Identifying learning needs to enhance communication skills between doctors (MDs) and nurses (RNs) in long-term care facilities (LTCFs) to deliver safe care to residents

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ABSTRACT

Identifying learning needs to enhance communication skills between doctors (MDs) and nurses (RNs) in long-term care facilities (LTCFs) to deliver safe care to residents

Marilyn Richards-Douglas

The purpose of the study was to understand how nurses working in LTCFs perceive their communication with doctors in order to give safe care to residents and to identify learning needs to enhance communication skill between doctors and nurses. This qualitative study was based on narratives obtained through interviews with six nurse Team Leaders working in the same LTCF. The interdisciplinary team they lead includes nurses' aides, licenced practical nurses, the team leader, the head nurse and the doctor and they work with occupational therapists, social workers, ergo-therapists, pharmacists, kitchen aids and nutritionists. Other individuals present on the floor on a continual basis are the family members and companions of the residents. All six team leaders expressed their desire to continue to work in the role of Team Leader and helped better define the following areas of concerns and needs to improve communication in their setting especially with the doctors. The insights gained are discussed under the following titles:

A. Preparedness for Team Leadership in LTCs: Education and Practice as Team Leaders.

--Nursing Education
--Challenges encountered as Team Leader

--Autonomy in Nursing Practice

--The Need To Be Recognized

B. RN Perception/Narratives of Working Relationship with the MD
--Communicating with doctors in LTC
--Perceived Barriers to Effective Communication
--Developing the Skill of Communication
--Strategies for Collaborative Practice

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Key Terms

Centre Hospitalier Service Longe Durée [CHSLD]/ Long-term care facility [LTCF]: health care sites such as nursing homes that provide a home-like environment for residents who commonly receive care for the duration of their lives.

CHF: Congestive heart failure

Collaborative practice: "an inter-professional process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided" (Way, Jones, and Busing, 2000, p. 3 as cited in Donald, 2007).

Externship: a student nurse who has completed two years of nursing school and is permitted by the OIIQ to work with a nurse during the summer. The student is paid a salary but her scope of practice is limited and she has to work with the same nurse or two nurses for that period.

Intravenous [IV]: the infusion of liquids, fluids, nutrients, medication or blood products via a vein.

LPN: Licensed Practical Nurse

MD: Medical doctor

OIIQ: Ordre des infirmières et infirmiers du Quebec/Order of Nurses of Quebec.

PAB: Préposé aux bénéficiaires: Nursing assistant/orderly who provides basic hygiene care to patients.

PEG: Percutaneous endoscopic gastrostomy: used to provide feeding to a patient who is incapable of taking food or sufficient food orally.

RN: Registered nurse.

SBAR: Situation-Background-Assessment-Recommendation: A tool used to enable the nurse to communicate information about a resident's condition to the doctor by phone.

Team leader: An RN within a LTCF who is responsible for ensuring that all members of a unit provide appropriate care to residents. All RNs referred to in this proposal are team leaders whether novice or experienced.

Table of Contents

Chapter One - Introduction

In Quebec when nursing education was moved in the 1970s from hospitals to colleges and universities, nursing programs were created that included courses from a number of disciplines. Programs included courses such as biology, sociology, psychology, communication and practical skills. However, the communication skills taught in nursing school targeted communication between nurses and patient and family but not between doctors and interdisciplinary teams. Over time as rapid changes have taken place in the health care system in Canada, the scope of nursing practice has also changed (Stewart, 2007). It is expected that a nurse entering the profession is able to function autonomously, as well as able to work with members of an interdisciplinary team. Notwithstanding, Wade, (1999) and Brophy, (2000) believe that autonomy continues to be elusive to individual nurses and it seems to the entire nursing profession.

Some of the residents entering long term care facilities (LTCFs) are not only there to spend the rest of their lives but suffer from multiple complex illnesses. Stewart (2007) recalled that nursing school curricula focussed on practical training geared towards the patient and family. However, that focus has shifted more and more towards research and advanced medicine. Furthermore, a nurse entering the profession in an LTCF has to assume the leadership role without having acquired leadership skills. Added to the responsibility of managing the care unit the nurse has to be confident when communicating with the doctor in order to provide safe care

to the residents. Since communication with the doctor takes place for the most part through telephone conversations, this puts added stress on the nurse.

Upon entry to any health care facility the nurse gets an orientation period during which she is instructed regarding the policies and procedures of the institution and the specific unit. The probation period which follows the orientation is usually very stressful. For a novice nurse it may take about six months to a year to feel comfortable in her position. RNs working in LTCFs assume the role of team leader and are expected to function in that role whether novice or experienced. It goes without saying then, that when a novice nurse takes on such a practice in a LTCF, it could be extremely stressful. It is almost impossible to expect that novice nurses possess the level of autonomy and comfort needed to practice as a team leader in an LTCF. Nevertheless, it is expected of all nurses in LTCFs to practice autonomously and to be able to communicate with the interdisciplinary team, especially with the doctors, in order to provide safe care to the residents.

In addition to these challenges inherent to this position, MDs working in LTCFs prefer to work with experienced nurses from whom they could extract information which helps them in the decision making process. As a result, inexperienced RNs face the additional challenge of not being valued in decision-making. However, it is also more generally true that MDs do not like it to be known that the nurse may have had a role in the decision making process. The situation is very challenging for the nurse who has to work autonomously, with confidence and competence but at the same time be submissive and downplay her role. Stein (1967), in the well-known study of communication between doctors and nurses, reveals this fact that still holds true today which suggests that there is a place for education that helps all nurses communicate with doctors, and vice versa.

Background of the Problem

The idea to explore communication between Medical Doctors (MDs) and Registered Nurses (RNs) in long term care facilities (LTCFs) came from my own experience as a nursing student, nurse and, presently, nursing educator in a LTCF. As a nurse educator on the floor with RNs, I am witness to some of the stresses nurses experience when having to communicate with MDs. I reflected on my own stresses experienced as a student nurse when I was not encouraged to speak to the doctors in the clinical setting regarding the patients for whom I was responsible. Consequently when I started working in the acute care hospital, I felt stressed and intimidated when I had no choice but to do rounds and communicate with doctors regarding my patients' care. The argument that guides this study is that if students are encouraged to communicate with doctors in the clinical setting during stage, or if this was somehow included in the curriculum, integration would be much easier when the nurse is actually in the workforce and thus it would become easier to develop key competencies essential to nursing, such as asserting professional competence and self-confidence.

Since these skills are not really taught in nursing school, the nurse has to acquire and build on them as she works. I recognize this in the LTCF where I work. It is evident that the more experienced nurses, some of whom have worked in the acute care for many years, have built on those characteristics. Therefore, they experience a much easier time communicating with the doctors in LTCFs, as compared to novice nurses who are sometimes afraid to even communicate with the doctors. They may take an order without questioning the doctor even though they may not feel comfortable with the order.

Problem Statement

Safe and competent care of residents depend on efficient communication between doctors and nurses so as not to compromise the health of the residents. It is well documented that effective communication between doctors and nurses is essential when caring for the older adults because of their comorbidities, many diagnoses, susceptibility to poly-pharmacy and higher degree of functional and cognitive deficit (Burke et al., 2004, as cited in Kogan, Underwood, Desmond, Hayes & Lucien 2010).

For residents with cognitive deficits RNs are the advocates, the eyes and ears for those who cannot communicate effectively for themselves. Effective communication within the interdisciplinary team, especially between doctors and nurses, in such a case plays a very important role for safe care of those residents.

Miller (1977) stated "the explosion of knowledge and rapid social changes which resulted from increased urban/industrialization and technological expansion caused a re-evaluation and complete un-grading and even re-orientation of the education of doctors and nurses (p.3). In the same way, I feel that if nursing educators today gain knowledge about how former students are integrating into the workplace, especially in the role of team leaders in LTCFs, they might see the need to enhance the nursing curricula that will foster change. Hopefully the results of this study will illustrate the importance of such awareness.

Purpose of the Study

The aging population is living longer than ever before and with increasingly complex health care needs. In addition, in Montreal, there has been increasing demand within the health care system to move acutely ill elderly persons from acute settings to LTCFs (Program 68). By the time they move to a LTCF the hours of care and the quality of care to be delivered put special demands on health care providers. Nurses are expected to take care of residents who present with multiple illnesses, more than was expected before in a LTCF. Besides having to know about all of these comorbidities nurses must also know how to communicate effectively with the doctor as this is essential for safe delivery of care to residents.

Health care providers have to understand the link between care and communication. Clement (2010), believes that care as well as communication should be taught in medical and nursing schools. It is my own experience that patients rely heavily on doctors to make the right decisions about their health care needs. In LTCFs however, residents learn to trust and gain confidence in their RNs. It goes without saying then, that good communication must be established between the two professionals in order to achieve optimal care of the residents in LTCFs.

The health care system has changed considerably since I graduated from nursing school. As a nurse, nurse educator and student of Education, I wanted to know how nurses working in LTCFs deal with the added responsibility of communicating with the doctor concerning their residents' health condition in order to provide safe and best nursing care. I wanted to find out how nurses, in this context perceive their experiences, how they feel they could be better supported in this area of their nursing career and how as a nursing educator I could have an influence.

The reasons for undertaking this study are to learn how nurses and doctors communicate in LTCFs to provide safe care to residents; to identify areas where the nursing curriculum, on-the-job orientation programs or on-the-job training could be modified in order to support nurses in their practice in LTCFs and to build on existing theoretical knowledge.

In order to address the identified gap a qualitative study was conducted to: 1) examine the nurses' experiences from their own perspective; 2) identify facilitators and barriers to MD-RN collaborative practices through communication in LTCF, to enhance their relationship; 3) use this information to assist nursing, medical and institution policy makers in future decisions for improving curriculum.

Research Questions

The research questions that guided the study were:

1. What are the experiences of registered nurses (RNs) working with medical doctors (MDs) in long-term care facilities (LTCFs) in Montreal?
2. How do they perceive their working relationship with the MD?
3. How do they perceive communication with the MD in a LTCF?

Contribution to the Field

This research is important because there is presently a shortage of nurses in Montreal and over the next several years many experienced nurses will retire, leaving positions that will be filled by novice nurses, some of whom will be taking up practice in LTCFs. It is therefore imperative that nurses who have completed their studies feel comfortable in their positions and practice in LTCFs. This is particularly important in Montreal, which could be dealing with a

more serious shortage of nurses. Nurses who work in LTCFs in Montreal need to be autonomous, competent, confident, and possess good judgement skills so as to make the right decisions for their residents. Therefore, nurses need to be well-educated and ought to feel that they possess the level of autonomy that renders them capable of working in Long Term Care (LTC). These characteristics will enable them to serve in their position as team leader and gain the respect of others within their team especially the doctors with whom they work. Responsibility therefore, rests on nursing schools and their educators to produce nurses who are capable of showing good judgement and the ability to make well informed decisions. In so doing, the professional workplace, the citizens of Quebec and the entire population are well served.

Chapter Two - Literature Review

The aging population is living longer than ever before and with increasingly complex health care needs. By the time they move to a long-term care facility (LTCF) the hours of care and the quality of care to be delivered put special demands on health care providers. Moreover, the already overwhelming issues affecting nurses and the context in which they practice are becoming more and more complex. As of 2001, over 3.9 million Canadians were 65 years or older and this population is expected to grow to 6.7 million by 2021 (Health Canada & Interdepartmental Committee on Aging and Seniors' Issues, 2002). Therefore, the already-significant demands on LTCFs are expected to increase.

There has been increasing demand within the health care system to move acutely ill elderly persons from acute settings to LTCFs. This increase in the number of residents in LTCFs and the complexity of their needs, in combination with the limited availability of MDs to care for them, led the Ontario Ministry of Health to introduce Nurse Practitioners (NPs) to LTCFs. The establishing of this relationship serves as a partial solution to the challenge faced by delivering care to residents in LTCFs (Donald, 2007). According to Donald (2007), the effectiveness of the NPs' work relied a great deal on the successful collaborative relationships with doctors. This posed a challenge since the transition was new and the MDs were not always available. There is also the problem of hierarchy (i.e., that MDs do not always recognize the authority of NPs). However, in the wake of increasingly complex residents' needs, the increase in residents living in LTCFs and the limited availability of MDs in LTCFs, it is imperative that nurses and doctors communicate well with each other in order to provide efficient care to the elderly.

The accessibility of MDs to provide primary health care in LTCFs is limited because they have other obligations such as office practices, acute care coverage and hospital rounds. Also, in most long term care facilities nurses work on different units and come from diverse backgrounds with varying levels of experiences and education. This clash of differences as well as the lack of professional consistency detracts from the potential of building trusting relationships. In turn, communication is compromised.

While in Ontario NPs have been introduced into LTCFs to assist with the delivery of care to residents, they have not yet been given the mandate to practice in LTCFs in Montreal. While the voices of nurses are heard by their residents and by their communities, for a very long time they have been silent within academic discourse. Consequently, a greater understanding of MD-RN communication and relationships in LTCFs is needed. Effective communication between the two professions could reduce and even eliminate transfers to emergency rooms where elderly persons are liable to contract infectious diseases or develop other complications that would further compromise their health. Ideally, uncomplicated conditions should be treated within the long-term care setting rather than within the emergency room.

This literature review provides an insight into the issues of communication between nurses and doctors in LTCFs and shows a gap in the literature which proves that there is a need for education on how to enhance communication between doctors and nurses in LTCF. The first section briefly highlights some points in Quebec's nursing history which helps us to understand the origins of some of the problems faced by nurses today.

The second section examines competency in nursing with a focus on the transition from hospital based nursing education to college and university. This section highlights the importance of nurse educators to include in the curriculum theoretical as well as practical skills

competencies. The third section will discuss autonomy in nursing practice. The focus here is to stress the importance of nurse autonomy as a skill needed to be able to function efficiently in LTCFs and in the health care system as a whole. The fourth section of the literature review looks at communication between doctors and nurses as it occurs today and how it could be improved in the future. The literature suggests that there is limited research on this topic and less so on communication between doctors and nurses in LTCF. The fifth section explores the rationale for doing the study. It speaks to the fact that physicians and nurses have one common goal and that is to provide good patient care which depends on effective communication between the two professions in order to achieve this goal.

Brief History of Nursing in Canada and Quebec

According to Miller (1977), by the beginning of the twentieth century there was a huge expansion of establishing nursing schools which were primarily designed after the specifications of Florence Nightingale. Even though Jeanne Mance and Marguerite d'Youville were pioneers of the first hospitals—Hôpital Hôtel-Dieu and Notre Dame in Montreal—it was Florence Nightingale who was at the forefront of the global revolution in nursing. Florence Nightingale's revolution in nursing focused on making science, rather than compassion, the guiding force in nursing (Miller, 1977).

The Canadian Nurses' Association recognized the need for this change in nursing and concluded that the hospitals were not the appropriate institutions for the education of professional nurses (Miller, 1977). The program that eventually resulted from this ideology was guided by a nursing model which shapes the framework for the entire nursing program and contains a number of theoretical materials, nursing theories and communication skills. However,

the curriculum does not yet include courses or training for nurses on how to communicate specifically with doctors. The communication skills that nurses develop in nursing school are about how to communicate with the patient and family. While these are important skills, it could be said that there is need for deliberate instruction on how nurses are to communicate with doctors.

Competency in Nursing

As part of the shift from training in hospitals to education in college and universities, nursing education has moved to a competency-based curriculum which has resulted in the clinical skills aspect of nursing becoming less of a priority. A focus on general competencies has resulted in nursing's failure to define nursing practice. While general competencies are often used to assess students, it is in the best interest of the nursing students and would be more beneficial to them if they attained competency in specific skills (Pijl-Zieber, Barton, Konkin, Awosoga, Cane 2014). According to Pijl-Zieger et al., (2014) specific distinction should be made between nurses gaining certain general educational qualities and being proficient in particular nursing skills. This kind of education will benefit nurses as well as their patients as patients place high value on nursing skills. However, nurses must be able to incorporate their knowledge with skills and feel comfortable with themselves and the skills they must perform.

In her study on stress, anxiety and coping in nursing students doing clinical practice, Mlek (2011) talked about her own stressful experiences during clinical days which she said resulted from her feelings of perceived incompetency. She did not want to be in any situation where she would be perceived as incompetent. Consequently, she called in sick on certain days.

According to Pijl-Zieber et al., (2014), the areas in nursing education that present the most significant problems are the "measurement and assessment of clinical competence", (p. 677). It is difficult to measure clinical competence because it is often influenced by a number of personal factors, such as student self-efficacy and confidence (Pijl-Zieber et al., 2014). Recognition of the complexities of the entry level competencies in nursing have forced most of the licensing bodies in North America to make the requirement at entry level into nursing to be an undergraduate degree. In 2009, the provincial regulatory bodies of Québec set up an integrated program between the province's universities and CEGEPS. This program, called the DEC-BAC program, allows the college nurse to go directly into university after college to a shorter undergraduate program to obtain a baccalaureate degree in nursing (www.oiiq.org). At the baccalaureate level, nursing educators may be placing their efforts more on having students develop general competencies in critical thinking and problem solving and less on specialized clinical knowledge and skills (Pijl-Zieber et al., 2014).

Nurses need to be critical thinkers and problem solvers, thus education in critical thinking, self-reflective practices and self-directed learning is essential for their preparation in meeting the future challenges in healthcare, in the twenty-first century (Martyn, Terwijn, Kek, Huijser, 2014). Nurses must keep up to date with self-reflective practices. There is also an increasing focus on evidence-based practice which means that nurses are to be involved in research activities that will show relationships between clinical outcomes and evidence-based practice (McCurry & Cullen, 2010 as cited in Martyn et al., 2014). According to the authors, a nurse gains understanding of a patient's problem by being involved with the patient and the problem, doing self-reflection to discern any knowledge deficit and by doing research to emphasize the clinical decisions outcome of patient care (Martyn et al., 2014).

