Exploration of interaction and shared care arrangements of generalist community nurses and external nursing teams in a rural health setting

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KEY WORDS

Nursing, shared care, interaction, communication, care planning, case coordination

ABSTRACT

Objective

The purpose of this pilot study was to determine the understanding of nurses within a shared care model and the degree of interaction evident in their practice in the shared care nursing environment in a rural care setting.

Sharing of care between different nursing teams can allow for the improved use of minimal resources available in rural communities.

The objectives of the research were firstly, to identify the interactions of nursing teams in a shared care model and secondly, to determine how shared care is evident in their practice. The final objective was to draw attention to the importance of shared care models in rural health settings and to develop recommendations to support shared care models.

Design

A qualitative, non experimental, grounded theory descriptive study was used in this research.

Setting

Primary care

Subjects

The sample comprised the generalist community health team, which consisted of registered nurses with more than 5 years post registration experience in community health nursing and two external nursing teams, comprised of a palliative care team and an aged care team.

Main Outcome Measures

Identification of the nursing interactions and shared care practices in order to develop recommendations to foster and support shared care models in changing health structures.

Results

The study generated four themes: a lack of understanding of each teams' roles; difficulties in communication of information; the importance of setting shared goals in care planning; and the need for collaboration to ensure clarity in case coordination.

Conclusion

Results suggest that confusion around role, skills, communication, care planning and coordination of care within a shared care model are creating barriers to effective sharing of care. Co-location of services should enhance sharing of care. These results should facilitate the development of care approaches that maximise health outcomes and contribute to a better understanding of collaborative processes that can assist in the provision of health care in rural settings.

INTRODUCTION

Health care in New South Wales (NSW), Australia is at present in flux (Keleher 2003). Restructures, financial constraints and the limited availability of health professionals necessitate nursing and allied health staff innovatively working together to share the limited resources available (Keleher 2003). To achieve optimal and comprehensive patient care, services need to work collaboratively at all levels.

Services in rural areas are particularly in need of partnerships as fewer alternatives are available than exist in metropolitan areas. The trend toward earlier discharge from hospital and the move toward community based care, has flagged the need for creative partnerships in community services (Reutter and Ford 1998).

The benefits of shared care models are clearly documented (Sweeney and Kisely 2003; Hibberd 1998; Reutter and Ford 1998) with services evolving their systems to meet local needs. Research has indicated that barriers in interaction between teams blocks the sharing of care (Orton 1994). The existence of barriers within any of these themes has an impact on the ability of teams to provide effective shared care (Orton 1994). Evaluations of how nursing teams interact in a shared care rural environment have been limited. This research explored how nursing teams interacted in a shared care arrangement in a rural health care setting, examining their views and perceptions.

Literature Review

A literature review of the shared care concept indicated that there are many models of patient care and of multiple care services. Shared care models have been described in several different formats. Authors have looked at shared care from different viewpoints, but with a commonality of issues and determinants. For example, two such studies found that to enable shared care to occur effectively, organisations should have common aims and goals (Crawford and Price 2003; Hibberd 1998). Shared care models allow improved use of resources in rural areas, team members are able to support

and further enhance the expertise of other team members, and care is thus responsive to patients' changing needs (Sweeney and Kisely 2003). The literature informed an understanding that shared care needs to be structured. Without structure, care becomes complicated, with reduced patient follow-up and clouded outcomes. To achieve this, one overriding theme emerged from the literature, that of enhancing organisational structures (Sweeney and Kisely 2003; Crawford and Price 2003; Hibberd 1998). The organisational structures and the necessity for all team members to understand each organisation's purpose and their own role within the organisational structure are imperative in the shared care process.

