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Exploration of Nurses' Experiences Transitioning to a Team-Nursing Model of Care

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This is to certify that the doctoral study by

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Abstract

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MN, University of Toronto, 2009

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Project Submitted in Partial Fulfillment

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Doctor of Nursing Practice

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Abstract

In response to the needs of patients, coupled with nursing workforce predictions and the pressure of cost containment, a shift to a new team nursing model of care has been seen in Canada and Australia. Today's patients require multiple resources, nurses with additional skillsets and vast amounts of experience during their hospital stays, and a team of nurses can meet these needs. This project explored the experiences and perspectives of nurses during the implementation of a team nursing model of care on a 32-bed, inpatient, cardiology floor in southern Ontario. The purposes of this project were to conduct a formative evaluation of the pilot unit implementation and make recommendations for future units who will implement this change in model. The project tracked all nurses on the pilot unit, from frontline nurses to those of influence and authority. Guided by an action research framework and a qualitative approach, nurses' experiences were explored through observations and analysis of organizational reports. These data were triangulated and further validated with evidence from the current literature. Major themes included the need for clear definitions of roles and responsibilities, a strong organizational support system, and the recognition that team nursing was more than a division of tasks but was a shift in culture to that of shared responsibility and accountability for all patients. These findings have implications for positive social change by informing the work of those in the health care setting, illuminating the benefits of team-based nursing.

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Dedication

To my girls, Ava and Lana. Everything I do is to show you that it can be done. Work hard, but always have fun. And remember:

"You're braver than you believe, and stronger than you seem, and smarter than you think" - A.A. Milne

Love, Mommy.

Acknowledgments

Thank you to my husband Josh Pestill, who forever supports me in my academic ventures, yet reminds me when it's time to play. To my mom Theresa Matt, for always being there for my girls with open arms and cuddles, when my school work has pulled me away from them.

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Section 1: Nature of the Project

Introduction

Nursing models of care have evolved with the changing needs of nurses, their patients, and the health care system (Fairbrother, Chiarella, & Braithwaite, 2015). Ranging from primary nursing, under Florence Nightingale, where the nurse had sole responsibility for the patient during his or her entire stay, to traditional team nursing where the focus was on task allocation and shared responsibility of care, each model strived to improve on the previous (Fairbrother, Jones, & Rivas, 2010; Kalisch & Schoville, 2012;).

The late 20th century brought validation in the nursing profession; there was a need for growth in nursing scholarship and research, proof of critical thinking, professionalism, independence, and autonomy of nurses (Ferguson & Cioffi, 2011; Kalisch & Schoville, 2012; Registered Nurses Association of Ontario (RNAO), 2011). The individual patient allocation model of care was the answer; nurses function independently, take care of their assigned patients, and make independent decisions regarding the care they provide during their shifts (Fairbrother et al., 2010). Primarily an all-registered nurse (RN) model of care, individual patient allocation met the needs of nurses, their patients, and health care at the time.

Today, the patient population is significantly different than it was only a couple of decades ago. Given universal cost pressures and the redistribution of care outside of acute care hospitals, the in-patient population is more acutely ill than ever. Patients require more advanced care, multiple resources, additional skillset, and vast amounts of

experience during their hospital stays (Kalisch & Schoville, 2012; Kohn et al., 2000). The understanding has now evolved that one nurse alone cannot possess the complete knowledge and skills that are required to care for today's patient (Ferguson & Cioffi, 2011; Kalisch & Schoville, 2012). In its report, the Institute of Medicine (IOM) underscored the importance of teamwork in the health care setting, citing a lack of teamwork funds a decrease in quality of patient care, and further medical errors that contribute to an estimated 98,000 preventable deaths annually (Kohn et al., 2000). Furthermore, teamwork in nursing has been shown to increase the quality of care, improve both staff and patient satisfaction, and decrease the number of errors made—ultimately the better choice in model of care (Kalisch & Schoville, 2012; Fairbrother et al., 2015).

Problem Statement

Given the intensified needs of today's acutely ill patients, coupled with future nursing workforce predictions and the unceasing pressure of cost containment, a new team nursing model of care is needed (Fairbrother et al., 2015; Kalisch & Schoville, 2012; Ferguson & Cioffi). Greater than modifications to the routines or how nurses allocate tasks, this change in model calls for a change in nursing culture (Kalisch & Schoville, 2012). A change in culture that consists of a shift in the collective belief of shared responsibility and accountability for all patients, which in turn, will be rewarded with improved quality outcomes and well-being for all stakeholders (Kalisch & Schoville, 2012).

Purpose Statement

The purpose of this project was to explore the experiences and perceptions of nurses during the implementation of a team nursing model of care on an inpatient, acute cardiology floor. The goal of the project was to develop a real understanding of the execution, address barriers experienced during the process, and make recommendations for future units within the organization that will adopt the model in the future.

Nature of the Doctoral Project

The following research question guided this project: What are the experiences and effects of implementing a team nursing model of care from individual patient allocation model of care on an acute inpatient cardiology floor? Specifically, from the perspectives of nurses: frontline nurses, to those in senior management roles within the organization.

Significance

Much more than alterations to the tasks or routines of nurses, a team nursing model of care calls for a change in culture, or the shift to a collective belief in shared accountability and responsibility for all patients (Kalisch & Schoville, 2012). Team nursing, in a true intra-professional model, is a group of nurses working as a team to deliver care (King, Long, & Lisy, 2015). Using the diversity in team members' skillsets, education, qualifications, and experience, this model has been shown to deliver improved patient outcomes and increased satisfaction (Baum, MacDougall, & Smith, 2006; Kalisch & Schoville, 2012; Ferguson & Cioffi, 2011). As defined by the Registered Nurses Association of Ontario (RNAO), a healthy work environment is a "practice setting that maximizes the health and well-being of nurses, quality patient/client outcomes, and

organizational performance and societal outcomes" (RNAO, 2013, p. 17). The team nursing approach to care has been shown to increase nurses' satisfaction with their work environment, and, in select cases, improve quality patient outcomes (Baum et al., 2006; Kalisch & Schoville, 2012; Ferguson & Cioffi, 2011).

Regardless of the nursing model of care, the acuity of patients and the financial demands being imposed on the health care system contribute heavily to the complexity in nurses' daily work (Fairbrother et al., 2015; Fairbrother et al., 2010; Hall, McCutcheon, Deuter, & Matricciani, 2012). A nurse's shift can be a multifaceted balancing act; between addressing the rapidly changing needs of the patient, coordinating numerous administrative tasks, and supporting the needs of fellow staff, all while plagued with a chronic shortage of experienced nurses (Fairbrother et al., 2010; Hall et al., 2012). In a time where quality improvement drives change within health care, evaluating the model of care delivery is paramount to the improvement of clinical practice, in addition to the efficiency and cost-effectiveness of the organization (Hall et al., 2012).

Summary

Team nursing is a response to the demands of the heightened acuity of patients, and the awareness that teamwork and collaboration improve both outcomes and satisfaction. Through the participation of nurse stakeholders, and the inclusion of their knowledge and experiences, team nursing can bring about a positive shift including a change in unit culture to that of shared accountability, shared responsibility, collegial trust, and respect. Foremost, team nursing can accomplish the swing from that of an

individual “patient is mine” attitude to that of the “patients are ours” outlook (Kalisch & Schoville, 2012).

Section 2: Background and Context

Concepts, Models, and Theories

Action Research

Action research guided this team nursing model of care implementation, and, in turn, I used the methodology to guide the evaluation. Based on the premise that people who are affected by an issue can help create a solution, action research thrives on the participation of subjects (Stringer, 2014). It rejects standard practices and seeks solutions unique to a particular context or group, or that apply locally (Stringer, 2014). The fundamental basis of action research is that no single solution fits all problems; each approach is tailored to fit the needs of stakeholders and their communities - further clarifying that a community is *a state of mind*, rather than a location (Stringer, 2014). Community members/stakeholders/subjects are valued and engaged as full participants in the research process, breaking away from the traditional hierarchy of researcher and subject (Stringer, 2014).

