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Improving Nursing Unit Teamwork

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A lack of teamwork among nursing staff affects care delivery and unit operations. Barriers present in the structure of a typical patient care unit that make it extremely difficult to achieve a high level of teamwork include large team size, lack of familiarity, instability of the work force and assignments, the absence of a common purpose and destiny, and an inhibiting physical environment. The authors discuss strategies to overcome these obstacles to teamwork.

The enhancement of teamwork among nursing staff is a universal goal for nurse leaders. A team is 2 or more people with a common purpose, but a high performing team is "a small number of people with complementary skills who are committed to a common purpose, performance goals, and an approach for which they hold themselves mutually accountable."[1(p45)] All teams, however, do not function optimally or even adequately.

There are 3 types of teams: work teams (those that form natural work units, doing the day-to-day work of the organization such as a group of staff on a given patient care unit); task teams (those that address a specific problem such as nursing practice council, quality improvement team, or policy and procedures committee); and management teams (teams drawn from people who direct operational or organizational units such as medical-surgical nurse managers or nursing directors). This article focuses on work teams, specifically unit teams on general care units in acute care hospitals. Unit team is defined as a group of registered nurses (RNs), licensed practical nurses (LPNs), nursing assistants (NAs), nurse managers, and unit secretaries working together on 1 patient care unit.

The value of nurse-physician and interdisciplinary teams has been demonstrated in a number of studies. High-performing teams have been credited with such outcomes as meeting the complex needs of patients,[2] improving patient care,[3,4] increasing staff satisfaction,[5] enhancing organizational effectiveness,[5] and strengthening overall healthcare delivery.[6] Knaus et al,[7] for example, in his classic study, found that mortality in intensive care units is directly influenced by the quality of interaction between nurses and physicians. A more recent study by Stevenson et al[8] found that primary healthcare teams rated as good were associated with successful quality improvement. Major reports, such as those issued by the Institute of Medicine (IOM), also underline the importance of interdisciplinary teams. For example, one of the IOM recommendations in *To Err Is Human: Building a Safer Health System*[9] was to promote interdisciplinary team functioning to ensure patient safety.

What has received very little research attention is the impact of team functioning among the staff on a patient care unit. A search through CINAHL, using the key words "unit teams" and "nursing teams," uncovered few studies. The results regarding nursing teams focused primarily on clinical practice or specialized teams such as palliative care teams[10,11] or community nursing teams.[12,13] Additionally, the literature reported numerous articles on integrated nursing teams.[14-16] Although the definition of teams is described differently among these studies, the results underline the importance of teamwork for quality outcomes.

A high level of teamwork has also been found to lead to greater staff satisfaction. For example, Rafferty et al[17] demonstrated that nurses who report a higher level of teamwork are more satisfied with their jobs, plan to stay in them, and are likely to have a lower burnout score. Other research links nurse job satisfaction with team building interventions.[18,19] Anecdotal articles offer suggestions to nurse managers and nurses as to the importance of rewarding teamwork,[20] creating clear direction and meeting goals,[21] establishing team bonding and listening,[22] and coaching staff.[23]

In a qualitative study of teamwork, 12 focus groups with RNs, LPNs, NAs, and unit secretaries

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were conducted in a community hospital. Teamwork problems loomed large on every unit and among every group.[24] The specific issues identified include:

- One shift being critical of the quality and quantity of the work done on another shift
- "It's not my job syndrome" such as only the NAs should feed the patients
- Unwillingness, or lacking the skills, to deal with conflict
- Delegating teamwork problems upward to management
- Fixing problems rather than confronting team members
- Isolated work patterns/not asking for help
- Not being available when needed
- Hierarchical interactions (ie, nurses treating attendants as if they are lesser)
- Overdelegation to the NA.

The information available about teamwork in nursing work groups points to the fact that there are serious problems. Given the acknowledged importance of high-level nursing staff teamwork, why is it so rare?

Team Size

The general care inpatient unit in an acute care hospital employs approximately 30 to 80 staff members. A nursing staff member interacts with a large number of staff on his/her shift—regular staff RNs, LPNs, NAs, contingency/float nurses, agency/traveler nurses, unit managers, and unit secretaries—as well as staff taking over the care of his/her patients at the change of shift. If a group of 3 staff members are working together, there are 3 one-to-one interactions. When additional help is required to restrain a patient, for example, another nurse or assistant would be added to this team which double the number of one-to-one interactions from 3 (RN to LPN, RN to NA, LPN to NA) to 6 (RN to RN2, RN to LPN, RN to NA, RN2 to LPN, RN2 to NA, LPN to NA). As additional members are added to the team, the number of one-to-one interactions explodes with each additional person added to the team. For instance, 12 team members lead to 66 different one-to-one interactions.