Each model suggested that for collaborative processes to be in place, health professionals should understand organisational structures and team roles which assisted in interaction and management of actions (Sweeney and Kisely 2003; Crawford and Price 2003; Hibberd 1998). Misunderstandings occur when professionals cannot understand how other organisations operate. What each organisation, does, the capacity, the styles of working, responsible personnel, and individual and collective philosophies, are all significant. When health workers understand these things, they are then able to collaborate and form common goals, without conflict brought about through ignorance (Hibberd 1998). Organisational boundaries become less rigid, enabling teams to work within an integrated framework (Dion 2004; Sweeney and Kisely 2003; Crawford and Price 2003; Street and Blackford 2001; Hibberd 1998). Understanding organisational frameworks assists in the communication process (Dion 2004). Effective communication is imperative in a shared care model. Barriers to communication discourage collaboration and sharing of care (Sweeney and Kisely 2003).

Establishment of clear processes and frameworks for communication ensures that the shared care model achieves its aims. Each team member must assume responsibility for communication and interaction with other members. Interaction and communication between team members is a human

process and thus understanding the processes by which communication occurs, assists in the sharing of care.

Care planning within the shared care model is facilitated by the processes developed for communication. The ability to gain and share information and expertise allows planning of care to be multidimensional for the patient, and encourages optimal care (Yuen et al 2003). Themes within the literature recognised successful outcomes and focused care planning as being dependent on all team members (Hammer 2001).

Care coordination in a shared care model is best developed with collaboration, which is defined as the sharing of responsibilities, planning, interventions and information. All members of the teams provide input and participate in the coordination of patient care, ensuring shared goals are met. All members are responsible and accountable for the coordination of care. A significant part of the literature analysed revealed that outcomes regarding quality of care and effectiveness of interventions were the main concern of health professionals (Dion 2004; Keleher 2003; Hammer 2001). The causal relationship between collaboration and optimum outcomes is significant.

For any shared care model to be effective, the four themes: communication, understanding, coordination and planning are needed to ensure continuity of care and to establish and maintain the shared care model (Sweeney and Kisely 2003).

The existence of barriers within any of these themes has an impact on the ability of teams to provide effective shared care (Orton 1994). To more deeply understand collaboration and sharing of care, investigation of these external factors can identify barriers and assist in identifying strategies for improvement.

Each model reviewed had developed around the needs of each organisation and community. Investigation into interactions of staff is perhaps the key to understanding the strategies needed to ensure benefits to nurse and patient. Understanding

shared care models facilitates an understanding of the benefits of this form of collaboration. Improved strategies for shared care in the work environment would assist to optimise use of resources in the current health care system.

This study aimed to explore the interaction and shared care arrangements of generalist community nurses and external nursing teams in a rural health setting.

METHOD

A non experimental, grounded theory descriptive study design was used in this research. The disadvantage of such a study design is that it decreases control over the variables and the establishment of the cause-effect relationship between those variables is difficult to identify (Polit and Hungler 1993). In this research however, where the primary focus is on human interactions in a naturalistic setting, this type of design has been shown to be effective (Lomberg and Kirkewold 2003). The aim of the study was to explore the interaction and shared care arrangements of generalist community nurses and external nursing teams in a rural health setting.

Ethics

Ethics approval was sought and obtained from Greater Southern Area Health Service Human Research Ethics Committee (HREC) prior to commencement of the pilot study. Following HREC protocols, informed written consent was obtained from participants. Participants were assured if direct quoting was used in published work that anonymity would be maintained.

Comprehensive information on the study was provided to teams at all team meetings, and team members asked to participate.

Objectives

The objectives of the research were firstly, to identify the interactions of nursing teams in a shared care model and secondly, to determine how shared care is evident in their practice and to disseminate these findings to members of the health care teams. The

final objective was to draw attention to the importance of shared care models in rural health settings and to develop recommendations to support shared care models.

The pilot study endeavoured to obtain accurate accounts of the perceptions and experiences of the nursing teams within the shared care model. Based on examination of the literature a 10 point questionnaire was developed. Respondents were asked to indicate their understanding of each other's role, their understanding of the current shared care arrangement and how they provide input into care planning.

