Nursing Team Dynamics: Communication, Culture, Collaboration

by

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PROFESSIONAL COMMUNICATION

We accept the thesis as conforming to the required standard

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Abstract

There is abundant evidence verifying that patients benefit when nurses communicate better; therefore improving team dynamics will positively impact patient care and improve nurse engagement resulting in many positive outcomes for teams. This applied action research study assessed the research question: “What is the experience of team work and team dynamics among members of a multidisciplinary nursing team from a Licensed Practical Nurse perspective?” The experiences of licensed practical nurses (LPNs) and key external leaders (KELs) are explored and analyzed drawing from current literature in the field of teams in health, organizational culture in health, and transformative learning in health. Historical and leading communication, organizational culture, and leadership theories guide this study. During focus groups and interviews, the researcher and participants were influenced to generate new knowledge and insight on team dynamics, through appreciative inquiry. Manifest and latent content analysis identified key themes within each of the subtopic themes, generating a number of recommendations for future action. Through the identification of similar and unique perspectives between the literature and participants in this study, the action research goals of empowerment and emancipation of team members was dynamically met for research participants.

Keywords: nursing; team dynamics; communication; collaboration; culture; leadership
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Nursing and other health professions have been established in a hierarchical manner, based on a traditional model. In the past, this hierarchy was evident from the classroom to the bedside, within the different levels of nursing and throughout the interprofessional health care team. Today, health professions and governments focus on the importance of interdisciplinary collaboration. The core principles of interdisciplinary collaboration include trust and respect among all members of the health care team. However, a gap exists between what health professions and organizations say they want for collaborative practices, and what is occurring in the practice setting (Besner et al., 2005). Through assessment of the dynamics of teams, organizational culture, and transformative learning within the context of health care this study examines how nursing teams communicate by exploring the experiences of licensed practical nurses (LPNs), key external leaders (KELs), and current literature in the field.

The applied action research paradigm was utilized to explore the research question: “What is the experience of team work and team dynamics among members of a multidisciplinary nursing team from a Licensed Practical Nurse perspective?” This study focuses on one nursing profession, but may offer insights applicable to other members of the health care team. This is a qualitative analysis that utilizes the philosophies of action research, examining a heteroglossic view through multiple voices of front line nurses. Through the research process, I supported LPN volunteer participants in focus group discussions to study personal experiences of team work and team dynamics. Appreciative inquiry was utilized to examine nursing culture ideologies, which impact individual and team experiences in the practice environment. Several key leaders, (health leaders external to the LPN profession), were interviewed to discuss their experiences. This
process allowed opportunity to deduce common and unique perspectives between the participants and the related literature. The researcher balanced an emic and etic perspective in this project. An emic standpoint is represented from the researcher’s perspective within the nursing culture, as a licensed practical nurse working for the LPN regulatory college in Alberta. The etic perspective is achieved through interpretation of the voices of participants.

**Chapter 2 – The Context-Why Study Nursing Team Dynamics?**

There are three professional nursing groups in Alberta: LPNs constitute 19%; registered nurses (RNs) 78%; and registered psychiatric nurses (RPNs) 3% of the total nursing numbers in the province (CIHI, 2010). Most practice environments involve LPNs and RNs and sometimes unregulated health care aides (HCAs), with RPNs working predominantly in mental health environments. There is a large overlap in scope of practice between the three types of nurses, with much similarity in knowledge base, skill set, and role in practice. But differences do exist; LPNs complete a two-year diploma program and graduate as a generalist focusing on individuals and groups (OCCinfo LPN, 2010); RNs once completed a similar two to three year diploma, and now train through a four-year baccalaureate degree (BN), with a broader focus beyond care of individuals and groups to include populations and communities (OCCinfo RN, 2010); Alberta RPNs complete a two-year diploma focused on mental health and psychiatric conditions (OCCinfo RPN, 2010); and HCAs often trained in the workplace in the past, now complete an 8-10 month certificate program to provide basic care (OCCinfo HCA, 2007).

Many cultural ideologies exist in nursing. Many of these ideologies date back to the 1860 origins of the iconic nurse Florence Nightingale (1969) and link with the dynamic issues of gender and social class. As in other cultural studies, ideologies seen in nursing team dynamics include hierarchies, hegemony, and power structures; these concepts are reflected throughout the
literature review and the new data collected in this study. The nursing ideologies in health teams today have developed over many years and influence how practitioners feel about other categories of nurses, as well as their own place in nursing. This history has created a nursing culture that often negatively influences the way teams communicate and work together, impacting nurse engagement and ultimately patient care (Atwal & Caldwell, 2005, p. 272).

Today collaborative practice is discussed, debated, and deliberated from front line nursing units to the provincial and national departments of health (Besner et al., 2005, p. 23).

To enable a productive and supportive workforce for the future, the nursing profession could benefit from collectively examining and unearthing the cultural issues that exist at its core. Transformation within each nurse and throughout teams is necessary to enact a social revolution in the nursing world. This could potentially create a culture that no longer tolerates infighting and counterproductive behaviors that limit and negatively impact nursing careers, patient experiences, and collaborative practice. Through appreciative inquiry an opportunity for open dialogue was fostered and multiple issues related to team dynamics emerged. A goal of this research was to help nurses and teams understand the importance of their individual and collective role in creating the nursing culture within their practice environment. This study performs a micro view of a macro sized topic area.

Chapter 3 – The Current Data-Literature Review

This study begins with a review of current research in organizational culture that addresses health care team dynamics, and is guided by the theoretical principles of organizational culture and communication theories. Three subtopics emerged, with topic themes in each area:

a. Teams in health care: values, nursing team culture, collaboration, role dialectics, disruptive behavior
b. Organizational culture in health care contexts: environment, role descriptions, assumptions

c. Transformative learning in health care context: leadership, communication, personal transformation.

Teams in Health Care

Literature related to health care teams is prevalent, with extensive research available related to team dynamics. Nursing culture, collaboration, and nursing role dialectics are common themes, appearing to be in dynamic relationship with each other. There are many interpretations of ‘collaboration’ as discovered by D’Amour, Ferrada-Videla, San Martin Rodriguez, and Beaulieu (2005) as they performed a literature review dating from 1990-2003 examining the various definitions and concepts associated with the word collaboration. D’Amour et al. (2005) discovered that “the dynamic established between professionals is as important as the context of collaboration” (p. 128). Croker, Higgs, and Trede (2009) explored complexities related to collaboration and the concept of team, which led to the development of two different models “the first conceptualising collaboration in relation to domains of process, product and players; the other model proposing the notion of collaborative arenas” (p. 28). The differing perspectives in the literature related to meanings associated with teams and collaboration are valuable to further understand interpretation and collective meaning associated with nursing terms. This team dynamic study builds upon components of this literature to further assess collaboration and team dynamics from the perspective of front line nurses.

The development and maintenance of value sets within teams plays an important role in team dynamics. The following studies outline important factors and values necessary to create collaborative working environments and relate both to the data collected in this study and to
recommendations for further study. Horton, Tschudin, and Forget’s (2007) comprehensive literature review identifies the importance of understanding values and their relevance to nursing and illustrates how values are constructed within a profession. Phelan, Barlow, and Iversen (2006) mingle collaboration, communication, and relationships, focusing on peer relationships and the development of trust, respect, and language used in practice. Reeves and Lewin (2004) examine interprofessional collaboration and its related meanings by assessing verbal and non-verbal interactions. Several studies tunnel deeper into the issues linking collaboration, trust, and respect (Abe & Henly, 2010; Atwal & Caldwell, 2005; Donald et al., 2009; Horton et al., 2007). All of these studies contributed to the deductive analysis in examining the issues nurses believe impact their ability to communicate well with each other and practice collaboratively today.

The necessity to address issues of communication, conformity, and collaborative practice is evident in the magnitude of literature discussing these topics (Apker, Propp & Ford, 2005; Atwal & Caldwell, 2005; Croker, Higgs, & Trede, 2009; Reeves & Lewin, 2004; Tarrant & Sabo, 2010). Several studies address differences in collaborative practice and the need for it to support interprofessional learning (D’Amour, Goulet, Labadie, SanMartin-Rodrigueux, & Pineault, 2008; Phelan, Barlow, & Iverson, 2006). Further analysis of this literature will support and build on the discussion of impact in development of culture, values, ideologies, and hegemony throughout the nurse’s education and into the practice environment.

“Role dialectics is the ongoing interplay of contradictions that produce, shape, and maintain behaviors associated with a particular role” (Apker, Propp, & Ford, 2005, p. 97). Examination of role dialectics within interprofessional health care teams, specifically in relation to nursing cultural ideologies, is an important factor in this study. Multiple issues, including conflict and lack of clarity over nursing scopes of practice remain prominent issues throughout
the nursing professions (Besner et al., 2005); with many teams challenged by changes to roles and responsibilities that further impact role dialectics and collaborative practice (Apker et al., 2005; Atwal & Caldwell, 2005). Collaboration and leadership within a team of physicians and nurses, is examined by Stein-Parbury and Liaschenko (2007) through a “conceptual lens of knowledge” (p. 470), providing purpose for examining both leadership and hierarchies affecting nursing teams in this study. Through the examination and observation of negotiated roles, role advancement and enactment, and hierarchies associated with status and professional identity, these studies identify intricacies of team dynamics and greatly assist in analyzing and validating findings in this study.

Another theme in this section is nursing disruptive behavior, which captures a variety of other theme categories and intermingles with collaborative practice and nursing values. Not surprisingly, disruptive and aggressive behavior impact health team dynamics and culture in multiple ways (Walrath, Dang & Nybert, 2010); with oppressive behaviors further affecting team functioning and patient outcomes (Abe & Henley, 2010; Roberts, DeMarco & Griffin, 2009). The findings from these studies have guided the assessment of disruptive behaviors, which emerged in this team dynamic study, and were useful in the analysis of the experiences representing disruptive behaviors that emerged through the dialogue.

**Organizational Culture in Health Care Context**

In this literature review, three themes emerged related to organizational culture: environment, role descriptions, and assumptions. Schein (2010), an organizational culture theorist, believes multiple layers of culture exist within organizations, particularly in the health care system (p. 67). Although there is overlap in the literature and in this study between organizational culture and teams in health; the literature referred to in this section focuses more
on the organizational components within the themes. A good example of this overlap is evident when examining environmental issues in the study by Aiken, Clarke, Sloane, and Sochalski (2001) as they make a pointed case that although inadequate staffing of nurses has become a chronic issue, other issues such as work design and workforce management contribute to poor patient outcomes (pp. 261-262). New heterarchial versus hierarchical models are examined in the Dietrich, Kornet, Major, May, and Riley-Wasserman (2010) research outlining an organizational change process involving shared professional decision making that enhances health care team experiences. Creating new healthy environments after change and trauma is a challenge; and symptoms of survivor syndrome can be seen in those affected (Mathew, 2010). With all the health restructuring in Alberta, assessing the effects of organizational change was an important consideration while drilling deep into the data collected in this study.

Scope of practice issues form a large component of the role dialectics/role description issues; however, these issues also impact other themes identified in this subtopic area. A few articles, including some Alberta-based projects, examine broad cultural concepts such as scope of practice, role ambiguity, job satisfaction, delegation, and perceived barriers in practice (Besner et al., 2005; Quallich, 2005; Tarrant & Sabo, 2010), with further exploration of facilitators to role enactment in the White et al. (2009) research. A useful component in analysis of environment comes in Douglas’ (2010) use of Peter Senge’s “Ladder of Inference” to challenge that soft and hard data be examined in staffing, and that there is value for nursing to leverage its understanding of human needs (p. 55). The human side of health care delivery is a point that emerges clearly in this study and is discussed in Chapter 6.

Examining culture and communication issues in an organization is important. Casida’s (2005) adaptation of the Denison Organizational Culture Model (DOCM) was used in a pilot
project assessing LPN communication culture in Alberta (Appendix 2) and provided a background guide for the focus group and interview questions in this study (T. Bateman, personal communication, August 2010; Casida, 2005). Discussion of the ambiguity associated with assumptions, beliefs, and values of health care teams, and how these core components relate to organizational culture theories, was a vital part of assessing team dynamics (Casida, 2005, pp. 106-107).

**Transformative Learning in Health Care Contexts**

Transformational and inspired leadership is noted as key to moving teams forward in a positive way. In fact leadership is strongly supported as some believe that “the single most visible factor that distinguishes successful cultural change is competent leadership” (Jarvis, 2007, p. 3). Leadership is a theme apparent throughout all organizational culture and communication texts and articles. Appreciative inquiry employs a leadership approach with similarities to transformational and inspired leadership in that “appreciative inquiry supports a values-centered leadership style that encourages members of different groups, cultures, and points of view to focus on what is working well in a system versus what is not working well” (Moody, Horton-Deutsch, & Pesut, 2007, p.320). Jarvis (2007) continues to pose this question: “How are we to challenge and change the current situation and move to a culture that promotes transforming behaviours, such as vision, creativity and innovation, decision making, empowerment and autonomy?” (p. 3). This thesis study speculates that by examining the barriers to changing and improving organizational culture, a challenge is created to make a difference in teams of today.

Although the research associated with nursing culture discusses nursing values extensively, some specific literature calls for the need for nursing engagement (Fasoli, 2010) and
the practical value and association of engagement with the nurturing profession of nursing (Taylor & Keighron, 2004). Nursing engagement is profoundly discussed by Brown (2010), who states so eloquently in the Nursing Administration Quarterly editorial: “Every nurse leader has a responsibility to take the time to make a difference and know that every day presents an opportunity to create a culture for nursing engagement” (pp.1-2). Kerfoot and Wantz (2005) discuss inspired organizations and suggest such organizations use new models of leadership that generate excitement and commitment within employees. Kotter’s (1995) perspective on transformational change takes an insightful look at the time it takes to simplifying the change process, an important point that emerged clearly in this study (p. 67). Leadership, change, and crisis management are addressed through re-engagement and rebuilding of trust through communications in some literature (Tarrant & Sabo, 2010; Quirke, 2010). Mentorship in a specific rural setting is examined to assess the value of the supportive learning relationship toward engagement by Mills, Francis, and Bonner (2008). Change management literature is significant as it identifies the need, value, and process of developing support within organizations. Managing change effectively can also build on realigning nursing values through engagement, which may influence and transform nursing culture. All the literature in this section guided discussion and analysis related to change, crisis, and the transformational needs of nurses and leaders identified through this research project.