Gary Salton[25] has developed a model of team interaction entitled "Organizational Engineering." His database includes 2,267 teams in a wide range of industries.[25] These teams vary in purpose from drilling oil wells to developing a new medical device. The most frequent team size is between 5 and 8 people. The average, which takes into account the extremes is about 9 people. The research literature also suggests 5 to 10 members is ideal.[26] Contrast this with the 30 to 80 staff members who comprise a typical nursing unit team.

An analysis of nursing team interactions was conducted by the authors to determine how many different staff members 16 nurses working on a medical-surgical unit in a community hospital interacted with over the course of 1 month (February 2005). Four nurses were chosen from each of the following shifts: 11 PM–7 AM (midnights), 7 AM–3 PM (days), 3 PM–7 PM (afternoons), and 7 PM–11 PM (evenings). This particular unit used these shifts for scheduling purposes because of their mix of 8- and 12-hour shifts. Starting with the first day the nurse worked in the month, the number of people on that shift was counted. Then, each different staff member the nurse worked with on all subsequent shifts in the month was added to make up the total for each nurse. This included individuals both on their shift as well as the staff they took or gave report to on the off-going and on-coming shifts. It did not include any non–unit staff such as physicians, support department staff, other unit staff, nor did it include visitors to the unit.

The results of this analysis showed that these staff members worked with an average of 36 different staff members during 1 month (Figure 1). Nurse 5 worked with an astounding 48 different people, whereas nurses 6 and 14 worked with the fewest number (29) of staff members. Translated into how many new people a staff member worked with on any given shift, it ranged from a low of 3 to a high of 6. In addition to the interactions between the RNs, LPNs, and NAs, the staff also worked with unit secretaries and nurse managers not included in the above analysis. On the unit studied, there is 1 manager and 2 assistant nurse managers, one working days and one evenings. The particular unit examined had 4 unit secretaries who worked consistent shifts. Therefore, each RN, LPN, and NA would have additional interactions with 1 or 2 unit secretaries per shift.

The difference between the high and low number of different staff a nurse interacted with was influenced by 2 factors: the mixture of 8- and 12-hour shifts and the use of part-time/contingent staff. Those nurses on 12-hour shifts interacted with more individuals, as 8-hour staff came and left during their time at work. Part-time nurses were only seen on the month's schedule a few times, thus reducing the number of different people worked with over the course of the month. However, they worked with more new people per shift than the full-time staff. For example, the nurse who worked the least number of shifts in the study (nurse 6 who

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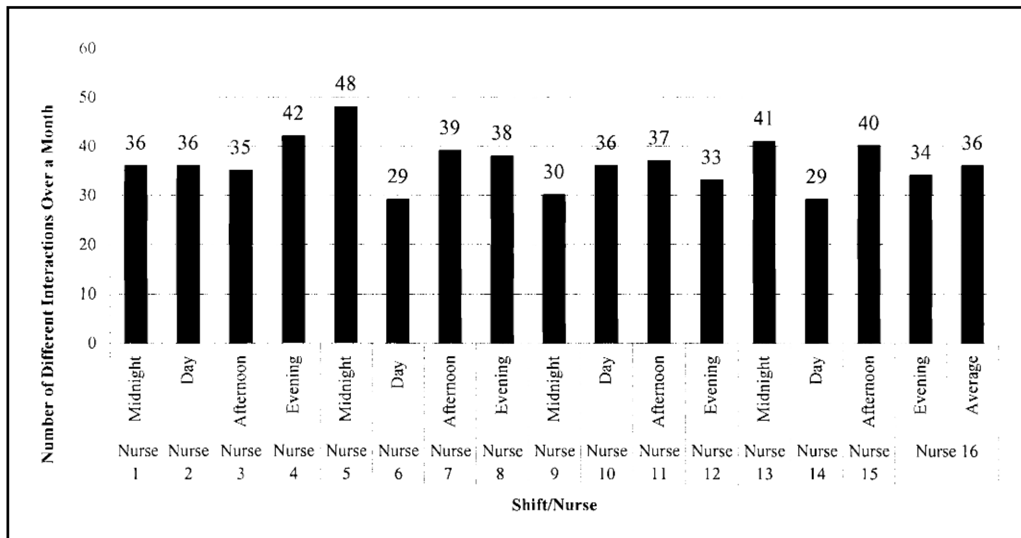

Figure 1. Number of different staff each nurse worked with over 1 month.

worked 5 shifts) interacted with more new people every time she came to work than did anyone else.