Over the past one-hundred-and-fifty years, nursing and nursing care have evolved greatly. However, some principles and tasks remain the same or similar to the traditional role of nursing. Presently, nursing educators seem to be confined to the traditional curriculum of nursing as they try to deal with the political, social and economic realities that accompany the transformation of the healthcare system. Nevertheless, in the midst of this transition, nursing educators and nurses must work and prepare for the changes happening in society and in the transforming health care system (Ross, Fotheringham, & Crusoe 2014). Although Florence Nightingale stressed the importance of sobriety and hygiene, caring and interpersonal relationships were also introduced by her. Nightingale made sure to outline and reinforce the relationship between doctors and nurses, which was one of subordination. Nurses must be there to carry out the doctors' orders (Ross et al., 2014). And even now this adage unfortunately remains accepted by many within the profession.

According to Ross et al. (2014), in view of the evolution of the nursing profession and the changing face of the health care system to a more complex one, nursing curricula need to be re-evaluated. It seems that nursing educators are hesitant about modifying the curriculum for fear of moving away from the tradition which, in nursing, has been rooted for so long (Ross et al., 2014). Still, this re-evaluation is happening within the nursing hierarchy. As the roles of nurses are being evaluated according to their educational statuses, there is a turning over and delegation of nursing roles and functions to the group below. For example, as the nurse practitioner takes on some responsibilities from doctors, nurses are also taking on roles that once were performed by NPs. Likewise, Licensed Practical Nurses (LPNs) are assuming some of the roles of the nurses and so on down the hierarchy.

This shift in roles is forcing nursing education to place more emphasis on preparing

nurses to work in collaboration with inter-professional teams. Nurses educated at all levels will have to learn how to work with and adapt to their shifting roles in increasingly complex health situations. In these situations, properly-educated nurses should ideally know how to organize, prioritize and make decisions when faced with any uncertainty. Furthermore, nurses form relationships with people who would support their decisions such as physicians, patients, residents, their families and members of the inter-professional team (Ross et al., 2014). In LTCFs the nurse is viewed by the resident and family as the one with the competence to make the right decisions concerning their health.

Carr (2003) states, "We are living in an age where healthcare is dominated by advancements in technology-an age in which healthcare is increasing in its complexity and diversity. However, as the nature of illness becomes more clinically complex, the need for clinical oversight and the delivery of patient care will become more complex as well."(p. 224). Hospital based nursing schools were concerned with producing competent bedside nurses and even though this is still the case to some degree in college nursing school, it is questionable whether this is happening with university education nurses. Educators at the university level may be placing their efforts more on having nurses develop general competencies in critical thinking and problem solving and less on specialized nursing knowledge and skills. However, the curriculum should be developed to accommodate both for the future of competent nursing practices. As is the case already, nurses are faced with focusing their work more on community based nursing in an effort to promote health, prevent diseases and avoid unnecessary hospital admissions (Ross et al., 2014).

Autonomy in Nursing Practice

A simplistic definition of *autonomy* is freedom to act on what you know. Therefore, nurses must have confidence in their knowledge and be cognizant of the boundaries dictated by the scope of practice. Nurses need to be problem solvers, always thinking critically to make the right decision or good judgement call. In order to do so it is imperative that nursing students receive the most up-to-date training in nursing best practices and keep themselves updated on all the latest technological advances in nursing that would enhance their knowledge and enable them to do this. For this reason nurses should take responsibility for their professional development by further educating themselves in areas where there is a lack of education. Critical thinking is particularly important in allowing nurses to meet future challenges in healthcare and to be problem solvers in their profession.

In 2007 Stewart looked at novice nurses' perspectives' and concluded that students needed to learn how to "develop into autonomous individuals able to function as respected members of an increasingly well-educated interdisciplinary health care team" (p.3). Adamson, Kenny and Wilson-Barnett (1995), report that nurses are aware of their subordination to the medical profession. Their review of the sociological literature attests to the medical dominance "as a structural feature of the health division of labor" (p. 173). This is evident by nurses' lack of autonomy in decision making regarding patient care, the continued dominance of doctors in most work places, the incongruities in the way nurses are taught and the way they must practice. Even today, these observations are still being made. We see the continued authority of physicians in most work places and the lack of nurses' control over their work. Also evident are the lack of nurses and the lack of resources that nurses must work with. When nurses are forced to work

under such conditions they become disempowered followed by a sense of lack of autonomy. However, the profession has been striving towards full professional status of which professional nurse autonomy is an essential attribute (Wade, 1999).

Professional Nurse Autonomy

Providing a concept analysis Wade (1999) defines *professional nurse autonomy* "as belief in the centrality of the client when making responsible discretionary decisions, both independently and interdependently, that reflect advocacy for the client" (p. 310). The author believes that professional autonomy should be learnt in nursing school and should be part of the nursing curriculum. In support of the development of nursing autonomy the curriculum must emphasize a good knowledge base, understanding and clinical decision making.

The practice of autonomy should be part of the nursing educational curriculum. Students should be encouraged by their teachers to practice with autonomy in the clinical setting. This practice would boost their level of competency and confidence. The priority in nursing education should be to produce nurses with the utmost level of autonomy so that they are able to cope with the ever changing complexities of the healthcare system. The concept of professional nurse autonomy is introduced at the baccalaureate level (Wade, 1999). However, if nursing is to attain its full professional status, nursing educators must rethink the curriculum to include the concept of autonomy at all levels of nursing education. To this end it was stipulated by the order of nurses of Quebec, in the *Outlook* (2010), the following specifics:

> Nursing practice aims to enable people (person, family, group or community) to take charge of their health, according to their capacities and to the resources available in their environment, regardless of their stage of life and regardless of the phase of their illness. Nursing practice also has the purpose of enabling persons to ensure their own well-being and to maintain a good quality of life (p.11)

The OIIQ standard went on to specify the seven categories of statements that describe the various aspects from which the practice of nursing can be considered:

- Nurse-client partnership
- Health promotion
- Prevention of illness, accidents, social problems and suicide
- Therapeutic process
- Functional rehabilitation
- Quality of life
- Professional commitment (p. 11)

In October 2015 The Code de Déontologie of the OIIQ regarding nursing practice states in the Code of Ethics,

> The duties and obligations are based on the values of the nursing profession: integrity, humanity, respect for the individual, professional autonomy and competence, excellence of care, professional collaboration. It is a guide for nurses, especially in relations with patients and their decision-making in everyday life (www.oiiq.org)

Stewart (2007) predicted that as technological and medical advances take place nurses will have to adapt to the role of helping people understand their diagnoses as well as their required treatment and even helping them with navigating the health care system. She also predicted that advanced practice nurses will in the future run certain clinics like diabetic and coronary clinics and be able to prescribe certain treatments. In October 2015 Lucie Tremblay, the president of the OIIQ, announced that in collaboration with the nursing and medical associations the decision was made for nurses to be able to prescribe certain treatments. This will start in January of 2016. This is a huge accomplishment in nursing practice in Quebec, and although the prescription does not include all types of medication, the expectation is that nursing autonomy will continue to such proportions. The president said,

> Our memory will remain forever marked by the acquisition of the right to prescribe for des infirmières et infirmiers du Québec. An important step has been taken in nursing practice and it is a major gain for the whole of the Quebec population that will benefit from January 2016, a net improvement in access to health care..... It is therefore the result of a consultation with many clinical experts....that right to prescribe hinges in the exercise of the profession and for the recognition of nursing leadership. In fact, the nurse prescription in certain clinical situations will allow us to go further in our interventions for the benefit of patients. We therefore acquired greater professional autonomy which will only intensify in the coming years. With this professional autonomy, Quebec will ensure better access to care for its population. This autonomy is also our workhorse for years……The right to prescribe for nurses is an effective solution that focuses on nursing skills. (www.infoiiq.org, October, 2015)

The above statement is one of the major reasons why nurses working in LTCFs ought to feel that they are capable of working autonomously in order to gain the confidence of other team members especially the doctors with whom they work. It is also why doctors and nurses must communicate effectively for the safe care of the residents in LTCFs.

Communication between MDs and RNs in LTCFs

A review of the literature reveals that there is limited available research on communication among MDs and RNs in LTCFs. According to O'Daniel and Rosenstein (2008), effective teams are characterized by trust, respect, and collaboration and an interdisciplinary approach should be applied when considering a teamwork model in health care. This means that all members of a team work together to achieve the same results. Therefore, doctors and nurses interact and share knowledge and skills of both professionals that would influence the care that they give to residents. However, as members of the team work autonomously, they sometimes may jeopardize team collaboration, especially when culture differences exist among the team. This can occur in cases where the nurse is from a culture where she/he refrains from being assertive or challenging doctors' orders. As well, in many healthcare environments hierarchy differences exist with the doctors at the highest level.

When these differences exist they may diminish the collaborative interaction needed between doctors and nurses to deliver safe care to patients or residents. Being on the lower end of the hierarchy, some nurses may feel uncomfortable speaking up about problems or concerns. "Intimidating behavior by individuals at the top of a hierarchy can hinder communication and give the impression that the individual is unapproachable" (O'Daniel & Rosenstein, 2008 p. 4). Patient safety may be at risk for several reasons when health care professionals are not

communicating efficiently. Some of the reasons may be: insufficient critical information about a patient's condition, misinterpretation of information or unclear orders over the telephone. All of these reasons may lead to medical errors causing severe injury or even death.

Stein (1967) published the first paper that researched collaboration between MDs and nurses. He described the relationship between the two professions as a kind of power struggle with the groups communicating in a sort of indirect way, manipulating each other to get whatever they wanted to accomplish. According to Stein (1967) the relationship between the doctor and the nurse is very special and they share mutual respect for each other's profession. However, their attitude towards each other presents a huge stumbling block that prevents meaningful communication between doctors and nurses.

As recognized by Stein (1967), doctors rely heavily on nurses' suggestions to complete their decision-making for their patients. The nurse must be bold, show initiative and be competent when making suggestions. Unfortunately, the unspoken rule is that the nurse should not appear as if she has anything to do with the decision making in order to protect the relationship between doctor and nurse. Even though doctors valued nurses' comments and suggestions it was not made known to the nurse.

There have been few studies done on collaboration or communication between MDs and RNs in LTCFs and very limited literature with a focus on how MDs and RNs collaborate in LTCFs or factors associated with the collaborative relationship. However, studies have shown that when nurses are able to communicate with doctors there is the feeling of satisfaction but when there is conflict, there is major stress, as nurses perceive doctors as mainly giving orders

(Donald, 2007). As well, interventions that foster nurse-physician collaboration improve the satisfaction of doctors, nurses, and patients.

For this reason, understanding the significance of good teamwork between nursing and medical staff is important for improving patient safety, avoiding medical errors and ensuring patient outcomes and staff well-being. When health care professionals are not communicating effectively patient safety is at risk in several ways. For instance, lack of critical information, misinterpretation of information, unclear orders over the telephone and overlooked changes in a patient's status could lead to unsafe practice and medication errors (O'Daniel & Rosenstein, 2008). Therefore, team collaboration is essential for safe care of patients.

Rationale for Improving Physician-Nurse Communication

It is well documented that physicians and nurses have one common goal and that is to provide good patient care, which depends on effective communication between the two professions in order to achieve this goal (Kogan et al., 2010). Furthermore, effective communication between doctors and nurses is essential when caring for the older adults because of their comorbidities, many diagnoses, susceptibility to poly-pharmacy and higher degree of functional and cognitive deficit (Burke et al., 2004, as cited in Kogan et al., 2010). During the transition period from one institution to another the care of older adults could be compromised and consequently their health could deteriorate. Therefore critical information about their health condition, medications and plan of care must be discussed between doctors and nurses (Kogan et al., 2010). Hence the emphasis is on effective communication between all health care providers, doctors and nurses, resident and their family in order to provide high quality care that is

"responsive to resident's needs, values, preferences and informed decisions" (Winn et al., 2004, p.129).

Although life expectancy has increased, the majority of residents in LTCFs are especially frail (Winn, Cook & Bonnel, 2004). It is therefore imperative for nurses and doctors to work together to develop a palliative model of care for residents in LTCFs since these residents will remain in the LTCFs for the rest of their lives. Furthermore, enhanced communication between doctors and nurses can reduce or eliminate emergency department visits by providing appropriate, timely, and consistent medical intervention. When providing care to the elderly, physicians have to be culturally sensitive and accommodating to the values and preferences of residents and their families. Consequently, the physicians will rely heavily on the partnership collaboration of nursing faculty to accomplish this task (Winn, et al., 2004)

Collaborative practice in health care is essential for efficient delivery of care. As argued by MacDonald, Stodel and Chambers (2008), there is a critical need for education opportunities that support the development of collaborative practice skills among health care workers. And good team work is considered a prerequisite for enhanced communication among health care professionals and caregivers. Furthermore, all health care providers working collaboratively together could improve quality of health care and also decrease cost expenditures. As stated by the authors, "Moving towards a collaborative model of healthcare service delivery requires that healthcare providers are trained in this way" (p.21).

If we must move forward to a collaborative model of health care, it means that the health care provider must be trained in collaborative practices. Good team work with professionals who have good team spirit that encourages good communication, is essential. When health care

professionals work together in a team with good team spirit, communication among member of the team is enhanced and the outcome is improved health care and cost savings and patient care (MacDonald et al., 2008**).**

Multidisciplinary team (MDT) training is important for overcoming barriers to effective nurse–doctor collaboration and effective communication and team work is essential for the delivery of high quality, safe patient care. (Leonard, Graham & Bonacum, 2004). The two professionals must realize that team work is the key to effective communication and the differences between the two professional identities will allow them to shape their beliefs and attitude about teamwork. If each professional recognizes and respects the difference in the role others play this will allow for equal amount of respect for each other`s role and for each other. To achieve positive client outcomes in a complex health care system, professionals must be engaged in a collective enterprise.

A combination of MD-RN behaviors could lead to ineffective communication in LTC, which could have significant implications for patient safety. As well, safe patient management depends on clear and concise communication between health care providers. When health care professionals are not communicating effectively patient safety is at risk in several ways. Therefore, team collaboration is essential for safe care of patients. For instance, lack of critical information, misinterpretation of information, unclear orders over the telephone and overlooked changes in a patient's status could lead to unsafe practice and medication errors (O' Daniel & Rosenstein, 2008). Furthermore, this is crucial for understanding MD-RN relationship and how they communicate so that constructive communication interventions could be developed to improve the quality of nurse-physician communication (Tjia, Mazor, Field, Meterko, Spenard, & Gurwitz, 2010).

The literature review supports findings that communication between doctors and nurses could have important implications for patient safety (Tjia et al., 2010). The authors confer that telephone communication occurs more often in LTC than in other clinical settings and most of the calls take place after hours and during the weekend. This is because there are no doctors on site and the covering doctors must take the calls. Yet, this type of communication has not been researched enough. It must be noted that most of the time the covering doctors do not know the resident for whom they are answering the calls. It is therefore imperative that the nurse presenting the resident by phone gives a clear and concise picture of the resident's condition he or she is calling about.

Tjia et al. (2010) state that nurses reported that sometimes it the physician seemed not to want to address the problems by telephone calls especially when these were not from the floor with which they are familiar. They would prefer to have the problem addressed by the attending physician for that specific floor. However, when the nurse puts a call to the doctor it means that the problem is more of an emergent one and cannot wait for the attending doctor's next visit. It is also understandable that the doctor has to work harder at making an informed decision when the resident in question is someone he or she is not familiar with and the nurse on the phone is one he or she has never worked with. In these situations, it is as distressing for the doctor as it is for the nurse.

The table on the following page was used by Tjia et al. (2010) in their study on "*Nurse-Physician Communication in Long-Term Care Setting: Perceived Barriers and Impact on Patient Safety*". They used this table as a model for providing a framework when "considering breakdown in communication of information to physician" (p.6).

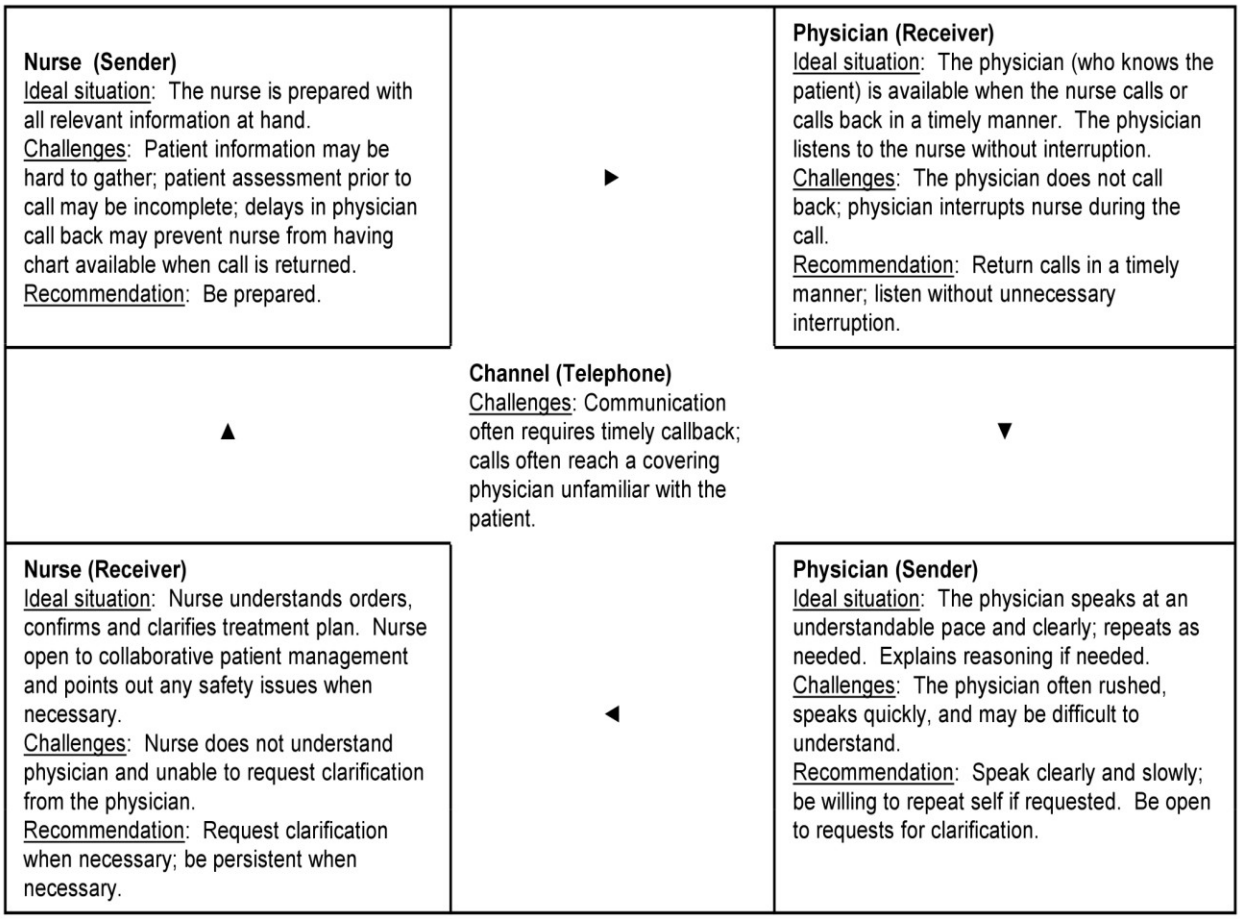

Figure 1. *Communication-Health Information Processing (C-HIP) Model of Nurse-Physician Telephone Communication in the Long-Term Care Setting*

According to Tjia et al., (2010) using this model allows for revelation of possible reasons for failure of the communication process and also for identification of possible solutions. Telephone conversation is the channel of communication used in the table but this could apply to face to face communication as well. The nurse (sender) is the one speaking to the doctor whether it is on the phone or in person and the doctor is the one receiving the call whether by phone or in person. In the model the *receiver* (i.e., the one processing information), may process information through four stages: attention, comprehension, attitudes/ beliefs and motivation. The authors explain that the stages are all inter-related and feedback circles around in every stage. To further explain: the receiver's perception of the sender may be transmitted during the conversation

which may affect the sender's attention and motivation. In turn this may affect the receiver's ability to listen effectively. Also, the receiver's attitude may affect attention and therefore his ability to listen. It is worth noting then, that effective communication between the doctor and nurse is a "two way street" (Tjia et al., 2010, p.7). Nevertheless, nurses in their study have said that doctors do not reply in a timely manner, appear rude and condescending when speaking and only recognize the nurses role when the nurse is firm and shows competency.