Gaps in the Literature

Although the literature is plentiful related to leadership, organizational communication, and team culture, there is a gap in research related to interactions that involve nursing across the LPN, RN, RPN, and HCA groups. Considering that most research does not specify who is included as a nurse; it is impossible to ascertain the different professional perspectives within the
nursing teams based on credential. There is also a dearth in the literature of nursing culture issues that nursing team members’ all know exist, but do not normally discuss. These matters include the cross professional problems among LPNs, HCAs, RPNs, and RNs such as: hierarchies, turf, cross professional disruptive behaviors, and how team members at all levels are impacted when roles and responsibilities change. These gaps clearly identify a need for this research study to provide some initial insight into the intricacies of team dynamics commonly affecting nursing teams of today, which ultimately impacts the quality of patient care and degree of nurse engagement. The LPN perspective in this study is unique, which fills a gap that currently exists in the literature.

Chapter 4 – The Chosen Way-Method

Design

Action research is the methodology governing this research project. Action research creates a forum for “generating knowledge that is both valid and vital to the wellbeing of individuals, communities, and for the promotion of larger-scale democratic social change” (Brydon-Miller, Greenwood & Maguire, 2003, p.11). The philosophies of action research include involving participants throughout the research project, which approaches social change through emancipation, empowerment, and democracy for all. Issues, barriers, and core values related to the topic areas were examined through appreciative inquiry; creatively engaging participants through dialogue to negotiate and generate new perspectives. Inductive content analysis was utilized to analyze discussions from focus groups and interviews, and to examine personal and team-based nursing experiences through the manifest and latent content within the dialogue with participants. Findings were then shared with participants through a summary to validate the concepts, and initiate opportunity for reflection and further feedback.
During this project the researcher, participants, and all involved were guided to generate new knowledge and insight through a reflective process using an integrated focus, essentially making participants co-researchers in reflection and discussion to develop suggestions for action. (Henderson, 1995; J. Walinga, personal communication, November 10, 2010).

Action research goes beyond the notion that theory can inform practice, to a recognition that theory can and should be generated through practice…theory is really only useful insofar as it is put in the service of a practice focused on achieving positive social change. (Brydon-Miller et al., 2003, p. 15)

Questions were developed to create transformation through appreciative inquiry focused on research subtopics. A specific goal of this project was to engage the LPNs in dialogue and reflection to impact personal and social change, which was realized by several participants as noted in Chapter 7.

Multiple components, including nursing experience and social and communication theories, form a basis for the researcher’s standpoint related to team dynamics. From this standpoint, the philosophy of organizational communication cultural theorist Edgar Schein is applied throughout the study (Schein, 2010). Schein’s (2010) organizational culture model outlines three significant areas: artifacts, espoused beliefs and values, and basic underlying assumptions (p. 24). Artifacts involve the things you see, hear, and feel in a specific environment; espoused beliefs and values reflect a person’s sense of what ought to be; and basic underlying assumptions are those ‘taken for granted’ beliefs that guide behaviors within a group (Schein, 2010, pp. 23-28). The Schein philosophies are integrated throughout this study, and play a role in interpretation of the participant dialogue.
Participants and process

Three phases progressed through this research: 1) Focus groups with LPNs; 2) Interviews with key external leaders (KELs), and 3) Feedback with LPNs and KELs via email. This study utilized principles of appreciative inquiry to provide a forum for focus group discussions and interviews that would “engage and sustain individual and collective affirmation and aspiration among differing groups and interests” (Moody et al., 2007, p. 321). Further exploration of perspectives created natural linkages from the point of view of the LPNs and KELs in relation to all aspects of the team dynamics topic (Barbour, 2005; Kitzinger, 1995; Macnaghten & Myers, 2007). To provide opportunity for organic growth within the discussion, a minimal number of semi-structured focus group questions based around the topic areas were used in Phase 1 (Appendix 3). The topic areas were generated from the literature review and a pilot study that assessed Communication Culture and the LPN, conducted in mid-2010 (Appendix 2). The exploratory nature of the focus groups allowed linkages to emerge with the subtopic themes of key areas not normally discussed (Barbour, 2005; Kitzinger, 1995, Macnaghten & Myers, 2007). The focus groups allowed for group interaction and participants engaged in discussion together, challenging thoughts and further enhancing the research experience (Kitzinger, 1994).

Phase 1 of this project included four focus groups with volunteer LPNs; three face-to-face focus groups convened in the province of Alberta (Edmonton, Red Deer, and Calgary), with one via teleconference. To ensure non-biased participant selection LPNs were solicited by broad email invitation through the Licensed Practical Nurse regulatory membership in Alberta. A total of 24 LPNs participated in the focus groups, representing multiple employing agencies not recorded for the purposes of this study. The LPNs came from a variety of practice areas, both rural and tertiary care, which included acute care, mental health, community, long term care,
assisted living, and clinic practice settings. To capture the experiences of an LPN beyond novice practice, those with less than 4 years of practice experience were excluded from participation. Participant information related to years since graduation is outlined in Table 1.

Table 1: Participant information

<table>
<thead>
<tr>
<th>Total number of LPN participants</th>
<th>Range of years since graduation</th>
<th>Cumulative years since graduation</th>
<th>Mean years since graduation</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>5-38 years</td>
<td>481 years</td>
<td>20 years</td>
</tr>
</tbody>
</table>

The focus groups were tape recorded, with the researcher noting latent content, and the research assistant taking initial transcription notes throughout the dialogue. Suggested actions for changing team dynamics were pursued and were framed by the participants, as co-researchers in this process.

In Phase 2, specific key external leaders (KELs) were approached on an individual basis through email invitation to participate in a one-on-one interview. Involvement of specific KELs was incorporated to broaden the scope of this project, providing a base of participants external to the LPN profession, with leadership views related to nursing teams. Two of the KELs had nursing credentials, and two had other health care credentials; all of the KELs had experience in front line care, management, and leadership roles with inter-professional teams, and every KEL had practice experience of more than 17 years. Two KEL interviews were face-to-face, and two were held by teleconference. The KEL interviews were performed with the researcher and participant only, and recorded for transcription later. During the interviews, latent and initial manifest data were transcribed by the researcher, to guide the analysis process.
Phase 3 in the study provided an opportunity for reflection and feedback. The action research approach enables a transformation in thinking, in this case related to team dynamics and nursing ideologies, the individual nurse’s role, and factors involved in creating and maintaining nursing culture (Henderson, 1995; Wade, 1998). Therefore, all LPN participants received an initial summary of the findings of the project via direct email 7-14 days following the focus group. This email provided opportunity to clarify or engage further in the topic areas. Several key questions (Appendix 5) were asked during this Phase to elicit further participation. The questions, which examined how the focus group dialogue impacted the participant and if they had more feedback, evoked reflection on the individual LPNs thinking or behaving since the focus group. During the KEL interviews, summary points from the LPN focus group summary were shared to generate further discussion and perspective from each KEL. Each KEL discussion transcript was shared via email with the individual KEL, with invitation for further clarification or comment.

Analysis

Considering action research is participatory, data analysis starts from the first moment of data collection. As Henderson (1995) states, “Participatory research is a methodology of how knowledge production is created in the research process” (p. 59). With this in mind, it was interesting to see how the themes from the focus group discussions emerged organically throughout the dialogue process, with similarities among all focus groups. Transcription of the focus groups allowed for merging of the manifest and latent content, and produced opportunity for analysis that was not fully expected at this phase in the project. Once this initial analysis was completed, a summary of the key themes was created and shared with the LPN participants for confirmation of overall tone and content. A more comprehensive analysis was then performed,
assessing latent visual cues and interactions noted during the focus group discussions, thus further expounding the emergent themes (Elo & Kyngas, 2007; Kitzinger, 1995; Macnaghten & Myers, 2007). Team dynamics is a multidimensional topic area, which was evident through significant interconnectivity noted among the themes within this study. In fact, throughout the focus group and interview dialogue there are multiple cross references between the subtopics and themes in this study. At times, questions within the prepared format were unnecessary as the discussion had connected through to that topic area organically. This interconnectivity is evident in the quotes and findings noted throughout this paper, and the extreme cross applicability in each area.

Chapter 5 – The Touchy Stuff-Ethical Considerations

As stated so eloquently by Schein (2010) “You must realize that gathering valid data from a complex human system is intrinsically difficult, involves a variety of choices and options, and is always an intervention into the life of the organization” (p. 180). Because ethical considerations are vital to live data collection, this project received ethical approval from Royal Roads University (RRU) and the Community Research Ethics Board of Alberta (CREBA). As a researcher, licensed practical nurse, and director with the College of Licensed Practical Nurses of Alberta (CLPNA), my emic standpoint from within the profession of nursing helped to build trust and collegiality with participants. The etic perspective is realized through interpretation of the voices of participants during observations and analysis of focus group and interview discussions. The heteroglossic view from front line nurses provided open disclosure of issues that affect team collaboration and communication.

Ethical considerations in this project including risks and benefits were examined as they apply to the researcher, participants, sponsor agency (CLPNA), and society. Formal consents,
which outlined the risks, benefits, and confidentiality associated with the project, were signed by all research participants. Information shared by participants in the recordings and transcripts are maintained for the purposes of this research project only, unless specific consent is obtained. Confidential assurance of participant identity promoted open communication and mitigated risk participating LPNs and KELs felt of professional ramifications for disclosure of specific behaviors, actions, or perspectives. Research data from this project will not be merged with the LPNs professional file at CLPNA, the sponsor agency. Participants and employers are not named directly in this research; with all transcripts coded by participant number to protect the identity of the LPNs and KELs. Due to the low number of participants, LPNs and KELs who participated may be identifiable to each other during data collection, however all efforts were made to summarize responses and remove identifiable information in the research findings section to ensure individuals remain anonymous. Through my goals of emancipation of nurses on the front lines, I performed this research with a strong commitment to create a forum to conduct ethically sound research, with results that could potentially serve collaborative nursing teams into the future.

Chapter 6 – The Goods-Study Findings & Discussion

In this Chapter the data collected from the LPN focus groups and the KEL interviews will be presented and discussed, comparing applicable literature throughout. Ascertaining the LPN perspective was the intended objective of this study, therefore, the findings in this study emerged mainly through the LPN focus groups. The KEL perspectives were captured to validate the perspectives from the LPNs, and balance the findings from the LPN discussion with KEL perspectives to provide a voice external to the LPN profession throughout this study. At times, the LPN and KEL quotes exemplify the shared perspective of both groups.
Teams in Health Care

Health care today cannot be delivered effectively without a large blend of professional competencies to meet the needs of those requiring health care services. This creates environments with large, multidimensional teams, containing a plethora of different professional dynamics (Atwal & Caldwell, 2005, p.272). Somehow this blend is expected to develop into a unified team to function efficiently and effectively to meet a set of unified goals. Although this study indicates that unified goals are usually easily agreed to within team structures (i.e., patient centeredness, high quality care, respect and trust for team members); the study clearly indicates these goals may not be so easily enacted within teams. Teams in health, this subtopic area, is complex and broad and contains the most data collected in this study, with high interconnectivity to other sections. Table 2 outlines the four subtopic themes in this section, along with the diverse categories that emerged through the LPN and KEL discussions.

Table 2:

Teams in Health Care Subtopic Themes

<table>
<thead>
<tr>
<th>Values</th>
<th>Nursing Culture</th>
<th>Collaboration &amp; Role Dialectics</th>
<th>Disruptive Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respect</td>
<td>Assumptions</td>
<td>Flexibility</td>
<td>Lack of Trust &amp; Respect</td>
</tr>
<tr>
<td>Trust</td>
<td>Communication</td>
<td>Team Focus</td>
<td>Poor Communication</td>
</tr>
<tr>
<td>Open Communication</td>
<td>Education Level</td>
<td>Hierarchies</td>
<td>Negative Attitude</td>
</tr>
<tr>
<td>Competence</td>
<td>Leadership</td>
<td>Feeling Valued</td>
<td>Lack of Leadership</td>
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<td>Support &amp; Compassion</td>
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<td>Overconfidence/Ego</td>
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Most nursing teams in Alberta contain a mix of LPNs, RNs, and HCAs. Therefore, one can assume that most of the team dynamics in nursing involve these three providers. Although LPNs often commented about the relational dynamics between the LPN and RN, there was much compassion for the struggles within and between all professionals (including physicians, registered psychiatric nurses, support staff, etc.) involved in the team. The majority of LPNs and KELs involved in this study experience fair to good overall team relationships most of the time. However, many challenges and issues emerged that involve individuals and team functioning. The LPNs regularly noted they see their RN and HCA colleagues experience the same issues they themselves experienced. The literature also supports this notion, making it fair to say that team dynamics affect every member on the team, whether they are occasional staff on the unit or regularly scheduled members of the team.

Values.

Professional nursing values are demonstrated through practice standards, a code of ethics, and each nurse’s professional practice. “Good nursing is defined by its values. It is therefore important for nurses to understand the values with which they practice, so that good nursing practice can be achieved” (Horton et al., 2007, p. 725). When asked what values are seen in a positive team environment; trust, respect, open communication, positive attitude, and appreciation and compassion for the team consistently emerged in the LPN focus groups and KEL interviews. Trust and respect arose as being vital to building a team that functions well together. “Trust in the group working together...to be able to work cohesively together” (LPN 1D). “Respect for one another, for your team mates and patients” (LPN 2D). Participants noted that in their experiences, teams struggle with trusting each other and interprofessional disrespect is a rampant issue. Lack of trust and respect was associated with levels of understanding of
professional roles and abilities within teams. “Being comfortable that you know what your role is, your colleagues role, and being able to support it…it helps to build the trust” (LPN 8C).

