far as I know, Medicare won't pay for it, 'cause: a) she's in the nursing home, b) its an injectable drug, and ... and Medicare will only pay for injectable drugs if it's administered by a doctor. So-o-o-o, you know, I mean, for something like that, you know, we were dealing with the nursing home and the doctor's office. I d... the only ones I talked to is the nursing home, but, I mean, I suppose that the team concept, there. I don't know what's going to happen, but...

Pertinent Literature

Unwanted or ineffective treatments could take place when the resident's goals of care were not honored, increasing costs of care. Ahrens, Yancey, and Kollef (2003), Arford (2005) and Krichbaum et al. (2005) recommended having an APN focus on improving communication with patients and patients' families, resulting in reduced lengths of stay and resource utilization. Hoffman et al. (2003) found the nurse practitioner spent more time interacting with patients and families and collaborating with health team members. This enhanced quality of care and shortened patients stay.

Most of the components of the Synergy model regarding the patient and nurse were substantiated through the interviews. Different ITMs and residents gave examples of their relationship with each other, reflecting different components of the model (refer to Synergism section). In this study, collaboration encompassed evidence based practice. Collaboration was found to impact the health care system. Teamwork was found to be

more effective than working independently; teamwork can enhance patient outcomes and save healthcare expenses.

In retrospect, the Synergy model does not fully address the interaction between the nurse, resident and the health care system. The model does address how the advance practice nurse is more accountable to the other staff, but does not include how the nurse or resident actions, opinions or characteristics influence the health care system. The model was somewhat limited in the institutional approach and could be further expanded upon with further research studies. It was difficult to study the Synergy Model in relation to this study, because the researcher had minimal information on the health care system.

Health care costs could be affected when ITMs do not collaborate successfully. As expressed in the literature, additional research is needed with interdisciplinary health care team models regarding their impact on collaboration related to team functions and patient outcomes (Phillips et al., 2002; Zwarenstein & Bryant, 2000; Zwarenstein et al., 2003).

Theme Seven

LTC facilities need a support network to assist staff and residents with grieving when death occurs on a unit.

Assertion One. Support networks should be provided on-site for employees to deal with emotional issues.

Assertion Two. It is important to assign staff to the same residents every time they work.

Assertion Three. It is important that ITMs feel support from each other, and have good relationships with each other.

Chronic health conditions will eventually end in death. If the residents were more prepared, death would be less stressful, becoming a more comfortable and peaceful process for the resident. If a support network is provided, it can be more accepting for the staff and families. This applies to Assertion One, Two, and Three in each having an optimal relationship conducive to assist each other through the grieving process.

Collaboration needs to occur prior to the event, so expectations and wishes of the resident and family can be met. Less uncertainty by staff would occur regarding what to do in this type of situation. This relates to Assertion Three. A more cohesive work group can result from successfully handling significant events. This applies to Assertion Three. Many of the residents become like family which can be more difficult for the grieving. This pertains to Assertion Two.

Communication should occur so advanced directives can be made with the resident, families and physicians so they can be followed when it is required. Less confusion would occur from the staff since wants and needs could be communicated prior to the event by both the resident and family. This pertains to Assertion Two and Assertion Three, when there is a good relationship, communication is enhanced.

Expectations of staff and residents should be openly communicated, leading to less confusion and resulting in appropriate care to the residents. This relates to Assertion Two. This could lead to more effective cost utilization and better outcomes for the residents. Grief work should be provided for all the staff and families to assist them in processing the loss of a family member. This is applicable to Assertion One. Many of the staff became like family, even the housekeepers. It can make an employee more productive if they are able to move through the process of grieving sooner, feeling better

about the situation. A debriefing session could occur after the event; this was done with some situations at the LTC facility, but not all. This applies to Assertion One, Three and Four.

Variables that enhanced collaboration when working with end-of-life included being honest, being supportive, having confidence in the medical providers' decisions, having discussion of goals, and having a good rapport. Some variables that enhanced collaboration included when the staff became like family to the residents. The resident became an extended family for the ITMs. ITMs knew about their children and about what went on in the families. ITMs were treated as an extended family member. When ITMs did more in family education, collaboration was enhanced. ITMs used pet therapy, having a change in policies, changing facility policies from no pets to allowing pets. When ITMs supported each other, ITMs trusted each other. ITMs had support in their home, as well. Putting all these factors in place, would enhance collaboration when end-of-life issues would occur.

