 Contemporary Nurse (2009) **33**(1): 2–12.

Team nursing in acute care settings: Nurses' experiences

Jane Cioffi
Senior Lecturer, School of Nursing and Midwifery, University of Western Sydney, Parramatta Campus, Penrith South, NSW, Australia

Lorraine Ferguson AM
Adjunct Associate Professor, School of Nursing and Midwifery, University of Western Sydney, Parramatta Campus, Penrith South, NSW, Australia

ABSTRACT

A shift to the practice of team-based models of nursing care has occurred as a response to skill mix changes in acute health care settings. Little is known about nurses' experience of working in team-based models of nursing care delivery. This paper reports the findings of a qualitative study of the experiences of nurses working in teams in acute care settings in an area health service. Main findings are benefits of team nursing, team approach, team effectiveness, increased responsibility, availability of support and engagement with the multidisciplinary team. These findings have implications for understanding the essential elements of team nursing as experienced by team members; providing key messages for health services implementing team nursing and giving direction for further research.

Keywords: nursing; team nursing; models of care; skill mix; experience; acute care

Introduction

A review of models of care and nurses' roles in the New South Wales (NSW) health system has shown that a range of models involving team nursing are being used to organise the delivery of nursing care in acute care hospitals (NSW Health Office of Nursing and Midwifery, 2006). Further it was found there was a move towards the use of team nursing and away from patient allocation (NSW Health Office of Nursing and Midwifery, 2006). Therefore more nurses are working in team nursing situations. Nurses working in these team nursing situations have received little attention in the literature. Some evidence suggests nurses working in teams are dissatisfied with skill mix, number of staff and availability of clinical advice (Hayman, Cioffi, & Wilkes, 2006). These aspects have been shown to influence job satisfaction (Adams & Bond, 2000) and are strongly linked to patient safety and quality care (Kalisch, Curley, & Stefanov, 2007). This study explored and described nurses' experiences of team nursing in acute care hospital settings.

Literature review

Team nursing evolved in the 1950s in response to criticisms of task allocation being considered to depersonalise the patient (Ellis & Hartley, 2008). This approach to delivering nursing care has been operationalised in different ways with key elements including team members giving total care to a group of patients under the supervision of a team leader, a registered nurse (Tiedeman & Lookinland, 2004). A recent major nursing review of models of delivery of care found '… a move away from patient allocation towards some form

of team nursing model' (NSW Health Office of Nursing and Midwifery, 2006, p. 18) was occurring in response to changing skill mix. This reflects the opinion of Ellis and Hartley (1991) who predicted the possibility of team nursing re-establishing itself in conditions where fewer registered nurses were available and more enrolled nurses were employed. An increased reliance on teams to deliver nursing care is therefore occurring in the changing environment of nursing workforce issues.

The use of team nursing is considered to provide patients with continuity of care by a team therefore addressing the potential for fragmented care often resulting from more task oriented care delivery models (Adams, Bond, & Hale, 1998). For nurses team nursing facilitates increased potential for meaningful care giving and provides the opportunity for developing responsibility in team members (Adams et al., 1998). According to Tiedeman and Lookinland (2004, p. 294) 'the focus is to work collaboratively and cooperatively with shared responsibility, and to some extent accountability, for assessment, planning, delivery, and evaluation of patient care.' Critical to team effectiveness is leadership by the team leader who has responsibility for team performance (Tiedeman & Lookinland, 2004) on the assigned shift.

Effective clinical leadership by team leaders is extremely important in team nursing. Team leaders support, monitor and evaluate team members and their care giving (Tiedeman & Lookinland, 2004). In this way team leaders can act to decentralise decision making and accountability for patient care from the nursing unit manager to a marked degree. The experience, skills and knowledge of team leaders is critical to team performance and patient care as is the use of clear communications within the team (Rafferty, 1992; Tiedeman & Lookinland, 2004; Waters, 1985).

Different interpretations of 'team nursing' are evident with many types of team approaches being described in the literature including registered and enrolled nurse partnerships, zones based on patient acuity and use of equivalent teams in same area (NSW Health Office of Nursing and Midwifery, 2006). According to Tiedeman and Lookinland (2004) the team model can be implemented in a number of different forms. For example, team leaders make decisions to organise care giving that is task-centred or patient-centred (Rafferty, 1992). The staffing composition of the team model can also vary as it enables the use of enrolled nurses and assistants in nursing as they are under the supervision of a team leader, a registered nurse who is responsible for patient care. Recommendations from a systematic review of nursing teams found evidence to indicate that staff need to be involved in the development and implementation of unit policies if team function is to be improved, and a coordinated multidisciplinary approach to the delivery of care is to be incorporated into nursing units to achieve improved outcomes (Pearson et al., 2006).