Originally derived from Lewin's theory of change, and work with the dynamics of groups, action research is often tasked to determine how to get groups of people to carry out activities that not only benefit themselves but also benefit society (Fairbrother et al., 2010). The action research model (ARM) provides a structured, yet flexible, cycle of planning, observation, reflection, and evaluation that allows for a deepened understanding of the effectiveness of an action (Stringer, 2014). See Figure 1.

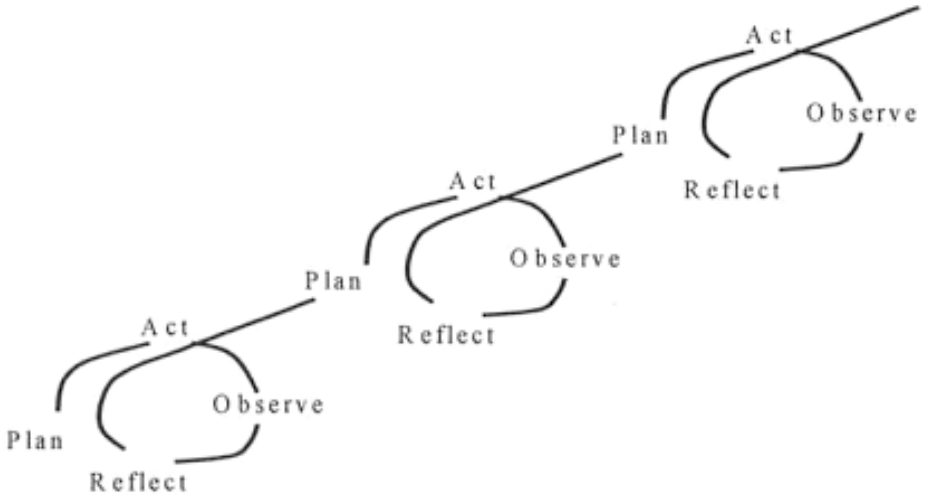

Figure 1. A visual depiction of action research cycles.

In a comparative study, Fairbrother et al. (2010) employed the ARM to guide in the design, implementation, and evaluation of a team nursing model of care for six of their acute care, in-patient units. Seeking out the feedback of participants during all stages of their study, they were successful at designing a team nursing model of care that met the needs of their stakeholders (Fairbrother et al., 2010). Similarly, the ARM was employed by Hall et al. (2012) to evaluate and improve on a model of nursing care. These researchers chose the ARM as it empowered nurses to have ownership over change, input into solutions, and strategies for improvement (Hall et al., 2012).

As previously mentioned, the ARM offers no "set of fixed prescriptions . . . it is flexible and practical," it employs the life experiences of stakeholders as they can offer the most valuable insight into the solutions to their everyday problems and research inquiries (Stringer, 2014, p. 3). For these reasons, as well as the fact that it guided the implementation, I chose the ARM to drive the evaluation of the project.

Healthy Work Environment Best Practice Guidelines

The key best practice guideline drivers for this project were as follows: (a) intra-professional collaborative practice among nursing teams, and (b) developing and sustaining inter-professional health care: optimizing patient/client, organizational and system outcomes. Found in the RNAO's guiding principles and assumptions of intra-professional practice among nurses, nursing is based on the relationships with patients and team members, further stating that effective teams produce better outcomes for patients and team members (RNAO, 2016). With the findings of the RNAO's key best practices guidelines as drivers, and consideration of the significant influence the RNAO has on practice in Ontario, a transition to a team nursing was unmistakable.

Accepting the firm connection between healthy work environment and quality of patient care, the RNAO developed ten Healthy Work Environments Best Practice Guidelines (See Appendix A, Healthy Work Environments Best Practice Guidelines; (RNAO, 2016). The principle focus of the best practice guidelines being to "maximize the health and well-being of nurses, improv[e] patient outcomes, increase organizational performance and benefit society" (RNAO, 2016, p. 20). Research has been successful in drawing the connection between nurses, their work environment, and patient outcomes (RNAO, 2016). Furthermore, healthy work environments generate improved organizational performance and yield financial benefits by improving productivity and decreasing absenteeism and employee health care costs (RNAO, 2016).

Relevance to Nursing Practice

Several studies have determined that using the right number of nurses in the correct ratio has a direct correlation to quality patient outcomes (White & Dudley-Brown). Similar studies have also demonstrated that when working in teams to care for their patients, nurses report increased satisfaction and improved outcomes for their patients (Fairbrother et al., 2010; Ferguson & Cioffi, 2011; Kalisch & Schoville, 2012). The RNAO urges that effective teamwork within health care is part of a healthy work environment (RNAO, 2013). Consequently, healthy work environments maximize nurse well-being, patient outcomes, and organization's performance (RNAO, 2013). Today, with the emphasis on teamwork in the health care setting reinforced by the IOM, coupled with pressures of cost containment, and increased patient acuity, the re-emergence of team nursing is common in the 21st century (Kohn, et al., 2000). Along with this resurgence, the culture-shift to the fundamental belief in shared responsibility and accountability for all patients is being woven into the nursing profession (Kalisch & Schoville, 2012; Ferguson & Cioffi, 2011).

Team nursing models of care have been associated with a decrease in medical errors, improved quality patient outcomes, increased staff and patient satisfaction, decreased patient length of stay, decreased readmissions, and overall improved delivery of care (Fairbrother et al., 2015; Kalisch & Schoville, 2012; Kohn et al., 2000). Through the inclusion of and full participation from frontline nurses, their knowledge and experience can contribute to unique versions of team nursing models that answer the local needs in each context (Stringer, 2014; Fairbrother et al., 2010).

Local Background and Context

With the rapidly advancing health care system, health care organizations are faced with many complex challenges. While being confronted with a more acutely ill patient population than ever, being challenged to continuously improve patient outcomes and organizational safety, while tackling workload concerns, and remaining fiscally responsible, one moderate-sized regional health center in southern Ontario was no exception. To gain a better understanding of its current model of care, and examine strategies to improve the workplace environment, the organization completed a model of care review. Based on the College of Nurses of Ontario (2016) 3 Factor Framework, the following themes were identified during the review, each in agreement with the client, the nurse, and the environment:

1. Overwhelming workload.
2. Multidisciplinary, not interprofessional practice.
3. Uncoordinated, inefficient care, with existing silos in care.
4. Workload distribution inconsistencies.
5. Fixation on ratios, no flexibility to meet patient care needs.
6. Variation in models of care and roles throughout the organization.
7. Poor morale, lack of trust.
8. Scope of practice varied, and not maximized.
9. Equipment lacking.
10. Lack of standardization in care processes.

To address the aforementioned themes, as well as enhance the workplace environment, increase patient and staff satisfaction, and improve the overall patient experience, the organization proposed an interprofessional model of care redesign (IMCR). Aligning with the most current best practice guidelines, as well as the organization's strategic direction "to build a culture of interprofessional care; creating the ultimate hospital experience," this redesign would be a significate transformation within the organization ([redacted], 2016a).

Consisting of a total of 12 deliverables, the primary two deliverables were (a) design and implementation of a team-based model of care, and (b) implementation of bedside shift report. The project, totaling 14 inpatient units, would span 3 years, including seven waves, and was anticipated to cost more than $1.3 million. The organization chose to begin the IMCR project with one pilot unit, an acute inpatient medical cardiology floor. The floor consisted of 32 beds, with an all-RN complement.

To steer the process toward the goal of creating the ultimate hospital experience, the organization developed ten guiding principles:

1. Our patients will be active partners within our interprofessional teams.
2. New processes will embrace the opportunity to foster shared team decision making and patient/family centered care.
3. Environments will strive to inspire, empower and engage our people to work, practice, and learn together as interprofessional teams accountable to each other.

4. The design will be guided by evidence-informed best practice to ensure sustainable safety and quality outcomes for our patients and our people.
5. The design will facilitate our people to practice to their maximum scope.
6. The design will support effective communication strategies aimed to foster trust, respect, and equity amongst all team members by valuing all voices.
7. The design will foster innovation, curiosity, continuous learning, and a healthy work environment.
8. The design will support seamless transitions throughout the continuum of care within the hospital and to the community and other health care partners.
9. Metrics and measurements will monitor outcomes for our patients, our people, and our systems.
10. Technology and tools will enable effective interprofessional practice and support evaluation of identified outcomes.

