Teamworking in nursing homes

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Background. Nursing homes have an important role in the care of frail older people, but concerns have been raised about the quality of care. High standards of care appear to be facilitated when nurses work in effective teams. Greater understanding of teamworking in nursing homes could have implications for training and policy-making.

Aim. The aim of the study was to explore the experiences and perceptions of teamworking with qualified nurses working in nursing homes.

Method. This was a small, exploratory focus group study. The sample was 12 qualified nurses working in nursing homes in the south of England. Transcriptions of the focus groups were coded by the research team and agreement was achieved by discussion.

Findings. Teams described were constructed in 'vertical', hierarchical terms rather than as 'flat', collaborative structures. The achievement of good teamworking was hindered by inadequate communication, particularly as many staff worked part-time and on shifts. Management was perceived as remote, and lines of authority were ambiguous and unfocused.

Conclusions. This group of nurses were aware of the difficulties of working in a hierarchical, profit-making culture. Individually, they tried to provide good quality care for patients and aspired to teamworking, but seldom succeeded to their satisfaction. There may be considerable potential to improve the working lives of staff and quality of patient care by effective teamworking. However, significant barriers, particularly concerning organizational culture, need to be overcome.

Keywords: teamworking, nurses, nursing homes, focus groups, quality of care

Introduction

Nursing homes

The care of frail older people is a challenge to many developed societies. In the United Kingdom, the recent government National Service Framework for Older People (NSFOP) aims to improve standards of care (Department of Health 2001a). For those who are unable to live independently, the past 20 years have seen a substantial shift away from long-term National Health Service (NHS) hospital care to provision by for-profit (or private) nursing homes. In

England there are 144 000 general nursing home beds (Department of Health 2001b), compared with 136 000 acute and elder care hospital beds (Department of Health 2002). There are over 4000 general nursing homes in England caring for older people with mainly physical frailty. On average, each home has about 35 beds and employs 33 care staff, approximately a third of whom have professional qualifications, usually as Registered General Nurses, and they are often employed part-time (Department of Health 2001b).

The increasing importance of the for-profit sector in the care of older people has raised concerns about ensuring quality of care (Turrell 2001). In the United States of America (USA) analysis of inspection data has shown that for-profit homes provided worse care than not-for-profit or publicly-funded homes (Harrington *et al.* 2001).

Teamworking

In the UK, since the 1970s, there has been a transition from the traditional, hierarchical model of nursing to primary nursing in which individual professionally accountable nurses work within more horizontal, collaborative team structures (Bowers 1989). Teamwork is seen as a central feature of current NHS health care (Department of Health 2000), and the Code of Professional Conduct for UK nurses emphasizes that Registered Nurses must co-operate with others in teams (Nursing and Midwifery Council 2002). In the UK, audits of diabetic care showed that improved outcomes were associated with primary care teams who perceived their teamwork to be good (Stevenson *et al.* 2001). A large survey of qualified hospital nurses in England showed that those with higher teamwork scores were more satisfied with their jobs (Rafferty *et al.* 2001).

Effective teamworking implies a sharing of goals, an understanding and respect for roles within the team, and collaborative working (Vanclay 1997). A study of nurses, midwives and health visitors' views of teamwork in primary care found that topics they identified as important included team identity, roles and responsibilities, leadership and philosophies of care (Wiles & Robison 1994). A small-scale study of teamwork in a palliative care team identified positive influences on teamwork as the setting and maintaining of agreed team objectives and having sufficient educational opportunity, whereas understaffing was a significant negative influence (Donaghy & Devlin 2002). A literature review on the interdisciplinary education and teamwork concluded that education on how to function within a team was essential to effective teamworking (Hall & Weaver 2001).

Little seems to be known specifically about teamworking in nursing homes, and improving such understanding could have implications for training and policy-making. Therefore a study was carried out to investigate this topic.

The study

Aim

The aim of the study was to explore the experiences and perceptions of teamworking with qualified nurses working in nursing homes.

Participants

Using the principles of purposive sampling appropriate to exploratory investigations, we set out to capture views from a heterogeneous sample of qualified nurses. In this study the term 'qualified' was defined as those nurses certified as a Registered General Nurse, and/or a Registered Mental Nurse.

All 15 nursing homes in a defined area of central southern England were approached. The senior nurse at each home was asked to distribute an invitation envelope to all qualified nursing staff. This contained a study information sheet and a letter with a return reply slip to indicate availability and willingness to participate in the research. Participants were offered a small gift voucher, and travel expenses were reimbursed. Responses were received from six nursing homes employing a total of 46 qualified nurses. From the 22 nurses responding, a convenience sample of 12 was chosen on the basis of their availability to attend the focus groups, and then divided between two focus groups. A mix of participants based on factors such as age, gender and experience of working in nursing homes was intended. However, in view of the limited availability of participants, professional role was mainly taken into account in the composition of each focus group as it was considered that this might foster freer discussion.