Studies have examined the effects of team nursing on patient care and satisfaction. An early comparison between a team nursing model and a primary nursing model with medical-surgical type patients showed no statistically significant differences ($p = 0.28$) for the overall quality of care when measured using Qualpac scale (Skukla, 1981). A more recent study that compared team nursing model to patient allocation model in an orthopaedic ward also detected no statistically significant differences and patients from both models of care delivery reported satisfaction with care (Wu, Courtney, & Berger, 2000). However when a team midwifery model of care was compared to standard model of care, women in the team midwife model of care were more satisfied in the antenatal and intrapartum stages of care ($p < 0.01$ and $p < 0.001$ respectively) with no great differences being shown in postnatal period of care (Waldenstrom, Brown, Mclachlan, Forster, & Brennecke, 2000). These findings are inconclusive and indicate further investigation is required to determine the effectiveness of team nursing not just for patient care but also for nursing staff working in team nursing situations.

Only a small number of qualitative studies were found that had explored team nursing. These had

focused on team working and team supervision. Nurses' experiences of team working in a nursing home found teamwork was considered vital for delivery of high quality care and was facilitated by a collaborative team structure (Wicke, Coppin, & Payne, 2004). Earlier a Finnish study in the 90's found that nurses considered togetherness among team members, communications and expressions of opinion, team relationship, team working methods and work motivation were major aspects of team nursing (Hyrkas & Appelqvist-Schmidlechner, 2003). Because of the shift towards team nursing models of care in the acute care setting it is important to develop an insight into, and understanding of, the experiences of nurses involved in the delivery of patient care using team-based models of care delivery. This study answers the research question: What are nurses' experiences of team nursing?

Method

Design

A qualitative study with an exploratory descriptive approach was used to identify and describe nurses' experiences of working in teams to give direct patient care to adult patients in acute care wards. A qualitative study within the philosophical framework of naturalistic inquiry was selected for the study as it explores the responses of people in real-world situations (Erlandson, Harris, Skipper, & Allen, 1993; Lincoln & Guba, 1985). Further, the exploratory and descriptive approach is considered appropriate as little is known about the team experience within the acute care setting.

Setting

In an area health service in New South Wales three acute care hospitals were selected as the study sites. Of the three hospitals involved two are metropolitan tertiary referral centres and one is a metropolitan general teaching hospital.

Sample

Fifteen nurse participants volunteered to participate in five small group interviews with each group being coded consecutively as they met, for example, Group 1 was coded as G1, Group 2 was coded G2 and so on. The inclusion criteria for nurse participants were: a registered or enrolled nurse with two or more years experience giving direct care to adult patients in a team nursing environment; and employed in an acute adult medical or surgical ward at their current hospital continuously for last six months. Ethics approvals for the study were obtained from the area health service and university Human Ethics Research Committees.

The convenience sample consisted of thirteen participants who were registered nurses with a median of 9.5 years experience and two enrolled nurses, one with five years experience and the other with 35 years. Eight had been practicing team nursing for five or more years and seven for four years or less. The highest educational qualification six registered nurses had obtained was a bachelor degree, six had post-basic or graduate certificates and one had a diploma. The highest educational qualification the enrolled nurses both held was an advanced enrolled nurse certificate.

Data collection procedures

Informed consent was obtained prior to each small group interview being held. A topic guide was used to assist with exploring nurses' experiences of team nursing. The topic guide areas were: work environment, team characteristics, model of care, team building, standards of care, workload, communications, satisfaction and multidisciplinary team relationships. These topic areas were derived from themes in the literature review (e.g. Borrill et al., 2002; Pearson et al., 2006) and anecdotal evidence from stakeholders. Small group interviews were about an hour in duration and were audio taped. These interviews were held in a meeting room in each hospital.

Data analysis procedures

From verbatim transcriptions data were coded and categorised using NVivo and Wolcott's (1994) approach to qualitative analysis to obtain a description of the experience of working in a team giving direct patient care to adult patients.