It is believed that effective communication between MDs and RNs could sometimes prevent unnecessary transfers from LTCFs to emergency rooms. And although it is sometimes necessary to transfer a resident to hospital for safe and high quality care of some acute condition, this brief period of hospitalization can result in iatrogenic complications, morbidity and extra healthcare expenditures (Ouslander, et. al., 2011). According to a recent study reported in the Canadian Medical Association Journal, the risk of acute infections, mostly respiratory and gastrointestinal viruses following a trip to the Emergency Room (ER) is almost three times higher among the elderly from a LTCF (Quach, et. al., 2012).

In addressing potential reforms to the health care system in the United States, Clement (2010) refers to the importance of understanding what specifically can be reformed or altered in order to change the way health care is understood and administered. Presently in Québec, health care is also under reform with the merging of many health care institutions, as a strategy by the government to decrease healthcare costs. In so doing extreme pressure is placed on health care workers especially nurses who have to work with less staff and at the same time are expected to deliver the same kind of exceptional care to patients.

Clement (2010) believes that it is important to analyze the way health care providers recognize both care and communication. The author indicates that medical education curricula

might be changed in the future to better equip future doctors with communication skills that will result in the delivery of quality health care to patient. This statement refers to communication between doctors and patients. In the same way it should be expected that nursing and medical curricula be changed in the future to accommodate communication between doctors and nurses in general in all aspects of health care management. In so doing, communication skills would enhance the relationship between the two professionals in order to deliver safe care to residents in LTCFs.

Summary

According to Stewart (2007), the role of the nurse is changing to meet the needs of an increasingly complex health care system. The responsibility lies in the hands of the nurse educators to facilitate this transition toward adjusting to the new demands of the patients within Canada's LCTFs. Ross, Fotheringham and Crusoe (2014) feel that,

> the revaluation of nursing will be achieved through radical qualitative change in our education of nurses. Conceptualizing the nurse as one that can be valued through judgment in decision making, building trusting relationships, and confidence in self and conferred by others, may be a new focus for curricular re-visioning (p. 689).

Chapter Three – Design and Method

Method

The literature review presented in chapter two suggests that there is a gap in the area of education of doctors and nurses in relation to communication between the two professions in general and especially in LTCFs. I have also been cognizant of this in my own practice. In order to address this gap, I conducted a qualitative research study to understand the experiences of RNs in their efforts to communicate relevant information to MDs regarding care of their residents in LTCFs.

I proposed a qualitative design for this research because the purpose was to better understand the experiences of RNs working with MDs in LTCFs. The study employed a narrative -descriptive approach because I needed to develop an understanding of the RNs' behaviors, experiences and relationships with MDs from which I could then recognize how they understand and make sense of their experiences and relationship (Bogdan & Biklen, 2007). I wanted to understand nurses` perceptions of RN-MD communication in long-term care settings, the ways they perceive their working relationship with the MDs and to understand how they communicate in order to provide safe care to the residents. The main goal of the study was to understand the experiences and the perceptions of the RNs from their own perspective, in a specified setting, through their own narratives. Furthermore, I was hoping that the nurses would offer strategies that can be used to improve MD-RN communication to overcome barriers to effective communication thereby advancing patient safety in LTCFs

Research questions were formulated to investigate topics or issues in all their complexity, and the researcher was concerned with understanding behaviors from the participants' own frame of reference (Bogdan & Biklen, 2007). Therefore, I used interviews to collect narratives about the experiences of RNs communication and building relationship with MDs in LTCFs. This approach to data collection contributed to rich data which provided insight to the world of the RNs working as team leaders in LTCFs.

The following section outlines my design for this research study including: setting, ethical approval, population description, sampling technique, data collection and analysis, and validity.

Setting

There are several LTCFs in Montreal but because of the exploratory nature of the study, interviews were conducted with RNs from one particular LTCF. This is a large accredited LTCF with 320 residents who come from a diversity of ethnic and cultural backgrounds. The employees are also from different cultures and ethnic backgrounds. The interviews were carried out in a place agreed upon by the participants and special care was taken to protect their identity. For instance, all participants were given pseudonyms. The participants all agreed to have the interview conducted in a quiet room at the LTCF (my office), secluded from interruptions and where their presence would be considered business as usual and not identified as research or data collection.

Ethics Approval

Before commencing the study I presented my research proposal to Concordia's University Human Research Ethics Committee (UHREC). After permission was granted by the Ethics committee of the University of Concordia, I presented my research proposal to the Human Research Ethics Committee of the LTCF and gained approval.

Population

Due to the small sample size, purposeful sampling was used to select the participants. The sample consisted of six RNs from the same LTCF in Montreal, whom I met individually to explain the purpose of the study and the method to be used for data collection. The participants were three RNs who have been working in the LTCF for less than four years and three RNs who have been working in the LTCF for more than ten years.

Sampling Process

The process of identifying and selecting participants consisted of the following steps:

- I delivered a letter of invitation to ten RNs outlining the purpose of the study and provided a description of the process (Appendix A).
- A Consent Form was given to the selected participants, which was read, signed and returned to the researcher in order for the participant to take part in the study (Appendix B).
- A Consent form for contacting the research participants was also given to the participants which was signed and returned to the researcher (Appendix C).

- The letter included a form to collect demographic data relevant to the sample (Appendix D).
- I addressed and intended to give out eighteen letters of invitation but from the first ten that I delivered all of the RNs were willing and showed interest in participating in the study. I therefore did not proceed with delivering the remaining eight invitation letters but decided to select the final six participants based on the criteria determined for the sample.

Data Collection Method

The method used for collecting data for this study was a semi-structured one on one interview approach initiated by open-ended questions that allowed for full expression of self and participation which could invoke questions not thought of by the researcher. The interviews were about one hour long and were conducted in such a way as to allow for self-reflection and verbalization of perceptions based on personal experience and practice.

Each of the research questions was assigned four or five sub-questions in case further probing became necessary after the open ended initial question did not generate enough information to answer the research questions. Participants were encouraged to discuss how they feel about practicing nursing in a LTCF to launch the interview. Interview questions were tested as a pilot project with one of my colleagues who was not a participant in the study and data collected from the pilot study were not included in the research findings. The reason for doing the pilot study was to ensure that the questions were relevant to the study, that they were appropriate, and easily understood (van Teijlingen & Hundley, 2001). I was aware that during the research process some of the pre-prepared sub questions might have to be resorted to collect the necessary information to answer the three research questions of the study. During the

interviews the sub-questions used were based on the free narrative provided by the participants. Some participants covered the questions in their narrative and there was no need to resort to the sub-questions. Others did not go into enough detail and the sub-questions elicited further and deeper narratives.

According to Glesne (2011), the researcher has to be the learner and has to approach the study as one who has little or no education as to what is going on in the field. The researcher's approach would be as one gaining information and education from the participants. As the interviews take place the plans will evolve. Questions may have to be rephrased as insights develop and strategies change. Bogdan and Biklen (2007) believe that there is no precise research design. They feel that the structure of the research is developed as the research takes place and not before.

Data collection entailed note taking and audio taping, as was permitted by the participants. Time allotted for the interview was anywhere between 45 minutes to an hour for each participant.

I kept reflective field notes after each interview and transcribed the interviews myself. I obtained permission from the interviewees to contact them by e-mail or phone after the analysis of the data was completed (Appendix C), in order for each participant to review my data transcription.

All data collected are kept locked away in a safe place in my home and also stored in computer files with password protection. Five years after the study is completed and the thesis has been presented all data will be destroyed. All participants were informed that the results of the study will be available at the Concordia University Library through Spectrum, after the thesis is completed.

Data Analysis

To analyse the data I used the transcripts of the interviews and my reflective field notes. I did the analysis on an ongoing basis during data collection so as to provide myself with guidance for the subsequent interviews. This ongoing analysis, in the form of an emergent coding scheme, became more exhaustive as I continued my study. Consequently, it was more beneficial for me to do ongoing analysis instead of leaving all for the end of data collection (Bogdan & Biklen, 2007). Common themes that developed during data analysis included: (1) the importance of team leaders to be well trained and prepared to work in LTC. (2) developing and using communication as a skill (3) the need to be recognized as professionals (4) the desire to practice with more autonomy (5) Eliminating barriers to effective collaborative practice

Research Credibility

The debate is on, regarding how researchers must strive to ensure rigour when conducting research. Rolfe (2006) contends that applying rigorous strategies and procedures do not guarantee quality of research. The author asserts that the quality of a research study is not only revealed in the finished product but in the ability of the reader to gain insight, fair and wise judgement. However, Morse, Barrett, Mayan, Olson and Spiers (2002), argue that researchers must integrate strategies to verify their work throughout the research process, especially during the inquiry, and not wait for the finished product to be evaluated by the consumer. According to the authors, the researcher must employ certain strategies such as methodological coherence to ensure that the research question matches the method which in turn matches the data and the process of analysis. Morse et al. (2002) continue to say that the sample must be appropriate, meaning that the participants have knowledge of the research topic.

In light of this uncertainty, I employed certain criteria to address issues of rigour in this study. For instance, prior to conducting the interviews I did triangulation, through literature review, to look at related issues on communication between MDs and RNs in LTCFs and searched for any relevant education resources in the literature review on the topic. I tested the research questions by interviewing another experienced colleague to test the relevance of the questions to the research topic. I validated the findings with the participants since they are arguably the only ones to really judge the credibility of the results (Beck, 2009). To do so, I met with the participants to go over the findings to see if they agree with the conclusions I drew from their contributions. The data and conclusion were further read for comments by one of my colleagues who has experience and expertise related to the research questions of this thesis (Merriam, 2009).

Role of the Researcher

I am a nursing educator at a LTCF. I have a great interest in the topic because of my own experiences as nursing student, nurse and nursing educator. Therefore, my qualifications and experiences enhance confidence in the findings. The purpose of the research is to understand the phenomenon of interest from the perspective of the participants, and how as a nurse educator I could have an influence.

I graduated from a CEGEP nursing program in Montreal in 1996. I have worked in the same general hospital for 18 years, as a nurse and assistant nurse manager, while also working as nursing coordinator in other institutions on a part time basis. For the past six years I have been working as a full time Clinical Nurse Educator/Consultant in a LTCF, concurrently continuing as a nurse, part time, at the same general hospital on the Cardiac Care Unit (CCU). Working with

nurses in LTC gives me the opportunity to bring a unique perspective to this research, whereas someone who possesses no experience with that culture would not have the same type of understanding of the settings in which the participants work. I also know about the different cultures existing within the institution among nursing staff and also among residents. I know the working conditions and the problems that exist in the system.

As a nurse educator spending time on the unit with RNs, I am a first-hand observer to how some RNs, especially novice RNs struggle with communicating information relating to their residents' health status to the MDs. The RNs come from different background with different levels of education. The more experienced nurses are better able to cope with the stress of dealing with the MDs and seem to be more respected by them. For nurses who have had experience in acute care and then move to LTC, the transition is much easier than for nurses who go to LTCFs right after graduating from nursing school.

The healthcare system has changed considerably from the time I entered the profession. Patients in hospital and LTCFs suffer from a variety of illnesses, the cases are more complex and nurses are expected to give the same quality of care even though there is a shortage of nurses. During the data collection phase of the study, my role was that of an active listener. Some researchers see their participants as co-constructors of the knowledge generated and may encourage the participants in collaborative relationships (Hatch, 2002).

At the same time I was aware of 'backyard research' as described by Glesne (2011). To avoid all biases I paid attention to difficulties I could encounter with playing the role of researcher instead of educator or colleague. I remembered summing up an answer for one of the participants and when she said "exactly" I realized that I had somewhat left the role of researcher

and had to quickly resume that role. I avoided using leading questions during the interview. In the letter of invitation to the participants I clearly stated my role to avoid confusion (Appendix A).

Timeline of the Study

The preparation for the study started in the spring of 2015. The research proposal was submitted for approval to the MA Committee of the Educational Studies Program of the Department of Education at Concordia University and Concordia University's Human Research Ethics Committee (UHREC), in the summer of 2015. Once the approval was obtained, the proposal was submitted to the Human Research Ethics Committee of the LTCF. After approval was obtained, participant selection took place in early fall of 2015. A pilot study was done in September 2015 followed by the actual interviews that took place in late fall of 2015. Transcription of the data took place between November and December 2015, followed by data analysis of the findings in January and February 2016. Member checking/peer review took place in March 2016.

Summary

This section has described the methodology of the study. The goal was to understand the experiences and perceptions of RNs collaborating with and communicating with MDs in LTCFs from their own perspectives. Participants were recruited from a single bilingual LTCF in Montreal, Quebec, where there are nurses, doctors and residents, from a variety of ethnic, socio-economic background and cultures and the main languages used are French and English. I interviewed six nurses who articulated the use of good reflective nursing practice. The nurses

were among those who use best nursing practices along with evidence-based practice. Among the participants were experienced and novice nurses. The interviews were conducted in English. All interviews were audio-taped and transcribed verbatim by me. The data were then examined for common themes. As explained in the Data Analysis section, I followed the strategy of doing on-going analysis after each interview. Therefore, although the transcribed narratives were free flowing in nature and not structured by fixed questions, common themes emerged as I analyzed data collected from each participant on an on-going basis. Common themes that became apparent in this process were: a) Nursing Education-Preparedness for LTC, b) Communicating with doctors in LTC, c) Experience as Team Leader, d) Autonomy in nursing practice in LTC, e) RNs Perception of Working Relationship with the MD, f) Perceived barriers to communication, g) Educational strategies. These themes will be discussed in the next Chapter. Therefore, Chapter Four presents the narrative of each participant organized around these themes, although they each approached these points in a different order in their free flowing narratives.

Chapter Four - Presentation of Findings

By actively listening to the responses of the participants and how they addressed the research questions one can understand their perceptions of the phenomenon. Merriam (2009) states, “The most common form of interview is the person-to-person encounter in which one person elicits information from another” (pp. 88-89). She went on to say that the main purpose of an interview is to obtain a special kind of information that is necessary when we cannot obtain information which involves feelings, thoughts and peoples’ interpretation of their experiences. Therefore active listening is an important criterion and on-going analysis of data was helpful in identifying themes.

The names of all participants have been modified. Three of the nurses/team leaders are experienced and have been working in the same LTCF for more than 10 years. The other three are novice nurses and have been working in the same LTCF for less than four years. Common themes, as identified in the on-going analysis process with the completion of each interview and as summarized at the end of Chapter Three, will be used to present the profile of each participant although the narratives did not follow this structure but were rather free-flowing.

Data Presentation

The purpose of the thesis is to understand how nurses working in LTCFs as team leaders, narrate communication between doctors and themselves in order to provide safe care to the residents. Data was collected through one hour long interviews, using semi-structured open-ended research questions. The results will be presented in this chapter. To keep the readers engaged and to capture their interest, a detailed presentation of the interviews is given with

comments from the author who tried to make meaning of their stories. The research questions that guided the study were:

1. What are the experiences of registered nurses (RNs) working with medical doctors (MDs) in long-term care facilities (LTCFs) in Montreal?
2. How do they perceive and narrate their working relationship with the MD?
3. How do they perceive communication with the MD in a LTCF?

The study illustrates RNs' lived experience and perception of communication with MDs, their working relationship with the MDs, mutual understanding and respect, language comprehension, frustration, nurse preparedness and barriers to communication.

The table below illustrates the participants' name, level of education, number of working years and number of years working in LTC and as team leader.

Name of Participants	Highest level of Education	Number of years of working experience	Number of years working in LTC	Number of years working as Team Leader in LTC
Kimberley	College Diploma BScN in progress	3	2	2
Joanne	College Diploma	22	21	21
Dominique	College Diploma	37	26	24
Thanga	College Diploma	12	12	1
Jayson	College Diploma	3	2	2
Anne	College Diploma	19	17	17

Table 1. *Participants' Education, Number of years of working experiences, number of years of Experience in LTC and years of experience as team lead.*

Kimberly

Kimberly is a 25 year old nurse who has been working in LTC for two years. She has been a nurse for three years but worked in different institutions for short periods of time for the first year of her nursing career. Kimberly is originally from the Philippines and migrated to Canada at the age of ten. Her mother tongue is Tagalog. Working in LTC is her first job as team leader. Kimberly obtained her nursing degree from a college in Montréal, and presently is working on getting her BScN through online education. She is in her last semester. Immediately after obtaining her nursing license in 2012 she worked at a general hospital in Montreal for four months but could not obtain full time work. She also felt that working in the general hospital was difficult as she did not do any externship. She then worked for nursing agencies until she was hired in the LTCF where she is working presently. Kimberly said she likes working in LTC because it gives her a sense of belonging and also being a team leader makes her feel that she is really making a difference in the field of nursing, which in turn makes her feel special.