([redacted], 2016b).

Furthermore, the organization projected that the IMCR project would "elevate the patient experience . . . build a culture of interprofessional care . . . maximize scope of practice . . . and create a healthy work environment" ([redacted], 2016b).

The financial implications of not adapting the new team-based model of care include the following: increased patient length of stay, increased number of readmissions, increased medical errors, and increased number of preventable deaths, all due to an overall decrease in quality of care (Kalisch & Schoville, 2012; Kohn et al., 2000). Further financial implications that were perceived to incur as a result of lower staff satisfaction

seen in traditional patient allocation model of care could be as follows: increased staff turnover, difficulties in staff retention, burnout, and staff feeling unsupported (Fairbrother et al., 2015; Ferguson & Cioffi, 2011; Kalisch & Schoville, 2012).

Role of the DNP Student

The principal focus of my DNP practicum placement has been to assist with the design and delivery of a new team nursing model of care on the pilot unit in an acute care hospital. All of my practicum hours were spent with stakeholders of this project: the chief nursing officer, director, manager, clinical educator, and project manager.

Commencing the fall of 2015, as part of my DNP practicum, I began working with the organization to implement a team nursing model of care on the selected pilot unit. Tables 1 and 2 describe the steps for the team nursing model of care, including stakeholder inclusion strategies.

Table 1

Stakeholder Inclusion Strategies

Stage	Step	Data collection method to address step,
1. Plan	Issue identification: Shifting from individual patient allocation to team nursing as means of improving satisfaction, and quality of care.	Preliminary meetings with director and unit manger to discuss broad project goals, and viability of proceeding
2. Map (establish baseline environment)	Mapping existing Model of Care: baseline data/needs assessment.	Interview with unit manager and educator to discuss (a) structures, (b) unit practices, (c) unit culture, (d) communication patterns.
3. Baseline data	Baseline data.	Survey all staff. Aim to understand the views of staff re: above 1-4.
4. Focus groups	1st round of focus groups: Held among the intervention wards. Where possible, *without the participation of the nurse unit manager*.	Focus groups (staff only). Emphasis on gaining confidential staff feedback re: problems with current model, job satisfaction.
5. Re-interview	Re-interview nurse unit managers: Discuss results of surveys/staff focus groups without betraying staff anonymity.	Meet with Unit Manager, discuss issues, gain perspective. Discuss any changes to proposed model of care (before implementation).
6. Triangulate	Triangulation of inquiries (or in Lewin's terminology, 'fact finding missions').	Triangulate the results of the above to all stakeholders. Aim to establish a true picture of the environment before the change in model.
7. Redesign	Staff Model of Care redesign sessions inclusive of poster formation: Interactive group work with staff using paper/ whiteboard methods.	Defining the new model of care. Posting for staff, ask for reflection, work through any concerns prior to implementation. Group work, key definitions, establish ward philosophy.
8. Act	New Model of Care implementation: 'Go live' with the new Model of Care.	*Flexible* implementation of the new model, maintaining that there will be an opportunity for evaluation.
9. Evaluate	Assess Model of Care impacts: Ongoing evaluation and cycles of planning, action, and inquiry.	Continuous reassessment and evaluation including stakeholders. Regular huddles with stakeholders to establish implementation issues and identify solutions. Reporting of 'Lessons Learned' via email.

Table 1 adapted with permission from "The Nine Step Action Research Method," in "Changing model of nursing care from individual patient allocation to team nursing in the acute inpatient environment," by G. Fairbrother, A. Jones, & K. Rivas. 2010, *Contemporary Nurse,* 35(2), p. 207. Copyright [2010] by eContent Management Pty Ltd.

Table 2

Timeline Team Nursing

	Task									
Phase 1	Identification of the issue. Map existing model of care.									
	Baseline data, needs assessment. Administration of surveys to determine culture.									
	Recruit stakeholders (frontline nurses) to participate in program design. Focus groups and triangulation. 4-day workshop.									
	Develop team nursing model, decide on implementation strategies. Post for staff, allow for input/redesign period.									
Phase 2	Flexible implementation of team nursing model. Go-live on pilot unit, with 6- wk window prior to first cycle reassessment.									
Phase 3	Evaluate/action 1st cycle.									
	Reimplement (continue model with suggested changes from 1st cycle).									
	Continuous re-evaluation Cycles 1-3 moving forward. (See Figure 1.)									
	Commence organization-wide team nursing implementation based on findings from pilot unit evaluation.									
	Projected full implementation complete, begin formal evaluation using predetermined metrics.									
		Sept 2015	Oct 2015	Nov 2015	Jan 2016	March 2016	Jun 2016	Feb 2017	Jul 2017	Mar 2019

Developing an understanding of the culture of the organization, as well as the unit itself, listening to the needs of the stakeholders, and acting as a content specialist on the topic of team nursing, I have had the benefit of being immersed into all stages of the transition. The organization's end goal is to implement an organization-wide team nursing model of care in the upcoming years (Table 2). Therefore, the experience and success of the pilot unit's implementation were central. I completed a formative evaluation of the implementation of the model on the pilot unit. Within this formative evaluation, I made recommendations for steps moving forward to the next units in the organization who are yet to implement this team nursing model of care. Rather than reporting to external stakeholders in the form of performance measurement, the formative evaluation has focused on the program implementation, the success of it, and the lessons learned that can be applied to future units to implement this model (see Ketter, Moroney, & Martin, 2013).

Section 3: Collection and Analysis of Evidence

Introduction/Practice-Focused Question

In response to the needs of today's patients, nurses, and health care system, a shift toward team models of care is occurring. Supported by current literature, professional organizations, and the Institute to of Medicine, the resurgence of team nursing and emphasis on teamwork in the health care setting is common in the 21st century (Ferguson & Cioffi, 2011; Kohn, et al., 2000; Kalisch & Schoville, 2012; RNAO, 2013). Of paramount importance in today's health care setting are quality of patient care, patient experience, staff work environment, and scope of practice, in addition to the pressures of cost containment and fiscal responsibility (Ferguson & Cioffi, 2011; Kalisch & Schoville, 2012; O'Brien-Pallas, Meyer, Hayes, & Wang, 2010). Health care organizations are challenged daily to meet these needs. This regional health centre in Ontario was no exception, and after completing an evaluation of its model of care, it opted for a complete redesign in an attempt to provide the ultimate experience to its patients, while simultaneously improving the work environment for its staff.

Commencing with a pilot unit, the organization implemented a new team nursing model of care. To advise the future, full organization-wide implementation, I conducted a formative evaluation of the pilot unit. The purpose of this DNP project was to explore the experiences of those stakeholders on the pilot unit, during the implementation of the team nursing model of care. The goals were to develop a real understanding of the execution of the project, address barriers experienced during the process, and make recommendations for changes in the model as the project is implemented organization-wide.

Sources of Evidence

Guided by the principles of action research methodology, the primary objective of gathering data is to expand one's understanding of the experience and perspective of stakeholders (Stringer, 2014). Removing myself as the expert, I endeavored to claim a parallel role with the subjects, as a participant, to gain a deep understanding of their experiences and to work toward a solution (Stringer, 2014). I sought to actively engage the stakeholders, helping them explore their experiences, to not only to arrive at a solution unique to the culture but more so to allow the participants to arrive at their own solution to the problem (Stringer, 2014).

As an active participant, I collaborated with all stakeholders involved in the implementation of the new model of care. Being present during the design and implementation phases allowed me to share in the experiences, promote deeper discussion, and ultimately a greater understanding of the issues as that arose (Stringer, 2014). Collaboratively, the participants and I worked to develop a vision of the experience of the change in model of care, which has further liberated these nurses, helping them to gain ownership over the project and the solutions that were developed (Stringer, 2014).

The data gathering was an ongoing and cyclical process (Figure 1) that developed as the implementation proceeded (Stringer, 2014). The sources of data for this evaluation were as follows: site records, including huddle minutes, meeting minutes, casual observations, and the research literature.