Methods

Focus groups were chosen as they enable a range of experiences and viewpoints to be elicited and participants to challenge one another (Hennink & Diamond 1999). Group processes can enable the exploration and clarification of views in ways that would be less accessible in one-to-one interviews (Kitzinger 1995). Each of the two groups met once in March 2001, during participants' own time, at a convenient location away from their workplace, and lasted between 60 and 90 minutes. Both focus groups were attended by two researchers; one facilitating the discussion and the other

acting as observer. Observation of focus group discussions is essential in order that non-verbal communication, the reactions of research participants to particular topics, and dominance within groups can be noted and used in the analysis (Kitzinger 1995). Based on the experience of the research team and a review of the literature, a focus group guide was developed which was tested, with a group of qualified nurses, for acceptability and ability to elicit relevant aspects of teamworking. Demographic details for each participant were recorded, including age group, gender, qualifications and length of time working in nursing home-nursing.

Ethical considerations

The Local Research Ethics Committee approved the study. Information was given to participants as described earlier, and each participant signed a consent form.

Data analysis

All discussions were audiotape-recorded and transcribed verbatim. Transcriptions were checked for accuracy, and statements and individuals were given a code number; identifying information was removed to anonymize the data. All members of the research team read the transcriptions and individually undertook line-by-line preliminary open coding. The aim at this stage was to identify empirically grounded descriptive labels (categories) for phenomena related to teamworking. A system of coding was agreed by the research team and applied to the remaining text. This was followed by discussion of the emergent codes until agreement was reached on the identification, grouping and labelling of distinct themes. During coding the researchers were attentive to the possibility of further categories arising from the data.

Evidence for establishing the credibility of qualitative analysis has been widely debated and a number of criteria have been proposed (see Yardley 2000, Willig 2001). In the presentation of data in this report, identifiers in brackets relate to individual participants, and quotes were selected on the basis of being indicative of the views expressed. Quotes attempt to capture group discussion as well as individual comment; such concordance of views is considered by some to have greater validity (Webb & Kevern 2001).

Findings

Six sisters (senior nurses with a clinical management role) were invited to the first focus group, but one did not attend. Three sisters and four staff nurses were invited to the second focus group and all attended. Unlike the NHS, for-profit nursing homes do not have a unified system of grading and titles; therefore such titles as 'sister' and 'staff nurse' are not necessarily comparable between different homes or with those employed in the NHS.

The 12 participants were drawn from five nursing homes, which were all 'General Nursing Homes' for older people, rather than caring for those with mainly mental frailty. Eleven were female and their mean ages were between 41 and 50 years decile, with a range between 21–30 and 51–60. All were Registered General Nurses, except one who was a Registered Mental Nurse. Their length of experience working in nursing homes ranged from 1 to 21 years (mean 8·4 years). Ethnicity was not recorded.

All the nurses in the study described themselves as being part of a 'team', and in this paper we focus on the team as a discursive object. Our analysis identified how these nurses described and accounted for teamwork in relation to four major conceptual categories:

- communication;
- patterns of work;
- management; and
- decision-making.

We do not regard these as mutually exclusive categories, but will demonstrate how they were used to present various positions on teamworking. We will highlight how the language used by the nurses served to construct the meaning of 'team' both explicitly and implicitly.

In the focus group extracts, teamworking was constructed in at least two different ways. On the one hand, it was seen as required for delivering good care. This was described as: 'Being one to serve the benefit of the residents' (Staff Nurse K). On the other hand, it was constructed in a mostly negative sense concerning, in particular, how certain circumstances and structures impeded teamworking. The accounts emphasized the difficulties of achieving 'good' teamworking arrangements. Thus, the majority of focus group discussions focused on these two competing accounts:

1 the aspiration of achieving 'good' teamworking, which was perceived to be of benefit to the residents and to some extent to the nurses as well; and
2 the practical difficulties in achieving 'good' teamworking.

We did not find evidence of a serious questioning of the notion that teamworking was 'good'. This was largely regarded as self-evident and was not challenged. A closer examination of the discursive context within which the two different constructions of teamworking are deployed is examined in the four categories.