Nursing Education-Preparedness for LTC

Kimberly did not feel that nursing school prepared her to work in LTC.

> My nursing school was very focused on skills, like IVs, PEG tubes chest tubes etc.[…] At the CHSLD we don't have that much skill to perform so it is more about communication with doctors, and other members of the team. As a team leader it's more about teaching, delegating tasks, leadership. School is more clinically based, school prepare you for nursing in the hospital but here in the CHSLD it is so different you have to communicate to family, staff…. In the hospital you barely have the time to sit and talk to patients you have to see your patients and move on to the next patient. Here you have more time to sit and talk to the residents to ask how they are doing, what can we change to make them better.

In response to the question on how she communicated any concerns about her patients as a student nurse she answered,

> As a student umm! as students, we did not have the autonomy to speak to the doctor, we had to go to our teacher or she would send us to our nurse, umm, the nurse in charge. Sometimes the nurse would tell the student 'since the doctor is here speak to him.' I saw some of my colleagues speaking to the doctor but I did not have that opportunity. I guess that depends on how comfortable the nurse you are working with feels about the data you are presenting I guess.

The orientation for a nurse in any specialized area including gerontology, in the hospital setting in Montreal, is between four to six weeks. When she started working in the LTCF, Kimberly had eight days of orientation by another nurse before going on the floor to practice on her own as a team leader. At first Kimberly told me that she was fine but as she expressed her experiences she admitted to being overwhelmed especially at the beginning of her practice in LTC and at times in her current situation.

> **Early experiences.** She described being very nervous in her early experiences, she said,
>
> Oh! I was scared at first. In the hospital you have four or five patients but here I had forty residents under my care. I was scared. I had two Licensed Practical Nurses (LPNs) and six Beneficiary Attendants (PABs) working with me, depending on which floor I was working. At first I was like, "am I able to do this? I am a new nurse and only one year out of school, with only one year experience, am I capable?"..... But I am doing it, yeah! with experience I am doing it. At the beginning I was asking the LPNs and PABs for help because they know the residents better than me. I asked for help. I could not do it by myself. I was nervous, it was scary, but I did with the help of my other team members. When something is going wrong with any of my residents and I have to call the doctor, I still get nervous at times depending on which doctor is on call.

Communicating with Doctors in LTC

I asked Kimberly what she thinks is the main purpose of communication between doctors and nurses in LTC. She said that in order to provide safe care to the residents it is imperative that she communicates with the doctor.

> It is best for the residents because as a nurse there are certain things that we cannot do as nurses. Even if we know what to do we cannot do it because it is not within our scope of practice. We are limited in our practice, so we have to communicate to the doctor. For the safety of the residents, we have to communicate the needs of the residents. eg. the resident is coughing, and I listen to the lungs and think that umm, maybe she needs a chest x-ray but I cannot send the resident for the x-ray unless the doctor orders it. So even though we know the residents' needs, we need the doctor to order, so we have to communicate to the doctor. So it is all for the safety of the residents.

When asked what she learned in school about communication with doctors Kimberly replied,

> At school there are some communication courses. I find that it did not really prepare me for working in LTC because that kind of communication is not taught. I find that it is with practice you gain that kind of experience. They did teach us that when speaking with doctors we have to be firm and precise in what we say when we are talking to the doctor. With family you have to be compassionate.

Kimberly continued to explain,

> In nursing school they tell us to be precise about what we want the doctor to know, but we could not present to the doctor. They told us that we had to have an overall picture, a holistic view of the patient's condition. What we would like the doctor to know about our patient, but we could not present to the doctor. It was our teacher or the nurse we were working with who presented the case. This is what they taught us in school. As a student, no! (laugh). They were saying when you become a nurse this is what you are supposed to do. As a student I had no communication with the doctor.

A skill developed over time. Kimberly felt communication with the doctor is a skill she developed over time.

> Oh yeah this is a skill that is developed overtime. Up to now I still do not feel comfortable with the doctor especially by phone. I prefer face to face, I do better with face to face. Some doctors do not have patience. I feel that I have grown even if it is only one year.

She talked about how often and the means by which she communicates with the doctor:

> It depends, I do not work full time so whenever I work and I have a concern like a blood test that is abnormal or a resident not doing well. Within one month I will call the doctor about four times. Some nurses are very comfortable with talking to the doctor so they call them about any question but I am still not comfortable talking to the doctors. If I have any concerns I will ask the head nurse or another nurse before calling the doctor. That

> will be the last resort. One doctor already told me "stop inventing things in your head". That's exactly what he told me. This is an example of why I do not like to call as much. There are some doctors who I am comfortable with and there are some I do not want to call at all unless it is very necessary, unless I really have to. I communicate by phone or in person when the doctor is in the institution.

Experience as Team Leader

In regards to her experiences as a team leader in LTC she said,

> It's nice […] rewarding but it could be scary. I am still not very comfortable because sometime when people come to me I am not too sure yet about every question. You know, you just have to be able to make that decision and sometimes you are not quite sure of the decision to make or the answer to provide. But you have to make that decision, you are the team leader. So, on the other hand I find it very rewarding to be a team leader. I cannot really explain but it feels rewarding. I think it is because I feel I am able to make decisions for what is best for the residents, especially when I see it is working, and to lead the staff to give good care. As a team leader you are supposed to know, so it could be nervous at times. I guess with more experience I will reach the place where I will not feel so scared or nervous. I got good feedback from the staff which made me feel very good about the work I am doing. We were at a "plane tree" retreat and each staff member had to speak out loud about other members of their team. It made me feel so good when they said that I do not make them feel that they are on the bottom of the scale, the said "she makes us all feel equal and a part of a team". I was like "Oh! that is so nice" it makes me want to continue as a team leader. They respect my role as a team leader and I respect them for their contribution to the team, I do not make them feel different. That makes me feel encouraged to continue to be a team leader.

Kimberly said that all the staff members on the unit that she was working on when she started as team leader had been there for many years before she started. Furthermore, most of them were way older than she is. She admitted that this contributed to her feelings of insecurities. Nevertheless, she stayed strong and eventually overcame that fear as the staff she works with recognized her confidence and capabilities. I asked Kimberly if she felt that her experience as team leader has enhanced her working relationship with the doctors, to which she answered,

> Yes, it has enhanced my relationship because it has built my confidence when speaking to the doctor. I have to make sure the residents receive safe care so I need to have the confidence to talk to the doctor. This has built my relationship with some doctors. Some doctors make you feel comfortable…. they allow you to ask questions.

Working experience with the doctors. In talking about her experiences with the doctors she works with most of the time as compared to the ones she does not work with most of the time, she said,

> Some doctors are difficult to work with and there are others who are so nice. This particular doctor takes his time to answer questions and does not make you feel dumb. Even if you are not the regular nurse he works with all of the time he is patient with you and takes the time to listen. He is so approachable every nurse wants to talk to him. It depends on the MD you are talking to, the challenge is for them to listen to you. They should trust our ability to make decisions, trust data that we have collected for them. Some get agitated very fast.

Autonomy in Nursing Practice in LTC

As team leaders in LTC nurses possess a certain amount of autonomy. They are responsible for the care of the residents, as well as overseeing the standard of care delivered to the residents by the other members of the team including the doctors. I asked Kimberly if she thinks she possesses this kind of autonomy to which she replied,

> We already have certain autonomy because we have to make certain judgements for our residents. Even though I am not alone when it comes to making complete decisions, I feel that I am very autonomous […] maybe the nurses working longer will be able to answer that because for me I am here less than a year and I feel that I work very autonomous in terms of what we do. Maybe there is somethings that I have not done as yet, something I have not yet experienced.

RNs Perception of Working Relationship with the MD

Challenges faced when communicating with the MD. Kimberly had already expressed the fears she experiences when communicating with the doctor but I wanted to know about challenges she experienced.

> I think, you only have challenges when you talk to a doctor who is closed minded and does not want to take the time to listen to you, you know. Or they feel that you are telling them what to do but you are only telling them what you think. If you are talking to a doctor who has respect for you or who is taking the time to listen, you would have a better relationship with that doctor in that sense. They want you to be able to make decisions but when you do they do not like that either.

In the following two paragraphs Kimberly talked about a *negative* and a *positive* experience she had in communicating with the MD.

A negative experience. Kimberly shared an experience that could have caused some discouragement and made her feel incompetent as a team leader.

> The doctors could be very impatient that is why I try not to call too much. There was one case, a lady for whom the doctor ordered to stop PEG feeding the day before as she was vomiting a lot. She was started on intravenous fluids at 100ml/h for hydration. When I came in to work the next day, the lady was vomiting and coughing, very congested, crackles all over the lungs. She already has diagnoses of CHF and pneumonia. She was about 92 years old. I called the doctor to explain what was happening with the lady, umm. I told him that the fluids might be too much for her especially as she is already diagnosed with CHF and pneumonia. Uh! The doctor started getting mad with me. His exact words were "stop your nonsense, it could be pneumonia, it could be CHF but you do not know so stop being creative". I was like (laugh) oh my God, and after all that he gave me the order to decrease the fluids. It was clearly too much fluid for the patient, but he did not want me to tell him what I thought. Also, it would seem that he had made the wrong decision to start her on so much fluid in the first place. I am the nurse caring for the patient and all I expected him to do was listen to what I had to say and then made the right informed decision for the patient's safety, but he made it seems as if I was telling him what to do. I am a young nurse questioning his order and he did not like that.

I asked Kimberly how she felt after realising that she was right in her decision to question the previous order in light of the resident's condition, she said she was nervous when she got the first response from the doctor. This could have been a set-back for her in her progress as team leader. She is young and was a new nurse on the "block" which made her vulnerable. However, she held firm and showed that she had the level of competency, knowledge and autonomy needed to work as a team leader and an advocate for her residents. The doctor was not on site so she presented the resident's situation by phone and gave a clear picture of what was happening with the resident. She needed the doctor to take the time to listen so he could make a well informed decision and order the proper intervention, which he did. She proved that she had the level of autonomy it took to work as a team leader on the unit.

A positive experience. Kimberly likes when the doctor takes the time to listen and also to teach as this increases her knowledge base.

> I questioned a doctor's order to administer potassium to a patient whose potassium level was of normal value. I did not understand why he would want to add potassium when the level was of normal value. He took the time to explain the rationale and I understood. That was a sure positive. That particular MD always takes the time to explain rationale for doing something. He is like a teacher-doctor. All the nurses like him because he has patience. He is an older doctor but he is really nice to the nurses and he takes his time when seeing his patients also.

I asked Kimberly if she feels that her experience has changed over time, she explains,

> As I said earlier, at the beginning I was scared and did not have the confidence and courage in myself or my work. Now I have built my confidence. I know that I have the right to talk to the MD about my resident's condition. I have a right to present the case. I am a new nurse and a new team leader at that so I was scared. I did not know what to expect except what I observed in my 8 days of orientation on the floors with the other nurses. At first I felt like I did not have the right to talk to the doctors. But you need to be strong and show them that you are strong and confident in what you are saying. I am a professional you need to listen to me. That reassurance has helped me to build my confidence. Doctors need to hear that you are strong and firm and know what you are saying. If you are mumbling (laugh) no. if you present your data with a firm voice and confident then they give you information that you need. This way they build their trust in you because it is like they see your strength and that you are confident in your approach and what you are approaching them about. They need to see that you know your stuff. If you are mumbling, they would ignore you because they would think right away that you do not know what you are saying.

Perceived Barriers to Communication

We talked about barriers to collaborative practice and what could be done to eliminate them and this is what Kimberly had to say,

> Doctors need to be, I repeat, more attentive to us, more respectful, trust us more. They should ask questions if they do not understand us. In terms of nurses, speaking for myself, you have to be more confident, more precise on what you are talking about. Make yourself be heard. As nurses we have to be clear and make ourselves understood. Doctors could do the same. We as nurses must show that we have the knowledge and competency, make them know and see that you know what you are talking about. Make

> the doctor know that you know. You have the knowledge so you have to show that you know it so they could recognize that you know.

Educational strategies. Kimberly gave suggestions for certain educational strategies that could be used to help eliminate or reduce barriers to effective communication between MDs and RNs.

> Can we do classes like coaching, classes with both professionals, actual courses, you know, classes like with doctors and nurses, both parties have to be there and have to verbalize. Maybe the doctors have a side of the story that the nurses do not know and the nurses have a side of the story that the doctors do not know. During this interaction the doctors and nurses will be able to know what they do not like about how nurses communicate when they call. If this is possible, if we could hear each other, what the other side is saying. We might be able to clear up some barriers. Like, maybe the doctors have things that they do not like about how we communicate information to them. This way the nurses will know what annoys them and so they will not do it. Maybe what and how we communicate could be annoying to the doctors? So we need to hear from them too. We need to change our nursing school curriculum. If this could start in school this would be great. In the LTCFs we could have classes and invite two or three doctors so we could hear them say what they expect when we communicate with them, are we annoying them? Could we better present ourselves? We want to know their perspectives as well not just the perspective of the nurses.

In the clinical setting the teachers should give the students the autonomy to speak to the doctors, as this will really help for when they go to the real world of taking care of patients. Then they would have the confidence to talk to the doctors and not be scared and nervous.

Summary

Kimberly did not feel comfortable in the acute hospital because she did not work as an extern and felt this was a disservice to her. She feels that her role as team leader in LTC is very rewarding and even though she is still nervous about her practice she feels she has grown tremendously and continues to grow. An RN working in LTC is a team leader, the one who makes the decision along with the doctor for the safe care of the residents under her care. The opportunity of participating in an externship program, especially in gerontology would have left

Kimberly feeling more confident and less nervous when communicating with doctors. During this time she would have worked side by side with an experienced nurse and would have acquired the autonomy of managing the staff, working with and communicating with the doctors.

Nevertheless, she is doing well. She said she wishes to remain in LTC but hopes that someday she will not be so nervous when she has to speak to the doctor. She thinks that with longer practice and more experience she will accomplish that goal. Hopefully she could get some education on leadership and also on communication with doctors at the LTCF where she works as that will help her to build on her confidence.

Joanne

Joanne is 54 years old. She has been working as an RN for 22 years and as a team leader in LTC for 21 years. She graduated from a college in Montreal and started working in LTC right after graduation, through nursing agencies which sent her to different CHSLDs. One year later she applied at this LTCF and got the job as a nursing team leader. After working with the aging population for one year Joanne felt that this is the area of nursing she wanted to specialize in, so she obtained a certificate in gerontology at University de Montréal. Before coming to Canada to study nursing, Joanne was living in the United States where she migrated from Haiti and has worked as a beneficiary attendant. She has been living in Canada for about twenty seven years.

Nursing Education-Preparedness for LTC

When asked if nursing school prepared her for work in LTC Joanne replied,

> When I went to College there were no courses in gerontology per se. I did basic care in the first year of nursing but I learnt most of what I know about gerontology at the LTC where I work. With life experience I learn every day, at the LTCF we got courses in gerontology and then I went for the courses in gerontology at the University. That gave me more ideas about how to work with older people. At University is where I really

> learnt about elder care. But even after school you really do not know, it is only by experience.

In nursing school the first semester is devoted to geriatrics which is really basic care such as bathing, grooming and communicating with the patient and family. According to Joanne at the time when she did her nursing program there were no other extensive gerontology courses given. As she explained in the above paragraph, she took gerontology courses at University and at the LTCF where she works in order to help her in her role as a gerontology nurse.

Communicating with the doctors in LTC

I asked Joanne what she learned in nursing school about communication with the doctor to which she responded,

> Not much at all, most of the communication was learnt at the workplace, on the job. In-services played a very big part in learning how to communicate with the MD. Some courses that were given were very helpful. As a nursing student we did not have any communication with doctor. It was really with my teacher or the nurse I was working with in stage. Communication courses in school were really about communicating between the patient and family.

A skill developed over time. Joanne said when she started working as a team leader in LTC she did not feel prepared to communicate with the doctors. At first it did not go well at all but with time she felt the situation improved.

> The communication skills I acquired were developed over time, with experience. I communicate with the doctor sometimes three to four times a week. If it is not urgent and the resident could wait till the doctor's visit I will wait. We communicate by phone, or I leave a message in the communication book for the doctor and also when he visits in person.

Joanne described the purpose of RN-MD communication in LTC this way:

> If we do not have good communication the resident would suffer. If you do not recognise the need of the resident to do the proper follow up, if the family calls us about follow up, if the family calls us about a problem, we have to do the proper follow up so we could

> talk to the doctor about it. I am going to make sure I talk to him about the needs of the residents because if we do not communicate, the residents' needs will not be met. It is for good and safe patient care.

Experience as Team Leader

Joanne said she likes her role as team leader in LTC and knew that this is where she wanted to work for the rest of her nursing career. This is what she had to say:

> I liked it right away – I felt good about it then and I still feel good about it now. We have to be the leader to answer all questions and make sure the floor is working properly. I am in charge of the entire staff, you have to take charge. If you do not do it someone else who might not be the appropriate person might do it for you. You need to show that you are in charge. I know about all my residents care and needs so I could instruct the new people. I am there if they have any questions.

Autonomy in Nursing Practice in LTC

Talking about the kind of *autonomy* team leaders need to practice in LTC Joanne responded with the following:

> Team leaders have to be given the tools to work with; therefore the curriculum should include gerontology courses. They need to have the knowledge, understanding the signs and symptoms of deterioration of any kind in the elderly. Then courses should be developed within the curriculum together with how to communication those information to the doctor. We have to develop our thinking skills in order to ask pertinent questions and in order to make informed decisions.

When asked if she thinks she possesses this level of *autonomy* to work in LTC Joanne says

> This is something that has to be developed with time. There is no way one can really feel prepared to work as a team leader right after school. This is something that really comes with time and experience, we have to work as a team because we are here for the resident, we have to work together to accomplish the needs of the resident. Good communication with the team, talk to them during report time, if I need to meet with them to communicate something to them. Example, if the resident has to go for an appointment, I have to communicate this to the rest of the staff so they would know what time the resident has to go so they would get the resident ready on time etc. This makes them feel that they are a part of the team; the importance of writing the elimination pattern of the resident, etc.