Variables that provided barriers to collaboration included ITMs that distrusted and disrespected decisions. Physicians who were overly optimistic when the situation was not optimistic were barriers. Family not being aware of a decline in a resident's status was a barrier. Many conflicts occurred when a family was not informed of a decline in functioning of a resident. If ITMs were not aware of the process of decline or dying, or failed to recognize situations requiring collaboration, this caused problems with collaboration.

The LTC facility in this study had an informal support network of social workers and clergy that assisted some staff with the grieving process when a death occurred on a

unit. Some of the ITMs mentioned that it could take a long time after a resident dies to go through the process.

A participant described their relationship with the residents:

> ... when my son was born, so I said all of his Grandma and Grandpas, you know ... That's ... that's a tough time. ... you know, you get close to the residents, but you know they're in a better place. They don't have to suffer anymore 'cause a lot of them are ... they're ... they come here for end-of-life. They usually have cancer. They're either very sick and they're, I mean, they're suffering. You know, they're in pain.

Another described a crisis that occurred, and the work the social workers needed to do for the staff.

> We've had residents; several years ago ...one of our residents, her brother took her out,... decided that she'd lived long enough and shot her in the back of the head. ... so we've had that kind of an issue where you have to deal with, ... not only the rules and regulations, but the staff. Oh, my goodness, they floundered. That was really, really, really difficult.

Pertinent Literature

Ferrand et al. (2003) felt physicians should invite interdisciplinary collaboration by allowing all the involved staff to communicate their own opinions regarding decisions to forgo life-sustaining treatment. This required a high degree of collaboration.

Providing care to residents was physically and emotionally demanding. Ahrens et al. (2003) recommended using a palliative care team to assist with caring for end-of-life families and patients. Conlin Shaw (2004) recommended orientation, educational preparation and ongoing support of direct care staff to handle resident care needs. Baggs et al. (2004) recommended involving ethics and palliative care teams early. The earlier interventions resulted in: (a) cost savings, (b) improved communication among patients,

families, and ITMs; (c) improved family and staff satisfaction; and (d)treatment plans that reflected the patient's goals for care.

As in Lucena and Lesage (2002), interviewing the consulting psychiatrists may assist in understanding collaboration since they are being utilized more by the social worker and NP. Assessing the link between resident outcomes and teamwork may also prove helpful (Wheelan et al., 2003).

Norton et al. (2003) described communication difficulties with families when end-of-life care included the withdrawal of life support. Families in Norton's et al. (2003) study mentioned communication difficulties with unmet communication needs such as the need for timely information, the need for honesty, the need for ITMs to be clear, the need for ITMs to be informed and the need for ITMs to listen. Families felt the burden to obtain information was on them.

Ferrand et al. (2003) recommended sharing decisions among the caregivers and family about which treatments should be withdrawn or withheld, and providing ways of not having life-sustaining treatments, and providing information to all of those affected by the decision was important. Seventy-five percent (75%) of nursing staff and 75% of physicians felt that the family should always be informed of decisions to forgo life-sustaining treatments. In actuality, only 42% to 66% believed families were always informed in actuality. The main reason given why families were not informed was it might add to the family's distress. This was also believed by those interviewed in this study, and not all the ITMs that could participate did participate in the Round Table discussions.

Few studies have addressed that good collaboration could improve the experience of dying patients (Baggs et al., 2004; Ferrand et al., 2003). Six of the top ten obstacles to good collaboration were related to issues with patients' families that could make care at the end-of-life more difficult, such as the family not fully understanding the meaning of life support, not accepting the patient's poor prognosis, requesting more technical treatment than the patient wished, and being angry. Other added obstacles related to problems with physicians' behavior. Ways to make dying easier for patients and patients' families included agreement among physicians about care, dying with dignity, and families' acceptance of the prognosis, and allowing music, pets, and so forth into the patient's room (Ferrand et al., 2003). These ideas could be adopted by this facility.

As in Norton et al. (2003), families seemed to have communication difficulty when end-of-life had not been defined. As in their study, it was found that ITMs needed to be honest, be listened to, and be clear and informing. This was also seen in this study.