Findings

Nurses' experiences of team nursing can be described using six categories. These categories were benefits of team nursing, team approach, team effectiveness, increased responsibility, availability of support and engagement with the multidisciplinary team. Each category is reported below with example extracts.

Benefits of team nursing

Nurses working in team nursing situations described team nursing as patient-oriented, facilitating accountability, encouraging collaboration, enabling better coverage of patients and providing better access to more experienced nurses as a reference point for their decision making. Members in the team situation were identified to provide help and support especially for new graduates, to avoid things being missed and to enable the delivery of safer, better care. Some nurses commented that working in a team had improved relationships.

> It's much more patient-orientated. I think they get far better care because people know directly who to go to if something's not done. – G5

> … everybody knows what's … happening with all of the patients … more of an understanding … come together to collaborate what you have done and what needs to be done … you can ask other nurses if they are an expert … to help make decision for patient … team members will remind you that we've missed this and that and then you get onto it. But if you are working alone … miss it … – G1

> … good for new graduates, learn from others, get assistance, see how things can be done differently. – G2

> Working as a team it is a lot better, because then you can have somebody else backing you up and helping you out … – G3

> … I think it has actually improved, the way everybody gets on… – G4

Nurses also commented on improvements in quality of care with team nursing. Quotes included:

> … most of the time it *(team nursing)* is really helpful, patients get better care out of it. – G2RN

Despite these benefits a number of nurses did acknowledge the difficulty of trying to ensure quality care when patient acuity was high and the skill mix in the team was inadequate. For example:

> … had really high patient acuity … Things tend to go wrong then … when it's really heavy or you get a lot of sick leave and that's when staffing is low, that's when it tends to go wrong. – G4

Team approach

When team nursing commenced in their clinical setting nurses considered they had not been consulted and received little preparation. They indicated they had little input into the decision making process and found themselves in situations where they 'just had to get on' with what had been decided.

> We were told this *(team nursing)* is what is going to happen – they didn't say this is what you are going to do. Instead of having these five patients here you can have 10 now, with this other person. So really it is like five patients each, divided up, but you are in a team of 10 for instance. – G1

> Preparation for team nursing … Just fall into it … no training. – G2

> … the preparation basically was that's how it's going to work, not actually how to make it work and how to deal with issues. There was no preparation in that way, it was just this is what we are going to do … we have to trial it and then you just have to go with it or maybe some articles on the notice board for team nursing, if you have time please read … – G5

The way teams worked to provide care to patients was approached differently within teams

and between ward areas. Some nurses described the use of task allocation within the team, some worked together in teams going from patient to patient, others were allocated their own patients in the team situation and required some of the care of these patients to be provided by other nurses as they were not able, for example, to give medications. All teams had team leaders and these leaders in the most part had patient loads.

> … you might need to give them jobs to do and that way it can all get done. You can still sort of do things together, but break up medications, maybe you do that room, I will do that room and we will meet in the middle type thing, or you measure those drains, and I'll start at this end and you start at that end, and work together otherwise you end up doing the lot. – G4

> I am able to give medications so you do sometimes split them so the RN might have 4. I'll have 4. I will call on No. 1 to come and help me. Sometimes you do work together, they will go and do the medications while I am showering, and then they will come and help me. – G3

> … at the beginning of your shift talk about what/how we are going to attack it … half way through the day right did we get those things done and talking about what the other person might not of been able to do … make lists of things that are standing out such as tests … what needs to be done and prioritise that always helps. – G1

> Our NUM is our team leader in the morning but … allocated team leaders in the afternoon and night shift … The team leader (*allocated*) has a patient load … usually take the lighter load or a smaller number so they can deal with their patients and if there are any other issues. – G3

The effectiveness of team nursing was considered by nurses to be influenced markedly by 'helping each other'. Descriptions of ways of helping each other out were assisting a team that was struggling, offering to help when time was available, and enlisting the help of the next shift. Typical comments were:

> One *(team)* is not doing too well and one *(team)* is fine. One person from the good team will … help out the other team … – G1

> The patient wouldn't get the proper care if we all didn't help each other … you all try and help each other out on the ward … you are relying on each other to sort of back each other up … say I'm finished I'm always going up to the RN's saying … you need a hand or anything like that they might need. – G3

> … if you are really busy and you are behind … there is a 2 hour overlap of the shifts … the afternoon shift … will just get in and help you. – G4

A main difficultly identified with not 'helping each other' arose when nurses did not work together. When this occurred it placed an additional burden on team members to address shortfalls in care. From their comments nurses considered that working as a team required particular skills and that there was a lack of education about how to work as a team. Typical examples are shown in the extracts below.