It is clear from her explanation in the above paragraph about autonomy that Joanne feels being autonomous in nursing means being able to make strong clinical decisions for the residents and she is certain that she possesses this kind of autonomy. However, as she states, this kind of autonomy is developed over time.

RN Perception of Working with the MD

Working experience with the doctors. In describing her relationship with the doctor she works with most of the time, as compared to the ones she does not work with all of the time, this is what Joanne had to say

> The only thing I could say about that is you have to have all the necessary information. Really before even calling or attempting to speak with the doctor. We have a good relationship. He takes his time to listen. Even if he is rushing and I forgot something, I could call him back. He is fine with me. As a team leader I have to communicate everything about the resident to the doctor because I am the one there all the time with the residents. He is not there all the time. But with some of the doctors I feel they are rude with the way they respond. Is like the nurses are not intelligent enough to talk to them or ask questions. You have to show a lot of intelligence and confidence to be able to get an answer or for them to even look at you.

Challenges faced when communicating with the MD. Joanne encountered some challenges during her practice as team leader while working with others doctors with whom she does not work with all of the time. She said:

> With the doctors I do not work with most of the time, some of them are alright and others are very difficult to work with. Some understand the fact that they do not work with me and do not know me and so they have to take the time to listen to me because I know the patient and they don't. Others act like if I am dumb. They are the ones who do not know the patient as I do, so they have to listen to me but they act as if I do not know what I am talking about and make me feel real stupid even after working as team leader for so long. I do not feel comfortable talking to most of the doctors but I am very comfortable with the doctor who I work with most of the time, even though at the beginning it was not as good as it is right now with my regular doctor. Our relationship grew overtime.

A negative experience. Joanne recalled a *negative* experience she had:

> One time a resident was dying and the family did not know about it. I was not the nurse on the floor but I was called and I saw the resident was dying. No one had called the doctor or family to let them know that the person was dying. I called the family and when I called the doctor she was very, very upset. This was very upsetting for me because this was not even my floor; I went to help. I did not know that the doctor was not aware of the situation. This was negative for me.

However, for her it was not all negative. Joanne describes her experiences as changing over time. She says,

> Changes for me happened over time with experience working as a team leader. I have gained the confidence of my doctor, that is, the doctor I work with most of the time. We have an established relationship. This did not happen right away, it happened over a period of time.

Joanne appeared very confident when speaking of her role as team leader and communicating with the doctor. Nevertheless as she expressed in the previous paragraphs, she is finding it still difficult to communicate with the doctors on call whom she does not work with all of the time.

Perceived Barriers to Communication

I asked Joanne about *barriers* to effective communication between RNs and MDs in LTC. She replied,

> the nurse feeling insecure or incompetent when she has to communicate with the doctor. She does not want the doctor to feel that she is incompetent. Once you are made to feel that way it is very difficult to regain your confidence to do it again. However, there is no other choice, you have to overcome that if you must practice as a team leader. You just have to do it over and over again and with time you will overcome that main barrier. Like the example I gave above when the doctor was upset with me.

Educational Strategies

Joanne shared her feelings about educational strategies needed to be developed that could break down those barriers.

> Classes should be given in school on how to communicate and what should be communicated. Nurse must gain their respect but in order to do that they have to show

> that they are competent and professional so they could gain the confidence and respect of the MD. Doctors also need to know how to communicate with nurses and to understand that we are professionals too.

Summary

Joanne feels that her role as team leader in LTC is very rewarding and is one that developed over time. From the beginning of her practice she realised that she needed to build on her experience so she took courses in gerontology at the university level and she also took courses on communication that were given at the LTCF where she works. These courses have really helped her, especially the ones on communication. She hopes that the nursing curriculum could somehow accommodate educational courses on communication in the clinical setting so future nurses could benefit. Joanne concluded by saying,

> Team leaders have to be given the tools to work with….therefore the curriculum should include gerontology courses. They need to have the knowledge, understanding the signs and symptoms of deterioration of any kind in the elderly. Then courses should be developed within the curriculum together with how to communication those information to the doctor. We have to develop our thinking skills in order to ask pertinent questions and in order to make informed decisions.

Dominique

Dominique is a 57 year old nurse who graduated from a Montreal College and has been working in LTCF for 26 years. She is Canadian born and has lived in Montreal all her life. She has been functioning in her role as a team leader for 24 years. After graduating from nursing school she worked for a French hospital in Montreal in the oncology research department. As an RN she headed the project in the research involving a drug used for cancer treatment. Dominique worked in this capacity for 12 years after which time she left to work in LTC. She described her reasons for leaving that role as personal and also because of doctors who could not get along with each other. She took one year off work and then applied at the LTCF where she is working

currently. She said she likes her job in LTC acting as a team leader and has stayed on all this time.

Nursing Education-Preparedness for LTC

Dominique feels that nursing school did not prepare her for practice in LTC. This is what she said,

> Nursing school did not prepare us at all for LTC. I did not know a lot about geriatrics because the courses in nursing school, at that time, were geared towards medical, like obstetrics, medicine, pediatrics and psychiatry. What I learnt in school about geriatric care was very basic, like washing the patient and that's about all. That time gerontology was not very popular, not very detailed and not very appealing to nursing. The curriculum just did not cater for that kind of nursing.

Early experience. When Dominique started working at the LTCF she was not functioning on her own in the role of team leader for a while. Unlike all the other participants she had the opportunity of working with and observing experienced nurses. She worked on different floors and because at that time the floors were well staffed with nurses she worked as an extra nurse. This gave her the opportunity to observe and learn well from other nurses so by the time she took up her position as team leader she was confident in her role.

> When I started in LTC there were a lot more senior nurses, so I was working under them for about 2yrs. I was not a team leader right away. I was floating everywhere which means I worked on every floor. When some senior nurses retired then I got a position as a team leader on June 1st 1995 and I am still on the same unit today. I relate to my unit as my second home and the residents as my second family. Since I have been in this LTC I have seen a big turnover of head nurses, about 11 in my 24 years. Just on the floor I am working on now I saw 5 different head nurses come and go. Stability started about 6 years ago with the present head nurse I have right now. By the time I got my position as team leader I felt ready, a bit nervous but I wanted the challenge because I felt competent enough to do it. By observing the senior nurses, I learnt a lot.

Communicating with the Doctors in LTC

In response to what she thinks is the purpose of MD-RN communication related to work in her facility Dominique replied, "If we want to treat the residents well and give them the appropriate care, the care they need and deserve you have to have good communication with the MD".

A skill developed over time. When asked what she learnt in nursing school about in her facility Dominique replied,

> Not much, in my time we felt more like being servants, staying quiet, listening to what the doctor said, never arguing, accepting whatever he said, if you had an opinion you kept it to yourself because you did not know how he will receive it. We did not dare to ask questions that we felt needed to be asked because we did not know how he will reply or react to us. At that time it was the doctor standing around with his white lab coat, intimidating most of the time, nurses always a few feet in the back of him and dared not approach him. Hierarchy was very important back then. The students were not allowed to approach the doctor. We had to go to the teacher and she went to the doctor. Things have changed quite a lot. The younger doctors have a better outlook on the working relationship with their nurses. Meaning we could approach them more readily. For instance the doctor I work with most of the time, I call him my doctor, he said to me "when I am not here you are my eyes, so when you call me it is because you have a concern and there is a need to talk about". What I like is I could call him every day during the day even if he is not the one on call. I find it is better for treating the resident instead of calling the doctors who do not know the resident at all. He has given me this autonomy to call him whenever it is necessary, like about something I am not sure of. At the beginning my doctor was a bit "high and mighty". Did not always take my opinion, was not quick to listen, it was always his way or no way. But as we got to know each other we gained each other's trust and he gained confidence in me. Today we could discuss any resident situation and he listens and actually asks for and takes my suggestions.

I asked "How often do you have to speak with the doctor?" She replied,

> I could call him every day because we could communicate all the time about our resident and he never gets upset. He comes once a week but the rest is by phone. The rest of the time he is doing clinic and rounds at the hospital. He is also teaching at the clinics and he brings his students here too.

Working experience with doctors. Dominique summarized her working relationship with the doctors she works with most of the time.

> The first two years were a bit difficult, there was guarding, getting to know each other and the level of trust. It works both ways with the trust. As he realizes my competency by the kind of questions I would ask him and the way I presented residents, he realized that I will not call for petty things that maybe a novice nurse still would call about. So our relationship grew into a trusting one.

When asked what she feels are the most important outcomes of MD-RN communication practice, Dominique spoke at length about this. I have included her entire response because her elaboration seems informative for the current research and potentially useful to future research in this field.

> The biggest important outcome is care of the resident and family. The family will be more at ease because of the information we give to them. They will feel more secure because they sense that the nurse and the doctor make a team for their loved one. It is team work and they sense that the nurse and the doctor work well together as a team and that gives them confidence and security in the care that is given to their loved ones. They do not want to see fighting back and forth because they lose trust. They know that if they ask the nurse or the doctor a question, the answer will be the same. So that builds their trust and they will be satisfied to know that they could ask the nurse or the doctor the same question and will get the same answer. They feel reassured. Sometimes we talk to the family together which is something they really appreciate….It is important for the family to know that the doctor and nurse have a good relationship, are on the same page so they feel comfortable. When the family realizes that the nurse appreciates and respects her doctor that gives them comfort and puts them at ease because the nurse trusts her doctor. So they themselves are more at ease to ask a question to the doctor and the nurse. Ex. there was a family member who was very wary and asking a lot of questions but with time realized that talking to me or the doctor was the same. So eventually she became at ease knowing that we both gave her the same answer. The family sometimes test the doctors and the nurses by asking the same questions just to see what answers they would get. Now they don't do that anymore. This is how I see that they need that kind of trust because that family member is not as nervous as before. She would ask me to ask the doctor so the next time she comes she has the answer already because I called him and we discuss the concern together and she trusts the answer.

I asked Dominique how she feels about working with other MDs she does not work with

all of the time. Even though she has been practicing the role of team leader for so many years this is what she had to say:

> I feel nervous sometimes to inquire with a doctor I am not comfortable with because if he is intimidating he makes me feel apprehensive and then I do not get my message across. The information might not be relayed properly because I do not have that comfort. I will stay very polite and professional but that comfort zone is missing. He feels it too and then he does not reply in a way that's appropriate. We might end up disagreeing. I might just take his orders even if I do not feel comfortable with it or do not understand why he ordered that. It is because I do not feel comfortable to question because I do not have that relationship with that doctor. Certain doctors put me at ease because they will take the time to listen and come to see the patient. A certain doctor will explain why he is making the prescription. That is very *positive.*

A negative experience. I asked Dominique how she feels about working with other MDs she does not work with all of the time. Even though she has been practicing the role of team leader for so many years, and she replied,

> I had a *negative experience* where the doctor was pressuring me to do something I am not supposed to do and would jeopardize my licence. When I refused and told him that nurses in our LTCF here do not do that act, he insulted me saying I should go back to school.

Experience as Team Leader

In describing her experience as team leader Dominique said,

> It could be tremendously rewarding and at the same time it could be very frustrating. It depends on the staff, the team you are working with. Some people do not take directive very easily. As a team leader you have to be fair and firm sometimes you have to tell them somethings they do not like to hear. For example, I had to change the luncheon schedule and they were not happy about it but they did it. It takes a while to gain their respect and trust. There is a friend and work relationship. We have to keep it at that. We all have our role to play and we have to respect each other's role. My head nurse respects me more now than before because she has gained my confidence.

Dominique feels her experience as team leader enhances her working relationship with the MD, she said,

> Each party has to recognize the other's roles. When that happens then you come together because you understand and that enhances the working relationship, and respect will be

> always there because you recognize and understand the different roles that each other play.

Autonomy in Nursing Practice in LTC

We talked about the kind of autonomy needed to practice as a team leader and this is what Dominique had to say:

> You have to be able to make informed decisions, be able to communicate to the team what we are doing what is expected of them. To be able to communicate to the doctor and not be afraid, stay calm. A big challenge I have overcome. Know your stuff, know your role, be knowledgeable.

RNs Perception of Working Relationship with the MD

Challenges faced when communicating with the MD. When talking about challenges encountered when communicating with doctors and how her experience has changed over time she said,

> My experience changed overtime with experience, but my confidence built with the doctor I work with most of the time. I still feel intimidated when I have to talk to certain doctors even though I have been here for 24 years.

Perceived Barriers to Communication

In response to barriers to MD-RN collaborative practice Dominique felt the worst feeling is one of incompetence.

> When a doctor makes you feel incompetent, you do not want to call him but you have to. You are the nurse and you have no choice. But the communication will not be as it should because you are apprehensive and on your guard.

Educational Strategies

Dominique offered suggestions that she thinks could help to eliminate barriers to collaborative practice. She recommends courses in communication for both professionals, she said,

> They can have special courses where they ask the doctors to go speak to the nurses. We need more and more communication. Doctors need to learn how to respect nurses. Change in attitude, to recognize each other's role? Nurses have to recognize and respect the role of the doctor just as the doctor should be made to recognize the role of the nurse

> and respect her. Nurses have to understand that the role of the doctor is such that he has certain autonomy that we as nurses do not have and we have to respect that but the doctor also has to realize that we are professionals who went to school and obtained a license to practice.

Summary

Dominique loves her role as team leader. She spoke with much confidence. She has worked on the same unit for 24 years and with the same doctor and head nurse for five years. The doctor she works with most of the time is a young doctor and has been in practice now in LTC for about nine years. They had a rough start but their relationship has grown in a very positive way. They are now comfortable with and trust each other. She feels this is a great plus for the safety and best care of the residents. She wishes that communication with other doctors will be as smooth and is hopeful that in the near future this will change as she observes the third year students who come on her floor to do *stage* are allowed by their teachers to approach the doctors and ask questions. She is hopeful that all schools will be doing the same thing.

Thanga

Thanga is 48 years old. She migrated to Canada from Sri Lanka at 18 years of age. She finished high school in Canada and got married at the age of 24. She then studied to be a Licensed Practical Nurse (LPN) and has been working as an LPN in the LTCF for eleven years. Three years ago she decided to upgrade to an RN so she went to a Montreal college where she studied for three years and obtained her nursing degree in 2014. She has been working in the capacity of RN for one year at the same LTCF where she worked as a Licensed Practical Nurse (LPN) for eleven years.

Nursing Education-Preparedness for LTC

Thanga feels that nursing school did not prepare her for practice in LTC:

> During my clinical stages I did basic care in the beginning and at the end in my last semester I also did a stage in Rehabilitation. Those experiences have helped me somewhat but not completely because there was not a lot of gerontology.

Early experience. Practicing as an RN in LTC is Thanga's first experience as team leader. I wanted to know how she feels about her experience in this role. Thanga said,

> You know, the first time was very challenging. I was called to work on a very difficult floor a few months after my orientation. The residents are very challenging. This was the first time I would be working as a team leader. I was a bit nervous because I did not know if this was a test to see if I could perform as an RN/team leader or not. I had no previous experience as an RN. All the experience I had was in stage and also observing the nurses when I worked on the floor as an LPN. I felt I had no support and no supervision, I was on my own. This was a bit scary but I managed. Also, the staff I was working with knew that I was an LPN just stepping into the role of RN. At the beginning they were giving me a hard time. The LPNs wanted me to do some of their work for them and the xxxx xx(PABs) were like testing me……My personality is different, I am not a person to talk back even though I felt they were trying to take advantage of me, they did not respect my position as an RN. But I used my resources: the clinical nurse instructor, the doctor, the computer and my own common sense and nursing judgement. When they all saw that I was firm and I took decisions then they showed me the respect.

Even though she was oriented months before she was ever called to practice, Thanga felt that she performed very well under the circumstances.

Communicating with Doctors in LTC

When asked what she thinks is the purpose of MD-RN communication related to her work in her facility, Thanga responded:

> For good quality of care for the residents. Based on our information we give to the doctor we are able to provide the care that the residents need. The treatment or intervention given by the doctor is based on whatever information I give to the doctor [no?].

I asked her what she learnt in nursing school about communication with the MD, this is how she replied,

> In my college, the teachers were very good. They allowed us to do some communication with the doctor. If we needed to clarify some information example, an order, we would communicate that information to the doctor but our teacher would be present to observe. We always had the teacher or/and the nurse in charge present.

A skill developed over time. Thanga said she did not feel prepared to communicate with the doctor when she started working as a team leader. Even though she had the experience of talking to the doctor on her stage in her last semester in school, her teacher was always present. Now in her role as team leader she was on her own and had to talk to the doctor without any supervision from any one. According to her, this is a skill she developed over time within the short year that she has been working as an RN. She is working full time so this has helped. She said, "It's a skill I had to develop overtime, always room for improvement because communication is not only with the doctor it is with the family, companions, staff etc. Sometimes there are also conference calls that could take place between doctor, nurse and family member".

I asked her how often she is required to communicate with the MD, she replied,

> Usually when I work on the floor I have to call the doctor almost every day, for lab results etcetera…by phone and when the doctor visits. It's for the benefit of the resident [no?] To receive the right treatment?

Experience as Team Leader

Thanga talked about her experience as a team leader.

> I like my job as team leader but it is very challenging. Presently I work on a floor where the head nurse is always checking everything, the PABs, the residents, the family, everyone is challenging to me. I know it is difficult but I told myself "let me handle it". I am a full time team leader on the floor. When I started there were a lot of things to follow up on but I take it one day at a time and I am managing. I delegate tasks to the staff, the LPNs and the PABs, I do not postpone anything. I do it the right away. It is not easy because things change a lot on that unit. What I do not like is when I say something to them and they do not do it, they challenge me. I say "when a resident is not listening to you about his shower or anything, tell me". For example, a resident refuse to have a shower, they did not tell me and I found out at 1pm. This is not good. I had to speak to the PAB again to let him know that this should not happen and he had to tell me about it.

> I had to tell the head nurse about that and I do not like that but he is not listening to me. You know, it is because he is working on that floor for so long before me. But I am the team leader he has to respect that. They are not respecting my role as team leader, they are used to not being checked so right now they do not like me but I have some very good employees also. Anyway, I find that I have to check a lot of things but I am a new RN and I like the challenge and I am managing.