Schlenk (1997) discussed Emanuel, Barry, Stoeckle, Ettelson, and Emanuel's (1991) findings for frequent barriers for writing advance directives. They included the patient's expectation that the physicians should take the initiative, and the belief that it was only relevant to older people or to those in poor health. No patients cited a lack of knowledge regarding advance directives. All reported they desired advance directives. A majority wanted the physician to initiate the discussion, and felt it was important to make decisions about life prolonging treatment while they were well. This was also expressed by the residents in this study and by most of the ITMs interviewed.

Summary

This study has added to the studies previously done, supporting the research that collaboration is beneficial to members of an interdisciplinary team, the residents, and the health care system. The administrators in the LTC facility in this study are supportive and a positive influence for collaboration. Collaboration is a skill that is fundamental to every discipline of health care. Barriers to collaboration were identified for ITMs working in the LTC facility in this study and should be removed, thus enhancing collaboration for the ITMs. Better collaboration would hopefully prove a cost savings to the facility and for all involved in this study. Key areas were described where interventional efforts could be directed to enhance collaboration. There is a definite need for further studies. Education, communication and experience with collaboration are needed to facilitate interdisciplinary collaboration. In the following quote, an ITM comments on the costs of chronic diseases and the family's expectations:

> …dementia, Parkinson's, ... the chronic diseases that are so prevalent in the population, ... and they're expecting, "Well, hey we're ..., they're here and we're paying $5,000 to $6,000 a month. In addition, we have a $2,000 pharmacy bill and what are we getting for our money? ... and you are doing nothing to make this situation better." When in fact it may be an individual who's end-of-life...

All ITMs need be open and honest, collaborate efficiently, with a resident when a resident is first diagnosed with chronic conditions. All ITMs should be included when collaborating, with human resources being accessible to all team members. Inter-disciplinary team members can work towards an enviornment that supports utilization of human resources for collaboration.

Contributions to Nursing

This study has allowed for a greater understanding of the influence collaboration has for an interdisciplinary team practicing in a rural Midwestern LTC practice and identified some barriers that may hinder collaboration.

The benefits to society are an increased understanding regarding the impact of collaboration in the work setting, and possibly, planning effective interventions to increase collaboration. Such interventions could increase collaboration and thereby enhance teamwork, assist with cost containment, and maximize patient outcomes.

This study added to knowledge of the concept of collaboration, guiding and generating ideas for research and practice; research and practice assess the worth of a theory and provide a foundation for new theories. If a theoretical hypothesis fails to account for the observed facts in the world, one explanation is eliminated and science is thus advanced. This study generated further ideas for science.

Implications for Nursing Education

Educating nursing students with other disciplines was recommended by several authors to enhance collaboration early between the disciplines. Some group work should occur with dysfunctional staff, enhancing teamwork and collaboration, team building, training workshops or communication skills. This also may be expensive for the organization, but could become more cost effective in functional work groups.

Education regarding utilizing human resources personally and professionally needs to be available for staff. This may be expensive for the organization, but could become more cost effective if ITMs function as more effective work groups, having less turnaround and burnout and possibly enhancing patient outcomes.

Implications for Nursing Practice

Openness and collaboration by providers needs to occur with families when residents are first diagnosed with chronic conditions or an illness. Nurses are in a favorable position to reach residents and families, to assist them in decision-making, and to assist them in preparing for future life events when the disease process can be predicted. Allowing nurses time and resources to accomplish these goals is necessary.

End-of-life situations need to involve a collaborative effort with all disciplines. Grief work should occur with those involved with the residents, allowing them to "tell their stories." Grief work should start from the beginning. Death is not an easy process for family or staff. Many of the residents are like family to staff members and if staff is allowed to go through grief work with support, there may be less turnaround and a more cohesive work group.

Not all disciplines in the LTC facility utilized collaboration. An important resource for collaboration could be the CNAs and PT aides. They are underutilized and need to feel important, listened to, and part of the team. Different shifts of CNAs and PT's should be allowed to interact at the Round Table so both can experience the wealth of benefits that each can receive from this collaborative process.

Some physicians are invisible collaboration members and should become visible. When physicians choose to become more active in the collaboration process, and when they become more visible, those physicians that enhance and have qualities conducive for collaboration should be rewarded.