The items included: the communication techniques the teams used, strategies for case coordination they perceived as important, and what strategies they used in their practice, together with their perspective on the aims and objectives of their teams. A Likert Scale format was used. The questions included are listed below (see table 1).

Table 1: Sample questionnaire

- Do you know and understand the skills and roles of all members of the shared care teams: generalist community health team, palliative care team, aged care team?
- What do you perceive as effective practice in shared care?
- Do you believe the current shared care arrangement you are currently involved in with generalist community health team, palliative care team, aged care team ensures effective patient care?
- Is input into care planning attended by all members of the health care teams?
- What input do you have into the care planning of patient care within the current shared care with the generalist community health team, palliative care team, aged care team?
- What communication techniques are used in the shared care arrangements you are involved in?
- Is input into case coordination attended by all members of the teams?
- What strategies are used in case coordination in the shared care?

Model
- Who ensures effective care coordination occurs for your client?
- What are the aims and objectives of your team in client care?

Sample

The sampling for the study was purposive and comprised registered nurses from the generalist community health team and two other external nursing teams; a palliative care team and an aged care team, both of which work in the Greater Southern Area Health Service, NSW, Australia. The teams operate from separate sites and have separate management teams.

Each team member brings different skill and expertise to their teams. The teams included: three team leaders/managers, eleven registered nurses with more than five years post registration experience in rural community health nursing and two allied health members. Two members from each team participated in the survey.

As previously described, participation was voluntary and anonymity was guaranteed. A questionnaire was sent to each participant who was given one month to complete it and return it to the researcher.

FINDINGS

A response rate of 100% was achieved. This meant that two members from each team (generalist, palliative, aged care) participated in the study. All respondents were included in the analysis. Data from the 10 point questionnaire was placed in a descriptive matrix, used to elicit characteristics in the comments of the nursing teams. Using a continual comparative analysis, the data was rechecked for accuracy and emerging themes highlighted (table 2).

Four recurring themes became evident. These were:

Care Planning
Answer from respondents showed 50% agreement and 50% disagreement about whether they were providing input into care plans. Comments indicated care plans were developed by each team in isolation, without consultation with other teams, or with only minimal consultation.

Case Coordination
All respondents indicated they had a firm understanding of the strategies needed to assist

case coordination, but that a lack of utilisation of these strategies existed. Fifty per cent of respondents agreed they provided input into case coordination, while 15% acknowledged they provided no input; and 33% were undecided as to whether any input was provided by them or not. Sixty six per cent of respondents indicated that management played the primary role in case coordination. Eighty per cent of respondents stated that key workers/case managers coordinated care. All respondents however, saw this as their role and several indicated concerns as to how key worker/case managers were differentiated. One respondent stated case coordination was: *"an all staff role"*.

Role of Teams

Although the questionnaire showed each team had an appreciation of each member's role, knowledge of how each team worked was varied. Fifty per cent of respondents had a clear and comprehensive understanding of each team's role, while the other 50% had very different and diverse understanding of each others roles. For example, knowledge of the work and responsibilities of specialty teams, such as an understanding of the palliative care role around symptom management, control strategies and focus on spirituality, was particularly varied. Fifty per cent of respondents referred to the location of teams on different sites as being a barrier to sharing. Being located on the same site increased the ability to share information with other teams. A lack of understanding of other's roles was cited as: *"who does what"*, with another respondent concerned with: *"the lack of understanding and knowledge of other teams"*.

Communication

All respondents described communication techniques used as verbal, written and through team meetings. Only one respondent however found these techniques concise, informative and accurate. This question gave rise to many comments, although comments had not been requested in this section.

For example: *"communication very brief"*, *"not always comprehensive"*, *"systems are available but not well used"*. An enduring theme was a lack of processes for communication and difficulty in achieving feedback

from other teams. One respondent commented on the problems that ensue with part time staffing for continuity of care: *"part time work makes it difficult to maintain communication networks and obtain current feedback"*.