> … if you are not working together … it does all fall apart because you need a backup … working as a team doesn't always happen … – G1

> … sometimes you might be paired with somebody who is not willing to work as a team … have to do your job plus remind them to do theirs. So you are covering yourself running around for the whole 8 or 9 patients – it's difficult. – G3

> … there is no point if you team nurse with somebody who is not going to do it, and then you end up doing all the work anyway. – G4
> I think one of the main things was you always get one person on every shift who tends not to want to work as hard as others … people have lost the skills of working in a team … just have a lack of training and of how it works …

people didn't like working with some of the other staff, they resented having to … – G5

The other contributor to team effectiveness nurses described was the importance of communication. A typical comment was:

Communication is really important … develop good communication with the people that you are working with … – G5

Lack of communication had been found to be particularly problematical when team nursing first commenced and in daily team situations when members did not pass on information, did not indicate when they were having problems with their workload or a patient or when concerned about a patient. The following extracts show examples.

Communication not with each other about what is happening probably main problem … first started … hard to communicate … not done this kind of nursing before … as time progressed it became easier to communicate. – G1

… a bit tricky if you don't keep in touch with your fellow nurses. – G2

… some people don't pass on message that they probably should … don't tell anybody 'I'm having problems with this patient'. – G3

… somebody might have a patient that's deteriorating and not really letting anybody know … You don't know what's going on. – G4

There was recognition by some nurses that it was important to build rapport to facilitate communication and that some team members were better at communicating than others.

I always make a point of trying to know peoples names and be a little bit interested in them … having some rapport … always check how they are managing if they feel they have got any concerns … got to know that you will be able to communicate … I think building rapport with people and having some connection with them is very important. – G5

Some people … communicate more and better than other people … quite an individual thing. – G1

As communication is recognised to be an essential element of team performance (Borrill et al., 2002; Pearson et al., 2006) various strategies for more effective communication in the team nursing process were described as being used. These strategies addressed handover, staying in touch, and passing on information.

… communication – at the beginning of the shift is essential … just communicate continually that's the most important thing … also listening … need to be able to listen to other people … if there is a problem and you are not listening then it will just spiral out of proportion. – G1

Handover very important … have a handover sheet that we update every shift. – G2&3

We also have a nurse's communication board that we document things … we put the plan and we normally put physio then a box … regular meetings all the time, where can raise the issue and we can try and resolve it … do walk around handover in our ward … walk by the patient's room and check and make sure they are all okay. – G3

… after I come from my break go to the nurse … what's happening with that patient, any update … try to update everything so by the end of the shift whatever has been done has been updated to what has been changed or altered. – G4

Increased responsibility in team nursing

In the team situation registered nurses described experiencing an increased degree of responsibility sourced from looking after more patients and having to supervise staff with varying skills and experience.

… you are not only responsible for your patient, you have responsibilities as a team … a lot more responsibility … at the end of the

day if you're the RN … at the end of the day it's your 12 or 10 patients. – G1

… when you get budded with an TEN (*Trainee Enrolled Nurse*) or undergrad it gets a bit harder. – G4

If you have got a heavy load and you are working 3 shifts, like 3 consecutive days and you are budded with a TEN, so at the end of the 3rd or 2nd shift you feel burnout. You can't focus properly at times. – G4

… team nursing … really quite taxing … if we get a double load of patients with someone else it is because the skill mix is inadequate and it's not that you are working with the experienced person … they (*the Trainee Enrolled Nurse*) are counted as a half staff member you actually give the same amount of load as 2 people. – G5

The issue of responsibility was being actively addressed. Nurses in teams were being encouraged to be more responsible and nurses were being watchful of those they were working with till they knew they could trust them.

Try to cut down on major incidents and problems with patients, patients deteriorating and junior staff not getting help and group leaders not knowing that it is even happening and that sort of thing. Trying to make them more responsible. – G4

… you don't know if it's been done … you can only take peoples word that it has been done … you have to develop a level of trust … you have to feel confident that you can rely on what they are doing … you keep an eye on people that you don't know until you do know … that you can trust *(them).* – G5

With the varying skill mix and experience of staff in teams particularly new and agency staff, nurses described actively managing the complexity this created in the team situation. Nurses checked on less experienced staff, 'buddied' new staff and students, aligned patient acuity to nurse experience/skill, reduced the number of patients responsible for, and provided agency staff with an introduction at the start of the shift.