Implications for Nursing Policy

The increasing cost for medications, technology, and nursing, is a concern for the future, a challenge for the health care system and government. New approaches and innovative ideas are necessary for revamping the culture in health care facilities that has been in existence. This can be achieved by providing legislation and federal funding for programs and institutions that are ready and want to collaborate with others. Quality evaluation and measurement of collaboration will need to be achieved to build incentives and technical assistance into programs. The federal and state governments could partner with those that have had successful implementation of programs that enhance collaboration, disseminating the information and knowledge of successful practices. Human resources and funding would need to be provided to those that are ready and want to collaborate. Administrative support for these programs will need to be achieved.

Implications for Nursing Research

As evidenced by the literature, further exploration into other interdisciplinary teams in other health care settings is recommended. A larger sample with more variety of ITMs should be studied. Including residents and family members in/or/as separate interviews may be beneficial. This study was done in a rural area with a small population; other studies could include more urban areas and larger populations. With increased technology and the opportunity for increased chance of collaboration, international interdisciplinary studies could be beneficial, adding a further cultural dimension.

Lingard et al. (2002) described tension levels varying across ITMs and how these created a complicated "dance." Additional interviews under a wider variety of conditions

need to be performed to determine the type of "dance" that is occurring between ITMs. Surgenor et al. (2003) found in addition to being of value, effective teamwork and collaboration was associated with a lower risk-adjusted length of stay, lower nurse turnover, higher quality of care, and a better ability to meet the needs of families. Douglas and Machin (2004) evaluated multidisciplinary group categories, which included: (central concept) project momentum, support, power, context, group life and barriers. These were not measured in this study, but should be considered for further studies. Hoffman et al. (2003) and Arford (2005) found strategies to enhance collaboration and communication included using unit based APNs to manage interdisciplinary teams. These were not measured in this study but should be considered and recommended for further studies.

Due to the positive and economical effect of collaboration for the residents, the interdisciplinary team, and the LTC facility, further studies are warranted to assist the health care system and the aging populations. Research about the effectiveness of interventions is needed. Further qualitative studies would be beneficial since they allow the free flow of ideas from participants. The majority of interviewers were white Caucasian Americans; other cultures may interpret their interpersonal interactions differently.

APPENDIX A

CONSENT FORM - INTERDISCIPLINARY TEAM MEMBERS

Dear study participant,

My name is Michelle Conley, RN, CCRN. I am a Registered Nurse working as a graduate student at the University of North Dakota. I am currently working on a research thesis as part of my Master's Degree in Nursing. I am exploring interdisciplinary teams to gain a better understanding of how they work. I would like to interview you at your convenience and at a time and place of your choosing. The interview will require approximately an hour of your time. I will make every effort to accommodate your schedule. The interview consists of open-ended questions.

There is no apparent risk to your participation in this study. It is possible that concerns may arise regarding confidentiality of statements made by you. Your information will be confidential and only themes that arise from the data as a whole will be reported. This aggregate form of reporting qualitative data will ensure that your individual comments can be identified back to you. There is a small chance that some of the information I ask will cause psychological discomfort. In the remote chance that psychological discomfort is experienced by you the interview will be stopped, I will give verbal support, and you will be given the option of seeking additional counseling services at your own expense. To insure confidentiality of your responses the following procedure will be used.

1. Your name or job title(s) will not be on any tapes or transcripts.
2. The interview will be conducted in a private setting.
3. Specific details will not be shared with any other members of the interdisciplinary team.
4. The results will be reported in summary form only with no identifying details of any one person in the final report.
5. All collected data will be on audiotape or handwritten notes, being kept in a locked file at the College of Nursing for three years before being destroyed. Only the student researcher and the advisor will have access to the collected data.

You do not have to participate in this study. Your participation is voluntary and you may choose to withdraw your consent at any time without penalty. If you withdraw your consent, the interview will be stopped at that time. You will receive no financial gain for your participation. It is hoped that the results of this research will provide a better understanding of interdisciplinary teamwork in the long–term-care setting.

If you have any questions regarding this study or would like a copy of the study results, pleases feel free to contact the student researcher, Michelle Conley at 701-746-7160, or her advisor Dr. Julie Anderson 701-777-4541. The study has been approved by the Institutional Review Board at Altru Health System. If you have any questions pertaining to your rights as a research participant you may call the office of the Altru Institutional Review Board at 701-780-6161.