From a KEL perspective, this lack of knowledge about professional roles and competencies was only part of the issue, “A basic lack of acknowledgement and respect for diversity...that other people aren’t like me...they’re not doing things just like me” (KEL 1). The link between trust, respect, and role clarity is broadly interconnected throughout this team dynamic study and will be discussed more in relation to role dialectics and disruptive behaviors.

One could argue, as Horton et al. (2007, p. 723) that the list of values noted in this study is part of every health professions standards of practice and code of ethics, and it likely is. However, the issue appears to be related to how professionals transfer professional expectations beyond interactions with the patient, into their behavior with members of their team. “Values determine a person’s beliefs and actions” (Horton et al., 2007, p. 722). All participants in this study, including the KELs noted respect as a core value necessary in a positive team environment; connecting respect to the development of trusting teams that interact and communicate well. “Everyone has a voice, shared decision-making, voices are equal, good dialogue...” (KEL 2). The KELs also linked positive team values to improved patient outcomes, and a happier team that was easier to retain in the workplace. Presence of these values “impacts the patient centeredness...if you’re efficient, you’re effective, it ultimately affects the patient” (KEL 4). The notion that respect is necessary to create high functioning teams, is strongly supported in the literature related to quality care, and only touched on in this study (Atwal & Caldwell, 2005; D’Amour et al., 2005). When thinking about the aspects necessary to grow in any professional role, it is no surprise an individual needs to feel trust and respect from the team they work with.
Support and compassion for team members emerged strongly as a value associated with building a positive team environment. Both the LPN and KEL participants saw value in building a supportive personal relationship with co-workers. This did not necessarily mean the development of friendships beyond the work environment, but it did include getting to know a colleague beyond who they are as a professional. Participants commented they wanted to understand what a team member’s life challenges and stresses may be, and what values are important to them personally. Participants linked relationship building with being compassionate for the struggles of coworkers. “We are so busy focusing on the patient….it’s good for someone to bring you back and say…how was your day?” (LPN 5B). Several studies found this as well, with social support evident through friendly dialogue, caring attachments, and interaction between individuals on the nursing team (Apker et al., 2005; D’Amour et al., 2008; Reeves & Lewin, 2004). The importance associated with relationship building links to the human side of nursing, which is discussed in more depth in proceeding sections.

D’Amour et al. (2008) refer to internalization as a necessary awareness for professionals to connect with each other and form a sense of belonging to build trust (p. 189). One LPN discussed an exceptional experience with a supportive team “It was a beautiful team that cared about each other...turned negative into positive, trying to make it better...demonstrated compassion and caring for the team...was lovely to experience (LPN 1B). Although highly supportive and compassionate teams were seen as desirable, it was not commonly experienced by those involved in this study. One issue that was linked with this relates to staffing associated struggles, as social support and trust within a team is more difficult to build on teams with high levels of casual or float team usage. “I find a lot of casuals don’t have...[the] skills, management needs to be checking what they have and what they don’t have” (LPN 8A). When staff regularly
work together, trust, respect, and value for team members is more likely, which enhances the team relationship over time.

Overall, a few LPNs have experienced environments that exemplified positive team values noted in this subtopic area, as well as positive team dynamics overall (exemplary dynamics). “We are extremely fortunate that if we do have concerns we have great latitude” (LPN 3D). “I love my job” (LPN 3B). Most LPNs involved in this project confirmed working, at some point in their career, in environments that hold and enact these values to some degree (moderate dynamics). “Lots of negative, but there are really good [staff] to work with out there too” (LPN 8A). “Definitely experienced team nursing more than not...when other units weren’t” (LPN 3B). All participants in this research commented that they have worked in environments where many of the core values noted in this section are lacking (negative dynamics). Some LPNs currently are working in negative environments and struggle with multiple factors best described as lack of engagement. “Unfortunately, it’s a very negative one here locally” (LPN 1D). “Stuff…happens too much in certain areas and it does pit people against each other” (LPN 5B).

Often individuals indicated that they would leave an environment to avoid practicing in an area that did not uphold professional values if there were other suitable employment choices available.

I found it’s quite different…behavior standards outline what is expected of employees…this creates a very different environment. (LPN 2A)

It does play a bit of a role moving forward, or if they want LPNs to stay where they are. (LPN 5C)

There were noticeable differences in experiences between these three types of environments (exemplary dynamics, moderate dynamics, and negative dynamics), which will be examined more in the organizational culture section.
Nursing culture.

The nursing culture in an environment has a large impact on team dynamics. “Cultures tell their members who they are, how to behave toward each other, and how to feel good about themselves” (Schein, 2010, p. 29). Nursing and health care environments are prevalent with cultural assumptions, which are often fluid based on the profession, organization, unit, or individual team members. Five categories emerged related to nursing culture: assumptions, communication, education level, leadership, and relationships. Through discussion of nursing team culture with the focus groups it’s evident that culture is variable unit-to-unit, within facilities, and throughout care settings. This difference in culture was seen clearly by those LPNs who have been employed in more than one nursing unit within a facility or community, and also validated by the KELs.

Communication within the team, particularly nurse-to-nurse, emerged as a huge issue in nursing culture and relates to team dynamics generally. The power struggle in teams affects everyone and is often based on education level, credentials, and experience. “Sometimes the job takes over the patient care. Task of job takes over and patient care gets lost, because of different personalities” (LPN 8A).

It really inhibits communication between LPNs and RNs, that…attitude, where you’re not capable. If you’re not communicating very well with your RN...because you feel devalued...what’s happening in the instances when you need those RNs...is that communication being inhibited by feelings of hierarchy...how much are patients suffering because communication is not there and trust is nonexistent... (LPN 2A)

This hierarchy and power struggle was not just noted coming from the RN toward the LPN, but sometimes the LPNs directed a negative attitude toward the RNs or other LPNs.

I also find a lot of bitterness between the LPN and RN. RNs are bitter that the LPN is getting more and more into their scope, LPNs are bitter because they feel that RNs should be doing this. (LPN 4B)
A lot of those girls [LPNs]...they’re holding us back...and they’re kind of complacent...everybody should be to full competency. (LPN 8A)

Development of a healthy nursing culture is impacted by multiple factors, including assumptions nurses make about each other and the education level and competence of the individual members. These are issues that require further consideration and will be discussed more in relation to collaboration and role dialectics.

Although many of the issues in this section contribute to the variability of nursing cultures, workload and stress emerged as significant factors affecting relationships for both the LPN participants and the KELs.

I think people get into these bad behaviors, damaging our culture just because of emotionally where they may be...stressed, managing a difficult family at home...we have a challenging health care system, we have really sick people, lots of bad things that go on, and they really challenge you. (KEL 2)

I think playing with the role...is very stressful. I find LPNs are working under high stress because of the uncertainty. (LPN 1A)

So many lifestyle stresses out there that it’s easy to carry into the workplace. (LPN 1D)

The notion that nurses carry a great deal of stress is not a new concept and has been studied for years. Sometimes stress can be healthy and relates to personal and professional transformation, pushing individuals forward (Tarrant & Sabo, 2010, p. 79). However, team stress and workload are complex issues that impact teams today, and will be discussed later in the organizational culture and transformative learning sections.

Every discussion within this project touched on the concept that a healthy nursing culture is almost impossible with ineffective unit leadership. Participants represented this perspective through examples of poor leadership and perpetuation of negative nursing behaviors within teams.
It has a lot to do with leadership...if you take a new grad who has this seed planted and you immediately employ them in a situation with poor leadership, and all of this nonsense [negative behavior] is permitted to go on unchecked...I do think you begin to solidify...that attitude. (KEL 3)

Management skill in top management is not fostering [good behavior]...it starts at the top and filters down. Poor management...reflects all the way down to the person who is low man on the totem pole. (LPN 4A)

As noted in relation to values, there were a few exceptional examples of healthy nursing cultures that exemplify trusting and respectful environments. However, most LPNs and KELs, at some point in their career had experienced an unpleasant unit specific culture (moderate to poor dynamics) lacking the positive values discussed earlier.

Participants noted multiple factors that perpetuated a negative values set in unpleasant environments; particularly ineffective unit leadership, negative interprofessional dynamics, and unbalanced organizational politics. Perhaps Schein (2010) says it best as he examines cultural intelligence:

Because culture is so deeply embedded in each of us, this process must confront the fundamental reality that each member of each culture begins with the assumptions that what he or she does is the right and proper way to do things. We each come from a social order into which we have been socialized and, therefore, take its assumptions for granted. Intellectual understanding of other cultures may be a start in granting that there are other ways to do things, but it does little to build empathy and does not enable us to find common ground for working together. (p. 388)

Participants in this study were eager for more support and leadership from unit level management, as it was seen by all as something that “makes it or breaks it 100%” (LPN 3B). Nursing culture is a diverse and broad topic area, with this study only skimming the surface of the concepts involved. It was interesting to find that this brief opportunity for discussion about
team dynamics impacted participants understanding of, and commitment to, improving the culture around them. More about participant perspectives is listed in the action research follow up in Chapter 7.

**Collaboration & role dialectics.**

Collaboration is a gigantic concept and from my experience in the health system, collaboration occurs when teams work toward a common goal, focusing on the patient rather than on individual team member roles. For this to occur successfully many factors must be in place. D’Amour et al. (2005) note five underlying concepts in their literature review of collaboration. These five concepts; sharing, partnership, power, interdependency, and process were all evident in the dialogue within this project. As evident in this section on collaboration and role dialectics these concepts emerged in a variety of ways, but were integrated throughout the dialogue with LPNs and KELs. As Croker et al. (2009) discuss, there are many diverse meanings and interpretations associated with collaboration, which causes ambiguity related to team understanding of the broad concept of collaboration (p.28). Other literature also presents: “Collaboration involves direct and open communication, respect for different points of view, and mutual responsibility for problem solving” (Stein-Parbury & Liaschenko, 2007, p. 472). Every LPN and KEL noted that a collaborative team environment completely influences the nursing culture of a team, which was evident in the multiple factors that emerged in this study.

The valuing principles of sharing, respect, and team work were primary discussion points in this section, just as they were in nursing culture. This concept is also supported in the literature: “In a truly collaborative environment, the team expects all members to contribute to decision making, regardless of differences in education or experience” (Apker et al., 2005, p.
With this same perspective, the LPNs mention the need to be flexible and supportive as professionals, and to do what the team needs:

*Be supportive of each other... your own nursing team... to support what work you are trying to accomplish, without getting so stressed, which a lot of us do... I do get a lot of support from my RNs, we have a lot of senior nurses on my unit, and they have been very supportive through our transition, our changing job roles. (LPN 4C)*

The LPNs voiced that a positive team focus was important as well. “I always find that if you do your job to the best of your ability... there is] always time left to go help someone else with theirs” (LPN B4). Although this concept was supported by other LPNs, there was concern that there was not enough time to build and maintain a collaborative team focus.

Some of the most prominent issues in collaboration and role dialectics mentioned by the LPNs, related to a lack of fair orientation and mentoring periods for new staff due to workload and unit pressures. These issues were seen to affect overall ability to build collaboration within teams. Many LPNs voiced the increased need for teams to build collaboration together; to support the growth of teams, particularly with our aging nursing workforce. “I see that now as older LPNs or RNs are leaving critical roles; we are losing a lot of tribal knowledge. Mentorship is lost and it’s essential in a healthy team” (LPN 1A). Many concerns were shared about inappropriate assignments to new team members. Assumptions of individual competence based on credential often placed nurses in situations they may not be competent to manage.

*I think we just need more patience with the young graduates... they don’t know all of this... we need to be their mentors. I see that lacking... a lot of young graduates get frustrated... being told “you should have known...” I see that for everybody. RNs a lot of times thinking the younger RNs should have known better. (LPN 9C)*

This suggests that participants saw a link between collaboration, role dialectics, and the mentorship necessary to build team members collaborative skill. These are important links to
overall team dynamics. Mentoring and orientation will be discussed in more depth in the personal transformation category.

Many LPNs commented about the difficulty in building collaboration while feeling isolated, with examples of not being seen as real nurses. They described this through comments made mostly by RN colleagues such as “I’m working alone tonight” (LPN 6A), which is heard by many LPNs when only one RN is assigned on a shift. “I am sitting right here, and you are talking to me that way… I would never do that to a PCA” (LPN 6A). The LPNs discussed how these interactions generated stress and feelings of personal devaluing, causing increased divisiveness within teams. Discussion of these interactions brought forward strong emotion, demonstrated through increased tone of voice, multiple perspectives, and boisterous agreement amongst most within the groups. While some LPNs felt this was unique to the LPN profession, other LPNs saw that all members on the team experience this type of isolation to some degree. Stein-Parbury & Liaschenko (2007) validate this perspective, as they found that RNs feel devalued in their relationships with physicians at times (p. 476). Isolation and hierarchies emerged throughout the LPN and KEL discussion as a primary barrier to collaborative practice.

Hierarchies affect the majority of teams, and at multiple levels within teams. The LPN/RN hierarchical struggle was noted by all who participated, both in the LPNs and KELs. Many LPN comments indicate this is Just the way it is. However, all participants including KELs see leadership modeling of team expectations as the key to how smooth the LPN/RN team work together. Many LPNs see most difficulty in the hierarchy with interactions with some diploma RNs: “Years ago, when LPNs were being trained [with new skills] the extra education was intimidating to the RNs… some of the RNs felt threatened” (LPN 2A). Although the LPN/RN
hierarchy is evident to all participants in this project, all have witnessed hierarchical struggles at all levels; particularly between RNs and physicians, but also LPN/LPN and LPN/HCA.

Overall though, the nursing relationships seem to be improving, with most of the LPN participants noting a change in the LPN/RN relationship.

Seeing less bitterness now between LPNs and RNs...maybe we take it personally and we think... they don’t like me because I’m the LPN...maybe they are just having a bad day...we take a lot personally. (LPN 4A)

I think every LPN that came on board had to prove themselves...not so much the case now...they realize how far the LPN has come...they try to have a senior LPN with a new RN. (LPN 7C)

I think lots of things have to be fixed, but I personally think it’s getting better. (LPN 2A)

Most participants voiced great compassion for other team members and discussed the need to find a healthy collaborative space where everyone on the team is respected and valued for their unique contribution.