Familiarity of Team Members

Increased familiarity of team members—the extent to which individuals know the strengths, vulnerabilities, and idiosyncrasies of all the other members—increases productivity and effectiveness.[27] Evidence such as this supports the claim that teams composed of "…familiar members carry out their work more effectively than a team composed of strangers."[27(p312)] Essentially, people can learn about each other faster if there are fewer people.

Although nursing staff on a unit obviously do not all work at the same time, the typical scheduling plan rotates staff by days of the week and sometimes by shifts, thus making it probable that any given staff member will work with the majority of the unit staff. The ability to offset vulnerabilities or magnify the strengths of one another depends on team members being familiar with one another. As the group size grows, the probability of synergistic behavior, which requires a thorough knowledge of other team members' strengths and ways of practicing, declines.

There is another aspect of large group familiarity that merits attention. As group size increases, the precision of interactions becomes clumsier. The more members on a team, the greater the number of individual interests that need attention. The larger the group, the greater the difficulty they have communicating with one another in a clear and concise manner. In this case, one can predict that vital patient care information will be lost, quality of care will diminish, and more errors will occur.

One of the characteristics of a high-performing team is that one person's vulnerabilities are offset by another person's strengths relative to the issue being addressed. For example, a nurse may be especially skilled at teaching self-care to a new diabetic patient or at starting IVs. This talent may be unknown by many team members. Because the strength is unknown, the team cannot tap into it. Team performance declines relative to its potential. The only thing that the members can depend on is the basic skills of the nurse's particular job description (RN, LPN, NA) and even that is questionable.

Stability

The stability of staff on a patient unit has a tremendous impact on team functioning. A study by Adams and Bond,[28] found that staff instability undermined nurses' working relationships. In units where instability was high, the standards of professional nursing practice were perceived to be low. An association was also found between staff instability and nurses' stress level, which was evidenced by low perceptions of their ability to cope on the unit.[28] In an earlier study, Adams and Bond "…confirmed the importance they attach to staff stability in relation to the social aspects of work organization: creating cohesion amongst peers and developing effective work relationships."[29(p294)] Additionally, this study found that nurses reported limited value from agency staff or nurses from other units. Light[30] found that stability in teams was a key element in providing a higher quality of care at a lower cost.

The stability of teams that the typical nursing staff member encounters is very low. They work

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different days of the week and sometimes different shifts and in varying amounts. They also work with nurses floated from different units and agency/traveler staff. There are also many part-time staff who work only a few hours a week or perhaps every other week. Nursing staff are also sent home or floated out of the unit when the census drops or asked to come in when the census increases. The combination of 8- and 12-hour shifts creates instability. As people enter and leave the unit at 3 PM, 7 PM, and 11 PM, the resources available to solve a team's problems change markedly. In addition to changing staff members, patients are added to or subtracted from the census as the day progresses. It is hard to conceive of another work group that is so unstable!

Common Purpose and Destiny

The research on teams illustrates that high-performing teams have a common purpose and a common destiny. Although nursing staff generally believe they have a common purpose which is to provide quality care, they do not see their purpose as providing quality care 24 hours a day and to all of the patients on the unit. Instead, they assume accountability for only their patients on their shift. Many nurses do not even assume responsibility for the work of the assistive staff who work under them. If the nursing staff is only focused on taking care of their patients on their shift, a high-performing team cannot be achieved.

Added to this problem is that nursing staff do not have what is called a common destiny. Common destiny means that all members of a team share equally in their successes and their failures. If a patient is dissatisfied with their nursing care, who is held accountable? In reality, it is impossible to hold 30 to 80 people accountable. Even if a team-based reward system is in place (group vs. individual reward), when the team is as large as the typical nursing team, it will not achieve the desired impact. The problems/occurrences that caused a given patient to leave the hospital unhappy, for example, may have happened on a wide variety of shifts and in connection with a large number of different staff members. Conversely, if a patient reports a high level of satisfaction, there is no way to attribute any particular individuals with this outcome.