Autonomy in Nursing Practice in LTC

At the time of this interview Thanga had just obtained the position as team leader on the floor she is working presently. Before this time she had been working as a float nurse/team leader on different floors. And even though she was just beginning to feel comfortable in her role, from the description she gave in the paragraph above about how she manages the unit, one can see she is already demonstrating autonomy. However, when asked about the kind of autonomy needed to practice as a team leader in LTC, Thanga responded,

> You always have to be prepared before calling the doctor. Some doctors want you to be very detailed. You have to know how to apply your knowledge, and you have to be able to take the decisions on your own. Good judgement, should I call the doctor or should I wait? Example, a resident started having blood in the stool and vomiting undigested food, large BM but the blood continuing. I checked the resident's chart for previous diagnosis and I saw that she has myelodysplasia, disorder of the blood produced in the bone marrow, mal production of the red blood cell, decreased platelets leads to bleeding. She is also diagnosed with ovarian cancer. All other condition is fine and stable, general condition has not been changed, so I used my judgement to observe further instead of calling the doctor.

I asked her if her decision to wait and observe the resident's condition was the right decision to which she replied, "Yes, because later on there was no more bleeding and the doctor saw the resident on her next visit."

Thanga feels that she has been given the kind of autonomy needed to work in LTC but she said

> I find that nurses in LTC should have more autonomy. The doctors are not here all the time so we should have some autonomy to prescribe simple treatment. We have the collective order in LTC which gives us some autonomy to carry out prescribed orders from the doctors but we have not yet been given the autonomy to prescribe anything such as certain medication or dressing for wound care.

RNs Perception of Working Relationship with the MD

In regards to the experiences she had in working with and communicating with the MDs she said,

> no one has complained about me because I always have all pertinent information ready before calling the doctor. I check the computer internet so I will not seem stupid, I always ask questions. Very helpful if you know what you are talking about. You have to give pertinent information. It takes time to learn the doctors' routine and style of communication, what their expectations are. How they like to be approached.

Thanga described one *negative* which turned into a *positive* experience she had with a doctor.

> My first day working on my own, a few months after my orientation, I had to call the doctor several times. Not because I wanted to but because I had to call him. It was not even for the same patient. Each time it was for a different patient. I had to call because the floor was busy and there were a few residents who were very sick. Even in that situation I checked information on the computer before I called him but he was not happy that I called him a few times because he was in his clinic. I said "doctor I am sorry but I have to call you, it is not about the same patient and I have real concerns" I proceeded to explain the problems of the patient with sensible explanation for my concerns. When he saw that I was knowledgeable he took the time to listen and to respond appropriately.

When asked how working as a team leader has enhanced her working relationship with the doctor, she replied,

> Working as a team leader has enhanced my working relationship with doctor because I have to communicate with doctor often about my patients needs and whenever I call the doctor I make sure I am really prepared to talk about the patient and he does not have to wait on me to find pertinent information. I already have all my information at hand so when I am talking to him he could get a clear picture of the patient in his mind because he is not here with me so he is not seeing the patient.

Thanga emphasized the importance of being prepared before calling the doctor. She said when the doctor has to wait on the phone while the nurse gathers pertinent information that does not look good for the nurse because the doctor gets impatient and loses trust in the efficiency of the nurse.

When asked to describe her working relationship with the doctor she works with most of the time as compared to the ones she does not work with all of the time, she said,

> We have a good relationship. It is not a long time I am working as an RN/team leader with this doctor, but she sees my confidence and has already gained my trust. Working with other doctors could be challenging but some others are nice to work with, because they are patient and take time to listen to the concerns, but not all of them.

Challenges Faced when Communicating with the MD

Thanga did not feel that she has faced any real challenges except the first day she started in LTC when she had to communicate with the doctor about several sick residents on her unit. However, she described what she thinks are barriers to communication in the following paragraph.

Perceived Barriers to Communication

I asked Thanga to talk about barriers that she might have encountered or might have observed during her short working experience with the doctors in LTC, she describes those like this:

> Language barrier when the nurse English is not quite good and the doctors might not understand or vice versa. I have to make myself be heard. Even if my English is not quite good I let the doctor know that I know what I am talking about and I repeat my words sometimes. I tell him English is not my first language and I ask him to slow down when he is giving an order for example. I show him that I am confident and brave and not afraid of asking questions. Because my language is not very good I have to be very precise with the information I am giving to him and be firm as well, make myself be heard. Because my English is not good does not make me stupid and I will not let anyone think I am stupid because I do not speak good English. Some other person may have English as a first language and could speak it very well but that person could be perceived as stupid because she is lacking information, confidence and is not firm, seems insecure and scared. I analyze all my information before calling the doctor. I show him that I know what I am talking about I show confidence and the doctors all seem to appreciate that.

Educational Strategies

When asked about educational strategies that she would recommend or that could be implemented in RN-MD education that would reduce or eliminate barriers to collaborative practice, she said,

> I find that as long as you have all the pertinent information before you call the doctor you will be fine. The doctors like it when you come across as competent. They hate it when nurses come across as not knowing what they are talking about. So you must have the confidence in yourself. How do you gain that confidence in yourself? You have to check out everything about the resident you are calling about before making the call. Check out the internet for anything that you are not sure of so you could give that information to him also. When he sees that you are intelligent, he listens and feels compelled to answer you instructively. I make sure that I do not have any problem with the doctors by educating myself before calling them. The key is competency.

She further added that,

> [The] Nurse needs to have and to show that level of competency in order to gain the doctors trust. Therefore they need organized classes in nursing school and invite the doctor to attend. They will let the students know what is expected of them when they go to work in LTC.

Summary

Even though she is a new team leader, during the interview Thanga showed herself to be very confident in her role. She stressed that nurses have to be well prepared when speaking to the doctor whether by phone or in person. She feels that her *stages* in college in the last semester, which was only about a year and a half ago, prepared her for working with the doctors. She recommends that all colleges do the same. That is, give nursing students autonomy to speak to the doctors on their stages because this could significantly enhance their confidence and their level of autonomy. She feels that if this kind of education is implemented nurses will not be afraid when speaking to the doctor when they start practicing in their role, even if they have a language barrier, like she has.

Jayson

Jayson holds a BScN from a university in the Philippines. He came to Canada six years ago and attended an international school of training for nurses at a college in Montreal. The course was six months, after which he did the Quebec Nursing licensing board exam and obtained his license to work in Quebec as an RN. He is 26 years old and one of the two youngest participants in the study. He did his *stage* in the LTCF where he is working presently and has been working there for three years. Having done his stage in the LTCF where he is presently working should be an advantage for Jayson as he will have had the opportunity of observing the nurses as they work as team leaders on the unit.

Nursing Education-Preparedness for LTC

A college nurse is trained to work in all areas of nursing, obstetrics, pediatrics, medicine, surgery, psychiatry and geriatrics. However, the training obtained in school is not extensive in any of the above named areas of nursing. Therefore, in the acute care hospitals in Montreal, when a registered nurse is accepted to work in any of these areas of nursing, he or she is given an extensive orientation lasting between four to six weeks. This orientation was to familiarize them with the unit, equipment and expertise they need to be able to function in that area of nursing. However, when Jayson was hired in LTC, he received an orientation which lasted only eight days, after which he was expected to work autonomously on the unit. I asked Jayson if he feels nursing school has prepared him for practice in a LTCF, and he replied,

> I could say like 70% of what I learnt in school was on theory and stuff, like about diseases and medicine, and the rest is about practical. It's different when you are in actual nursing. I gained my experience actually from working on the floor as a team leader. It is a continual learning and I am still learning. In nursing school and the clinical setting I learnt all about medical and theoretical stuff but in LTC I learnt about leadership skills and working with other people, like the interdisciplinary team - the dietician, the physio therapist. As a student you are in the clinical setting where you have the resource

> person who is your teacher and your colleagues and other students and other people around you. But here I am working independently dealing with the doctors, dietician and other people. When there is a follow up to do I have to depend on myself as I am the one responsible for the floor, I am the only nurse on the floor, I am the team leader. So here is where I learn about leadership skills.

Early experience. When asked how he felt about practicing as a young team leader when he started working in LTC he replied,

> When I started I could say that [umm] I did not have enough experience yet. So to be honest I was [umm] learning to adapt, how to become a leader, so I read a lot of books on how to become a leader and I searched the internet for ideas. I read books on nursing management to apply myself as to how I should apply myself as a leader, a team leader. I really like the job. I felt that I did not have the competency to be a leader so I learn how to be a leader on my own.

Communicating with Doctors in LTC

Jayson explained what he thinks is the main purpose of MD-RN communication related to work in his facility.

> For me, the main purpose of communication is to have a better quality of care for the residents and for continuity of care for the residents. It really matters most to give the pertinent data which we gather as a nurse, [umm], to give to the doctors. For example I am working as a nurse on the evening shift, in case of emergencies I have to call the doctor on call because there are no doctors on evenings. If the matter is not urgent, if according to my judgement it could wait, I have to put it in the communication book so the doctors could attend to it on his next medical visit but also the next shift will follow up. For example if the resident umm, the resident condition has changed but is not deteriorating I will continue to observe or put in the doctor's book so the doctor could follow up on his next visit, but if it is something that cannot wait, like anything urgent I will have to call the doctor right away.

He feels that he did not learn anything much in nursing school about how to communicate with the MD. Jayson responded,

> In nursing school we learnt about SBAR, which is a sort of communication tool. It was introduced to us but it was a short version. We did not learn much about SBAR it was just basic teaching on how to use it to communicate with the doctor but not in great detail. But I learnt more about it here in LTC.

A skill developed over time. Jayson said he has been building on his communication skills over the time he has been working in LTC. He describes communication as a very important skill that must be developed as it saves time and lives. When asked how often he communicates with the MD, he replied,

> I communicate with the MD during emergency situations only. For instance when the resident condition is deteriorating, when there is a lab result that comes back and it is abnormal, like a positive urine culture test which means that the resident needs antibiotics therapy. I have to call the doctor so he can treat the resident. I am not full time so I would say about twice a week. I communicate with the MD by Phone or in person. Before it was very difficult for me because I did not know the residents nor the doctor. I had to ask a lot of questions to the regular workers, but I had to assess the resident so I could know their problem. When I work with the doctor on doctor's visit day I had to assist the doctor on his round to help identify as well as learn about the residents' problem. Now when the doctor asks me any questions I am capable of answering with confidence because I got to know them all. Experience is the best friend and teacher, it takes time to develop that skill but it comes with time and experience.

From his explanation in the above paragraph one can see that upon taking on the role of team leader Jayson had some challenges with confidence and autonomy but was able to build on these two skills over time. Jayson states that the most important outcome of MD-RN communication practice is that,

> as nurses we could know what the best solutions are for the residents, so that there are less mistakes, and so we could render the best care for the residents to the best of our abilities.

He stressed that effective communication with the doctors is vital for the safe care of the residents.

Experience as Team Leader

Jayson felt that his experience as a team leader is very challenging. He said,

> A team leader is kind of difficult because you do not only have to deal with the residents but with all the team that surrounds you. So, [umm], it feels challenging because there are some conflicts at times and you are the team leader so you have to solve the conflicts/problems. You have to try to solve it first before calling superiors. This is a challenge that I am still learning about, how to deal with doctors and the entire staff and

> the family and the residents. Having to deal with the interdisciplinary team, my staff, resident, family and doctors is my biggest challenge but I am learning every day.

Autonomy in Nursing Practice in LTC

Jayson and I talked about the kind of autonomy needed to practice as a team leader in LTC. He feels that it takes experience from which stems competency and autonomy. This is what he said:

> [umm] for me it requires a lot of experience to work as a team leader and it requires experience to develop that competency. Since I am the only nurse on the floor I have to assess my residents and do the nursing intervention that I have to do. Given that we have the collective order I could give some medication based on collective orders. For example the resident is experiencing shortness of breath, I could administer Atrovent and Ventolin as a collective order which is as per my judgement the resident has shortness of breath and has difficulty breathing. If she is doing better I do not have to call the doctor because I already have that autonomy to proceed. I just have to put it in the report so there will be a follow up and continuity of care. So I do have the kind of autonomy needed to work in LTC but we could have some more autonomy by writing our own prescription and not depending on the doctor for every little prescription. This would be beneficial for the residents. As a team leader I have the autonomy of managing my staff, supervising if they are not sure of what they are doing, if they have any questions I have to be able to answer. Example, in the case of new staff who do not know how to do somethings I need to be there for guidance and to lead them for the better care of the resident.

RN Perception of Working Relationship with the MD

He went on to talk about other experiences he had working with and communicating with the doctor:

> There are lot of experiences working with the MD because in LTC we are calling the doctor by phone in case of emergencies. Sometimes they are hurrying me up and sometimes it seems that they are losing their patience. But as a nurse I have to communicate well with them. For example, the doctor was giving me a medical order by phone which I had to verify with another nurse, so I had to ask him to repeat the order he did not really like this, he told me he was very busy and was giving me an attitude [laugh] but I told him that I really had to do this because this is part of my job and it is also part of our protocol here. He then agrees and repeated the order. Another experience I had is that of another way of communicating pertinent information to the MD. I learned how to use my "I phone" for communicating information to the MD electronically. Two days ago I was speaking to the doctor and was describing a large bruise of a resident

> which was the size of a golf ball and she is on Aspirin. He would have to see it to make an informed decision so I took a picture with my "I phone" and sent it to him because he allowed me to do so. That was a good experience because he ordered a treatment for the resident.

Working experience with the doctors. When asked if his experience as an RN/team leader enhanced his working relationship with the MD, Jason said,

> I become more confident when speaking with doctors, and I learned how to take initiative when communicating well with them. The doctors have different personalities so I have to learn how to work with all of them. The doctors also like for us to make recommendations to them. For example, one of my residents was not voiding so I did a bladder scan and there was 500 cc in the bladder. I called him to tell him the problem and asked right away if I could do an in and out catheterization to eliminate the urine from the bladder. He was happy with that and gave me the order. They like when we make good suggestions.

In describing his working relationship with the MD he works with most of the time, as compared to the ones he does not work with all of the time he said,

> I work part time so I work with different doctors all of the time. When speaking with the doctors, all of them have different personality so there is a different approach for each of them. Example, one doctor needs your advice as well, if you give your advice he will say yes or no. He wants you to do your own evaluation and also give suggestions. As compared to this other doctor who wants thorough and complete assessment by the nurse but he wants to be the one to make all the suggestions. He also gets upset most of the time if the nurse is lacking confidence. There is another doctor who takes his time with the nurse whether she is new or there for a long time. He listens and teaches and then gives his orders. He is so approachable.

Challenges Faced when Communicating with MD

With regards to challenges he faces when communicating with the MD, Jayson admits that working with a doctor he does not know or on a floor where he is not familiar with the residents is one of the biggest challenges he faces, he said that,

> when I work on a floor where I am not familiar with the residents or the doctor, I have to take time to read the chart even though this is time consuming. I have to read everything about the resident before calling the doctor. For me that is challenging because I cannot call the doctor right away. If you are fulltime you already know the resident so you will

> not take that much time. Also, because English is my second language it used to take me more time to comprehend, now it is much better than before.

When asked if he thinks his experiences change over time, Jayson said:

> With more and more practice, I gained more confidence and I learn more. I am still learning.

Perceived Barriers to Communication

There appears to be a number of barriers to collaborative practice and Jayson talked about the ones that he has encountered he said,

> When I have to reach the doctor and he is driving. For instance, I had a resident who was deteriorating and needed to be transferred right away. The doctor was in transit so he could not understand me, he could not hear me. He told me he will call me back in fifteen minutes. I did not have fifteen minutes to wait because the resident was not doing well. So I spoke with the coordinator and we decided to transfer the resident to the hospital. Other barriers to communication are the call bells on the units. The main server is placed in the nursing station and that is very disturbing when trying to talk to the doctor on the phone. Also the doctors are rushing me off the phone. They want you to finish right away, telling me he or she is very busy because they have other patients to attend to. This is because they are in their outside clinics.

I asked Jayson what he thinks could be done to reduce or eliminate barriers to collaborative practice. He suggests, "meeting with the doctors and nurses so that each party could express themselves regarding how to communicate better, maybe the doctors have ideas on how to improve the communication".

Educational Strategies

When talking about educational strategies that could be included in RN/MD education that could enhance communication and collaboration between the two professions Jayson suggests,

> More courses, maybe twice a year in the institution to help the nurses with communication with the doctors. It may be a good idea for the doctors to be included in these courses because they have a big role to play in the communication with nurses. Courses should also be included in the nursing and medical curriculum as well.

Summary

Of the participants, Jayson is one of the younger nurses and has had a difficult start in LTC. He talked about how it was very difficult for him as a novice nurse who had not worked anywhere else in Canada. After graduating in the Phillipines he migrated to Canada without any experience at all. He feels that he has accomplished a lot since he started and because of his persistence in staying in the nursing profession, he has been able to adjust himself in the position of team leader. Jayson also claims that he has grown in his capacity of team leader but still struggles with confidence and autonomy which he attributes to working only on a part time basis.

Anne

Anne is 47 years old. She went to a college in Montreal where she did social sciences and then went on to University and did sociology. She realized that she did not like sociology so she decided to go back to college to study nursing. She has been a nurse for nineteen years and has been working in LTC for seventeen years. For the first two years of her nursing career Anne worked with nursing agencies before taking up nursing in the LTCF where she is presently working.

Nursing Education-Preparedness for LTC

Anne does not feel that nursing school prepared her for working in LTC, she said,

> They give you the tools to be able to work in a hospital environment ex. in medicine, pediatric, surgical, psychiatry. I also did courses in aging which was good at helping me to be able to work in LTC, but the courses were more geared towards hospital nursing. When you actually work in the field, you sort of put together all of the theory that you learnt in school together with the practical. It is only with practice that you really understand the field.

Early experience. Anne said that when she started practice in LTC she was very nervous because “as a team leader you are on your own to make decisions.” She described her beginning

days as a team leader this way:

> nervous, very nervous, because I was thinking about all the things that could go wrong. You are told what to do in class but when it is actually happening? My biggest fear was like "do I know exactly what to do if someone is not doing well, like experiencing a heart attack or when a code blue is called?" I was new so "am I going to remember what to do?" But with time it got easier.