I think compassion for each other is important too, there are times when I feel that an RNs a little high and mighty...(but I) have to realize that sometimes when they are in charge and they are having a difficult day, they just seem that way...I think a lot of LPNs take it personal, when the RNs...just being a human being. (LPN 5A)

Overall, all participants voiced hope that with new understandings of roles and compassion for each other, there could be further improvements in collaboration.

Collaborative practice was noted as an important factor in team dynamics by the KELs as well, but with organizational issues that relate to how well teams collaborate. “We are not working in a collaborative environment, we haven’t embraced that value yet...so when you ask me whether teams take on that role, seriously...they CAN’T!” (KEL 1). Also noted, was the importance of context related to the design of care delivery and perhaps work load requirements best exemplified in settings such as intensive care and community. “They are forced to talk to each other and tag team simply just to get the work done...through that process...the
opportunities to talk to each other, refer to each other, and share information...builds the collaboration” (KEL 3). Again, unit level leadership skill and ability emerged as a strong indicator of whether a unit would function collaboratively, regardless of what type of work the team performed.

Role confusion in nursing teams emerged as a core issue associated with team dynamics and strongly linked to collaboration as well. Many LPNs felt devalued when trust and respect for their role or competence level was lacking. Levels of hierarchy were noted by almost all participants, indicating rank, laddering, and levels in nursing with the HCA at the bottom, the LPN in the middle, the diploma RN just above, and the BN just under the nurse practitioners (NPs) or physician. These levels were clear in latent hand gestures indicating height of rank from both the KELs and LPNs. Rank levels and misunderstanding of roles is an issue modeled in the literature in a study of NPs and physicians where “Territorialism and role confusion are recognized barriers to collaboration and require further study” (Donald et al., 2009, p. 85). The LPN/RN struggle was noted regularly throughout the LPN discussions “definitely a struggle with older RNs, a definite struggle, I think it’s job protection” (LPN 8A). However, most LPNs felt that teams today, with specific changes in new graduate BNs, are valuing the LPN competencies more than in the past,

The younger ones (BNs), the new ones that come in, they’re awesome because you’re an equal. They know what you can do and they don’t question anything...we know what we can do within our scope and I am very confident of what I can do and what I can’t do...if I don’t know it, I will ask questions. (LPN 8A)

I found the change in BN knowledge of the LPN surprising, as in my experience with daily practice consultation at CLPNA, new graduate knowledge or understanding of roles does not yet appear to be influencing role clarity on a unit level. It is also unclear how much role clarity the LPNs have about the RN role, and how that affects role dialectics and collaboration.
When focus groups were asked what role they have in developing a collaborative environment, there was a resounding *Lead by example* perspective that emerged from each group. All LPN participants agreed with this concept, with a strong professional responsibility shared through statements such as “we need to be that change that we want to see out there” (*LPN 3D*). As this positive perspective was discussed, it was obviously empowering to the LPN participants, with eager commitment to their personal role in improving collaborative practice. This perspective and hope for improvements in the system will be examined more in the transformative learning section.

**Disruptive behaviors.**

Discussion of disruptive behaviors emerged more or less organically through the discussion of values and culture in both the LPN focus groups and the KEL interviews. In a recent study focusing on hospital based RNs, Walrath et al. (2010) found three themes in nursing disruptive behaviors: incivility, psychological aggression, and physical violence (p. 108). Although physical violence only emerged in discussion with 2 KELs, incivility and psychological aggression were experienced or witnessed by all participants. Key issues related to disruptive behaviors that emerged through this study include lack of trust and respect, poor communication, negative attitude, lack of formal/informal leadership within teams, and oppressive behaviors based in overconfidence or excessive ego. Abe and Henly (2010) studied workplace bullying among Japanese nurses and most of the components assessed in their study emerged in the discussion about disruptive behaviors in this study. The categories Walrath et al. (2010) use to describe incivility (rude/disrespectful) and psychological aggression (gossip, passive aggressive behavior, power play, condescending language, professional disregard) were seen commonly in the examples from LPN participants, with bullying only being mentioned
once. These examples did not always involve traditional hierarchical levels of behaviors, but were experienced or witnessed within any and all levels of the team, as either lateral or horizontal disruptive behavior. Just as I found in this study, Walrath et al. (2010) discovered “while some nurses reported that they avoided or accommodated the disruptive individual, others accepted the negative behavior as part of their job” (p. 111). This literature validates the LPNs perspectives that they don’t feel they are the only ones exposed to disruptive behaviors, making this a team dynamic that potentially affects anyone who is part of a team.

Lack of trust and respect was described consistently in devaluing of professional competence and role; experienced by every LPN participant. Devaluing occurred in many ways and emerged with the most impact through role inconsistency: “We are very devalued ...relegated to night duty...not supposed to assess patients...you can’t talk to these patients...you can only do rounds” (LPN 4A). The LPN participants discussed devaluing from all levels; organizational, unit, individual, and even from the public with some LPNs being asked if they are real nurses. The continual need to prove professional competence also emerged as cause for feeling devalued and many LPNs were strongly disturbed by this. “We are still trying to prove ourselves to the RNs, that we are part of the team and we can work here” (LPN 10C). Several LPNs expressed an understanding for this simply as a normal part of practice that all team members, including RNs, are exposed to.

Having to prove myself, which is fine, you have to do that in any position. (LPN 2D)

I don’t think it’s unique to the LPNs, there may be a couple of additional factors with the LPNs, but we see that a lot with our new grad RNs... ’eating your young’ …seasoned nurses that think people have to prove themselves to be here. (KEL 2)

The discussion in this section relates back to the issues discussed earlier about mentoring and supporting new nurses. Considering new nurses were not included in this study, disruptive
behaviors from their perspective can only be alluded to through participant past experiences and witnessed accounts.

One of the largest issues that emerged in the disruptive behavior section centered on lack of leadership. Often the LPNs and KELs discussed the leadership skill and support necessary to manage teams that demonstrate inappropriate or disruptive behaviors. Situations with lack of leadership emerged with multiple issues noted. Issues involved favoritism of individual team members, breaches in confidentiality about staff, facilitation of communication triangulation, perpetuation of negativity, and general lack of skill, will, or ability to manage and lead within the environment. Concerns with confidentiality and triangulation emerged strongly: “We should be doing it [maintaining confidentiality] for staff too...illness or other things...managers should be keeping things under a tight lip. Trust that if I tell you something...your manager will keep things confidential” (LPN 6A). Participants shared multiple examples and scenarios that showcase how leadership either models, or fails to model, acceptable communication patterns.

When someone doesn’t talk to that person [they have issue with], and they go and triangulate with other colleagues...and that[other] person thinks they need to solve it. (KEL 4)

Really dependent upon the leaders comfort and experience to resolve conflict; and if they have aligned relationships with people, take sides, or triangulation, it’s just a disaster. (KEL 1)

The importance of unit leadership’s role in managing disruptive behaviors was seen clearly as indicative of the perpetuation or elimination of such behavior.

Not all comments about unit leadership focused on the negative aspect of how leaders perform their roles. Many participants noted an understanding and empathy for leaders who are placed into a position with little to no support or training in management of interprofessional teams.
In the workforce what happens is...you don’t technically need leadership training to go into a leadership position...in health care there are just so many different areas...because we have so many units and programs...they go by experience, they don’t go by maybe if they have had any formal training. (KEL 4)

As mentioned previously, participants saw that unit level leadership holds a considerable amount of power in the development of a positive environment. However, horizontal violence also affected managers and leaders, making it difficult for them to make change even when they feel it necessary to do so (Roberts et al., 2009, p. 291).

Some of the participants discussed issues with human nature, ego, and the basic human condition when clarifying why they saw some disruptive behaviors in leaders and team members. These behaviors included poor communication, triangulation of communication, negative attitude, and overconfidence.

It’s more ego, the human condition. We have our own personalities that we bring to the table, give that personality some skills, nursing skills, how are they going to deliver the nursing skills. (LPN 11C)

It’s a leadership organizational culture thing...I am the leader, so I’m going to do it, and If I’m learning and doing it wrong and if you tell me, or you come up and try to assist me, that’s a lack of respect. (KEL 1)

Perhaps we have created environments where leaders and team members are expected, similarly to the front line nurses, to assume their roles and know exactly how to function effectively to improve performance, outcomes, and team dynamics. Yet, we have not created a culture with consistent opportunity that allows leaders to learn, be mentored, or grow into the role, with support from their staff or another leader (Apker et al., 2005; Kotter, 1995; Schein, 2010).

Although this lack of support may not always be the case, based on the participant discussion, it appears to be a relatively common.

Perhaps the issues discussed in this section are symptoms of the power and posturing that professionals experience as they struggle for a place on a team. Schein (2010) explains some of
the behaviors discussed in this section as learning anxiety, which can be based on valid reasons such as: a fear of loss of power or position; temporary incompetence; punishment for incompetence; loss of personal identity; and loss of group membership (pp.303-304). Through a change management process, good leadership can address all these areas of concern; managing a team in a positive way while rebuilding or maintaining a positive culture. Leadership is a diverse area and will be discussed in further depth in transformational learning.

Organizational Culture in Health Care Contexts

“Culture is pervasive and influences all aspects of how an organization deals with its primary tasks, its various environments, and its internal operations” (Schein, 2010, p. 17). Culture impacts individuals and teams in the workplace every day. In this study, culture includes those assumptions, values, behaviors, and beliefs that individuals, groups, and professions acquire throughout their education and career. Based on the literature review, the core areas of environment, role description, and assumptions were examined. Although participant discussion organically merged all topic areas, it was possible to glean sections out of the dialogue with more focus on the organizational components within the themes of this subtopic area. This subtopic, organizational culture in health care, shows high interconnectivity with other subtopic areas. Table 3 outlines the three subtopic themes in this section, along with the varied categories that emerged through the LPN participant focus group and KEL interviews.
Table 3:

*Organizational Culture in Health Care Subtopic Themes*

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**Environment.**

Health care environments have many challenges. In fact, Aiken at al. (2001) posits “there are fundamental flaws in the design of clinical care services and the management of the hospital workforce worldwide” (p. 261). Several factors emerged in this study, relating environmental issues with organizational culture through management, resources, and a patient centered approach. Although unit managers/leaders were not directly involve as study participants, much of the data collected from the LPNs and KELs indicated the effects of upper and unit management on team environment. Unit managers have a difficult role, as they are challenged to provide overall unit leadership; balancing unit/department budgets, supporting staff, and handling patient, family, and staff issues. The importance of management’s role to the development of a positive organizational culture is key. The LPN and KEL participants noted lack of or ineffective leadership at the unit level as the largest issue affecting the environmental culture and team dynamics within a unit.

Although unit management was seen as highly linked to environment, there was a great deal of understanding and support for the associated challenges. Many participants noted sympathy for the role, expectation, and lack of support available to unit leadership.
It has to be that supervisor or manager that is taking that leadership role to get people to…look at what the values are and discuss what does that mean for us. (KEL 4)

Many leaders…don’t have [extra] education, no fault of their own, because you didn’t need it, but now you are needing it. (KEL 4)

I don’t know how they can keep things together at the bottom when the top is in disarray. That seems to be part of the problem right now. (LPN A4)

I don’t think it’s because people [teams and managers] don’t want to [make it work]. When you are overstretched, trying to do too much, you can’t see how you can work as a team. (KEL 2)

All participants could relate to issues with ineffective or complete lack of management (due to a manager vacancy) in an environment. As evident in the leadership linkages throughout this entire study, there is importance in how leadership affects team dynamics.

Many LPNs have experienced exceptional management practices, with leaders modeling professional behaviors that exemplify team goals and team member expectations.

We have had two managers now, and both of them have zero tolerance for the RN/LPN thing. (LPN 3B)

My manager is very respectful to staff and very appreciative…makes you want to go to work…others make you resentful. (LPN 5B)

Participants were clear that effective management sets clear guidance about professional roles and expectations in a setting. Apker et al. (2005) found this as well with hierarchies within nursing teams; however, nurses can gain collaboration by leveling status issues and managing hierarchies appropriately (p. 111).

We have had three managers…all very open about what’s going on, very open about expectations…definitely a difference between the RN and LPN [role], and they…set that out there…I completely see that in all the successful places where I have worked. (LPN 3B)

The philosophy that effective management can successfully level hierarchies was evident in participant perspectives in this study and is reflected throughout.
Several LPNs worked in management positions themselves and discussed firsthand the
difficulties they see from a manager perspective.

_When I took this position, I took it with the mindset that I would change it…from every
other place that I worked. There are some things that you just can’t change, and I’ve
learned that over the last few years… For the most part…I don’t treat anyone
differently…it’s the way that you approach it._ (LPN 9A)

The KELs saw the management issues similarly to the LPNs, differentiating upper level
expectations from unit level. The KELs noted that upper management was often an unknown
entity at a distance from the front line staff, and sometimes even from unit leaders.

_When we look at [an upper level] structure, where we have values that come out of
that…it’s less impressive to a team, unless you’re at some of those higher levels. It’s the
organizational values of that particular manager that affects team and culture._ (KEL 2)

_Culture change has to come from the leader. The highest leadership has to be absolutely
relentless in delivering the message of collaboration and cooperation…to convey that
down the line…if this were embedded in performance expectations [for managers]…there
would be a big change._ (KEL 3)

There is support for this philosophy, as Schein (2010) discusses how “changes in the reward and
punishment system are also one of the quickest and easiest ways to begin to change behavior
and, thereby, begin to change some elements of the culture” (p. 108). One of the largest struggles
noted in health care teams is with models of the past; as in the “mama/papa management which
dictates that mama/papa knows best” (Kerfoot & Wantz, 2005, p. 132). Environments with
hierarchical models of leadership emerged strongly in the discussion as having a great deal of
negative impact on team dynamics, as is evident in some of the statements already noted by
participants.