Analysis and Synthesis

Prolonged engagement. During implementation, the nurses were observed interacting with each other during huddles, as well as any formal and informal meetings. A previous initiative set by the organization, huddles happen during weekdays, at the nursing station as a time for the nurses to meet informally with the educator or manager (or others depending on the topic). During the first 6 weeks of implementation, the huddle topics were designated for team nursing issues or concerns. During this designated time, neutral and nonleading questions were used, such as (a) How is team nursing going today? (b) What is working for your team? And (c) How can we support you today? Peer-to-peer respect was of high priority, and every participant was given equal opportunity to speak. Responses from the huddles were recorded and made available to all participants in the form of a weekly communication, titled "Lessons Learned." The strategy of prolonged engagement enabled a time for sufficient exploration of the feedback from participants, while the weekly written communication provided full transparency to the stakeholders.

Meetings. Meetings were conducted during all phases of the implementation, both formally and informally. The goal of meetings was to contribute to the understanding of the context of the pilot unit, identify any commonalities in the concerns identified, record any issues for future implementations, and provide a basis for any adjustments made in the implementation. Meeting minutes were made available to the leadership team as a means of transparency, and all primary participants seem assured of the accuracy of them.

Triangulation of Multiple Sources. In all cases, themes that were found in the analysis were supported and validated by those found in the scholarly literature.

Participants. Purposeful sampling was employed to include all those stakeholders involved with the new model of care design at the organization. Included were all those in positions of influence and authority, as well as frontline nurses on the pilot unit.

Ethics. Ethical approval was obtained from Walden University (Walden IRB approval No. 03-21-17-0528330). The organization's research ethics board concluded that the project was a quality improvement initiative not requiring ethics oversite, additionally, it authorized the use of secondary data related to the model of care implementation for the use of this project. All participants were clearly informed of the purpose, goals, and potential outcomes of contributing to this formative evaluation.

Published Outcomes and Research

As a means to improve the understanding of team nursing, while providing validity and support for the findings of this project, evidence from other sources was sought out (Stringer, 2014). Databases included CINAHL, ProQuest and Ovid nursing journals, and Google Scholar. In addition to the RNAO Best Practice Guidelines. Search terms included: nursing, team nursing, interprofessional team, intra-professional team, model of care, and skill mix. Acknowledging that team nursing is a concept found in the early nursing years, the timeline of this search expanded beyond the standard five-year window. Upon reviewing all relevant articles, data were extracted and entered into a literature matrix.

Review of the Literature

Found in the RNAO's guiding principles and assumptions of *Intra-professional practice among nurses*; nursing is based on the relationships with patients and team members, further stating that effective teams produce better outcomes for patients and team members (RNAO, 2016). Beyond simply the tasks associated with nursing models of care, are the collegiality, the shared belief in mutual responsibility and shared accountability for all patients, regardless of nurse's seniority, nursing type, or employment status (Fairbrother et al., 2015; Kalisch & Schoville, 2012, RNAO, 2016).

Since 2000, health care has seen a shift in interest to team nursing models of care, with this shift the question has become; how does team nursing compare to the current patient allocation model? (Fairbrother et al., 2015). Fernandez and colleagues (2012) conducted a systematic review exploring the various nursing models of care and how they affected both nurse and patient outcomes. Notably, the team nursing model of care demonstrated a statistically significant decrease in the number of medical errors and adverse intravenous outcomes, while also producing lower pain scores among patients (Fernandez, Johnson, Thuy Tran, & Miranda, 2012). However, the same review showed no significant differences in nursing outcomes such as role clarity, job satisfaction, and absenteeism, between the various models of care (Fernandez, Johnson, Thuy Tran, & Miranda, 2012). King et al. (2014) conducted a systematic review exploring the effectiveness of team nursing compared with total patient care specifically on staff wellbeing. The authors found that the literature was lacking when evaluating the impact of model of care on nurses' wellbeing, as only three studies met inclusion criteria

(Fairbrother et al., 2015). Ultimately, the review determined that there was no statistically significant difference in the overall job satisfaction, stress, job tension or turnover between team nursing and the total patient care model (Fairbrother et al., 2015). However, the team nursing model did show a greater satisfaction in the nurses' work environment (Fairbrother et al., 2015). Healthy work environments are foundational in the promotion of the RNAO's best practice guidelines. Further supporting the effort towards healthy work environments; studies have shown the positive correlation between them and the quality of patient care (RNAO, 2016). Recognizing that they are not easily attained, healthy work environments have demonstrated increased staff satisfaction, improved patient outcomes, and overall financial gains through reduced absenteeism and increased productivity (RNAO, 2015). Further echoing the importance in achieving a healthy work environment in health care.

The same systematic review found that novice and new graduate nurses were significantly more satisfied with team nursing than the total patient care model (King et al., 2014). Many other studies supported the finding that new graduates saw the most benefit in team nursing models of care. Fairbrother and colleagues (2015) conducted a review of the literature exploring the benefits of team nursing, determining that it is the "reliable structure …collegial support … [and] clinical mentorship" that accompanies team nursing, which fosters the growth of new graduate and novice nurses. Further stating that the higher skill mix and levels of experience promote a safe environment for support, learning, and nurse to nurse consultation, that provides the level of care that today's acute patients require (Fairbrother et al., 2015; Fairbrother et al., 2010; Kalisch.

& Schoville, 2012; O'Connell, Duke, Bennett, Crawford, & Korfiatis, 2006; RNAO, 2016).

Another theme in the literature that exists is the importance of *team* and culture of *teamwork*. O'Connell and colleagues (2006) explored the theoretical foundations of team nursing, stating that the success of team nursing depends greatly on what happens in the team itself. Many studies echo the importance of team qualities, siting effort, commitment, preparation, collaboration, and communication as key aspects of successful teamwork (RNAO, 2016, O'Connell, Duke, Bennett, Crawford, & Korfiatis, 2006; Kalisch. & Schoville, 2012). In studies that explored the implementation of a team nursing model of care, challenges were noted in the definition itself. Cioffi and Ferfuson (2009) found that there were different interpretations of the term *team nursing*, leading to questions surrounding role, task allocation and responsibilities of each team member. Other studies cited the importance in providing in-services and education to nurses on the topic of team nursing, working towards the goal of a shared understanding before implementing the model (Hall et al., 2012). Further linking to the recommendations of the RNAO's best practice guideline; that provide opportunities for nurses to develop an understanding of roles and scope of practice of all nurses on the team, ultimately leads to the achievement of intra-professional collaborative practice among nurses (RNAO, 2016).

The care that nurses provide and how they organize their work have a significant impact on not only their patients but also the nurses around them (King et al., 2014). With the changing needs of patients, and the reality that nurses must combine their skills

and abilities to care for the heightened acuity of today's patient (Kalisch. & Schoville, 2012). Nurse leaders, policy makers, and organizations have come to the realization that nursing teams foster better patient outcomes, and improved work environments (RNAO, 2016; Kalisch. & Schoville, 2012; Fairbrother et al., 2015; Fairbrother et al., 2010; O'Connell, Duke, Bennett, Crawford, & Korfiatis, 2006). Moving forward, nursing research must continue to explore the nurse's experience of team nursing, and determine what characteristics are needed to foster solid teamwork and collaboration, while further exploring measurable outcomes (Cioffi & Ferguson, 2009; RNAO, 2016; King et al., 2014).

Summary

Through this formative evaluation, guided by the methodology of action research, I sought to develop an in-depth understanding of the experiences of participants as they implemented a new team nursing model of care. Through interviews, meetings, casual observations, and review of written documents, I collaborated with stakeholders to identify the issues experienced, validate them with evidence, and arrive at an individualized action plan. Further, taking these experiences and strategies, and making recommendations for the next in-patient units within the organization to implement this team nursing model of care.

Section 4: Findings and Recommendations

Team Nursing Implementation: Brief Overview

Phase 1: Planning Stage

Commencing in the fall of 2015, the organization began work designing a team nursing model of care that would enhance the workplace environment, increase patient and staff satisfaction, and improve the overall patient experience (See Phase 1 in Table 2). In addition, this new model would address the organization-specific themes identified through their model of care review:

1. Overwhelming workload.
2. Multidisciplinary, not interprofessional practice.
3. Uncoordinated, inefficient care, with existing silos in care.
4. Workload distribution inconsistencies.
5. Fixation on ratios, no flexibility to meet patient care needs.
6. Variation in models of care and roles throughout the organization.
7. Poor morale, lack of trust.
8. Scope of practice varied, and not maximized.
9. Equipment lacking.
10. Lack of standardization in care processes.