Communicating with Doctors in LTC

Apart from being a team leader on the unit managing staff and residents, Anne has to communicate with the doctors for safe care of the resident. She said the main purpose of communication between RN-MD in LTC is,

> to make sure that the residents are getting the proper and necessary care, the proper medication. I have to let the doctor know what is going on with the resident so the proper care would be given.

When asked what she learnt in nursing school about communication between MD-RN, she said,

> In nursing school I did not have any communication with the doctor per se, but my teacher and nurse-in-charge would have us present when the nurse was speaking to the doctor on the phone or in person so we could observe the way she was communicating and what she was communicating about. As a student I was instructed to make sure I have all of the information I need before calling the doctor, so I brought this into my work as well, this has helped.

A skill developed over time. Communication between doctors and nurses in acute care takes place on a daily basis because a doctor is always present but in LTC communication occurs during doctor's day of visit or by phone. Anne said that the skill of communicating with the doctor is one that is developed over time. I asked her how often she communicates with the doctor she said, "It depends on the residents' condition, once a week with the doctor's visit and as necessary. Sometimes it would be like as often as 3 times in one day and sometimes once a week, it varies."

Experience as Team Leader

When talking about her experiences as team leader she said,

> My experience is good, I like it. I do not have any issues with the staff and families. I get along well with everyone. Sometimes there are certain concerns, like the way some of the residents are cared for, I have to approach the staff and talk about this. For most of the time they are approachable with me letting them know about the residents' needs, like when they have not done the mouth care for instance.

Autonomy in Nursing Practice in LTC

We talked about the kind of autonomy needed to practice in LTC. Anne believes she possesses this kind of autonomy. However, she feels that nurses in LTC should have a greater level of autonomy because for most of the time a doctor is not on site. She elaborated,

> As a team leader I have to be able to problem solve, communicate effectively with the staff, family, residents, interdisciplinary team and doctors. If there are any emergencies I have to be able to manage.
>
> I have this kind of autonomy but I think as nurses we could have more. We have the collective orders which give us the autonomy to execute as if they were actual orders, which really they are, because they are already pre-ordered by the doctor. Maybe the nurses could have some autonomy in ordering certain tests, like urine culture, dressing change. For instance, the resident shows signs of a urinary tract infection. I have the knowledge to know that the signs I am observing are most probably a urinary infection so I would like to go ahead and do the culture and urine analysis and send to the lab but I have to call the doctor and wait for him to call me back. Ex, one time I have a resident who has been showing signs of a UTI. I found out that she has been showing these symptoms for days. I called the doctor to explain the situation, he told me to push fluids. Pushing fluids is alright if it was the first day but this was about three days already, the resident is suffering. At this time I felt the resident needed medication not pushing fluids. It was already too late for pushing fluids. If I had this kind of autonomy to order, I would have sent the urine test right away instead of waiting to see if fluids would help. Instead I had to get the verbal order from the doctor to send the urine culture to the laboratory, wait for the result before starting the resident on antibiotics. The poor resident suffered in the meantime with burning on urination and confusion.

Anne spoke about other experiences she had working with and communicating with the MD. She described one particular *negative* experience.

> A few years ago, one of my residents was clearly in respiratory distress and on oxygen treatment. I felt I had no time to call the doctor so I transferred her quickly to the hospital and called the doctor after, which is something we as team leaders were told by our superior to do if with good judgement we see that the resident is clearly in distress.

> However, the doctor on call was very upset with me that I transferred the resident before getting in touch with him. Sometimes when we call the doctor, it takes them so long to get back to us and I did not want to risk the resident's life. The resident was clearly, by my judgement not doing well. She died at the hospital. I have not had any other negative experiences with any doctors but I have heard of other nurses having problems and I have heard them talking about it all the time.

RNs Perception of Working Relationship with the MD

I asked Ann if she feels her experience as a team leader enhanced her working relationship with the MD; she responded,

> Like I said I was very nervous in the beginning but as time went by and I gained my experience, learning what the doctors want, my relationship has really gotten a lot better. I could say that I have no problems. With practice, the more I speak with doctors in person or on the phone, it gets easier and easier.

And she described her working relationship with the MD she works with most of the time as compared to the ones she does not work with all of the time, she said,

> My experience with the doctor I work with most of the time is very positive. We have a good working relationship. He takes the time to explain things that I do not understand. He gets along well with the entire team, he is great. He is one of the most senior doctors and he likes teaching us. Even the PABs feel that they can talk to him if they are not feeling well or if they have a question. He is so polite and has a lot of patience with staff, residents and family. He takes his time and never rushes the residents and family. Sometimes he takes too long with each resident he sees but this makes the resident and family comfortable with him and they trust him a lot because of who he is. They see that he takes the time to listen to them and to me, the nurse. Compare to the ones I do not work with all of the time, no, I do not feel nervous as in the beginning. It is a matter of getting to know the doctor and how they work. If you are working on a floor that you are not familiar with, you don't know the doctor and you do not know the residents either, that could make you very nervous. I make sure that I have all of the information before talking to the doctor. You have to know in advance what questions he might be asking so you have to be prepared.

As she described in the above paragraph, Anne feels that she is comfortable with the doctor with whom she works with regularly. She is still nervous when she has to communicate with a doctor with whom she does not work all of the time, especially if she is working on a floor where she is not familiar with the residents. She agrees that having all pertinent information in

advance, before calling the doctor, is a plus.

Challenges Faced when Communicating with MD

When asked to describe some of the challenges she faces when communicating with the MD Anne said,

> When working on a floor you are not familiar with and it is doctor's rounds on that day. You do not know how the doctor works and you do not know the residents either, that is challenging.

Perceived Barriers to Communication

When talking about barriers to collaborative practice that she has encountered or is aware of she said,

> I observed language barriers, nurses not having enough experience to deal with the doctor, the doctor yelling at the nurse so loud that I could hear. So loud that the nurse had to move the phone away from his ear, I witnessed that. I told the nurse to hang up the phone because I will not take that kind of abuse. The new nurse just stayed there and listened. That is doctor abusing a new nurse.

Educational Strategies

Anne had some suggestions regarding strategies she thinks could help to reduce or eliminate barriers to collaborative practice; this is what she said:

> Before calling make sure you have everything the doctor needs present. It is only by experience that a nurse will know how to prepare for the doctor. Some courses should be organized, to educate the nurses in school or on the job training how to deal with the doctors. Doctors and nurses need to respect each other's profession. Nurses are also professionals and intelligent enough to do the job.

Summary

Anne was very articulate when making recommendations. She said that nurses need to know how to prepare themselves when communicating with the doctor. According to her, nurses need to know what they need to communicate, what the doctors need to hear from them, and what pertinent information the doctors need them to communicate besides what they think is pertinent. As compared to when she started as a team leader seventeen years ago, Anne feels that

she has developed in competency, efficiency and autonomy. She also feels that doctors need to develop respect and appreciation for the nurses they work with and nurses in general. She concluded her interview with,

> I must say that one thing I learnt in school that help me a lot is during my *stage* the nurse-in-charge told us to make sure that we have all pertinent information before speaking with the doctor. They did not allow us to have that kind of practice in school, which would give us the autonomy we need to practice in LTC or hospital but they instructed us. It would be very good if they could do that in stage, allow the nursing students to approach the doctors and talk to them. Just like they allowed us to observe them, we could observe which is good but then we should have been given the autonomy to talk to the doctors ourselves. This would give us the practice, so anywhere we work we will be able to communicate well, whether by phone or in person. I think this practice is becoming more and popular because I observe the new students approaching the doctors, when they come to us on stage I see them talking to the doctors at times even if the teachers are not present. They are taking the initiative to ask questions to the doctors, especially the third year students. This practice should be allowed in all the colleges.

Chapter Five – Discussion, Implications and Recommendations

The initial analysis of the individual transcripts from the participants in the research had yielded the following seven themes under which the individual profiles were presented in Chapter Four:

a) Nursing Education -Preparedness for LTC

b) Communicating with doctors in LTC

c) Experience as Team Leader

d) Autonomy in nursing practice in LTC

e) RNs Perception/narratives of Working Relationship with the MD

f) Narrative of perceived barriers to communication

g) Educational strategies proposed

In an effort to refine the understanding of the themes that emerged from the individual interviews, it was decided to examine the themes to detect nuances and important results using the same transcripts but based on a further probe of the themes.

This Chapter is therefore organized along the following sections:

A) Preparedness for Team Leadership in LTCs: Education and Practice as Team Leaders.
   --Nursing Education
   --Challenges encountered as Team Leader
   --Autonomy in Nursing Practice
   --The Need To Be Recognized

B) RN Perception/Narratives of Working Relationship with the MD
   --Communicating with doctors in LTC
   --Perceived Barriers to Effective Communication
   --Developing the Skill of Communication
   --Strategies for Collaborative Practice

A. Preparedness for Team Leadership in LTCs: education and practice as Team Leaders

The discussion will follow within the four subsections described above: Nursing Education, Challenges as Team Leader, Autonomy in Nursing Practice and The Need to be Recognized.

Nursing Education

The nursing academic curriculum provides the basics for working as a nurse in any field of nursing but the orientation on the unit is where the RNs learn how to actually practice nursing. None of the participants felt that they were prepared for working in LTC when they had graduated from nursing school. Kimberly described her nursing education as focussing on skills such as:

> IVs, PEG tubes, chest tubes etc. […] At the CHSLD we don't have that much skill to perform so it is more about communication with doctors, and other members of the team. As a team leader it's more about teaching, delegating tasks, leadership. School is more clinically based, school prepare you for nursing in the hospital but here in the CHSLD it is so different.

Joanne said when she went to nursing school there were no courses in gerontology except basic care in first year. She did some courses in gerontology at University and also did some courses that were offered at the LTCF. These courses helped her in her role as a gerontology nurse, with her caveat being that "even after school you really do not know, it is only by experience."

Jayson summed up nursing school education in saying that "70% of what I learnt in school was on theory and stuff, like about diseases and medicine, and the rest is about practical". He added, "It's different when you are in actual nursing. I gained my experience actually from working on the floor as a team leader. It is a continual learning and I am still learning."

Anne felt that although nursing school helped with her practice, it did not prepare her for working in LTC she said they give you the tools to be able to work in a hospital environment like medicine, pediatric, surgical, psychiatry. The courses she did in aging in nursing school were more geared towards hospital nursing. She agreed that actually working in the field is what helped her to "put together all of the theory that you learnt in school together with the practical. It is only with practice that you really understand the field."

As the participants reported, it is with the actual practice on the floor and the experience that they learnt how to become team leaders. In her study on the comparison of nursing in LTCFs and intensive care units (ICUs) Leppa (2004) found that the "LTC nursing work environment is a complex, demanding, and interesting one that is different from, not less than, nursing work in acute care environments" (p. 26). Nonetheless, in acute care hospitals in Montreal, an orientation in any area of nursing, lasts anywhere between four and six weeks, whereas in the LTCF the orientation is eight days on average. For a nurse taking on the role of team leader, eight days appear to be insufficient for any RN starting in LTC whether experienced or novice. To add to their stress level none of the participants had received an externship in LTC or acute care. Externship is a program set up by the OIIQ whereby a nursing student after completing her second year of nursing school could work in a hospital or LTC setting for a period of six weeks before entering the third year in nursing school (www.oiiq.org). This program enables nurses to enter third year nursing school feeling more confident and less intimidated by the stressors of third year.

If Kimberly or Jayson, for example, had the opportunity of doing an externship in a LTCF, they would have worked beside an experienced nurse for six weeks learning how to be autonomous and how to manage a unit as a team leader. Consequently, when they entered LTC

they would have been less nervous in practicing in their role as team leader. Kimberly said "Oh! I was scared at first. In the hospital you have four or five patients but here I had forty residents under my care. I was scared." Jayson was very nervous. He said "when I started I could say that [umm] I did not have enough experience yet. So to be honest I was [umm] learning to adapt, how to become a leader, so I read a lot."

In sum: School is clinically based while in practice as Team Leader in LTC emphasis is placed on teaching, delegating tasks and exercising leadership. Gerontology courses should be coupled with actual practical experience in LTC settings. Even with the best preparation, assuming the Team Leader position puts the nurse in continuous learning mode. For other areas of nursing practice, the students are offered between four to six weeks of practical orientation training caring for four to six patients at a time. Team Leaders in LTCFs get only a one week orientation period for providing care to 40 plus residents.

Challenges Encountered as Team Leaders

During the three years of nursing school in college nurses are taught the basic physical and psychological skills needed to function as nurses. However, the role of team leader is not taught in nursing school. Consequently, nurses learn how to be team leaders on the job. As team leaders they have to assume the responsibility and autonomy of making sure that safe care is given to the residents by all members of the team including the doctors. Furthermore, they are expected to be able to communicate in an efficient and knowledgeable way, any concerns of the resident to the doctor.

Participants in this study all agree that communicating with doctors could be sometimes challenging. This is especially true of doctors who are on call because they do not know the nurse or the residents well. Kimberly said her experience with the doctor she works with most of

the time is positive. She said "You have to know in advance what questions he might be asking so you have to be prepared. The doctors could be very impatient that is why I try not to call too much." She described a negative encounter she had with a doctor when she had just become a team leader. This encounter could have discouraged her from becoming a team leader. The entire story of this encounter could be found in chapter four of this thesis.

Joanne also described some challenges she has when communicating with doctors. Like all the other participants she has a good working relationship with the doctor she works with most of the time. As compared to the doctors she does not work with all of the time she said that even though she has been working in LTC for twenty one years as a team leader, "With the doctors I do not work with most of the time, some of them are alright and others are very difficult to work with. Some understand the fact that they do not work with me and do not know me and so they have to take the time to listen to me because I know the patient and they don't. Others act as if I am dumb."

For Jayson his challenges occur when he is working on a floor that he is not familiar with. In an emergency, because he does not know the residents well, he has to read the residents chart in order to gather pertinent information about the resident to know what might have led up to the present condition, before calling the doctor. Having to get to know the resident at a critical time could be time consuming and anxiety provoking. Jayson said, "For me that is challenging because I cannot call the doctor right away". Jayson also had a difficult time because English is his second language which took him more time to understand and communicate everything to the doctor.

Anne also finds that working on a floor that she is not familiar with poses a challenge for her, especially when doing rounds with the doctor because she does not know the residents or the doctor well.

In sum: The role of Team Leader is not taught in nursing schools. As Team Leader, the nurse working in LTC has to exercise responsibility and autonomy to ensure that safe care is given to the residents. The practice is made difficult by the fact that Team Leaders often have to work on flours or with groups of residents with whom they are not familiar and by the fact that they do not really have a working and easy-going communication relationship with doctors who are on call in the absence of the doctor with whom the Team Leader works regularly.

Autonomy

As team leaders in LTC, nurses possess a certain amount of autonomy. Their responsibilities include overseeing the standard of care given to the residents by the staff, answering to the head nurse and working with the doctors for safe care of their residents. All the participants feel that they possess this kind of autonomy but feel that they could be allowed a greater level of autonomy when it comes to making decisions about the care of the residents. The doctors are in control of the medical decisions, as was stated by Adamson, Kenny and Wilson-Barnett (1995). This is still apparent today when a nurse in a LTCF has to wait for a call back from the doctor in order for him/her to decide if a resident should be transferred to the hospital or not, when the nurse is clearly observing a respiratory distress; or to send a urine specimen to the lab when the resident is displaying symptoms of urinary tract infection. Anne shared these two situations in which she felt that if she had the autonomy to act without waiting for the doctor's consent the residents would have received care in a more safe and timely manner. It was clear to her that she could no longer manage these situations in the LTC. And although the doctor

expressed discontent, this behavior, according to Kramer and Schmalenberg (2003), is the definition of autonomous patient care actions where the nurse is advocating for the patient. The authors describe autonomy as having the ability to make decisions and not always having to ask (p. 13).

It is no small matter then, that in October 2015, the president of the OIIQ announced that after much consultation with many clinical experts and the medical association in Quebec, permission was obtained for qualified nurses in LTCFs to prescribe interventions and treatment for wound care (www.oiiq.org). This is a very small addition to the autonomy given to nurses in LTCFs but it is a beginning nonetheless and a strong indication as to what could follow in the future.

Joanne feels that team leaders have to develop their thinking skills in order to ask pertinent questions and in order to make informed decisions. She described autonomy in nursing as being able to make strong clinical decision for the residents. She also thinks this is a skill that is developed overtime. She said “team leaders have to be given the tools to work with.” She added, “They need to have the knowledge, understanding the signs and symptoms of deterioration of any kind in the elderly. Then courses should be developed within the curriculum together with how to communication those information to the doctor.” Dominique echoed this by saying that being autonomous in nursing in LTC means that a nurse has to be able to make informed decisions, be able to communicate to the team what is to be done and what is expected of them. She added, “To be able to communicate to the doctor and not be afraid, stay calm. A big challenge I have overcome. Know you stuff, know your role, be knowledgeable.”

In sum: Even though the Team Leaders have the responsibility to oversee the standards of care given to the residents, the doctors are the ones in control of medical decisions. The participants concepts of autonomy was described as being able to take initiatives and make informed decisions on their own, with help from the doctor when needed. Nurses were taught how to be task oriented but as team leaders they have to be able to do both: tasks and critical thinking. The participants did not discuss autonomy as it relates to the profession as a whole. As described by Skar, (2010), "professional autonomy means having the authority to make decisions and the freedom to act in accordance with one's professional knowledge base" (pp 2226-2234). An understanding of autonomy is needed to clarify and develop the nursing profession in rapidly changing health care environments.

The Need to Be Recognized

The participants all share the same role but they are all at a different level in their experience as team leaders. Joanne, Dominque and Anne have been in the LTC for over ten years. Kimberly, Jayson and Thanga are considered novice team leaders because they have been team leaders for less than four years. All participants have expressed that they like their role and desire to continue in this role in LTC. Kimberly said, "It's nice […] rewarding but it could be scary. I am still not very comfortable because sometimes when people come to me I am not too sure yet about every question." She admits that she knows she has to be able to make the right decision but is sometimes not quite sure of the decision to make or the answer to provide.