In discussing compliance leadership models of the past, Kerfoot and Wantz (2005)
comment: “The person on the front line now is several layers, many people, and many miles
away from the CEO” (p. 131). This reality is clear in several larger organizations in Alberta.
It’s our charge nurses and our other RNs that are really running the show, and really
know what’s going on...when it comes to a difficult transition with a patient, then she
[supervisor/manager] gets involved...but for the most part...they aren’t easily accessible.
(LPN 4C)

Although autonomy and professional dynamics may be enhanced in a large organization, there
are many challenges as well. “Health professionals must consequently shoulder more and more
of the burden of the collaborative and coordinating activities required in clinical settings”
(D’Amour et al., 2008, p. 189). The issue here is not that the front line health professional is
incapable of handling the extra management burden; it’s simply that they are already overtaxed
with workload expectations and require overall unit leadership support.

Nursing workforce issues seem to ebb and flow like a changing tide. There are times of
high tides with excessive nurses and a lack of jobs and times of low tides with nurses leaving
both the province and the country for other opportunities. In my 22 year career, I have personally
experienced this cycle at least three times. Many participants in this study noted that human and
financial resource availability greatly impacts care delivery. Resource issues may include budget
restrictions and education access for staff. However, sometimes it’s the more practical side of
having enough people to support the team, with the staff and specialized knowledge readily
available (nurse specialists/managers). “In health care, the human part of the experience is not
limited to those who receive care; it is also related to those who provide it” (Douglas, 2010, p.
57). Being supported in the ‘human part’ of the experience of providing health care services
emerged as a core challenge throughout the discussions with LPNs and KELs.

It is easier to communicate when you know that you can go to someone [management]
and trust that they are going to look at this issue to help resolve or deal with a unit
problem. (LPN 4A)

I think for managers who manage health care teams...there is a foundation of
communication structure...people should just know needs to be in place if you are going
to be a team...[with] opportunity to communicate and provide feedback. (KEL 1)
Stresses on leaders and teams are enormous. Health care resources have long been at issue, with human and financial resources continually scarce, but perhaps we have underestimated the influence this has on the environment and the people in teams.

Concerns about workload and the busy nature of health care delivery are not new. What is often forgotten is that in order to develop and showcase leadership at all levels, people need time to learn and hone leadership practices. Aiken et al. (2001) note that health care management cuts worldwide have affected the role of the front-line nurse, with expectations for management of services and personnel taking time away from patient care (p. 259). “The system has grown so big…everything has an additional 10 steps to get a decision. I wish we could go back…to have that equal decision making or involvement in decision making” (KEL 2). “Nurses experience tension produced by expectations for them to build and nurture team attachments while simultaneously demonstrating the detachment advocated by the traditional bio-medical model” (Apker et al., 2005, p. 106). It is evident that environmental challenges are broad and multifaceted, and they affect teams dramatically. However, participants in this study had empathy for those charged with managing and leading teams at a unit level, and a desire to see more time to build leadership capacity in leaders and within teams.

Despite the multiple challenges noted in the environment, nurses remain strongly committed to providing good care, and this was obvious in the LPN and KEL discussions. Fasoli (2010) notes: “The assumption is that quality already exists in the healthcare system, but it will flourish only by changing the systems within care” (p. 26). Providing optimum patient care was a large theme in the discussion in both the focus groups and the interviews. Patient or person centered care “is a values based approach to nursing practice” (Jarvis, 2007, p. 4). All participants saw the value and responsibility of placing the patient at the center of care, but many
felt their teams were not doing this at an optimum level. “They are not focusing on the patient, they don’t have a common shared goal...they have disintegrated and they’re focusing on each other and what each of them is not doing right” (KEL 1). A passionate dialogue interchange between two LPN participants frames the team concepts discussed throughout this study and the impact on the patient:

*The patient gets the short end of the stick.* (LPN 4A)

*This power struggle...if there was not so much power struggle.* (LPN 2A)

*If we didn’t have all that, maybe we would have more time for patient care, just being able to talk to a patient, because this conflict takes...* (LPN 4A)

*...the focus off the patient.* (LPN 2A)

It is unquestionable that collaboration and patient-centered care are fundamentally interconnected (Atwal & Caldwell, 2005; D’Amour et al., 2005; Molyneux, 2001). As one KEL mentioned in relation to collaborative nursing cultures: “Where I have seen it break down is when they [team members] are not thinking about the patient...when they take the focus off the patient” (KEL 4). Participant examples showcased the connection between patient centered care and collaborative environments that respected and valued the team; areas that appear to indicate a strong and healthy organizational culture. Overall, the interconnectivity in team dynamics becomes very evident when considering all the environmental factors noted in this section.

**Role descriptions.**

Multiple interrelated role description issues emerged in this study. These issues include clarity and enactment, accountability, and consistency. Historic issues related to roles and accountability in nursing are clearly evident when examining today’s status for delegation within nursing (Quaillich, 2005, p. 121). Fasoli’s (2010) discussion verifies how variables in autonomy for nurses perpetuate the misconceptions around professional responsibility and accountability.
Several Canadian provinces and many jurisdictions in the United States have not transitioned from delegation to autonomy within LPN regulation. These historical variables associated with different regulation for the LPN profession are important to consider when clarifying job descriptions and scope of practice. Many issues in health care relate to role description issues. Perhaps these issues are due to the nature of the work; with many professions with overlapping practice in multiple settings with different policy structures.

As discussion of values, culture, and collaboration emerged through the focus groups, it was evident many LPNs experience situations involving misconceptions of professional accountability in Alberta. Often RNs and RPNs still believe they retain accountability and responsibility for the care provided by the LPN. Although LPN regulation in Alberta has authorized autonomous practice since 2003, a persisting lack of clarity around roles and accountability adds significantly to issues within team dynamics.

*When I started in 1982 the RNs always felt they had to take ownership of what we did; now we take ownership for what we do. For a lot of older RNs, that is a hard thing to let go of, hovering over whatever you do and thinking you can’t do it.* (LPN 6A)

*Depends on the RN, some days the RN gives you the assignment and the next the RN will say-Well what are you doing? An LPN can’t do that.* (LPN 5B)

This role inconsistency was experienced by almost all LPNs in the focus groups and witnessed by some of the KELs. “It’s hard…they take with one hand and give with another. “It’s frustrating…for the RNs as well, because my colleagues know I am capable, but their hands are tied too, it comes from higher up” (LPN 8C). Perhaps the issues related to assignment of care and support and understanding for the LPN role is based in fear and lack of knowledge.

Nurses who lack self-confidence may fear competition and feel that they diminish their own role when assigning nursing tasks, when in fact they are fostering efficiency by
increasing the amount of work that can be handled in a particular situation (Quallich, 2005, p. 122).

Because of the scope of this study, it’s impossible to assess the causes for distrusting the professional accountability of LPNs. It is also not possible to distinguish if the issues in this section are unique to nursing and health care teams, or common among teams of all kinds as Schein (2010) would suggest.

Every LPN and KEL participant has encountered issues with lack of role clarity at some point in their career. The need for more clarity of nursing roles is a mammoth issue, and is pervasive throughout health care environments and professions (Apker et al., 2005; Besner et al., 2005; White et al., 2009). Many LPNs associated the lack of role clarity with a general misunderstanding associated with the scope of practice for each nursing group. This issue impacts teams dramatically by affecting role enactment for all nurses and other health professionals.

*It comes from management down, knowing roles, what people can do, what they are capable of. That manager became very instrumental in using everyone [on the team] to their fullest. She was very good at empowering everybody.* (LPN 8A)

*The role of what a professional can do is very broad...what they can do on one unit, they can take over to another unit, but it’s a little different, but no one has ever told them.* (KEL 4)

White et al. (2009) discuss how role enactment for RNs cannot be achieved without “a collaborative practice model incorporating RNs, LPNs, and HCAs” (p. i). Issues with role enactment emerged in discussions with participants in this study as well.

*Definitely doing the same thing in [some settings].* (LPN 8A)

*There is no differentiation between the RN and the LPN [on some teams]... They do the exact same job, we know they come with different experiences and different knowledge base, but when they are doing the exact same thing it makes it very difficult to pull teams apart where there should be differences.* (KEL 2)
Often issues in role clarity, enactment, and consistency were at the base of concerns with role overlap, which at times was a contributing factor to disruptive behaviors between LPNs, RNs, and RPNs.

The White et al. (2009) study also indicates how vital the leadership role is in change management, which was evident in the LPN discussions (p. i).

> On some units...[we are] not allowed to touch an IV because you were an LPN...it’s demeaning. Management needs to be educated as to what LPNs can do, and then educate their staff as to what LPNs are allowed to do. (LPN 1B)

Most LPNs agreed with this issue, and some felt supported by their colleagues related to enactment of their role, as they saw RNs and HCAs experience difficulties within their roles. “I actually don’t think it’s unique to us” (LPN 9A); “I don’t either, the aides have their own issues” (LPN 1A); “I think the RNs are struggling too” (LPN 9A). This conversation was boisterous and supported by the entire focus group, with reflections of the same theme among the other focus groups as well. This validates research completed in the past in Alberta, and confirms issues originally identified over 5 years ago remain today (Besner et al., 2005; White et al., 2009).

> Overall, team dynamics are negatively affected when role descriptions are not clear and concise authorizing practitioners to work to their fullest ability in a particular setting.

Management at all levels in the system, but particularly at the unit level, serve a vital role in developing a positive organizational culture. The most successful teams integrate philosophies that value and respect individuals and their roles. Expectations for professional roles and accountability should be clearly articulated by organizations, with responsibility and accountability for enactment placed first on unit leaders, and then on team members. Again, in this section, the interconnectivity with other subtopic themes and categories is evident.
Assumptions.

There are many assumptions that relate to organizational culture and team dynamics. This study will focus on the assumptions that relate to competence, beliefs, and shared decision making. Assumptions are best defined as those basic values that “tend to be taken for granted by group members and are treated as nonnegotiable” (Schein, 2010, p. 23). In nursing, this includes all those core components individuals learn throughout the socialization process of becoming a nurse and transitioning from novice to expert in a practice setting. In fact, every health professional has a socialization process with associated assumptions and beliefs.

If there is strong socialization during the education and training period and if the beliefs and values learned during this time remain stable as taken-for-granted assumptions even though the person may not be in a group of occupational peers, then clearly those occupations have cultures. (Schein, 2010, p. 21)

Within organizational cultures, each member of the team is challenged to conform to the organizational structure and unit specific culture. In health care, the socialization aspect within professions is expected and obvious, in fact it is seldom questioned. However, the most debatable issue remains to be “who is ultimately accountable for the patient”; which contributes to the debate about appropriate competence, professional responsibility, and role misconceptions within teams.

Schein’s (2010) discussion of microcultures addresses health care team cultures succinctly; as a major challenge in health care is maintaining a common goal while blending different beliefs and assumptions of interprofessional groups (p. 67). Interprofessional assumptions emerged through the focus groups in several ways, particularly in how new nurses to the team are accepted, even within their own profession.
There is one LPN who has been there for 25 years and she is very protective of the LPN role. So when the new ones come in she is watching them to be sure they don’t overstep their bounds and they act professionally...so the new guys get it from the senior LPNs...and RNs...they [new guys] are very intimidated by us. (LPN 10C)

Transitioning new team members to an organizational culture can be a challenge, but motivating change within an existing team is sometimes a struggle.

It is based on the premise that professionals want to work together to provide better care. At the same time, though, they have their own interests and want to retain a degree of autonomy and independence; the main instrument for negotiating such autonomy is power. (D’Amour et al., 2008, p. 189)

The microcultures in health care are diverse and plentiful. Small, moderate, and large teams exist everywhere. In my regulatory work I have noted what I call different planets in nursing; where a specific setting sees their work as completely different from other settings, even in their overall value to the health care system. Although differences do exist in the care needs and nurse competencies in all settings, each area has value. “In rural…we feel swallowed by the big city” (LPN 1D). Size and resources available impact care dramatically, as in a rural center with significant differences in delivering and supporting care. All of the areas discussed in this study impact the assumptions people hold, impacting the organizational culture in each case.

While this study did not focus on gender in nursing, it emerged as possibly playing some role in the development of relationships and trust in teams. Although there was only one male participant in this study, there were comments from several females indicating a belief that part of the team dynamic issues occurring in health care teams is related to the female dominated groups providing care. “With predominantly female teams...I find that feelings are hurt when there is disagreement, so, gender makes a difference. I have had experiences that when you add a few male staff members, things lighten up very quickly (KEL 1). Atwal and Caldwell (2005)
touch on this briefly, indicating “male nurses felt a greater equality with doctors than their female colleagues” (p. 272). Although this belief did not emerge with participants, differences in communication styles did. “We are a female dominated organization...men deal with situations differently than the females. Communication is different, less triangulation” (KEL 4). Although oppression was not a term used by any participants in this study, concepts of oppression and power struggles emerged from all participants through the discussion of roles, relationships, and feelings of powerlessness (Freire, 2010, p. 44; Schein, 2010, p. 101). “I almost feel like we are fighting the women’s lib thing all over again, cause you have to go harder, faster, longer, to get some little bit of acknowledgement” (LPN 1A). Perhaps to a large degree these issues are not unique to one gender or professional group, but are common in nursing and health care teams in general. Clear perspectives on issues of power are impossible to fully distill in this study, due to its scope and nature.

Molyneux (2001) discusses a health care team successfully using a decision making model versus a traditional hierarchical medical model in forming a new team (p. 31). In my study, concrete current experiences with shared decision making emerged only twice from LPN participants, which is low considering “fewer than half the nurses…reported that management in their hospitals is responsive to their concerns, provides opportunities for nurses to participate in decision making, and acknowledges nurses’ contributions to patient care” (Aiken et al., 2001, p. 259). From the two LPN experiences, shared decision making through unit councils and organizational structures that support overall group decision making, showcased positive team dynamics. “Unit council has rules…it’s not for gossip, very professional; emotional, personal stuff doesn’t come into it. Everyone is committed to be there” (LPN 3B). Participants in the focus groups who did not have opportunities for similar shared decision making were vocal in their
approval when hearing about unit council activities, with several asking in a joking manner if there were job openings in those settings. “Those who were in workplaces where staff had input through committees were less silent and felt more satisfaction” (Roberts et al., 2009, p. 290).