Sincerely,
Michelle Conley, RN, CCRN

By signing below, I have read and understand the above information about the study and give my consent to be in this study. I have also been given a chance to ask any questions I have and feel they have been answered to my satisfaction. A copy of this form will be given to me for my records.

_____

Name of Participant (please print) Date

_____

Name of Participant (Signature) Date

APPENDIX B

CONSENT FORM - RESIDENTS

Dear _____,

My name is Michelle Conley. I am a nurse working as a student at the UND. I am doing a research paper as part of my Master's Degree in Nursing. I am looking at health care people that work as a team to see how they work together. I would like to meet with you at a time and place of your choice. I will need an hour of your time. I will make every effort to meet when you can. The meeting will consist of talking about your health care. There may be a need for a second meeting, but probably not.

There is no physical risk to you in talking to me. Your comments will be private and only general comments from all the meetings that I have for this study will be reported. I will make sure that your individual comments cannot be traced back to you. There is a small chance that some of the information I ask you will cause mental discomfort. In the rare chance that mental discomfort is felt by you the meeting will be stopped, I will give you verbal support, and you will be given the chance of seeing additional counseling services at your own expense. To insure privacy of your comments the following will be used:

1. Your name will not be on any tapes or papers.
2. The meeting will be given in a private room.
3. Specific details will not be shared with the healthcare team.
4. The comments will be reported as a summary, with no details of any one person in the final report.
5. All collected data will be on audiotape or handwritten notes, being kept in a locked file at the College of Nursing for three years before being destroyed. Only the student researcher, the teacher, and UND will have the collected data.

You do not have to be in this study. It is your choice and you may choose to not be in this study at any time without penalty. If you withdraw, the meeting will be stopped at that time. You will receive no money for having the meeting. It is hoped that the results of this research will give a better understanding of healthcare teamwork in the long–term-care setting.

If you have any questions regarding this study or would like a copy of the study results, pleases feel free to contact the student researcher, Michelle Conley at 701-746-7160, or her advisor Dr. Julie Anderson 701-777-4541. The study has been approved by UND. If you have any questions pertaining to your rights as a research participant you may call the office of the UND Institutional Review Board at 701-777- 4279.

Sincerely,
Michelle Conley

My signature below indicates that I have read and understand the above information about the study and give my permission to be in this study. I have also been given a chance to ask any questions I have and feel they have been answered to my satisfaction. A copy of this form will be given to me for my records.

Name of Participant (please print) Date

Name of Participant (signature) Date

APPENDIX C

COMPLETE LIST OF CATEGORIES, SUBCATEGORIES, AND CODES

CATEGORY	SUBCATEGORY
Chronic Health Conditions	Medical Conditions Medications
Collaboration	ITMs (Interdisciplinary Team Members) Relationships Teams Resources
Communication	Directives Goals Safety
Expectations	Visions Home LTC Facilities Factors in the Nursing Home
Influences that Enhance Collaboration	Communion (Sharing) Community (Connectedness) Independence Problem-Solving Responsibility Synergism
Barriers to Collaboration	Unresolved Factors Feelings of Isolation Interrelationships Lack of Understanding MDS / Medicare Physician's Role Unmet Expectations End of Life

Table 1. Categories, Subcategories, and Codes

CATEGORIES BASED ON INTERVIEW QUESTIONS				INFLUENCES TO COLLABORATION	
Chronic Health Conditions	Collaboration	Communication	Expectations	Those that Enhance	Barriers
Able to Control	ITMs	DIRECTIVES	VISION	COMMUNION (SHARING)	UNRESOLVED FACTORS
Assessment	Accountability for Issues	Accountable for Problems	Attitude of Expectancy	Active Use of Teams Energy	Conundrums
Behaviors	Appeasement of Family	Bond with Resident	Await Outcome	Contribute	Inexperienced
Co-morbidity	Assist ITMs	Decision-Making	Envision Wants	Design a Plan	Minimal Space
Communication	Charging for Services	Documentation	Hope	Entrust Information	Organizational Culture
Complex Care	Ignore Staff	Education	Restricted Resources	Expertise	Skills for Resolution
Cost/Expensive	Perform Pastoral Functions	Obscure medication	Quality Assurance	Improve Performance	FEELINGS OF ISOLATION
Death	Replacement Nurses	Opinion	HOME	Prompting ITM	Advise/Squeal
Denial	Report ITM	Perception of Issues	Alteration in Style	Process Information	Abuse
Education	RELATIONSHIPS	Play the Game	Extricate	Reference	Arrest
Expectation	Administrative Authority	Receptive to Issues	Niche	Share Information	Confinement
Goals	Capable ITM	Referrals	Quality of Life	Trust	Seclusion
Legal/Illegal Drugs	Connection with	Resident Wants Goals	NURSING HOME	Understand Day to Day Happenings	INTERRELATIONSHIPs
Loss of Control	Deal with Issues	Teamwork	Accepted Practice	COMMUNITY	Breakdown in Relationship