Phase 1 of the project consisted of recruiting frontline nurses to participate in the program design (See Stages 4-7, Table 1). Workshop days were scheduled and included topics such as the following: (a) What do patients want? (b) Role clarification and scope of practice, communication, and leadership, and (c) change, transition, and resistance.

With the primary goal of phase 1 being to seek input from these stakeholders regarding the actual structure of the model of care. In keeping with the participatory nature of action research, two options were developed by the group and brought forward to all nurses on the pilot unit for voting. The options were posted in the unit and sent via email for the nurse's consideration (See Table 3). Nurses were given the opportunity to provide feedback and encouraged to ask questions in the form of email and interactive meetings. Voting took place in the form of a secret ballot.

Table 3

Options for Team Nursing Ratios

Option #1 For day shift	2 nurses for 9 patients + 2 nurses for 9 patients + 3 nurses for 12 patients = 7 nurses for 30 Patients, plus charge nurse
Option #2 For day shift	2 nurses for 10 patients + 2 nurses for 10 patients + 1 nurses for 10 patients + 1 nurse float= 7 nurses for 30 Patients, plus charge nurse)
Option #3 For night shift	2 nurses for 10 patients + 2 nurses for 11 patients + 2 nurses for 9 patients (1 of the RNs for the 9 patients would be charge nurse) = 6 nurses for 30 Patients, including charge nurse

Option 1 for day shift and Option 3 for night shift was chosen by the staff. Patient rooms were assigned to one of three pods, which were identified geographically on the unit. Each pod contain the patients allocated to a team of nurses. In preparation for the implementation, new assignment boards had been posted for all to view, whereas medication administration records and patient kardexs sorted by pod.

Phase 2: Implementation on Pilot unit

January 2016, Phase 2, was a 6-week flexible implementation of the new team nursing model was rolled out, launching day-one on a weekday including every nurse

scheduled on the pilot unit. One additional nurse was scheduled every shift to help the teams work through the adjustment, and strategize any issues or challenges that presented. Daily 'huddles' were maintained and emphasized during this time as an opportunity for the teams to meet with the project manager, unit educator, and manager to voice any concerns they were having, and receive support in return. Also further supporting the principles of action research, underscored was the understanding that there would be the opportunity for continuous evaluation during this flexible implementation phase (See *Table 1*. Stakeholder inclusion strategies).

Phase 3: Continuous Re-Evaluation

Following the intensities of Phase 2 implementation, Phase 3 consisted of continued weekly leadership meetings, unit meetings, and unit huddles. Continuing to support staff through the change, strategize challenges, and adjust where necessary, were routine undertakings for phase 3. Additionally, during this time bedside shift report was initiated on the pilot unit. A complementary initiative to team nursing, the implementation was offset from the initial rollout in an attempt to ease the transition.

Findings and Implications

To better understand the experiences of nurses during the implementation of a team nursing model of care and make recommendations for future implementations, a formative evaluation was carried out on a pilot unit throughout the process. Guided by action research methodology, the experiences of nurses were explored through prolonged engagement, casual observation, analysis of minutes and triangulation of multiple sources; to validate the perceived phenomena (Stringer, 2014). *Figure 2*. Project phases

incorporating action research methodology; is a visual depiction that emphasizes the cyclical nature of action research methodology, and the continuous reflection and evaluation at all phases of the project. Topic guide areas were used to sort the nurses' experiences of team nursing into central themes. Themes were then further validated by those found in the literature. For this discussion, themes were sorted into three categories; (a) infrastructure and support systems, (b) roles and team characteristics, and (c) culture and work environment.

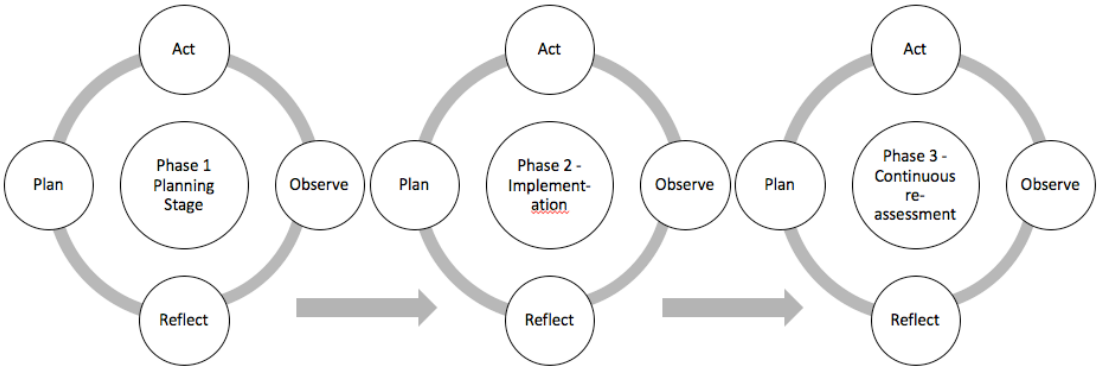

Figure 2. Project phases incorporating action research methodology.

Infrastructure and Support Systems

As with any change in practice, it is vital the team feels supported in making the change, while simultaneously feeling lead through the change (Ferguson & Cioffi, 2009; Kalisch & Schoville, 2012). Although not a strategy brought on with the team nursing project, one of the most valuable resources identified by the nurses was the support felt through daily unit huddles. It was viewed as a significant time to reflect on the challenges, and provide on the spot solutions (where possible) while being the primary source of experiential evaluation from the frontline nurses.

One of the initial strategies in the team nursing implementation was to have an additional support person on the unit through Phase 2 of the project. This support person was an RN from the floor who was identified as a ‘champion' as they had attended the workshops in Phase 1 and therefore had a further understanding of the content and design of the model of care. Early in the implementation, clarification was needed in defining the role of this support person as one not to provide patient care, but as a champion to help the nurses work through the challenges that presented, and strategize solutions on the spot. On occasion, this support person was used to fill the spot of a sick call on the unit. However, value ultimately was recognized in the support role, and every attempt was made to replace the sick call, and maintain the support person position. Similarly, every attempt was made to avoid the use of non-staff (agency) as replacement staff during phase 2, if needed, nurses from similar units within the hospital could float to fill temporary shift vacancies. Hall and colleagues (2012) supported this strategy and found that too much time was spent orienting agency staff to the new model when in the early implementation phase, staff nurses’ time was better utilized elsewhere. Another item identified by the unit manager and nurse educator was the importance in remaining entirely available to the staff nurses during Phase 2. An awareness evolved that they had wished they had cleared their schedules for the first one to two weeks of implementation to be entirely available to the frontline nurses. Similarly, in their implementation of team nursing in an acute care setting; Cioffi and Ferguson (2009) identified that unit managers often found themselves called to discuss and address any issues that arose during early implementation; working with the nurses to strategize and take immediate action.

Much of the other challenges fell from the perspective of infrastructure and equipment utilization. Initially, patients were divided geographically, however early on that was abandoned for patient acuity. Equipment, such as automatic blood pressure cuffs and blood glucose machines, were distributed and designated to each team. In similar team nursing models, it was observed that tensions arose in teams when there was inadequate communication among team members (Cioffi and Ferguson, 2009). Similarly, this was also experienced within this project. Nurses expressed concern that they could not always locate their team member or spent too much time looking for them on the unit. To facilitate communication within the teams; two-way telephones, central whiteboards, and standardized report and assignment sheets were made available. Some teams wrote notes on patients within the assignment sheets and then photocopied them for distribution amongst team members. These standardized assignment sheets also proved valuable when there were patient inquiries either via telephone or from other interdisciplinary staff members. Although it was an ideal that any member of the team could answer questions regarding any one of the patients within the team, this was not a reality in Phase 2. Confusion presented when the nurse for a patient was required at the nursing station, and the unit clerk was unsure as to which team member to page overhead. It was later decided that the team would be paged along with identifying the patient bed number, to assure the team was aware which patient the inquiry was concerning. Whiteboards were installed in all patient rooms, at the foot of each bed. They were updated daily and included the date, any significant plans or goals for the day and the names of all nurses on that team. Larger, central whiteboards were located at the nursing station, and contained

information helpful to all staff on the unit; team breakdown, patient acuity, flags such as falls risk, and infection control precautions, and any scheduled patient tests and procedures for that shift. Each of these strategies was utilized to promote teamwork, facilitate communication, and better prepare the teams for the shift (O'Connell, Duke, Bennett, Crawford & Korfiatis, 2006).