Even the KELs consistently voiced the need for shared decision making, identifying that they do not see clear examples of it routinely even though most settings discuss it as a value. “Anytime you have mechanisms where you can share information better or communicate better, those work” (KEL 3). Eagerness from all participants for more shared decision making opportunities was evident throughout this research study, leaving room for exploration of new models in health care.

Organizational culture is diverse and multifaceted. A study of this size cannot assume to delve into the depth necessary to assess the many intricacies. This study does, however, open discussion to some of the issues that affect interprofessional nursing teams. “It is not really possible to describe an entire culture, but we can describe enough elements to make some of the key phenomena comprehensible” (Schein, 2010, p. 35). Organizational issues will affect teams forever, but hopefully by engaging in discussion about some of the issues discussed here, we can learn how every team members can contribute to improve unit and organizational culture.

**Transformative Learning in Health Care Contexts**

In this subtopic area, transformative learning is approached through three main foci; communication, leadership, and personal transformation. When building and supporting a transformative learning environment, many things should be taken into context. The value of building teams through mutual acquaintanceship and trust is clearly noted (D’Amour et al., 2008). “The nursing profession’s role and challenge in this rising tide of transformational change is clear – the current guardians of the nursing profession must create a culture of engagement as
their legacy for future generations of nursing” (Fasoli, 2010, p.20). This section identifies areas where a social revolution in nursing may be conceived and propelled forward.

Authenticity, transparency, engagement, and support are vital to transformative learning environments, and emerged strongly integrated throughout dialogue with participants in this study. “If team work, communication, and leadership aren’t there, you have to correct all of them” (KEL 4). The initial questions regarding transformational learning created a silent contemplation among focus group participants. Continuing competence and lifelong learning are common philosophies for nurses, but perhaps the philosophies of transformational learning remain foreign to many. Wade (1998) defines transformation as “a forming over or restructuring” (p. 713). Therefore, as with the philosophies of action research, the question of how to create a transformational learning environment was reframed with more of a personal action focus, and thoughts emerged clearly and liberally. Through the dialogue in each focus group it quickly became evident that leadership, communication, and personal transformation are deeply intertwined topics. It was also clear there is a high need to focus upon these three concepts at all levels in the system.

This subtopic, transformative learning in health is highly interconnected with other subtopic areas and builds toward participatory action. Table 4 outlines the three subtopic themes in this section, along with the categories that emerged through the LPN and KEL participant discussions.
Leadership’s role in shaping the culture of a unit/organization cannot be understated. Perspectives on the need for leadership emerged strongly through all phases of this study from all participants. A recent study has noted that over half the employees in organizations lack trust in senior management; and although this isn’t new, it is worse than in past (Quirke, 2010, p. 25).

The challenge for leaders is to generate trust through everything they do; building enormous value in communicating with focused messages and authenticity. In this study, much dialogue linked to what leaders do, or don’t do. It became clear from the LPNs that unit level managers have a profound impact on the function of a team and the dynamics within a team. The philosophies of managers’ were noted to be linked to overall positive or negatives in areas of team empowerment, utilization, mutual respect and value, and nursing team culture.

The viewpoint about leadership from every LPN in the focus groups is best summed up with this statement: “It totally depends on your manager” (LPN 8A). The KEL interviews also showcased this perspective:

*I know the units that do well; it has to start from leadership. They have taken the time, they have stood up to budget constraints, [saying] I need to support my staff; I need to give them time off to learn about these things. It is still challenging. (KEL4)*
The KELs saw leaders as being charged with the role, whether prepared through education or not, and faced with enormous demands and challenges that may or may not be reasonable. Although the LPN and KELs agreed on this matter, those who had managerial experience related to the challenges faced by managers more so than those who had not experienced that role.

Nursing leaders have profound opportunity within the challenges of managing issues, motivating teams, sculpting culture, and building a new tomorrow (Brown, 2010; Jarvis, 2007; Schein, 2010). Perceptions of a leader’s ability to manage their own bias and beliefs, while building teams holistically was a consistent message from all participants, but one could argue individuals in teams have just as much opportunity.

Why don’t teams orient leaders to how they work...they are very, very passive. They wait for the leader to come on board and they go with the wind...it’s very difficult, when you have a very experienced team, and they have a brand new leader...leaders don’t receive any mentoring or support from those teams...and teams just go through it over again with a new leader. (KEL 1)

Management role has changed, becoming more a mentor than managing, and telling...but talking and mentoring through things. (LPN 2B)

Perhaps we are ready for the day that teams guide new leaders to prepare the leaders to further guide the team in a supportive and transformative way.

One may assume that nursing excels in mentoring, however, that is not always the case. “Nursing has historically been considered a profession focused on nurturing, yet today’s nurses experience contradiction, faced with new role expectations that diverge from the occupation’s caregiving tradition” (Apker et al., 2005, p. 106). Many comments from KELs and LPNs refer to the enormity of the manager’s role; calling into question a potential capacity expectation in the role that has excelled beyond reason. “The workload for frontline managers is so unbelievably high...by the time you do everything you need to do, you’re exhausted. I would argue that if they make the time right up front, it would save time later” (KEL 3). Kotter (1995), a corporate
cultural change guru, discusses reasons why transformations fail. One reason is the importance of “taking sufficient time to make sure that the next generation of top management really does personify the new approach” (Kotter, 1995, p. 67). Allocation of time would allow more discussion and involvement between leaders and staff; activities participants don’t commonly see occurring in health care teams today.

As noted already, the LPN discussion and the literature review elevate a few best practices that influence the interprofessional team. “We have a unit council, changes are filtered through, and it’s the buffer zone between staff…I was a big complainer, but once I got involved…[I learned] if you want to take the initiative, there is a committee” (LPN 3B). Other LPN participants in focus group B were eager for more information about unit councils, as it was foreign to them. According to the literature, organizational direction implemented through systems such as unit-based councils, facilitating shared decision making and a unified nursing team voice, can be highly successful (Dietrich et al, 2010, p. 54). An LPN in focus group D discussed her organization, which models shared decision making from patient through to every staff member in the organization “We look at both sides; 50% for the [patients], and 50% for the staff…you hear it from people all the time…saying how much they love it” (LPN 3D). All other participants in the group lamented they would like to work for her organization, commenting they have never experienced that type of workplace. This discussion links back to the development of organizational culture and verifies how valuable such work is to team dynamics.

The desire for shared decision making was unanimously evident in this study.

A lot of people wonder why, when things get changed, they [leaders] don’t ask the people who work on the unit or with the patient. (LPN 5B)

Have systems in place [so]… there actually is a team voice. (KEL 1)
Leaders who make people feel heard were discussed with high regard. Again, this may go back to the discussion about the humanness of working with people; as Douglas (2010) states “one could conclude that the business of understanding and addressing the experience of people matters” (p. 62). As indicated earlier in discussion related to transformational learning, psychological safety is necessary to build team, organizational comfort, and the will to move a process forward (Schein, 2010, pp. 305-307). Teams need to feel safe, heard, and valued, to truly be transformed, and once a team is transformed change is much easier for everyone (Jarvis, 2007). Ultimately, if a leader has a strong vision to build positive team dynamics, many factors are taken into consideration; including an authentic approach that is patient centered with shared decision making.

Communication.

Communication is a mammoth content area, with an abundance of references and resources specific to health care contexts. “The need for good interprofessional communication and collaboration to help coordinate patient care in an effective manner is critical” (Reeves et al., 2009, p.2). As noted in the leadership section of this study, open, transparent, and frequent communication emerged as strong influences to team dynamics. In building a positive learning culture “communication and information are central to organizational well-being and must therefore create a multichannel communication system that allows everyone to connect to everyone else” (Schein, 2010, p. 369). One might assume that good communication practices are inherent in health care due to the nature of the work, however, that is often not the case. In fact, many skills learned in effective patient communication are sometimes overlooked in colleague relationships. Teams do not necessarily communicate well with each other on a regular basis.
The value of good communication in relation to the team was stated explicitly throughout all the literature reviewed in this study. “The importance of nurses’ communication behaviors extends beyond the patient bedside to discourse with physicians and other healthcare providers” (Apker et al., 2005, p. 110). The value of team communication was also threaded through all the examples shared by participants in this study.

*I have seen teams where there has been...a basic breakdown of infrastructure for communication, so more of a chaotic experience when you come into work. (KEL 1)*

*When I think about our team I just think communicate! It’s really good, the level of communication that we have between LPNs, RNs, and charge nurse. (LPN 3B)*

An unhealthy communication practice, particularly triangulation, was seen commonly by all participants.

*Negative part of communication is triangulation...I see it everywhere, it’s part of human nature and affects everyone in the team. (KEL 4)*

*Communication is a big one and supporting the interaction...within the group, the working team of the day. (LPN 1D)*

There is a desire for regular communication from managers that is open, transparent, and focused. This philosophy was shared by every research participant and appears linked with other positive team dynamics in the creation of high functioning teams.

Information is power and open and clear communication is the best mode for sharing information amongst a team. Positive team experiences were clearly linked to frequent communication practices.

*The reason why there is good collaboration...[there is] lots of one-on-one discussion time, time to share knowledge, share views, opinions, thoughts, debate them in a professional manner, and that builds a lot of trust and respect. (KEL 3)*

*If it’s a siloed structure, and nobody ever takes the opportunity to talk to each other...you just get into...dismemberment of teams. (KEL 1)*
With all the historical hierarchical power structures in health care, it’s interesting that the 1921 theoretical works of Paulo Freire articulate this area so well:

As we attempt to analyze dialogue as a human phenomenon, we discover something which is the essence of dialogue itself: the word. But the word is more than just an instrument which makes dialogue possible; accordingly, we must seek its constitutive elements...reflection and action. (Freire, 2010, p. 87)

Reflection and action certainly could take a larger focus in health care teams of today.

Open communication, which engages elements of reflection and action, is vital to team dynamics. Along with trust and respect, open communication was seen as one of the most important values in a positive team environment.

*Being able to communicate honestly, openly and honestly, with everyone on team.* (LPN 8C)

*There are options to have a voice and have a say...[then] there is a lot of things we can do individually to get stuff done.* (LPN 3B)

It is evident that teams need regularly scheduled time to meet, reflect, and dialogue together. Regular and structured communication practices could improve team dynamics significantly; and everyone who participated in this study was anxious for this opportunity.

**Personal transformation.**

The transformation process allows for increased consciousness and enlightenment, which can occur unconsciously (Wade, 1998, p. 714). Personal transformation is a broad concept, which can be approached from many directions. This section examines engagement, mentoring, and professional pride. These categories emerged throughout this study in the overt dialogue of the focus groups and interviews. This study showcases examples of many individuals (both LPNs and KELs) who have achieved transformation to some degree, and a few who still face
major challenges. Some of the dialogue in the focus groups demonstrated oppression, negativity, powerlessness, and hopelessness; while also displaying incredible hope and engagement for future opportunity and privilege. One of the key concepts that emerged through the LPN focus groups is the strong need and desire to create and hold strong positive relationships within teams. This concept is also showcased by Taylor and Keighron (2004) in their discussion of a total healing environment, where they encourage a focus on the human spirit side of health delivery through relationships, inclusivity, authenticity, balance, and recognition (p. 241). Ultimately, participants want opportunity to transform personally and professionally, while working in their chosen profession—an occasion that could result in huge benefit to the patients and the system as well.

Professional confidence was discussed regularly by the LPNs. The value of trusting one’s own competence enough to actively participate on a team came out in discussions with all groups. However, oppression exists rampantly in many organizations and teams at multiple levels, and health care organizations have no immunity to this. For example, in discussing if professionals take the development of a collaborative culture seriously one KEL responded; “if their leader is [a] top down disenfranchised leader, or if the leader is brand new and learning...I don’t think they do, or know how to” (KEL 1). Several KELs voiced their inability in shared decision making or mentoring in their own relationships with leaders; even in situations where it would make sense that leaders be guided by more knowledgeable staff. “One of the premises of a collaborative environment is shared decision making and...that is not an organizational culture” (KEL 1). Although this is disturbing, it does epitomize what the LPN participants shared; they see negative team dynamics affecting everyone on the team. The stress ineffective team dynamics create is significant; and although “stress is necessary for an individual to
evolve… when there is excessive stress, negative outcomes can result” (Tarrant & Sabo, 2010, p. 79). It’s a tricky balance: To have enough motivation for change in an environment, while creating opportunity for an overall feeling of engagement. It is clear though, improvements could and should be made to nurse engagement in our health care system.

A dehumanized spirit lacks will, energy, and often ability to do anything about an undesirable situation (Freire, 2010, p. 48). Roberts et al. (2009) discuss oppression in their review of nursing workplace culture. “Nursing leaders have often not been able to change the balance of power” (Roberts et al., 2009, p. 289). Oppression begets dehumanization and the cycle continues until someone with strong insight and leadership ability changes the dynamics. “The powerless are also submissive and silent when confronted by authority and are unable to express their needs as a result of fear and low self-esteem” (Roberts et al., 2009, p. 289). Powerlessness was evident in many of the participants.

Who can I get a hold of who can make a difference…how safe is it for me…I question that all the time. Not just from my position…I see [what] happens on the floor too, how people are undervalued for what they’ve done for…years. How do I let anybody know that that’s happening and still keep my job? (LPN 6A)

It’s through personal transformation and liberation of the spirit that individuals can embrace their power and truly make change happen (Freire, 2010; Jarvis, 2007; Wade, 1998). Atwal and Caldwell (2005) discuss the importance of professional confidence and believe “professionals are not respecting their own individual autonomy or being an effective advocate for the client” (p. 272). This area of the project was very interesting for me, as the strength within the individuals who participated showcased a real will, spirit, and hope for a better future as valued members of the nursing team. “We have to lead by example” (LPN 6A) was a comment that brought passionate agreement and discussion, with similar themed perspectives occurring in the other focus groups and in discussion with the KELs. By examining our own power, nurses need
to “look at...an internal locus of control...what can I do, just for myself to make the organization or this area better” (KEL 4). Elements of personal transformation were indicated in most, if not all of the research participants. Even though all the LPNs have been exposed regularly to oppression and negative team dynamics, there was a strong will that they still have the power and ability to make it better.