Table 1 cont.

CATEGORIES BASED ON INTERVIEW QUESTIONS				INFLUENCES TO COLLABORATION	
Chronic Health Conditions	Collaboration	Communication	Expectations	Those that Enhance	Barriers
Networking	RELATIONSHIPS(cont.)	DIRECTIVES (cont.)	NURSING HOME(cont.)	COMMUNITY	INTERRELATIONSHIPs (cont.)
No assistance	Encumbrance	To Inform of Circumstances	Activities	Educate	Documentation
Plans of Care	Family Inclusion	Transfer Information	Assessments	Encourages Purpose	Invisible Team Member
Pro-life	Intimidation	Update Procedures	Assistance with Needs	Family Relationships	Lack of Staff
Support	Powerful Friendships	GOALS	Audits	Society	Wrong Occupation
Time	Respect	Aim for restriction	Continuous Dilemma	INDEPENDENCE	Process Information
Truth	Significant Person	Desire/Wishes	Endanger Residents	Autonomy	Mini-Crises
To place trust in	Staff Issues	Detach from Dependence	Icky Grub	Freedom	LACK of UNDERSTANDING
Transition	Unknown Persons	Participation In Change	Law	Reliance	Inadequate Information
Understanding	RESOURCES	SAFETY	LTC Stay	Self-Sufficiency	Mental Disorder
Well-being	Depend On	Imposter for Script	Nursing Home Home	PROBLEM-SOLVING	Non-Compliance
MEDICAL CONDITIONS	Hard to Deal With	Intoxicated Physician	Primitive	Accountable to Others	Uncertainty
Cancer Prevention Denied	Human Resources	Pass the Test	Policy	Freedom of Choice	MDS/MEDICARE
Constant Regard	Industry Preferences	Protection of Staff/Resident	Profit	Funding	Finance Care in LTC

Table 1 cont.

COMPLETE LIST OF CATEGORIES, SUBCATEGORIES, AND CODES

CATEGORIES BASED ON INTERVIEW QUESTIONS				INFLUENCES TO COLLABORATION	
Chronic Health Conditions	Collaboration	Communication	Expectations	Those that Enhance	Barriers
MEDICAL CONDITIONS (cont.)	RESOURCES (cont.)	SAFETY (cont.)	NURSING HOME (cont.)	PROBLEM-SOLVING (cont.)	MDS/MEDICARE (cont.)
Convalescence	Nonhuman Sources for Information	Statement of What To Do	Rank and File	Practical Planning	Interrogative Searching
Dilemmas	Restricted Choices		Reimbursement	RESPONSIBILITY	Prior Authorized
Illness Reoccurring	Staff Support		Religion Services	Attainable	PHYSICIANs ROLE
Increased Acuity	TEAM		Society	Dependable	On Call
No Communication	Direct Involvement		Surveillance	Monitoring Trends	Disagreeing Physicians
Non- compliant	Do not Recognize		FACTORS IN NURSING HOME	Open-Minded	UNMET EXPECTATIONS
Painful Tests	Program Develop		Conundrums	Proficient with Job	Assertive Education
Possessions	Social Changes		Differing Points of View	Truthful	Assurance from ITMS
Rehab	Trust		Inexperienced	Way of Acting	END-OF-LIFE
Sensory Deficits	Work Together		Minimal Space	SYNERGISM	Preparation for Death
Tales of Events Told			Organizational Culture	Anticipation of Needs	Reliance on Others
MEDICATIONS			Skills for Resolution	Assistance	Unfamiliar Enviornment
Medication Errors				Assurances	Decline in Status
Prescriptions Unknown				Credible Connection	Nirvana/Heaven

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