… keep going back to check on maybe the lesser skilled members of the team … new nursing staff on our ward and first years that need a lot more attention. – G1

Put experienced staff with high acuity patients and less experienced staff with less acuity patients. – G2

… so now if you work with a TEN you have only 6 patients, so you can actually treat them as a student first, employee second. – G4

… they *(registered nurses)* may have TEN and a student, or a TEN and a College of Nursing (*overseas nurse*) because there is just not enough expertise. – G5

… they (*agency nurses*) need to be briefed before they start the shift on how exactly the ward works … – G1

Availability of support in team nursing

Support available to the team was repeatedly stressed as a benefit in team nursing situations. This nursing support was identified as coming from within and from outside the team. The type of support within the team came from the team members and team leader and from outside team from the nurse unit manager and educator.

You've got your team leader, your NUM, your educators. If there is a problem, there is always someone you can go to. – G4

NUM supports team nursing … Responsibility of NUM to make it work … Some teams run efficiently and work well with support from the top. – G2

The educator is always there if we need them … if we needed an extra pair of hands or we needed to have some education or some insight into a particular procedure or so forth. – G1

… if sometimes you are busy we can call the clinical educator to come and help, so that's good. At the same time, practicing nursing in a safe way and at the same time getting the right teaching the right education. – G4

… You *(team member)* are in it together, you know the patient you are not sort of stuck there on your own and nobody's understanding what you are going through with that patient. – G3

Team leader can often be emotional support. – G2

… someone *(team leader)* you go to, someone who can check drugs with you, someone who can help out with your patients if you needed help … Obviously any sick patients they will help out. They check all the bloods and things like that. – G3

Working as a team it is a lot better, because then you can have somebody else backing you up and helping you out with them … – G3

Engagement with multidisciplinary team

The multidisciplinary team in the acute care setting also supports the nursing team in giving patient care. The nurses described their relationship with the multidisciplinary team as good on the whole. Typical comments were:

Very good … know what is happening with the patient, we know what the dieticians are doing … what the physiotherapists are doing. – G1

… we get on really well with all of our teams actually, they are all quite good … there have been problems in the past, so I guess because there have been problems, they've built on that and now they are very very good. – G4

For our ward I feel that the allied health (in our ward) we get along really well and we can approach them and they are quite happy to talk to us and we communicate quite well. – G3

Meetings, referrals and one to one conversations were main ways nurses engaged with multidisciplinary team members.

Allied health will come, nurses will come, and then the doctors will come and talk about what is going to happen to the patient … we can say what our issues are … It's basically a plan for discharge … – G3

We have to make a lot of referrals to allied health every day. – G3

… they *(doctors)* know who you are so they are familiar with you … they actually come and look for you and let you know what is going on. – G4

Some nurses did raise issues about the medical staff regarding communication both verbal and written and the difficulties they experienced at times when needing to continuously page them. Superiority and a lack of responsiveness from some multidisciplinary team members had been experienced by staff.

Doctors need to tell the teams what are happening … Interdisciplinary team communications not good. – G2

… have to write down in the notes that you have paged and how many times that they didn't answer … We are continually chasing all the time. If they don't document something properly, you don't understand you have to page because you don't know what they mean. – G3

But I think honestly there can be bit of a barrier at times. Superiority. – G1

Discussion

Overall nurses' descriptions showed nurses considered team nursing made a difference to patient care as it was patient-oriented, all the nurses in the team were familiar with the patients receiving care, care was more complete as things were missed less often and staff were supervised more closely so increasing

the likelihood of patients receiving better care. From the team perspective it enabled increased supervision of less experienced and less skilled staff, facilitated nurses helping each other as well as relieving over breaks, provided improved opportunities for students to learn as they were working with more experienced nurses, and support from educators was readily available. Consequently quality of care and patient safety were promoted when teams were performing effectively.