Communications

Issues of communication were the major factor on which effective teamworking was dependent. When asked which aspect of teamwork the group wanted to start by discussing, one nurse volunteered:

> Communication. Communication is important…because I work part-time, and I only see the same team members perhaps once a fortnight, so if I didn't have good communication, myself and from them, there'd be no teamwork. (Sister L)

Communication encompassed both the transfer of clinical and organizational information, and building and maintaining interpersonal working relationships. Barriers to effective communication were described, as were strategies to facilitate communication and overcome difficulties, which could involve either verbal or written forms of communication such as care plans and message books.

Although there was some disagreement, concern was expressed about relying mainly on verbal communication:

> I think some of the trouble in nursing homes, or at least our nursing home, is that communication tends to be verbal. Written communication is generally put in an office, which is only seen by, possibly, the team leaders. (Sister B)

One nurse explained the case for written policies, and for a consensual method of developing them:

> I would find it easier to work with unqualified staff if there were policies in place where healthcare assistants have helped build those policies, had a part to play, so when there comes a problem we have something to fall back on that we actually originally agreed to. (Sister D)

Another participant contrasted her experience of hospitals:

> I think in a hospital everybody knows exactly what happens. In nursing homes those things aren't written down. (Sister E)

'Referring to nursing home experience, another nurse responded: "There's no structure, there's no policy, there's no, there's nothing. It's very difficult" ' (Sister D).

Interestingly, care plans were mentioned only once as a way of trying to ensure continuity of care. Neither group described team meetings taking place at which clinical and organizational issues could be discussed and lack of time was mentioned as being the barrier:

> But again, it's down to communication isn't it, and actually being able to have the time to get all the people that are involved in the care to actually be able to put in an input. (Sister G)

Therefore, nurses' accounts emphasized the practical difficulties in achieving their aspirations of 'good' teamworking. Some features were regarded as especially problematic for nursing home work, such as limited contact with other staff due to part-time and shift working patterns.

Patterns of work

Both groups identified part time working as a hindrance to communication and hence to good teamworking:

> I think the other problem with nursing homes is that you get people like me who swan in for a few hours a week, cause havoc and go out again you know. (Sister C)

> A lot of moans come in, certainly in a nursing home, [about] the fact that quite often you get a trained member of staff in one night [then] they're not in for another week. (Sister E)

In talking about implementing change and communicating about roles and expectations, the frustration of working part-time was expressed, and some people were prepared to go to considerable lengths, even when off-duty, to try to overcome these problems:

> What I tend to do is try to work different shifts and meet team members at least once a week and also having a book to write down messages. Also allowing them to say if [they] don't understand my message [then] feel free to phone because I'm so conscious that I'm not there all the time and people might misunderstand me or the interpretation of my message might be different. (Sister L)

Shiftworking was also a problem in getting people together for meetings and training sessions:

> You get someone in who wants to come and talk to you about "Peg Feeding" or something like that, which is done at perhaps 2 until 3 in the afternoon while the afternoon shift that are on already are doing something [else]. Those that have been on to two o'clock want to go home and you usually end up with not as many as you would like attending it. (Sister E)

The difficulties of including night staff were at least as great:

> You are asking them to come in, mostly unpaid, possibly from a distance, possibly in the middle of a day's sleep for night staff. (Sister B)

Constructions of teamworking were based on the perceived need to make contact with others in the team. While physical contact through meetings was considered to be highly desirable, virtual contact through telephone and written exchanges, and being available at home even when off duty were also used to achieve teamworking. This implies that boundaries between working life and personal life became

blurred for some nurses, especially those in management positions.

Management

When considering these nurses' perceptions of teamworking, it appeared that they were describing a vertical, rather than horizontal, structure. Words such as 'up', 'down', 'top', and 'above' were used to describe teams and management. This hierarchical view of the team was described or alluded to in both groups:

> You've got to report to the person who is up above you and then that person has to take it up and then up and up. (Sister G)

Nobody challenged this view of their working organization. However, it was evident that particular problems arose with teamwork in such a structure. Generally the language used by the nurses positioned themselves as the collective of working nurses (we) or occasionally in the first person as 'I'. In contrast, managers of the nursing home, including the matron (nurse in charge) were socially positioned as 'them' or 'they', and were often referred to as an anonymous group with whom participants did not identify. They perceived 'management' as indifferent to teamworking, set apart from and above the team.