Table 2: Examples of issues identified that need further study

Care Planning
- collaboration needed to ensure positive client outcomes
- shared input into case discussion, assessment, review and referral

Case Coordination
- to enhance client access to services across organisational boundaries
- allocation of key workers/case managers
- need for regular cross team meetings
- client primary focus in decision making to be paramount

Role of Teams
- awareness of specialty roles
- understanding of each teams roles and skills
- location of teams
- Communication
- need for processes to assist communication
- accurate, concise and informative communication needed

DISCUSSION

The study provided a valuable perspective on sharing care in a rural health setting. The shared care model is one in which health provider's work together with common goals and objectives relating to client care. Shared care applies when the responsibility for the care of the patient is shared between individuals or teams who are part of separate organisations or where substantial organisational boundaries exist (Pritchard and Hughes 1995).

Sample participation was kept to a small number. Previous research showed accurate data could be derived from small participant samples (McCann and Baker 2003). Data collected from this small participant group enabled conceptualising of the data. Further research will allow for refining and further detail. A criticism of this method may be that more extensive initial information may have been

promoted by using focus groups however this may have created a sensitivity, discouraging staff from fully expressing their comments.

The study provided informative results. The themes discovered reinforce observations found in the literature. Four themes emerged as important and warrant further investigation. Firstly, care planning was viewed by most of the participants as occurring in isolation and current plans remain role and specialty specific.

Secondly, interaction among teams and transferring of information was limited and lacked accurate, concise and informative data. Results indicate that nursing members understand the need for shared goals and the need to use 'face to face' interaction to facilitate communication. Systems to assist consultation on care planning and understanding of shared goals would assist client care. Clear processes and systems for care planning would lead to improved mechanisms for case coordination.

Thirdly, the need to implement guidelines on key workers/case managers was obvious in the survey. Each team perceived themselves as key workers or case managers. This creates barriers to sharing of information, increasing the risk of overlapping of services. As Hammer (2001) found, a lack of identification of a key worker or case manager may encourage a model where referral is made to other services without communication or shared consultation regarding patient goals and desired outcomes. The literature suggests that care without some form of coordination and management encourages fragmentation of services provided to clients. The results of this study indicate that a common denominator is the need for key workers/case managers to be clearly identified, thus assisting health care teams to maintain continuity. To allow case coordination and care planning to be effective and seamless, an understanding of all team roles has been highlighted as necessary.

This research found that understanding of each others skills and role enables team members to use their skill and knowledge and facilitates improved

cooperation and collaboration between teams, assisting in decreasing work overlap and reducing potential for confusion and conflicting advice. This leads to the common ambition of achievable, identified goals for the client. By drawing on these skills and roles, a stronger team emerges (Headland et al 2000). Teams that have this knowledge are better equipped to form successful partnerships. Further investigation is thus indicated into communication processes currently in place and their use in assisting current practice. This may lead to the design of new systems to improve communication both within and between teams.

In conclusion, the exploration of the interaction of nursing teams in a shared care environment has allowed nurses to reflect on practice and respond in constructive ways to meet the challenges that have been exposed.

RECOMMENDATIONS

Rural health nursing has experienced many changes in recent times. The need to work innovatively to achieve outcomes for patients has seen the generation of many models of care. This research has focused on a shared care model within a rural community. A shared care model allows improved utilisation of resources in rural areas; team members are able to support and further the expertise of other team members. It allows care to be responsive to the patient and communities changing needs.

Health professionals need to consider establishing and implementing the following recommendations for future shared care models:

- Clear education of staff on each organisation's function and objectives.

- Sound communication frameworks and processes to negate barriers to communication and encourage collaboration of services.

- Enhanced care planning skills through education to enable information and expertise sharing and to facilitate multidimensional patient care planning, thereby encouraging optimal care. Care coordination should be a primary focus

in the shared care model. All members of the teams should be encouraged to provide input and participate in the coordination of patient care, ensuring the shared goals are met.

- The co-location of services may increase the ability nursing teams to share information with other teams, thereby neutralising barriers.

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