From nurses' experiences the effectiveness of team performance was dependent on working together and communicating effectively. These findings are similar to those of earlier studies by Hyrkas and Appelqvist-Schmidlechner (2003) and Pearson et al. (2006). Tensions arose in teams when nurses did not help each other and inadequate communications occurred. For registered nurses particularly, a further tension arose from the responsibility they faced having to supervise staff more closely especially undergraduates, trainee enrolled nurses, and agency nurses. This increased responsibility resulted from teams being assigned more patients and a registered nurse being required to be a team leader and to supervise less experienced team members. A few comments indicated that nurses were aware some nurses had moved to other areas to avoid being involved in team nursing as they preferred being responsible for their own patients and not being required to oversee and support other nursing staff in the manner team nursing required. This suggests that preparation and coaching maybe useful in supporting staff to develop themselves as team members and team leaders.

Nurses were quite satisfied with the support they had available to them in team nursing situations. This support ranged from 'an extra pair of hands' to help with the patient load or a very sick patient to formal instruction about an aspect of patient care. However, from most accounts nurses had been expected to shift to delivering care using a team nursing approach with very minimal preparation or with some rather ad hoc information with experiential learning being the main form of learning about team nursing. When issues arose with team nursing the most common approach used was calling a meeting to discuss and address the matter. Nursing unit managers were most frequently involved in working with nurses to plan and implement strategies in such situations.

Nurses did not indicate there were role descriptions for the position of team leader and team member. A systematic review made a recommendation that staff needs to be involved in the development and implementation of unit policies if team function is to be improved (Pearson et al., 2006). Therefore, the availability of protocols for team nursing and role descriptions for a team leader and team member may help to clarify expectations for performance in teams.

Nurses in this study indicated that relationships with the multidisciplinary team had improved. Some nurses attended multidisciplinary team meetings. However it was evident that not all members of all nursing teams participated, though most were aware they were held, and understood their purpose. Direct relationships with allied health professionals and medical officers were described as occurring on a day-to-day basis. Some accounts indicated these relationships were stronger with some multidisciplinary team members than others. From all accounts there is an opportunity to involve and develop a more cohesive multidisciplinary team with increased capacity to contribute to patient care and outcomes as recommended by Pearson et al. (2006).

The increased use of team nursing in acute care settings that is apparent in practice, and in the literature, indicates that team nursing is re-establishing itself in response to fewer registered nurses, and more enrolled nurses being employed, as predicted by Ellis and Hartley (1991). From nurses' descriptions of organising work in team nursing situations it is evident that within teams, task-centred and patient-centred approaches can be used, supporting the views of Tiedeman and Lookinland (2004) and Rafferty (1992). Team nursing therefore can be interpreted in a variety of ways and teams are in a position to explore the influence of work patterns and skill mix on the

processes and outcomes of care. This can lead to increased understanding of best practice development, therefore, so enabling nurses to accept new accountabilities of the quality of care that can result from this form of care delivery.

Though nurses were in the most part satisfied with many aspects of team nursing this study did not explore the experiences of patients and their families who were receiving care in team nursing situations. Further, the findings of this study reflect only nurses' experiences of team nursing in adult patient situations in the acute care hospital environment where the nursing staff in teams ranged from students to fully qualified staff.

Conclusion

The findings have important implications for the development of nursing knowledge. As team nursing is more commonly used and as it can be implemented in different ways the evidence base for team nursing needs to be developed. Skill mix, for example ratios of registered nurses, enrolled nurses and students, and different ways patient care is delivered within the team model, for example task allocation, need to be explored to provide insight and understanding into their effects on quality of care and patient safety. The experiences of patients and their families with team nursing by teams of varying skill mix in acute care settings also needs to be investigated including their levels of satisfaction. Within these investigations knowledge about teams and how they function in other fields should be sourced and applied in experimental situations to determine their relevance to nursing and health care.

The relationship nurses described with multidisciplinary team members and their teams suggests nurses may not be defining their role strongly within the multidisciplinary team and are to some degree seeing some separation between their nursing teams and these multidisciplinary teams. As the use of teams in nursing and health care delivery is increasingly being emphasised it is important to carefully consider the types of teams required to provide patient care with optimal outcomes that are professionally satisfying to all health professionals. Consideration should be given for a more inclusive role for nurses within the multidisciplinary team. From reviews of both nursing and multidisciplinary team approaches to care, emergent new team models may evolve that will contribute to team cohesiveness and improve patient outcomes.