> The management doesn't really know what teamwork is about. They are a group for themselves. (Sister K)

The hierarchical construction appeared to leave nurses feeling powerless to resolve communication difficulties with management, and left a sense of ambiguity as to whether management could be seen as part of the team or not. One remarked:

> I've never met the people who own the nursing home…But I would quite like to meet them because you know who you are working for and if you get a relationship, get to know them, [there is] the motivation to make the place run better. (Staff Nurse I)

Dysfunctional team management, which allowed favouritism and factions, was also described. One nurse related the power and influence of the matron in this hierarchical structure to make or break a cohesive team:

> I'm new in this country but I've worked in two nursing homes. I've found the weakness of the matron in those nursing homes is to make friends, to be best friends, of some of the members [of staff] and some of the members are going to talk bad of some staff and they [the matrons] don't go and investigate what exactly happened. They take exactly what they are told. And you find them distancing themselves from those so-called "bad" people, and then at the end of it all those "bad people" feel isolated and start causing trouble. (Sister G)

Her perceived solution, which was met with assent from the rest of the group, was for the matron's position in the team to be different:

> I think Matron should be at the centre, not at the top. Everyone should have access to her. And the matron, yes, should be a leader. (Sister G)

The hierarchy 'downwards', from nurses to care assistants, brought a different set of teamwork and communication issues. The nurses expected that they should be line managers of care assistants, but care assistants sometimes resisted this. The resistance seemed related to areas of patient care that care assistants felt came within their own domain of expertise, gained through continuous long-term service or better knowledge of the patients. Whilst this attitude received some sympathy from the nurses, it created a team structure in which lines of authority were ambiguous:

> We've a very hardcore of long-term residents and care assistants. They have got to know each other really like family and, in a way [if you wanted to change nursing care], you would have to tread very carefully, especially a nurse coming in who has no background [of working in that nursing home]. It's hard and you have to compromise. (Sister B)

Another nurse described the difficulty in being accepted as a professional into the existing team of care assistants:

> I found [it] hardest coming from a hospital setting into a nursing home…because basically I got told, "well you're working the way we work because we've been here longer, therefore you should fit in with us". And I was quite shocked by that. (Sister D)

On the other hand, having made an effort to train new care assistants, the team is disrupted if that person moves on:

> The depressing thing is you train care assistants, the young ones especially, and they say, "Actually I've decided to go and be a hairdresser or a shelf stacker" and you start all over again if you're lucky enough to get someone else. (Sister C)

Decision-making

In an effective team it might be expected that meetings would be the forum in which ideas were discussed and consensus reached, and guidelines to be the mechanism for their implementation. However, this seemed to be an aspiration rather than a reality, with very little mention of clinical meetings and much discussion about barriers to this consensual style.

The predominant view was of a hierarchical style of decision-making: in discussing decision-making in the management of venous leg ulcers, a nurse said:

She [the senior sister] knows that that [treatment] works, and therefore we will do it that way and everyone would do it that way. (Staff Nurse J)

The invitation of outside experts to advise on management of clinical problems was common, and mention was made of contacts with community nurses, specialist nurses and pharmaceutical company representatives.

There was some reference to a collaborative style of clinical decision-making, with the team leader having the ultimate say:

We would also, perhaps, ask the district nurse to come in [to advise on the management of a leg ulcer]…but I certainly would confer with my trained colleagues [in the nursing home] and would expect probably the sister in charge to say "okay we are going to do it this way or we're going to treat it this way". (Staff Nurse J)

Another nurse also saw keeping other members of the team involved as important, although her comments reflect the ambiguity of the management structure:

And we've even presented to matron who clinically doesn't have a lot of input on the floor, and we give her a copy [of the article from a nursing journal], because at end of day she's still the matron. And we say "Here you are matron, here's the article please have a copy and give us your opinion". (Sister L)

There was a widely held view that, once a decision had been made, there were difficulties in maintaining consistent practice.

One person has a policy you do this with someone with this condition. Another person comes in and they do it totally differently. (Sister E)

...otherwise there's a danger, you see, of some trained staff saying "Oh no I think we should do it this way, so on my shift I'm going to put that [dressing] on that [patient's leg ulcer]"…[murmurs of agreement]. (Staff Nurse J)

Discussion

Our findings suggest that nurses working in nursing homes aspire to work in a team providing consistent and effective care for residents, but they perceive significant difficulties in accomplishing this. It is clear that there were common experiences of particular challenges affecting teamwork and patient care. Thus, this study, despite its limitations, raises important questions about the nature of teamworking in nursing homes, particularly regarding issues of communication, work patterns, management and clinical decision-making.

What style and level of teamworking were described?