Physical Environment

Another influence on teamwork is the geography of the work environment. The structure and layout of some patient care units can decrease or increase the likelihood of teamwork. If a nurse is working on a unit with 2 hallways and no line of sight, for example, she will find it difficult to know how her team members are functioning and whether or not they need assistance. The cost of engaging another team member to help her is also affected by the physical distance she may need to overcome to do so. Knowing that engaging an additional staff member to move a heavy patient would reduce the danger of back injuries, for example, might be offset by the physical distance of that third person and the difficulty of engaging them to help.

Physical proximity allows team members to offset each other's vulnerabilities and magnify each other's strengths to a much greater extent than physical distance. Physical distance, on the other hand, reduces the possibilities for coordinated action and division of labor dominates over teamwork. Synergistic cooperation, a basis for horizontal effectiveness, is minimized.

The large team size, the unfamiliarity of the team members with one another, the instability of the team, the lack of a common purpose and common destiny and geographic dispersion combine together and interact to greatly inhibit the development of a high-performing nursing team on a typical acute care hospital unit. What you have in the name of teamwork is an extremely large number of staff working varying days and shifts that, for the most part, do not fully know one another's strengths and vulnerabilities, each performing what they consider their job and having no accountability for the whole.

Recommendations

Several strategies can be employed to mitigate the teamwork obstacles in a typical acute care hospital setting. They include: creating smaller teams, establishing consistent schedules, creating all 8- or 12-hour shifts, decreasing turnover and absences, offering rewards and incentives, and physically clustering teams.

Smaller Teams

The creation of teams with fewer members would greatly reduce the number of interactions. In one hospital, where the senior author consulted, smaller teams were created by dividing a 40-bed medical unit into 4 smaller units, each made up of 10 beds. Staff agreed to work for a period of 1 year on 1 of the 10 bed units with the same staff. This meant that they not only worked with the same people during their shift, but they also consistently handed off to the same staff members. This

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restructuring reduced the number of different people the staff had to work with by 75%. Instead of having to interact with 60 different staff members, they now worked with only 15 staff members. As patient and staff satisfaction increased markedly, they also achieved the high level of familiarity and stability required for the development of a high-performing team. Former patients even wrote the local newspaper complimenting the care they received and requesting, if they needed to be readmitted, that they be on that wing with those same staff members again.

The initial reaction that they would work consistently with the same individuals was negative. This resistance to working with a smaller group of the same staff members (still twice as large as the typical team across industries) is almost predictable. One reason for this resistance is due to the fact that staff are afraid they will be assigned to work with individuals who are poor performers either clinically or as a team member or both. Ironically, these performance problems have often been allowed to continue by the very staff who do not want to "get stuck" with them. They avoid confrontation with staff members who do not perform well, many times covering for them. If a nurse does not change the IV tubing on the previous shift, for example, another nurse may avoid confronting that nurse because she knows she will not be working with her for perhaps another 2 weeks or more. When they work so little time with these individuals, there are few incentives to deal with performance issues.

Consistent Schedule

If this type of structural change cannot be accomplished, consideration might be given to having staff work consistent schedules. In other words, each group of staff would be scheduled for the same days and the same weekends. Although there would be exceptions when staff need special days off, in general, it would greatly reduce the number of different people they worked with.

From another perspective, patients also suffer from the inconsistency of staff caring for them. Consistent staff for a given patient would obviously improve patient safety, quality of care, and patient satisfaction. If nurses worked set schedules with the same nursing staff members and handed off to the same staff on the other shifts, it is much more likely that patients would have more consistent staff caring for them. This staffing method would decrease the number of different team members each person worked with, increase the effectiveness of care, and improve patient satisfaction. The nurses would be familiar with and accustomed to each other's strengths and vulnerabilities and learn the best way to compensate for them. Although the patient assignments can never be totally consistent, consistency is built in through a stable work force.

8-Hour or 12-Hour Shifts

Another issue that greatly increases the number of different team members worked with is the mixture of 8- and 12-hour shifts. Staff leave at 3 PM and unless another 8-hour staff member comes in at that time to relieve her, her patients have to be redistributed among the other 12-hour staff. This also happens again at 7 PM when the 12-hour staff come on and at 11 PM when the evening shift staff leave. Obviously, instituting all 8-hour or all 12-hour shifts would limit the number of required new interactions.

If it is impossible to switch to all 12- or all 8-hour shifts, the team could be required to structure itself to accommodate for it. If the primary shift on a unit is 12 hours, staff members desiring to work 8-hour shifts could do so if they could create a team of other 8-hour staff nurses to hand off to. These staff members, for example, would sign on to work a 3-month period together and agree to cover for one another in case of call-offs or other emergencies.