Exemplifying a positive attitude and showcasing professionalism were noted by the LPN participants as important to developing a transformative learning environment. “Being passionate about education” (LPN 11C). “Understanding scope and extending to full use of it” (LPN 5C). “Self-care so that we can be positive” (LPN 5B). “Have compassion for them [colleagues], and...take responsibility for yourself” (LPN 4B). These comments indicate a willingness to mentor and support the team as a whole. The Mills et al. (2008) rural nurse mentoring project has lessons that are profoundly positive for all nursing environments and not unlike some of the comments in this research study:

Identifying experienced nurses who mentor another, as a part of their practice – affirming them and supporting them, will maintain this cycle. Mentoring new or novice nurses early in their career shapes how they frame their nursing perspectives of self to aspire to be significant others over time, creating a future culture of support. (p. 33)

By implementing these concepts into an environment, we create teams that trust, respect, and value each other.

Personal transformation perspectives for the KELs were similar to the LPNs.

On an individual level, if we encourage people to...model professional behavior, despite what’s going on, that is huge. (KEL 3)

One of the biggest ways we could make a difference is tapping each other’s knowledge and skill to enact change. (KEL 1)
There is still keen interest in staff working towards a better working environment...people want to be part of a team...I think there’s a lot of hope in trying to make small steps. (KEL 2)

They have to be engaged, they have to participate...they have to take ownership of how they are contributing to the team, that it’s not an individual, it’s a group. (KEL 4)

It is encouraging that hope for improvements in the system and in teams, along with interest and will to make it happen, emerged throughout all LPNs and KELS who participated in this study. Perhaps one factor in this is that those willing to volunteer to take part in a study of team dynamics are already underway in some type of transformation of their own.

Nursing engagement, complete with pride in the profession of nursing, are core to reforming and reframing nursing environments that struggle with negative team dynamics. Hierarchies, turf protection, professional posturing, and bad attitudes should be confronted, at all levels in health care teams. We are in a time when “the culture of nursing engagement must extend beyond any specific setting and the designated professional organizations” (Brown, 2010, p. 2). Why shouldn’t employers expect to have highly “motivated, committed, and experienced staff, who are willing to be flexible in their working relationships and working practices” (Molyneux, 2001, p. 33). This research study clearly indicates that many in the health system believe that each individual needs to take responsibility for their own transformation. It also confirms that team members are eager to see leaders who can make transformation happen. Multiple challenges for overall transformation remain; however, with the right will and spirit I would contend that anything is possible.

In summary, a transformative learning environment cannot occur without committed leaders, clear and open communication, and willing team members. Health care is constantly posed with the challenge of providing quality and timely services that are accessible to everyone, while maintaining costs. These are large challenges; however, committed people can achieve
great things. “Transformative change implies that the person or group that is the target of change must unlearn something as well as learning something new” (Schein, 2010, p. 301). Committing to unlearning the practices of the past that have created the team dynamics of today would be a bold step. The next step is to learn and practice healthy new practices and ensure they are integrated throughout the system. These are mammoth phases that should be integrated in every environment, education program, and individual for us to build a healthy team dynamic for the future.

**Chapter 7 – The Profound Thoughts - Conclusion**

**Research in Action - Summary**

This is an action research project, with research goals including empowerment and emancipation of participants through a process of appreciative inquiry, reflection, and transformation (Henderson, 1995; Moody et al., 2007; Wade, 1998). Phase 3 of this study elicited feedback from the LPN participants related to their perspectives following the focus group. The specific goal in Phase 3 was to aid the LPNs in seeing how their contributions created credible new data to enlighten and inform this topic area. It also was designed to allow opportunity for reflection and feedback about the impact the process had on individual participants. “The opportunity to normalize feelings and to realize that it was okay to have those feelings was crucial” (Phelan et al, 2006, p. 422). Sometimes simply voicing one’s perspectives and being heard makes one feel valued and that certainly was seen in this project.

Out of the 24 LPNs participating in this study, 11 responded (46%) with positive perspectives related to how the focus group dialogue affected them personally. Considering the focus of the study question was on the perspectives of the LPNs, the KELs were not asked to provide feedback at this stage. In retrospect, I wish this step had been integrated into the KELs
interview process as well, as it would be interesting to determine if the group discussion elicited more or different reflective response than the one-on-one interview discussions. All 11 LPN respondents noted it was a positive experience to participate in the focus group discussion.

*It has made me proud once again to be an LPN.* (LPN 2C)

*I found it enlightening and food for thought.* (LPN 10C)

*Very relevant to what is happening to our profession at present.* (LPN 8A)

*We can only grow from this point on.* (LPN 4C)

It was obvious through the research process feelings of professional pride were refreshed, leaving the LPNs thankful for the experience.

Most LPNs commented that being able to discuss the issues and share perspectives helped them to feel stronger and not as isolated. One LPN discussed that although it was positive to hear from others “*Good days and bad. Turf wars remain a problem. Empathy and burnout are big factors...difficult to be positive when one is always tired*” (LPN 1D). One LPN acknowledged that her career experiences have been a bit unique “*It makes me feel pretty lucky in my practice. A lot of my nursing years have been team focused, and I have had the chance to collaborate with many different disciplines*” (LPN 4C). In reviewing these comments it confirmed for me that although each nurse’s experiences are different through their careers the team dynamics they are exposed to along with their own perspective about practice and people truly affect how they feel about their career as a nurse.

This project endorses that people want to work in an environment that is supportive and respectful, and they want to feel appreciated for the competencies they bring to the team. Although many believe they do experience these factors to some degree, they also experience negative factors that hamper communication, productivity, and further relationship building. In
the business of health care we care for people, supporting them to reach optimum functioning until the end of their life. Perhaps it’s time teams’ talk openly about the issues that exist, and discuss how to take care of each other and truly be ‘human’ with each other. This study validates this type of openness is necessary for team members to reach optimum functioning as professionals.

Many positive thoughts and recommendations came forward from the LPNs; signifying how simple opportunities for structured dialogue through appreciative inquiry can be empowering to individuals and potentially impact teams (Moody et al., 2007).

A new sense of pride…it has made a huge difference in how I feel about what I do. (LPN 9A)

Renewed my interest in going forward with more education and showing some pride for being an LPN...The people I met certainly are very proud to be LPNs and that was refreshing for me to experience. (LPN 2C)

I am making a more serious approach to role modeling professional behavior, and to mentor fellow LPNs in a kind way. (LPN 1A)

It gave me insight to know that I am not the only one experiencing some of the frustrations in my job… It also made me take a look at what I can do and feel extremely proud of what I have accomplished and not feel ashamed of being an LPN. (LPN 8A)

By discussing and involving LPNs and KELs in this project, I expected to engage with participants in an effort to truly understand the issues of teams more clearly, building solutions for improving team dynamics. Sometimes solutions for change come in many forms, with personal reflection, awareness, and transformation affecting change of all kinds.

One thing that I have discovered from all of this is that we (RNs, LPNs, RPNs…) need to find a common issue that needs to be dealt with. One that we all can get behind and work together to find a solution. In doing so we will utilize our different strengths and abilities together, as individuals instead of our professional affiliations, and in the process build a stronger team dynamic. (LPN 10C)
Finding common ground is an excellent way to frame team dynamic projects that may result from this research, as essentially that is what collaborative practice and positive team dynamics are about.

Transformation comes in many ways and this research experience has been transformational for me as well. Hearing such frank and open discussion from the LPNs and KELs about issues of concern and best practice scenarios has opened my mind to confirm issues on the front lines. An open mind will serve me well in my future work within nursing and for this I am grateful to all the participants. As this is a research topic for which I am passionate about, the reflective comments from the LPNs struck an emotional chord with me. I find it amazing that through a fairly simplistic process of bringing people together for some structured dialogue, a profound individual impact can be measured—even if only qualitatively. My own sense of hope for nursing teams in the future is renewed. Although there are many struggles in team dynamics, there are exceptional best practices. “I do believe there is change underway…there is more openness and more realization that we have to practice collaboratively and so there is some attempt to do that” (KEL 3). Regardless of how most LPNs and KELs have been treated in their practice within teams, there is an undying hope for a better tomorrow and that is truly very good to hear.

“A shift in thinking will need to take place…If nurses hold shared values, they themselves form a powerful group who can start to influence the thinking about and attitudes towards the nursing profession by policy makers and governments” (Horton et al., 2007, p. 726). Herein lays the challenge for the family of nurses; to challenge our own hierarchies, turf issues, and negative behaviors, and commit to work together finding common ground toward creating a health care system that is truly focused on the patient. These activities, along with an authentic
desire to work together, will guide us forward to provide better patient care. If that is not a profound and meaningful direction to proceed, I would question what is? In closing, a final statement from one of the LPNs in the fourth and final focus group:

_Even being a member of this...reminds me to always try to be positive and look at the role with a real positive attitude, and portray that to others at all times...and sometimes I guess we forget about that. (LPN 4D)_

**The Outliers-Study Limitations**

Although this project approached a diverse and gargantuan topic area with vigor, there are many limitations to the study. Due to the richness in the literature and in the data collected, each of the subtopic themes could result in an independent study. For example, the topic of collaboration is extremely diverse and multidimensional. D’Amour et al. (2008) posit the need for a framework with ten indicators to assess collaboration and yet this does not assess all of the fine points (p. 200). Therefore a small, broad study of team dynamics of this magnitude cannot profess to even more than lightly touch the surface of this topic area. Therefore, this study does not:

- Assess all perspectives from within the nursing team (RNs, RPNs, HCAs, leaders, managers, and educators).
- Assess novice practitioner experiences.
- Assess the perspective of front line nursing managers.
- Use any techniques of observation in assessing team dynamics.
- Examine gender issues with any depth or fairness.
The Wish List-Future Research

This team dynamic study has the potential to impact the way teams, leaders, managers, professions, and other stakeholders consider how teams work together. There is also potential for generalizability to nursing teams that practice throughout health care, and perhaps teams outside of health care. Five main points have been considered for recommendations for future research and direction:

Table 5:

Future Research

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<th>Future Research</th>
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<tr>
<td>Broader Scale Nursing Team Dynamic Study</td>
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<tr>
<td>Enhance Leadership Capacity and Expectations</td>
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<tr>
<td>Examine Disruptive Behaviors</td>
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<tr>
<td>Build Collaborative Teams</td>
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<td>Enhance Orientation and Mentorship Programs</td>
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Broader scale nursing team dynamic study.

Provincially there is a need to consider a larger scale study that examines team dynamics within the interprofessional nursing team including novice and expert practitioners. This research validates that LPNs and specific KELs share an understanding of the issues, problems, and potential solutions to improving team dynamics. The knowledge of the people who work in the system could be tapped to a wider degree.

*We are really smart people in this province, and all we have to do is set up shared decision making, set up some kind of a mechanism... We know what the issues are, why*
aren’t we putting groups in place to run us out of this realm of discontent, and unhappiness, and chaos? (KEL 1)

This study identifies that by simply creating strategic opportunity for dialogue, people can change or be changed in some way. Time for dialogue in teams is a core component to manage issues with team dynamic and power structures (Schein, 2010, p. 391). Professionals must be given a chance to share their experience and expertise with each other. Involving them in a broad team dynamics project would showcase team members and build strength and support within the team. “Make a point of ensuring staff are aware that things are happening, makes them feel really good that someone is listening and is trying to do something about a current concern” (LPN 3D). This project validates that sometimes just being heard creates positive change.

Phelan et al. (2006) found “the impact of interprofessional aspect of dialogue on participants’ ability to recognize and consider alternative perspectives is noteworthy” (p. 422). As noted in one KEL interview “it’s not a healthy environment at all…if you were truly making shared decisions, then you would come to consensus about…meeting our patient’s needs, we need to be flexible” (KEL 1). Perhaps it’s time to question: What does ‘being flexible’ mean? How can we get dysfunctional teams to work toward shared decision making? Considering much of the literature in this study supports shared decision making and enhanced team dynamics, aren’t we obligated to examine these issues more deeply? The potential of utilizing a process such as appreciative inquiry involving the four stages of discovering, dreaming, designing, and determining what should be, could go a long way toward discovering future directions and engaging nursing team members (Moody et al., 2007, p. 322).

Considering all these factors, I suggest that a project be led by government and include employers, regulators, unions, and interprofessional team members to work together to look deeper into nursing team dynamic issues. Involving team members throughout a study drills
deeper into some of the larger scale issues that impact nursing teams, further unearthing struggles that exist and building on best practices in the system. I challenge to say that no stakeholders can rightfully argue about the value in this type of a project.

It is important to note that as I was in the final days of writing up the first draft of this research, Alberta Health Services launched a new realignment plan (May 3, 2011). This new plan outlines several immediate priorities that address some of the issues identified in this study. This is a positive sign that Alberta Health Services leadership has some understanding of components of the issues identified in this study. More information in the realignment plan is available at www.albertahealthservices.ca.

Enhance leadership capacity and expectations.

Leadership capacity addresses multiple areas including increasing decision making, utilization, morale, and engagement through leadership support and sharing of best practices. Again, this is a mammoth topic area, with multiple suggestions for future study or directions.

It was heard broadly in this study that healthy team dynamics are dependent upon unit level management and the leadership ability of each professional. The current system has multiple barriers to decision making and professional accountability; with negative nursing cultures, hierarchies, and professional posturing at all levels. Decision making throughout the system should be enhanced to encourage every member of the health care team to make decisions appropriate to their role and practice setting; including front line practitioners, unit level management, and leaders at all levels.

Authoritarianism is not an easy concept to release, especially in institutions that have followed a paternalistic doctrine for decades – but it is possible to have effective partnerships and alter the old way of doing things, given the effort, commitment,
collaboration, communication, trust, and respect of the relationship of authentic leaders with their employees. (Dietrich et al., 2010, pp. 54-55)

Jarvis (2007) strongly supports that building leadership capacity is vital, and could be enabled through resource and organizational commitment, which includes practice development and transformation (p. 3). I agree with this philosophy and challenge that enhanced leadership capacity that includes full utilization of team member competencies be encouraged and expected for all professionals at all levels in the system. Ultimately, it is difficult to justify to Albertan’s why educated professionals are not authorized and expected to work to their fullest potential.