To what extent do the experiences described in the focus groups match accepted descriptions of effective teamworking, such as that of Vanclay (1997)? Participants implied that their teams had shared goals and an understanding of the contribution of other members. However, the achievement of these goals seemed to owe more to individual industry than to organized collaborative working or self-management by the team. Neither the themes of leadership nor philosophy of care, which Wiles and Robison (1994) found to be important, and the setting and maintaining of agreed team objectives identified by Donaghy and Devlin (2002), were significantly in evidence. Indeed, obstacles to reaching these objectives were more prominent in our data. What emerged was a restricted pattern of teamworking in which individual nurses struggled to do what they perceived to be the right thing in relative professional isolation.

What factors influence the style and level of teamworking?

There appeared to be a conflict between the style of management and of teamworking. The Code of Professional Conduct for UK nurses (Nursing and Midwifery Council 2002) and other descriptions of good nursing teamwork (Sessa 1998) imply a horizontal structure, whereas the structure described was predominantly vertical. Nurses spoke of remote nursing home management influencing the matron, and a management structure with often blurred roles and inconsistent pathways of responsibility. Whilst the nurses accepted the obligation to work within this framework, they aspired to a more horizontal and collaborative team relationship. They clearly recognized the importance of the structures of teamwork such as meetings and dedicated time for team activities and learning. In the absence of these, some developed informal ways of compensating and improving communication.

How much of these limitations of teamworking are due to the inherent characteristics of for-profit nursing homes, and to what extent can they be overcome by effective management? Part-time working, lack of time and difficulties with communications are challenges to the successful running of nursing teams in many settings. However, unlike other nurses working with older people, such as on hospital elder care wards, the nurses in this study were describing their experiences working for small, private organizations. It could be that having profit-making as an organizational objective sits uneasily with the nursing team's aim of providing the highest standards of nursing care. The management agenda appears to exert a strong influence on the nature of teamworking, and this

What is already known about this topic

- There is an extensive literature on teamworking in health care.
- Little research seems to have been carried out in nursing homes.
- There appears to be no research referring to teamworking in nursing homes.

What this paper adds

- This is the first qualitative study exploring the perceptions of qualified nurses about teamworking in nursing homes.
- It provides evidence that, in the nursing homes sampled, the team structure was hierarchical rather than collaborative.
- It suggests that improved teamworking has the potential to improve quality of care and nurses' working lives.

echoes the tension that Harrington sees between delivering patient care and creating profit (Harrington *et al.* 2001).

It may be that a vertical team structure, with clear role definitions and adequate inputs of knowledge and time, could provide an adequate level of care within the task-orientated culture described. However, this seems unlikely to achieve the higher aspirations of teamworking, and it is also hard to see such a model coping with changing practices and personnel. In particular, it may not offer the potential for professional fulfilment necessary to attract and retain qualified nurses. Thus, more sophisticated models of teamworking (Boaden & Leaviss 2000) appear to be as appropriate in the setting of a nursing home as elsewhere.

It seems from this small study that further work on the nature and experience of working in nursing homes would shed light on this under-researched area. In particular, research could look at ways in which nursing home nurses could be better supported, benefiting both themselves and patients. As more older people are being cared for in nursing homes, it is imperative to ensure that nurses are recruited and retained, and this can be facilitated if their difficulties are understood and addressed.

Study limitations

For reasons of limited resources, only a small sample was recruited from one part of Southern England. As this was an exploratory study, this was acceptable on the grounds that generalizations are not being proposed. We separated nurses into two focus groups based partly on professional role; however, we do not know what impact this had. Group dynamics may have been affected by having some nurses who worked together being participants in the same focus group. Several nurses had trained in different countries, and this may have influenced their expectations of teamwork and hierarchy. Their varying fluency in English may also have had a bearing on how they expressed their opinions and participated in the discussion. Our analysis sought to explore the social constructions revealed in the focus group discussions. We would argue that how one talks about things has implications for the ways in which the world is experienced, both physically and psychologically (Willig 2001). However, it should be acknowledged that the context in which these discussions were elicited (focus groups for the purpose of research) might have influenced the nature of the talk generated. Therefore, questions may need to be raised about the stability of these constructions.

Conclusion

This study explored nurses' perceptions of teamworking in the setting of nursing homes in one part of Southern England. The findings suggest that these nurses were aware of the difficulties of working in a hierarchical, profit-making culture. They aspired to teamworking, but seldom succeeded to their satisfaction. Individually, they tried to provide quality care for patients, but had few mechanisms for implementing change and ensuring continuity of care. The findings suggest that there may be considerable scope to improve the working lives of nursing home nurses by fostering teamworking and, ultimately, to improve the care of nursing home residents. This will require an investment in time and resources, and the challenge will be how to convince nursing home owners of the benefits and cost-effectiveness of such investment. Further research and consideration of changes to the regulatory framework may be needed.

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