Roles and Team Characteristics

The overarching challenge regarding this team nursing implementation was identified in the specific roles and responsibilities of each of the team members. Several weeks into Phase 2, it was determined that team members were continuing to divide the patients, and going about their shift similarly to the previous model of care. This posed concerns as it was not t*eam nursing*, and the sense was that nurses lacked the perception of shared responsibility for all patients. Key concerns voiced during daily huddles were about accountability for medications; specifically, if one nurse takes the vital signs then can another nurse distribute the medications? Or rather, how do the team members divide up the skills/tasks? And, what does team nursing look like? The nurses struggled with defining their daily routine, including identifying precisely how one team functioned more successfully than another. Collegial trust was in question; nurses were challenged to believe that their team members had completed the tasks that they said they had, while at a standard of care that they felt was applicable. Cioffi and Ferguson (2009) considered similar challenges in their team nursing model; difficulties arose when team members felt they had different standards of care, levels of experience, or just, a different way of going about a particular task. In both this project and in the study conducted by Cioffi and

Ferguson (2009), nurses were repeating tasks to satisfy themselves that they were complete – unfortunately, not an efficient use of time. Interestingly, some nurses reported challenges in delegating duties or tasks to other nurses of similar rank, education, and experience level. They voiced that it was challenging to tell another nurse what to do, and found it was often easier to do it themselves. One of the most valuable skills nurses have is that of delegation; it can be quite challenging, and less common in situations when one RN delegates to another RN. Directly tied to trust and accountability, delegation is a skill that requires further education and skill (Weydt, 2010).

Unexpectedly, those nurses who resisted the team nursing model were often those previously identified as leaders on the unit; experienced nurses, who functioned autonomously and were often the ones that others looked to when they had questions. These nurses felt overburdened by team nursing; they expressed feelings of increased workload because they now had to care for (a) their patients, (b) their team member's patients, and (c) their team member. They expressed a lack of benefit in a team model, as they felt could already function well independently. Other team nursing studies reported similar findings; senior nurses feeling overloaded with additional work of other nurses, team members not helping each other equally, and the overall feeling of having to compensate for other team members lack of experience (Ferguson & Cioffi, 2009; Kalisch & Schoville, 2012). However, by comparison, the novice nurses on the unit expressed satisfaction in the team nursing model, they felt supported, and voiced that they were trying to *work up* to the skill level and expectations of the more experienced staff. In their systematic review, King et al. (2014) found that novice and new graduate

nurses were significantly more satisfied with team nursing than the total patient care model. Further, the nurse educator on this unit acknowledged that the team scenario provided insight into how each nurse went about his or her shift. Near misses, and areas for practice education and improvement were identified by team members that had not been identified in the past. These revelations by the nurse educator are supported through the literature; further echoing that team nursing demonstrates a significant decrease in the number of medical errors (Fernandez, Johnson, Thuy Tran, & Miranda, 2012). The nurse educator and manager felt that these exposures in practice inconsistencies alone were substantial enough to support this change in the model of care.

The opportunity for pre-set teams was explored. Distribution of skill mix and experience was considered when setting the teams, and six-week timelines were configured to allow teams time to learn to grow and work together. Similar discussions were found in the literature concerning team weaknesses due to the natural formation of teams. More specifically, when nurses were permitted to choose their teams; those with similar experiential levels, nursing values, and work ethic assembled, leading to significant mismatches and deficiencies in some teams (Ferguson & Cioffi, 2009; Kalisch & Schoville, 2012).

Culture and Work Environment

Weeks five through six of Phase 2, leading into Phase 3, provided a time for deeper reflection of participants' experiences of the team nursing implementation. The shock and heightened disruption of the initial rollout had passed, and all levels of nurses had been immersed into the new model for five weeks. Teams were working to apply

solutions to challenges daily, they were utilizing communication skills gained from in-services, and most were functioning well in the new model of care. The overarching theme continually tested by the nurses was teamwork; nurses were opposed to relinquishing the control or the *need* to have primary responsibility for their patients. They verbalized feelings of *knowing a little about all patients* rather than the preferred; *a lot about their patients*. This phenomenon is strongly tied to the literature that proposes; nurses are challenged to resign the culture of ownership over one's patients to that of shared responsibility (Ferguson & Cioffi, 2009; Kalisch & Schoville, 2012). Further acknowledging that a change in culture is what is needed; requiring time, education and acceptance.

Challenges were also presented with shift report; specifically, length of time, critical or unnecessary information, waiting for team members to arrive, and socialization. As a means of adaptation, the nurses chose to divide the team's assigned patients for the report, then photocopy the sheets and share with all team members. Although this appeared to be an efficient use of time, team members were beginning their shift lacking vital information on some of the patients. In turn, it was suggested that this lead to the perceived lack of accountability and responsibility for those patients. Kalisch, Weaver, and Salas (2009) shared these experiences in a qualitative study exploring what nursing teamwork looks like. They found that a fundamental disconnect and communication failure was in shift handover between teams; citing many of the same challenges experienced in this project (Kalisch, Weaver & Salsa, 2009). To combat these challenges, bedside shift handover was implemented. All team members rounded together

at shift change to receive the report, address questions from the oncoming team, and complete a safety scan of the bedside. More than a means to gain shift report, team bedside shift report was implemented to strengthen the team's connection with each other, and together, transfer and receive responsibility and accountability for the patients (Chaboyer, McMurray and Wallis, 2010). Although recognized by the organization's leadership team that implementing a new strategy within the already tense environment was not ideal, it was agreed that bedside shift report would help to facilitate team nursing, and therefore begun.

Driving by participatory action methodology, every attempt was made to keep frontline nurses informed of the implementation challenges and provide opportunities for them to voice potential solutions. Also, recognizing that the success of this team nursing model of care was highly reliant on the involvement of these nurses in all phases of the implementation (Ferguson & Cioffi, 2009). Key strategies included daily huddles and weekly reporting of the 'lessons learned' to all staff on the pilot unit via email (See *Table 1*. Stakeholder Inclusion Strategies). Additionally, the leadership team was proactive in recognizing even the smallest success stories of this implementation project. Understanding that this display of acknowledgment demonstrated their continued support of the nurses, it worked to strengthen the teams and revealed the successes of their hard work. The frontline nurses further supported these points of recognition, and eventually so did the organization.

Recommendations

Several recommendations have emerged from this formative evaluation of the implementation of a team nursing model of care. Likewise, several of the initial strategies presented with this implementation were successful and therefore are recommended to continue for the next units to implement this model of care. Recommendations are as follows:

1. Participatory action research. Include all members of the team in every aspect of the implementation. Allowing for continuous evaluation and opportunities for feedback on the process, while encouraging the nurses to gain ownership of the change in the model of care (Stringer, 2014).
2. Education/Workshop topics. Continue with Phase 1 workshop days for the multidisciplinary team, add separate days for the core nursing team. Expand topics to include;
    a. What is team nursing? What would a shift look like?
    b. Defining team nursing.
    c. Role clarification and scope of practice.
    d. Communication: skills and strategies.
    e. Change, transition, and resistance.
    f. Responsibility and accountability.
    g. Delegation.
    h. Problem-solving: What challenges might occur? How to mitigate issues.

   i. Bedside shift report: What does it look like, problems, and troubleshooting.
   j. Multidisciplinary team expectations.