As in Mathews (2010) examination of employee morale following dramatic organizational change, the issues of survivor syndrome may need to be further assessed in Alberta organizations (p.18). It is difficult to know what restructuring has done to teams and to our leadership ability within teams. It was clear through this study that many leadership issues exist that significantly affect team dynamics. Further study in this area is necessary to truly ascertain the dimensions of leadership issues. More examination at a leadership/unit manager level should occur related to how their roles can be supported throughout the current health system structure.

We need to make time for collaboration to happen; workloads should enable interprofessional team collaboration; leaders should be motivated to facilitate structures to support team development; and professionals should be encouraged to see the value in further building peer collaboration. Before impact can be felt uniformly at the unit level, building authenticity in leaders is a necessary first step. Leaders must be given time to focus on processes to build and encourage positive team dynamics. It is not appropriate for unit level leaders to manage extensive workloads, routinely removing them from contact with staff, while still
expecting they have the time to improve and manage team dynamics. Expectations and time allotments to build and support collaborative environments should be considered a priority in health care structures, with consistent processes in place to do so throughout the province.

There are many leadership and team best practices occurring in the province of Alberta; however, there lacks clear processes to share such practices with others. Therefore, I would suggest the development of an online network for best practices. This network could be openly accessible and available to health professionals, leaders, regulators, government, and other stakeholders. Discussion of positive practices could be supported as a potential way to spread best practices and manage challenges within the system building leadership capacity at all levels. Alberta could become an example of excellence in team practices, acting as a showcase of healthy interprofessional practices across our nation and internationally.

**Examine nursing disruptive behaviors.**

To build healthy environments, it is necessary to identify and stop disruptive behaviors in nursing teams. Just as open discussion of team dynamics influenced participants: Walrath et al. (2010) found in their study that “many participants expressed gratitude to the focus group facilitator that these behaviors were now being openly discussed. Others voiced appreciation as they learned for the first time that they were not the only ones experiencing these behaviors” (p. 114). A deeper interprofessional study of nursing team disruptive behavior, involving the nursing team and beyond would be invaluable to further identify how these behaviors are affecting the development of positive nursing cultures, collaborative practices, transformative learning environments, and quality patient outcomes. This new broader study could result in the development of train the trainer tools, which would assist in reframing the culture to one that no longer tolerates infighting and counterproductive behaviors.
It would also be valuable to consider a new confidential reporting or tracking process to track and align methods for management of behaviors that are impacting teams. This would provide a process to identify those issues that may or may not be managed successfully at a unit level. It would also potentially provide validation for the development of highly skilled conflict intervention services to support unit level leaders managing team issues.

**Build collaborative teams.**

The challenges in building collaborative teams are diverse and complex. It is time we examine and unearth issues of perceived status that impede team collaboration (Atwal & Caldwell, 2005, p. 271). The historic struggles seen between LPNs and RNs is essentially no different than the struggles between RNs and physicians (Brown, 2010, p. 2). Just as RNs seek respect and opportunity to be involved in the decision making with physicians (Stein-Parbury & Liaschenko, 2007, p. 476), LPNs seek respect and opportunity in nursing decision making with RNs and others on the nursing team.

There are “some key differences in the way in which different professions interact in multidisciplinary teams and…there is a degree of inequality in levels of participation” (Atwal & Caldwell, 2005, p. 272). Interprofessional collaboration poses a mammoth area for future study; with need for collection of observational data noting the actual interactions of nursing and multidisciplinary health care teams (Phelan et al., 2006; Reeves & Lewin, 2004). If collectively-government, employers, regulators, educators, unions, managers, and health professionals, truly want to improve team dynamics in health care teams, we have a big job ahead of us. However, the first major challenge is to seek commitment from all influential partners toward an authentic collaborative direction; as I am convinced this does not currently exist.
As so eloquently voiced by D’Amour et al. (2005) “every institution, manager and health professional faces major challenges in finding better ways to work together” (p. 117). As the health system has changed to create environments where collaborative, shared decision making is considered optimum, have we prepared leaders and health professionals to adjust to these environments? “Though recent advances have been made in research on collaboration, professionals need conceptual tools to help them develop collaboration amongst themselves in complex systems” (D’Amour et al., 2008, p. 189). We need to examine the issues central to the traditional hierarchical medical model in health care versus a patient centered model that includes shared decision making (Molyneux, 2001). Building on existing best practices, such as unit councils, may be a dynamic step toward building collaborative capacity in the system.

Creating venues for discussion between all professionals complete with professional behavior ground rules is vital. This could be a first step toward creating an expectation that environments not only support, but facilitate peer collaboration. “Peer collaboration was seen as a way of staying connected to colleagues and as an opportunity to consider alternative ways” (Phelan et al., 2006, p. 418). Although collaboration involving all types of health professionals must be addressed, there is a need to address nursing teams specifically. Government should consider leading a process to build nursing collaboration, as past practices to align nursing in the province of Alberta have not been entirely successful.

**Enhance orientation and mentorship programs.**

This study displays a link between communication, collaboration, role dialectics, and the mentorship necessary to build collaborative team members. Participants indicated the value and need for resources to support more adequate orientation and mentoring programs. There is a need to look deeper into the cultural change and competence required to build collaborative health
care teams from day one in the profession and throughout practice (Atwal & Caldwell, 2005, p. 268; D’Amour et al., 2005, p. 124; Schein, 2010, p. 19). Participants linked the ability to create and maintain a collaborative team with the time spent orientating and supporting all levels of staff.

The ability for teams to mentor and support team members is highly related to how that team communicates. “If members of the multidisciplinary team are not communicating within teams this can influence quality of care for the patients. In addition, they [team members] need to value their own vital contribution to effective and efficient interprofessional working” (Atwal & Caldwell, 2005, p. 272). The value of positive open communication in any team structure was evident in this study and cannot be argued; particularly in health care where people’s lives are involved. Therefore it is clear that communication competencies are an integral part of every team member’s role and allude to the success in building positive team dynamics.

There would also be value in assessing how leaders are supported to transition into their roles at all levels. Hierarchical expectations of role status should be set aside to build and support leaders and staff at all levels. New leaders should be expected to meet with teams to listen openly to how the team functions and what they need from their leader. As one KEL states, leaders should be empowered to “ask what can I do to help you [the team] to meet your patients’ needs?” (KEL 1). As participants in this study showcased, the leader has huge influence on the team. Therefore, there is value in enhancing opportunity and expectations of leaders to learn from and with staff.

Although current orientation and mentoring systems may be in place, they are inconsistent. Therefore, the system should support existing and additional orientation and mentorship programs for all levels of staff. Investing in leaders and staff will build teams and
create environments of excellence. Maintaining a role for experienced nurses with ‘tribal knowledge’ is also a vital part of this. Resources should be dedicated to mentoring and supportive team concepts on a regular basis and with priority. This recommendation could be merged with building collaborative teams, but should not be lost as a vital component of achieving collaborative environments of excellence.
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Appendix 1 – Glossary

These terms have been interpreted with these associated meanings for the purpose of this study.

**Culture:** A social order that exists explicitly or implicitly and includes assumptions, rules, beliefs, values, norms, and behavioral expectations for individuals who join a specific group or team. (Schein, 2010).

**Ideologies:** “Maps of meaning that, while they purport to be universal truths, are historically specific understandings that obscure and maintain power” (Barker, 2008, p. 10).

**Hegemony:** “The process of making, maintaining and reproducing ascendant meaning and practices” (Barker, 2008, p. 10).

**Nurse:** A regulated nursing professional who is authorized to provide nursing services by regulation within a given jurisdiction. This group includes licensed practical nurses (LPNs), registered nurses (RNs), and registered psychiatric nurses (RPNs).

**Nursing:** The provision of health care services provided by a nurse or health care aide, including a wide range of activities of daily living, treatments, and procedures applicable for quality patient care.

**Nursing team:** A group of providers who provide care for patients in any setting where care is delivered. This group may include LPNs, RNs, RPNs, and health care aides (HCAs).

**Patient:** The term used define the person who receives nursing care/services. Terminology was adapted in this study to standardize the terminology that sometimes is used in specific settings only (i.e., client, resident, patient).

**Role dialectics:** “Overarching issues of hierarchy, status, and professional identity that challenge…communication in the health care team” (Apker, Propp, & Ford, 2005, p. 93).

**Team dynamics:** The interplay of multiple factors that impact a group of people who are working toward a common goal. The factors may include assumptions, behaviors, collaboration, communication, culture, role dialectics, and values.
Appendix 2 – Communication Culture and the LPN-Pilot Study
Organizational Communication Analysis – Communication Culture and the Licensed Practical Nurse
Conducted by T. Bateman, Royal Roads University - August 2010       Presented to CLPNA Council September 23, 2010

Communication culture background
Within social science studies the culture of an organization/profession is evident through the manifestations of meanings constructed by those within the organization/profession. These meanings include language, signs, symbols, values, attitudes, ceremonies, rituals, and beliefs (Cheney, Christensen, Zorn, & Ganesh, 2004, p. 102). This project took a functionalist approach (theories of the mind) to assess the communication culture that exists within the LPN profession, including opportunities for leaders in nursing to manipulate and influence culture (Schein, 2004, p. 398). Nursing culture and team dynamics are intriguing areas, in which social science research is limited specific to nursing, and not existent in the LPN profession. Culture is an important area of study and it is necessary to submerge deeply into an organization, beyond the formal boundaries that define it, into the beliefs, values, assumptions, signs, and symbols that define culture (Cheney et al., 2004, p. 83).

Survey methodology:
The survey utilized an established organizational culture survey tool (Glazer, Zamanou, & Hacker, 1987).
- 31 items / 5 categories
teamwork/conflict, climate/morale, information flow, workplace involvement, supervision, and meetings
- 6573 LPNs received invitation to participate / 448 completed the survey
  (5% overall LPN population, 6.8% of those invited)
- 5 point scale used for ranking
  1-to a very little extent, 2-to a little extent, 3-to some extent, 4-to a great extent, 5-to a very great extent

Data Analysis:
Table 1:

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<th>Teamwork/Conflict</th>
<th>Atmosphere/Climate</th>
<th>Involvement</th>
<th>Communication/Information Flow</th>
<th>Supervision</th>
<th>Meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.16 (1st)</td>
<td>3.14 (2nd)</td>
<td>3.04 (3rd)</td>
<td>2.83 (5th)</td>
<td>2.94 (4th)</td>
<td>2.75 (6th)</td>
</tr>
</tbody>
</table>

Overall ranking was 2.98 – considering a ranking of 3 indicates an item is met in the workplace “to some extent,” mean scores under 3 indicate high levels of LPN dissatisfaction with the organizational culture they are exposed to.

No independent items had a mean score of 4 or over, with the highest item mean score at 3.53 and the lowest item mean score at 2.64.

References


Appendix 3 – Focus Group Questions

Teams in health: nursing team culture, collaboration, role dialectics, disruptive behavior, values
1. What values do you think are represented in a positive team environment?
2. What do you think represents a healthy team culture?
3. Considering our discussion so far, have you experienced these types of environments?
4. In what ways have you experienced disruptive or unpleasant behaviors in your team experiences?
5. How do you think collaborative practice influences nursing culture?
6. What do you see your role in developing a collaborative environment?

Organizational culture in health contexts: environment, role descriptions, assumptions, staffing
1. How do organizational beliefs and values affect nursing culture within your environment?
2. How does your role description impact the environmental culture you are exposed to?
3. How do you see members of your team contribute to development of team culture?
4. What assumptions do you think drive team beliefs and values associated with your team culture?
5. What role do you believe you have in developing a positive nursing team culture?

Transformative learning in health context: leadership, communication, personal transformation.
1. What is necessary for you to feel that you have a transformational learning environment?
2. How does leadership affect the development of a transformational learning environment?
3. In what ways is communication part of a transformational learning environment?
4. How do you think you could achieve personal transformation?
5. How could you impact other members of your team toward personal transformation?

Taking Action
1. What transformative action could we take as we go forward?
2. How would you see our discussion impacting your team?
3. What tools may be useful in this process?
4. How would you like to be involved in making change happen?
Appendix 4 – KEL Interview Questions

Teams in health: nursing team culture, collaboration, role dialectics, disruptive behavior, values
1. What values do you see in a positive team environment?
2. In your experience do you see disruptive or unpleasant behaviors commonly in health care teams?
3. How do you see nursing culture impacting teams?
4. What needs to happen to support more collaborative practice?
5. What needs to occur to develop more collaborative environments?

Organizational culture in health contexts: environment, role descriptions, assumptions, staffing
1. How do organizational beliefs and values affect nursing culture in teams?
2. Do professionals take their role in creating a collaborative culture seriously?
3. What assumptions do you think drive beliefs and values associated with team culture?

Transformative learning in health context: leadership, communication, personal transformation.
1. What do leaders need their staff to do to achieve a transformative learning environment?
2. What else do leaders need to create a transformational learning environment?
3. What needs to occur for health care environments to transform?

Taking Action
1. What transformative action could we take as we go forward?
2. How would you see our discussion impacting health care team?
3. What tools may be useful in this process?
4. How would you like to be involved in making change happen?
Appendix 5 – Reflective Questions for LPNs

I hope you have taken some time to reflect on your experiences since our focus group discussions. Now is your chance to add any further thoughts you have by answering the questions below.

1. Reflecting on the focus group discussion, how has it impacted you in your practice?

2. Do you have any further thoughts on action we should take going forward?

Now please read the attached summary. This summary is only a surface level summary analysis of the four focus groups. Some comments may not be reflected at this time. Please answer the following question following your review of the summary.

3. Does the summary capture the overarching themes of the discussion at the focus group you participated in? If no, please add your thoughts now:

Thanks again for your time and commitment to this research and our profession.