Decrease Turnover and Absences

Every healthcare organization is working to reduce turnover and absenteeism of their employees. Fostering teamwork is yet another reason for organizations to strive to stabilize its work force. Obviously, if stability can be achieved, larger work teams can be tolerated. Team members come to know what others can, will, or want to do. There is no need to engage in an interaction to find out. Thus, the less turnover and the fewer absences, the larger the team can be and still achieve high performance.

This represents a "which came first" situation: if teamwork is good, turnover and unnecessary absenteeism is less likely to occur and if turnover is low, teamwork is more likely to be effective. Although research has not been completed on the subject of level of teamwork and absenteeism or turnover rate in nursing, it has been studied in other fields. Higher levels lead to lower levels of absenteeism.[31] It is hypothesized that team members are reluctant to leave the unit they work on or their team members in a difficult staffing situation unless it is absolutely necessary. It is also more likely that team members will be willing to come in and work for another

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team member who is sick or has a personal problem, partly because they know that that person will reciprocate in the future. Because they work together on a consistent basis, this bond is much stronger among team members, and thus, their willingness to be supportive of one another.

Rewards and Recognition

How does one encourage nursing staff to buy into creating small nursing teams or consistent schedules or any other method to increase teamwork? Although nursing staff want better teamwork, and it is a reward in and of itself once it is achieved, like most people, they will be more likely to change if they are rewarded in some way for making the change. Creating a meaningful, cost-effective reward system is both one of the most important and one of the most frustrating challenges facing nursing leaders. Appropriate rewards for teamwork should be empowering, not manipulative, work synergistically with intrinsic motivation, produce energy to achieve even more, and make team members feel good about their current and past accomplishments.

There are 5 categories of rewards: consumables (meal tickets, treats on the unit), status symbols (plaques, trophies, parking spots, clothing such as shirts with the team name, pins), monetary (coupons, educational opportunities, movie passes), social (compliments on work progress, thank you's, recognition in organizational publications, letters, public acknowledgment of achievement in front of peers and managers, feedback about performance), and opportunity (job rotation, special assignments, use of recreation facilities, use of machinery or facilities for personal projects).

Extensive reliance on monetary rewards is problematic because it has serious motivational limitations, it is costly, and reward inflation inevitably occurs (attempting to motivate people by an ever increasing financial reward to have the same impact). Financial rewards do not have much staying power because employees become habituated to them and forget about them, and an excessive financial reward creates "money motivation" rather than "good work motivation." Money without appreciation yields little recognition value. It is important to build a great deal of recognition into every reward such as pizza delivered to the unit when the team is too busy to leave for lunch or dinner.

One method of increasing the longevity of rewards is to use symbolism. The more symbolic an item is of the accomplishment, the more likely it is to continue reminding the employee why it was given (t-shirt, mug with meaningful inscription). Many tokens of appreciation are kept for years. The most important element of effective rewards is to reward the right behaviors. For example, if teamwork is the goal, a nurse leader should reward teamwork and not internal competition. It is important to focus rewards on a critical few behaviors and results rather than diluting them.

Cluster Teams

Another strategy to enhance teamwork would be to create teams within the patient unit based on geography. Closer physical proximity would increase the ability of team members to determine assistance and consultation needs of other staff members and to obtain help and advice when needed. Many hospital units are arranged with 1 unit containing 2 to 4 different wings or sections. The staff members on these types of units many times work "split assignments" (caring for patients on 2 or more different sections). This often results because staff count and compare the number of patients they are assigned. The staff in these situations complain whenever they have 1 or more patients than another staff member, not considering the impact on their work load, quality of care, patient safety, and teamwork. In facilities where staff have agreed to take more or less patients on a given shift so that they can remain in the same geographic area, the results have been positive in terms of staff satisfaction, quality of care, and enhanced teamwork.

Conclusion

Ultimately, the goal is to eliminate sources of instability in the work force and environment and to keep the teams small. This is a risky concept when there is a shortage of nurses because it seeks to eliminate the use of agency/travel nurses. The independent mentality of nurses also causes a barrier because they may not see value of working with or like working with the same staff for 3 or more months. Yet, if incentives and rewards are used and a difference is actually seen in patient and staff satisfaction, then staff is more likely to embrace the concept. Additionally, this method creates a common destiny for the team because the nurses are now seen as one unit striving for the same goal and working towards the rewards and incentives together. The individualistic mentality of meeting the needs of the patient for their shift and not being concerned with what happens on other shifts is diminished. Overcoming the obstacles to small teams is challenging but well worth the effort.

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