3. Team structure/patient assignment.
   a. Distribute nurses' levels of experience (where possible) when determining teams.
   b. Rotate teams every 6 weeks to allow teams to learn to work together, and to share and develop areas of expertise.
   c. Assign patients first geographically, with consideration of acuity.
4. Communication tools. Standardized assignment sheets, central whiteboards, individual white boards in patient rooms, and a means for team members to communicate – for example, two-way telephones, radios or pagers.
5. Phase 2 start date. Commence Phase 2 rollout on a weekday, early in the week so as to ensure the team is well supported for the first days. Consider leadership support over the first weekend.
6. Quality huddles. Continue daily huddles.
7. Bedside shift report. Implement bedside shift report on day one of Phase 2, alongside the rollout of team nursing.
8. Support. One additional nurse 'champion,' for every shift of Phase 2 implementation.
9. Agency staff. Avoid the use of agency staff to fill temporary vacancies during Phase 2. Backfill with staff from similar units within the organization.

10. Leadership support. Unit nurse educator present on the unit for the first two weeks of Phase 2 implementation, and then readily available for weeks three to six of Phase 2. Unit manager readily available to staff for the first two weeks of implementation, and accessible for weeks three to six of Phase 2. Project manager readily available for Phase 1 and 2 implementation.
11. Acknowledgement. Recognize small successes and 'wins' within the team on a regular basis.
12. Policies for review. Medication administration and documentation practices, specifically concerning team nursing model of care – recognizing that they may be unique to each unit.

Strengths and Limitations

The major strength of this project was founded in the action research methodology. Through the processes of prolonged engagement, casual observation, analysis of minutes and triangulation of multiple sources, I sought to identify and analyze epiphanies or themes. Epiphanies, defined by Denzin (2001, p. 158) as a "moment of problematic experience that illuminates personal character and often signifies a turning point in a person's life." Though lacking in comprehensive statistical analysis, it was through compiling the participants' epiphanies that I was able to "capture the concepts, meanings, emotions and agendas that can be applied to problems affecting their personal, institutional, and professional lives" - or in this case; the implementation of this model of care (Stringer, 2004, p. 99).

The recommendations for change in the implementation, and solutions to challenges that arose came from the participants; the frontline nurses, unit educator, and leadership team. Through their participation in the implementation process, and reflection on their perception of their lived experience through this process, they gained ownership over this new model and were actively involved in the change. It is anticipated that the implementation of these recommendations will not only be a unique fit for this organization, but will also be more openly accepted and transferable to future units within the organization who will adopt this model of care. The potential for bias was evident in being an expert while claiming the role as a participant. To address this bias, all participant feedback was sent via email to stakeholders on a weekly basis for review and input, while any casual observations were incorporated within the triangulation evidence.

Pre- and post-evaluation of measures such as; patient and nurse satisfaction, length of stay, near misses, medication errors, value added time, and call-bell data can be further explored in future studies once the full organization-wide implementation of this team nursing model is undertaken.

Conclusion

Accepting the premise that a team nursing model of care addresses many of the patient, nurse and organizational concerns of today, this project sought to explore the nurses' experiences of implementation of a team nursing model of care on an acute cardiology unit in a moderate-sized regional hospital in southern Ontario. Using action research methodology, driven by the active participation of the nurses, recommendations were made that are hypothesized to improve the transition to a team nursing model of

care. Recommendations and key strategies have been derived from epiphanies related to (a) infrastructure and support systems, (b) roles and team characteristics, and (c) culture and work environment. These strategies will guide hospital administrators, policy makers, managers and frontline nurses in effectively implementing a new team nursing model of care in upcoming units within the organization. While further enforcing a culture of shared accountability for all patients, emphasizing the importance teamwork in the health care setting, contributing to a healthy work environment and ultimately improving outcomes for all.

Section 5: Dissemination Plan

Dissemination of Recommendations

Action research methodology is founded on the premise that through the analysis of stakeholders' experiences (or reflections on their experiences), solutions to their unique problems can be found (Stringer, 2014). In the breaking down of hierarchical boundaries, the researcher finds himself/herself an equal participant in the environment, observing, and noting the stakeholders' experiences as they see them (Stringer, 2014). Therefore, it should be no surprise that participatory research methodology emphasizes the importance of keeping all stakeholders informed of ongoing developments in their investigation (Stringer, 2014). Unique to action research is that the informing or dissemination of findings can take on many forms. This can be informal conversations where information is provided about activities and developments that may be emerging (Stringer, 2014). In addition, informing can be found in a short report, meeting minutes, or briefing notes. These reports need not be "dry," and, in fact, should be presented in a way that addresses the audience and their level of understanding, in the context of their individual circumstance (Stringer, 2014, p. 210).

The findings of this evaluation were disseminated to stakeholders in two ways. The frontline nurses were informed in an informal manner; presenting the findings in the course of several days (to capture the rotating shifts, acuity of the unit, and needs of the staff) during the daily unit huddles. Also, through informal discussions on the unit with frontline nurses, where comment was made on the findings - specific to these nurses, assuring time for questions and clarification. The second strategy employed took on a

more formal state. The audience, defined as the leadership team from the organization, received a formal presentation using PowerPoint slides, in addition to a briefing note for distribution. Included, were relevant data and methodologies related to process; while the specific action plan was presented for future units within the organization who will adopt the new model of care. This formal presentation also provided an opportunity to discuss plans for the formal evaluation of the future organization-wide team nursing implementation.

Analysis of Self

I have seen this team nursing project through the last 18 months. More specifically, the time during my practicum was spent supporting the design and implementation of a new team nursing model of care, to the final formative evaluation presented here in this capstone project. Noteworthy is my experience with this practicum site. As a staff nurse there for 12 years, I have an invested interest in this organization. Through the years, I have developed close working relationships with many of the organization's stakeholders at a variety of hierarchical positions. Through my strong clinical background and genuine interest in seeing this organization succeed, I believe that I have gained the respect, support, and buy-in of this team. As an authentic leader, I see value in experiential knowledge and walking the talk, working toward principles such as self-awareness; unbiased, balanced information processing; authentic behaviors and actions; and relational transparency (Bamford et al., 2013). This practicum experience allowed me to exercise my leadership qualities. It provided the time to work alongside stakeholders and develop a real understanding of their perceptions of their experiences,

while being present when challenges came about and working in real-time to realize evidence-based solutions. The experience gained during these challenging times has been invaluable. Facing resistance from frontline staff, while simultaneously working to prove and demonstrate value to their leaders, has been greatly beneficial to my growth as a leader. During this time, having experienced and lived through this implementation, I can see the change and evolution of my leadership style. I have embraced authentic leadership, demonstrated trustworthiness, and stayed true to myself, not conforming to the expectations of others (Lacoma, 2016).

As a quality improvement initiative, the project gave me the experience I needed in creating and sustaining changes at the organizational and policy levels. I gained experience with the funding proposal process, research ethics proposals, and scorecard preparation for this project. One of the largest areas of personal growth that I have noted is in my ability to demonstrate value and gain buy-in from stakeholders. I spent a significant amount of time as a content specialist, ensuring I was current with all the relevant literature regarding team nursing and being prepared to defend my strategies or recommendations at a moment's notice. This was often evidenced in the hallways of the organization when a stakeholder (e.g., frontline nurse, manager, or director) would stop me and express their concerns with some aspect of the project. Or similarly, when meetings or unit huddles were called because staff were unhappy or refusing to follow through with the plan for implementation. It was my role to actively listen, validate their concerns, reassure them that they are not the only ones who have been through this, and then offer insights and strategies to combat the issue. This daily, cyclical process was not

only part of my role but was the foundation of it. Acting as a content specialist, an expert and nurse scientist, an advocate and a leader, this experience has complemented my DNP education. I have refined the skills I need to be an active leader in health care and through leading by example, I will promote evidence-based change and advocate for the profession. I am looking forward to seeing the full implementation of this new model of care complete. I also look forward to the opportunity to measure the outcomes, publish the findings, contribute to nursing science, and demonstrate the positive results that I have been advocating for 18 months.

References

American Association of Colleges of Nursing. (2006). *The essentials of doctoral education for advanced nursing practice.* Washington, DC: Author.

Bamford, M., & Laschinger, H. (2013). The influence of authentic leadership and areas of worklife on work engagement of registered nurses. *Journal of Nursing Management, 21(3),* 529-540. doi: 10.1111/j.1365-2834.2012.01399.x

Baum, F., MacDougall, C., & Smith, D. (2006). Participatory action research. *Journal of Epidemiology and Community Health, 60*(10), 854-857. Retrieved from http://www.jstor.org/stable/40665463

Brill, N. (1976). *Teamwork: Working Together in the Human Services*. Toronto, Canada: Lippincott.