Within acute care settings changes in practice are continuing to occur as seen with the re-emergence of team nursing. However, an approach that includes collaboration with nurses who are the key stakeholders in team-based models of care in the decision making phase could have the potential for nurses to empower themselves both in nursing and multidisciplinary team situations. Further, development of these practice models can be made more effective if nurses are involved in identifying, planning and implementing continuing education grounded in available evidence. Securing necessary resources such as policies and protocols that establish operating processes and procedures with clear roles and responsibilities for team function appear to be an important element of preparation for the change management process when team nursing models of care are being implemented. Strengthening health care teams in this manner based on evidence can build foundations for quality care and satisfying professional practice.

Acknowledgements

The authors would like to acknowledge funding support from the School of Nursing & Midwifery, University of Western Sydney and to thank all registered nurses who volunteered to participate in this study, especially Miss Jacqueline Britton and Ms Brenda Hayman for their support with transcription and encoding in NVivo and Dr Joanne Cummings for editorial assistance.

References

Adams, A., & Bond, S. (2000). Hospital nurses' job satisfaction, individual and organisational characteristics. *Journal of Advanced Nursing, 32*(3), 536–543.

Adams, A., Bond, S., & Hale, C. (1998). Nursing organisational practice and its relationship with other features of ward organisation and job

satisfaction. *Journal of Advanced Nursing, 27*, 1212–1222.

Borrill, C., Carletta, J., Carter, A., Dawson, J., Garrod, S., Rees, A., et al. (Eds.). (2002). *The effectiveness of health care teams in the National Health Service*. London: Aston University, University of Glasgow, University of Leeds.

Ellis, J. R., & Hartley, C. E. (1991). *Managing and coordinating nursing care*. Philadelphia: Lippincott Williams & Wilkins.

Ellis, J. R., & Hartley, C. E. (2008). *Nursing in today's world: Trends, issues and management* (9th ed.). Philadelphia: Lippincott Williams & Wilkins.

Erlandson, D. A., Harris, E. L., Skipper, B. L., & Allen, S. D. (1993). *Doing naturalistic inquiry: A guide to methods*. Newbury Park, CA: Sage.

Hayman, B., Cioffi, J., & Wilkes, L. (2006). Redesign of the model of nursing practice in an acute care ward: Nurses' experiences. *Collegian, 13*(1), 31–36.

Hyrkas, K., & Appelqvist-Schmidlechner, K. (2003). Team supervision in multidisciplinary teams: Team members' descriptions of effects as highlighted by group interviews. *Journal of Clinical Nursing, 12*, 188–197.

Kalisch, B. J., Curley, M., & Stefanov, S. (2007). An intervention to enhance nursing staff teamwork and engagement. *The Journal of Nursing Administration, 37*(2), 77–84.

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry.* Beverley Hills, CA: Sage.

NSW Health Office of Nursing and Midwifery. (2006). *First report on models of care February to April 2005.* North Sydney: NSW Health.

NVivo 7. (2008). Retrieved October 10, 2007, from http://www.qrsinternational.com/products_nvivo.aspx on.

Pearson, A., Porritt, K. A., Doran, D., Vincent, L., Craig, D., Tucker, D., et al. (2006). A comprehensive systematic review of evidence on the structure, process, characteristics and composition of a nursing team that fosters a healthy work environment. *International Journal of Evidence Based Healthcare, 4*, 118–159.

Rafferty, D. (1992). Team and primary nursing. *Senior Nurse, 12*(1), 31–34, 39.

Skukla, R. K. (1981). Structure vs people in primary nursing: An inquiry. *Nursing Research, 30*(4), 236–241.

Tiedeman, M. E., & Lookinland, S. (2004). Traditional models of care delivery: What have we learned? *Journal of Nursing Administration, 34*(6), 291–297.

Waldenstrom, U., Brown, S., Mclachlan, H., Forster, D., & Brennecke, S. (2000). Does team midwife care increase satisfaction with antenatal, intrapartum and postpartum care? A randomised controlled trial. *Birth, 27*, 156–167.

Waters, K. (1985). Team nursing. *Nursing Practice, 1*(1), 7–15.

Wicke, D., Coppin, R., & Payne, S. (2004). Teamworking in nursing homes. *Journal of Advanced Nursing, 45*(2), 197–204.

Wolcott, H. F. (1994). *Transforming qualitative data: Description, analysis and interpretation.* Thousand Oaks: Sage.

Wu, M. L., Courtney, M., & Berger, G. (2000). Models of nursing care: A comparative study of patient satisfaction on two orthopaedic wards in Brisbane. *Australian Journal of Advanced Nursing, 17*, 29–34.

Received 11 November 2008 *Accepted 08 April 2009*