Canadian Nurses Association. (2012). Staff mix decision-making framework for quality nursing care. Retrieved from https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/staff_mix_framework_2012_e.pdf?la=en

Chaboyer, W., McMurray, A., & Wallis, M. (2010). Bedside nursing handover: A case study. *International Journal of Nursing Practice, 16*(1), 27-34. doi:10.1111/j.1440-172X.2009.01809.x

Cioffi, J., & Ferguson, L. (2009). Team nursing in acute care setting: Nurses' experiences. *Contemporary Nurse, 33*(1), 2-12. http://dx.doi.org/10.5172/conu.33.1.2

Fairbrother, G., Chiarella, M., & Braithwaite, J. (2015). Models of care choices in today's nursing workplace: Where does team nursing sit? *Australian Health Review, 39*(5), 489-493. https://doi.org/10.1071/AH14091

Fairbrother, G., Jones, A., & Rivas, K. (2010). Changing model of nursing care from individual patient allocation to team nursing in the acute inpatient environment. *Contemporary Nurse, 35*(2), 202-220. Retrieved from http://dx.doi.org/10.5172/conu.2010.35.2.202

Fernandez, R., Johnson, M., Thuy Tran, D., & Miranda, C. (2012). Models of care in nursing: A systematic review. *International Journal of Evidence-Based Healthcare, 10*, 324-337. doi:10.1111/j.1744-1609.2012.00287.x

Ferguson, L., & Cioffi, J. (2011). Team nursing: Experiences of nurse managers in acute care settings. *Australian Journal of Advanced Nursing, 28*(4), 5-11. Retrieved from http://www.ajan.com.au/Vol28/28-4.pdf#page=6

Fowler, J., Hardy, J., & Hawarth, T. (2006). Trailing collaborative nursing models of care: The impact of change. *Australian Journal of Advanced Nursing, 23*(4), 40-46. Retrieved from http://search.informit.com.au/documentSummary;dn=403540926342992;res=IELHEA

Hall, C., McCutcheon, Deuter, K., & Matricciani, L. (2012). Evaluating and improving a model of nursing care delivery: A process of partnership. *The Australian Journal of Nursing Practice, Scholarship & Research, 19*(4), 203-210. doi:http://dx.doi.org/10.1016/j.colegn.2012.07.003

Hodges, B. C., & Videto, D. M. (2011). *Assessment and Planning in Health Programs* (2nd ed.). Sudbury, MA: Jones and Bartlett Learning.

Kalisch, B., Weaver, S., & Salas, E. (2009). What does nursing teamwork look like? A qualitative study. *Journal of Nursing Care Quality, 24*(4), 298-307. doi:10.1097/NCQ.0b013e3181a001c0

Kalisch, B., & Schoville, R. (2012). It takes a team: Challenging the belief that each patient should be cared for by just one nurse. *American Journal of Nursing, 112*(12), 38-42. doi:10.1097/01.NAJ.0000421024.08037.0d

King, A., Long, L., & Lisy, K. (2015). Effectiveness of team nursing compared with total patient care on staff wellbeing when organizing nursing work in acute care wards: a systematic review. *JBI Database of Systematic Reviews & Implementation Reports, 13*(11), 128-168. doi:10.11124/jbisrir-2015-2428

Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (eds.). (2000). *To err is human: building a safer health system*. Washington, DC: National Academy Press. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK225179/

Lacoma, T. (2016). Definition of Supportive leadership style. *Houston Chronicle.* Retrieved from http://smallbusiness.chron.com/definition-supportive-leadership-style-21835.html

O'Brien-Pallas, L., Meyer, R. M., Hayes, L. J., & Wang, S. (2010). The patient care delivery model – An open system framework: conceptualisation, literature review and analytical strategy. *Journal of Clinical Nursing, 20*, 1640-1650. doi:10.1111/j.1365-2702.2010.03391.x. Epub 2010 Nov 30

O'Connell, B., Duke, M., Bennett, P., Crawford, S., & Korfiatis, V. (2006). The trials and tribulations of team-nursing. *Collegin, 13*(3), 11-17. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/17036450

Registered Nurses Association of Ontario. (2013). Developing and sustaining interprofessional health care: Optimizing patients/clients, organizational, and system outcomes. Retrieved from http://rnao.ca/bpg/guidelines/interprofessional-team-work-healthcare

Registered Nurses Association of Ontario. (2006). Health work environments best practice guidelines: Collaborative practice among nursing teams. Retrieved from http://rnao.ca/sites/rnao-ca/files/Collaborative_Practice_Among_Nursing_Teams.pdf

Registered Nurses' Association of Ontario. (2016). *Intra-professional Collaborative Practice among Nurses, Second Edition.* Toronto, Ontario: Registered Nurses' Association of Ontario. Retrieved from http://rnao.ca/sites/rnao-ca/files/Intra-professional_Collaborative_Practice_WEB_6.pdf

[redacted] (2016a). Corporate Education Funding Proposal IMCR 2016-17.

[redacted] (2016b). IMCR Evaluation Framework Jul16.

Stringer, E. T. (2014). Action Research 4th ed. Los Angeles, CA: Sage.

Stringer, E. (2004). *Action research in education.* Upper Saddle River, NJ: Pearson Education.

Weydt, A. (May 31, 2010) Developing Delegation Skills. *OJIN: The Online Journal of Issues in Nursing*, 15(2), Manuscript 1. doi: 10.3912/OJIN.Vol15No02Man01

White, K. M., & Dudley-Brown, S. (2012). *Translation of evidence into nursing and health care practice.* New York, NY: Springer.

Appendix A: Healthy Work Environments Best Practice Guidelines

1. Intra-professional collaborative practice among nursing teams*
2. Developing and sustaining effective staffing and workload practices
3. Developing and sustaining inter-professional health care: Optimizing patient/client, organizational and system outcomes
4. Developing and sustaining nursing leadership*
5. Embracing cultural diversity in health care: Developing cultural competence
6. Managing and mitigating conflict in health-care teams
7. Preventing and managing violence in the workplace
8. Preventing and mitigating nurse fatigue in health care
9. Professionalism in nursing
10. Workplace health, safety and well-being of the nurse

*Second edition available

RNAO, 2016

Appendix B: Definitions of terms

Collaboration "is the process of working together to build consensus on common goals, approaches and outcomes. It requires an understanding of own and others' roles, mutual respect among participants, commitment to common goals, shared decision-making, effective communication relationships and accountability for both the goals and team members" (RNAO, 2006, p. 62).

Collaborative leadership "reflects a shared accountability that addresses power and hierarchy" (RNAO, 2013, p. 25).

Healthy work environment "a practice setting that maximizes the health and well-being of nurses, quality patient/client outcomes, and organizational performance and societal outcomes" (RNAO, 2013, p. 17).

Individual patient allocation nursing model of care: "in this model, one nurse assumes responsibility for the complete care of a group of patients on a one to one basis, providing total patient care during the shift" (Fairbrother et al., 2010, p. 203).

Interprofessional team "Multiple health disciplines with diverse knowledge and skills who share an integrated set of goals and who utilize interdependent collaboration that involves communication, sharing of knowledge and coordination of services to provide services to patients/clients and their care-giving systems" (RNAO, 2006, p. 62).

Intra-professional team "a team of professionals who are all from the same profession."

Model of Nursing Care pertains to the practice domain of nurses, and describes the delivery of health care that they provide (Hall et al., 2012).

Nursing Team "the nursing team is a group of nurses working towards a common goal" (RNAO, 2006, p. 62).

Teamwork "…that work which is done by a group of people who possess individual expertise, who are responsible for making individual decisions, who hold a common purpose and who meet together to communicate, share and consolidated knowledge from which plans are made, future decisions are influenced, and actions determined" (Brill,1976).

Team nursing model of care: individual responsibility for one's patients, within "the idea of taking shared responsibility with team members for the progress of work for the entire team" (Fairbrother et al., 2010, p. 203).