Nevertheless, Kimberly finds being a team leader very rewarding. She attributes this feeling to her ability to be involved in the decision making process of giving best care to the residents, especially when she sees good results. Also, having to lead the entire staff in giving good care to the residents gives her the satisfaction that she is doing a good job. "As a team

leader you are supposed to know, so it could be nervous at times. I guess with more experience I will reach the place where I will not feel so scared or nervous. I got good feedback from the staff which made me feel very good about the work I am doing."

Joanne said she likes her role as team leader in LTC and knows that this is where she wants to work for the rest of her nursing career. This is what she had to said, "I liked it right away – I felt good about it then and I still feel good about it now. We have to be the leaders to answer all questions and make sure the floor is working properly." She likes being in charge of the entire staff, and making sure the residents are well taken care of.

In describing her experience as team leader Dominique agrees that it could be tremendously rewarding and at the same time it could be very frustrating. As a team leader one has to be fair, firm and direct and this does not go well with some people. "It depends on the staff, the team you are working with. Some people do not take directives very easily." At times she may have to tell them something they do not like to hear. "For example, I had to change the luncheon schedule and they were not happy about it but they did it." As she said each person has a role to play and has to respect the other's role." Like all the participants Dominique feels that it takes time to gain the trust of the staff, the head nurse and the doctor. She also feels that her experience as team leader enhances her working relationship with the doctor.

Thanga likes being a team leader but finds it very challenging. She is a perfectionist and is having some difficulty with getting the staff to comply. This is mostly because she was a float team leader but has presently taken up position as permanent team leader on the floor she is working on. She also has to deal with the challenge of a change of role from LPN to RN/team leader within the last year and a half. She thinks she has dealt with this situation successfully.

However, her present challenge is getting to know her new head nurse and the staff. She said, "Presently I work on a floor where the head nurse is always checking everything and the PABs, the residents, the family, everyone is challenging me. I know it is difficult but I told myself 'let me handle it […] I am a new RN and I like the challenge and I am managing."

Jayson also feels that his experience as a team leader is very challenging. For him, being a team leader is difficult because he has to manage not only the residents and family but also the entire staff. Solving conflicts is also a part of a team leader's job and he does not like dealing with conflicts. However, he admits that he has to solve the conflicts or problems first before calling the superiors. Jayson feels that this is a challenge that he is still learning how to deal with but his biggest challenge is "having to deal with the interdisciplinary team, my staff, resident, family and doctors is my biggest challenge but I am learning every day".

Anne is the only one who does not seem to be facing any challenges as of the time she did the interview. She said, "My experience is good, I like it. I do not have any issues with the staff and families. I get along well with everyone. Sometimes there are certain concerns …most of the time they are approachable with me letting them know about the residents' needs, like when they have not done the mouth care for instance".

In sum: From the accounts given above, one can see that the more novice team leaders are still in the process of taking control of their position as team leaders but are dealing with it to the best of their abilities. They feel that eventually with more experience as team leader they will become more comfortable in their role. All participants acknowledged the importance of being recognized as Team Leaders and to work hard to gain the necessary recognition as their experience increases.

B. RN Perception/Narratives of Working Relationship with MD

This section of Chapter Five is organized under the following sub sections: Communicating with doctors in LTC, Narratives of Perceived Barriers to Communication, Developing the Skills of Communication, Strategies for Collaborative Practice.

Communicating with Doctors in LTC

All the participants shared narratives of their perception of working relationships with the MD. All the participants described having a better relationship with the doctor they work with most of the time as compared to the doctor they do not work with all of the time. It is difficult to communicate with an on-call doctor who is the covering doctor and one who does not know the resident. It is a relationship that grows and become one that is built on trust. "As a team leader I have to communicate everything about the resident to the doctor because I am the one there all the time with the residents. He is not there all the time," said Joanne. Even after working in the same LTCF for some twenty one years, Joanne is still apprehensive when calling a covering doctor. She said, "With some of the doctors I feel they are rude with the way they respond. Is like the nurses are not intelligent enough to talk to them or ask questions." Joanne does not feel comfortable talking to most of the doctors but she is very comfortable with the doctor she works with most of the time. At the beginning their relationship was not as good as it is presently but it grew overtime.

Dominique's confidence also built with the doctor she works with most of the time. "I still feel intimidated when I have to talk to certain doctors even though I have been here for 24 years." However, she feels that things have changed quite a lot. She found that the younger doctors have a better outlook on the working relationship with nurses. Nurses could approach them more readily. For instance the doctor she works with most of the time she calls him "my

doctor." They have a good working relationship that was built on trust. As she said in the interview, they had a rough start because he was "high and mighty" and did not want to listen to her opinion. However, as they became more acquainted and worked more together he saw her confidence in her work and he realized that he depends on her because she knows her job well. Consequently, their relationship grew. "He said to me 'when I am not here you are my eyes and ears, so when you call me it is because you have a concern and there is a need to talk about it'."

That particular doctor has given Dominique the privilege to call him every day or evening if there is a health concern for any one of the residents. He prefers to be called because he is the doctor who knows the residents well and prefers to be the one to make the decisions regarding their care. This is very reassuring for Dominique or any nurse working on her floor. Given the privilege to be able to call him instead of the covering doctor on call puts the nurse at ease because she is sure to receive the proper treatment for the resident as he knows their condition. Also, because he has already granted permission to be called the nurse does not feel anxious when making the call.

The nurse has to be well prepared before calling the doctor so he or she does not cause him to wait while gathering information, in which case this may be interpreted as a sign of incompetency. Thanga, the team leader with the least experience, feels she has a good relationship with the doctor she works with most of the time despite her newness to the position. "It is not a long time I am working as an RN/team leader with this doctor, but she sees my confidence and has already gained my trust. Working with other doctors could be challenging but some others are nice to work with, because they are patient and take time to listen to the concerns, but not all of them."

Jayson too feels that the doctors are sometimes hurrying him and even appear to be losing their patience. “But as a nurse I have to communicate well with them. The doctors have different personalities so I have to learn how to work with all of them.” Jayson was happy to say that he has started to take initiative when communicating with the doctor. He found that the doctors also like when the nurses make recommendations or good suggestions. Jayson works part time so he works with different doctors all of the time. He admits to using a different approach for each of them since they all have different personalities. Here is what Jayson said that was interestingly in line with Klein (1967) study, “One doctor wants you to do your own evaluation and also give suggestions. As compared to this other doctor who wants thorough and complete assessment by the nurse but he wants to be the one to make all the suggestions.”

In sum: All of the participants admit to being comfortable with the doctor they work with all of the time but nervous when they have to communicate with a doctor they do not work with all of the time. This anxiety is related to the fact that they do not know each other and the covering doctor does not know the residents well. Acknowledging that this will always be a problem in LTC further research has to be done on finding ways to eliminate this discomfort and anxiety that nurses feel when it comes to communicating with doctors on call. Lindek & Sieckert, (2005) said, “Each health care profession has information the other needs to possess in order to practice successfully.” Collaboration is a complex process that requires intentional knowledge sharing and joint responsibility for patient care. Sometimes it occurs within long-term relationships between health professionals. Within long-term relationships, collaboration has a developmental trajectory that evolves over time. In this vein, the nurses all said that it took some time before they were able to feel comfortable with working and communicating well with the doctor they work with all of the time. It took time to develop trust in each other. It is very clear

that nurses have to earn respect and trust by showing that they are knowledgeable and have confidence with themselves and the work they do in order to gain the trust of the doctor.

Perceived Barriers to Effective Communication

Nurses play a very important part in the decision making process of patient or resident healthcare. Being a nurse myself and also listening to the participants, it is clear that doctors like to speak to nurses whom they perceive as intelligent, knowledgeable and confident because they need information from the nurses assessment in order to help them make their decision regarding the patients' or residents' health. The RNs in this study identified several barriers to effective nurse-doctor communication in LTC such as lack of MD openness to communicate, lack of professionalism, language barrier, feeling hurried by the physician, lack of respect, finding a quiet place for phone call, and difficulty reaching the physician. They reported that they need to be brief because they felt that they were hurried by the physician. Most importantly they revealed that they must be prepared with relevant information before calling the doctor. Ineffective communication between doctors and nurses affect patient care in all areas of health care but more so in LTC since doctors are not always present (Tjia et al., 2010).

All of the participants have communicated that it is much easier communicating about their residents' condition to the doctor they work with most of the time, that is, the doctor belonging to their unit who knows the residents. Communicating with doctors who do not know the residents always pose a challenge. They hesitate to speak to other doctors, but they cannot compromise the health of the residents so they have no choice but to call the doctor on call.

Kimberly said that doctors have to be more attentive and show more respect when communicating with nurses. She said, "Doctors need to be, I repeat, more attentive to us, more respectful, trust us more. They should ask questions if they do not understand us. In terms of

nurses, speaking for myself, you have to be more confident, more precise on what you are talking about. Make yourself be heard." To echo this statement Joanne and Dominique said a major barrier to communication between doctors and nurses is that nurses feel insecure or incompetent when they have to communicate with the doctor. If a doctor makes a nurse feel incompetent she becomes insecure and it becomes difficult for her to regain that confidence to speak with the doctors. However, the nurse has no choice but to regain her confidence because she is the team leader which means she has to communicate with the doctor for safe care of the residents in her care. Joanne said, "You just have to do it over and over again and with time you will overcome that main barrier." For Dominique the worst feeling is one of incompetence she said, "When a doctor makes you feel incompetent, you do not want to call him but you have to. You are the nurse and you have no choice. But the communication will not be as it should because you are apprehensive and on your guard."

In Sum: As expressed in the study of Winn et al., (2004), the participants in this study also feel that physicians perceive their level of competence as a barrier to effective communication, whereas nurses feel that the lack of professional respect given to them by the physicians remains a major barrier. The doctors on call sometimes question why the issue was not addressed during regular hours. This way the regular doctor or the doctor in the establishment will have to deal with it. Well, most of the time the issues come up suddenly. Throughout the course of the study, listening to the stories of the participants, and hearing their suggestions one can see that nurse preparedness and competency as well as doctor's willingness to listen are effective ways of eliminating barriers to effective communication and collaboration between doctors and nurses. If the nurse is well prepared before calling the doctor that means

she does not cause him to wait while she gathers information. In the same way if the doctor does not hurry the nurse and takes the time to listen well the nurse does not feel disrespected.

Developing the Skill of Communication

All the participants said that communication with the doctor is a skill that they developed overtime. Initially it is difficult especially when the doctor is one who does not know the nurse. They felt they had to build a trusting relationship with the doctor. The doctor has to come to the realization that he or she could trust the nurse's judgement in decision making. Kimberly, Thanga and Jayson find that when a doctor realizes that the nurse is firm in her conversation when presenting a resident and also offers strong suggestions, he or she listens more attentively. In other cases the nurses feel that the doctor makes them feel incompetent. It is like they always have to prove themselves. According to Tjia et al. (2010), nurse competency and preparedness are key components when communicating with the doctor about patients care.

In the literature review on competency Pijl-Zieber et al., (2014) state that general competencies resulted in nursing's failure to define nursing practice and while general competencies are often used to assess students, it is in the best interest of the nursing students and would be more beneficial to them if they attained competency in specific skills. According to the authors specific distinction should be made between nurses gaining certain general educational qualities and being proficient in particular nursing skills. Communication between doctors and nurses in acute care takes place on a daily basis because a doctor is always present but in LTC communication occurs during the day of doctor's visit or by phone. No wonder the nurses all said that the skill of communicating with the doctor in LTC is a challenge and is one that is developed over time.

As mentioned in the literature of this study, it is well documented that physicians and nurses have one common goal and that is to provide good patient care, which depends on effective communication between the two professions in order to achieve this goal (Kogan et al., 2010). Lack of communication could result in medical errors that could be detrimental to the recipient of care (O'Daniel & Rosenstein, 2008). Communicating with doctors in LTC in order to provide safe care to the residents is a crucial part of nursing care and the role of the team leader. As a young team leader Kimberly said that in order to provide safe care to the residents it is imperative that she communicates with the doctor she said, "As a nurse there are certain things that we cannot do as nurses. Even if we know what to do we cannot do it because it is not within our scope of practice […] so we have to communicate to the doctor."

Joanne also found that communication with the doctor is a skill she had to develop overtime. She said, "Most of the communication was learnt at the workplace, on the job. In-services played a very big part in learning how to communicate with the MD. Some courses that were given were very helpful." As a nursing student she did not have any communication with the doctors. It was the nurse in charge or her clinical teacher who spoke with the doctor when there was a need to. Communication courses in school were really about communicating between the patient and family. The communication skills she acquired were developed over time, with experience. She said, "If we do not have good communication the resident would suffer".

Dominque said she also did not learn much in nursing school about communicating with the doctor. "In my time we felt more like being servants, staying quiet, listening to what the doctor said, never arguing, accepting whatever he said, if you had an opinion you kept it to yourself. We did not dare to ask questions that we felt needed to be asked because we did not know how he will reply or react to us." She felt hierarchy was very important at that time.

Adamson, Kenny and Wilson-Barnett (1995), reported that nurses are aware of their subordination to the medical profession. However, in her current practice as team leader Dominique said that the biggest outcome of MD-RN communication is the care of the resident and family.

Thanga said she did not feel prepared to communicate with the doctor when she started working as a team leader. Even though she had the experience of talking to the doctor on her stage in her last semester in school, her teacher was always present. Now in her role as team leader she was on her own and had to talk to the doctor without any supervision from any one. According to her, this is a skill she developed over time within the short year that she has been working as an RN. Thanga said that based on the information the nurses give to the doctor they are able to provide the care that the residents need. Therefore, treatment or intervention ordered by the doctor is based on whatever information is given to the doctor. So they have to be well prepared before talking to the doctor.

Jayson said, "For me, the main purpose of communication is to have a better quality of care for the residents and for continuity of care for the residents. It really matters most to give the pertinent data which we gather as a nurse, [umm], to give to the doctors". However, like the other participants, Jayson agrees that his communication skills were developed over time. He noted that it is very important to develop this skill so that it could save time and lives. Jayson feels that "experience is the best friend and teacher, it takes time to develop that skill but it comes with time and experience". He talked about a communication tool that he learnt in nursing school and also at the LTCF.

He was introduced to the tool very briefly in school but in the LTCF he learnt more about how to use the tool. Jayson said this tool helped him when communicating with the doctor by phone. The tool Jayson is referring to is called **S**ituation-**B**ackground-**A**ssessment-**R**ecommendation (SBAR), a tool developed from the Interventions to Reduce Acute Care Transfers (INTERACT II) project. The INTERACT II project is "a set of evidence-based clinical practice tools and strategies initially developed under a Centers for Medicare and Medicaid Services (CMS) contract to the Georgia Medical Care Foundation" (Outslander et al., 2011, p.745-746). The authors claim that the results of their study showed that the tool had a good success rate in reducing the number of transfers to acute hospital, thereby also reducing the cost of hospitalization of these residents.

Anne explained that in nursing school she did not have any communication with the doctors per se, but the teachers and the nurse- in-charge would have the students present when they were speaking with the doctors. She further said, "As a student I was instructed to make sure I have all of the information I need before calling the doctor, so I brought this into my work as well, this has helped." Two of the participants, Kimberly and Jayson, the younger nurses were still nervous when communicating with the doctors but all of the participants found communicating with a covering doctor very stressful, especially by phone communication.

In sum: Communication between doctors and nurses in LTC has been a long standing problem, especially since most of the communication in LTC takes place after hours and on the weekend. The calls take place between a nurse on site and the doctor who is not present and does not know the resident. The treatment ordered by the physician depends strongly on the information provided by the nurse. The literature provides evidence that some nurses and doctors have been trying different tools to help them in the process of better communication.

Another such tool is the quality improvement initiative called **C**ommunicating **H**ealth **A**ssessments by **T**elephone (CHAT) that some doctors and nurses participated in to address the problem of dissatisfaction with after-hours telephone communication (Whitson et al., 2008).

Strategies for Collaborative Practice

All of the participants offered strategies that they think would help to eliminate barriers to collaborative practice between nurses and doctors in LTCTs. They recommend that courses in communication be included in the nursing school curriculum and doctors should be invited to attend and speak in the classes. Maybe communication courses should also be included in the medical curriculum. Since all of the participants have suggested the same things only some of the accounts are mentioned in this section.

Kimberly suggested in-class courses where both professionals could coach each other. She thinks this would be a good way for nurses and doctors to share their stories and through sharing their stories they could help each other understand and come up with better ways of communicating. She said, "Like, maybe the doctors have things that they do not like about how we communicate information to them. This way the nurses will know what annoys them and so they will not do it." She feels this will break down some barriers. Kimberly also expresses the need for the nursing school curriculum to be changed. Another one of her suggestions is that in the LTC, classes could be given where the doctors could be invited to participate and speak to nurses about what they expect when the nurses have to communicate with them. She asks, "Could we better present ourselves? We want to know their perspectives as well not just the perspective of the nurses."

It is clear that this issue is a major concern. Students should be given the autonomy in the clinical setting to communicate with doctors. In her study on "Nursing Students' Learning

Experiences in Clinical Setting: Stress, Anxiety and Coping Mlek (2011), the students who participated in the study said that communication with the medical team was difficult and was not encouraged by the nurses or the teachers. The students believed that this was either because of "doctors' personalities, the hierarchy within the healthcare setting or lack of respect for students' opinions" (p. 91).

Joanne agrees that classes should be given in school on how to communicate and what should be communicated. She said, "Nurses must gain their respect but in order to do that they have to show that they are competent and professional so they could gain the confidence and respect of the MD. Doctors also need to know how to communicate with nurses and to understand that we are professionals too." Dominque also suggests communication courses for both professionals. She said "Doctors need to learn how to respect nurses. Change in attitude, to recognize each other's role? Nurses have to recognize and respect the role of the doctor just as the doctor should be made to recognize the role of the nurse and respect her." She continues to say that nurses have to understand that the role of the doctor is such that he has certain autonomy that nurses do not have and we have to respect that but the doctor also has to realize that nurses are professionals who went to school and obtained a license to practice.

Thanga had a different approach to suggestions. She said, "I find that as long as you have all the pertinent information before you call the doctor you will be fine." She explained that doctors like it when nurses come across as competent and hate when nurses come across as not knowing what they are talking about. She encouraged all nurses to have confidence in themselves. She advised all nurses to acquire confidence in themselves by checking out everything that is needed to know about the resident before calling the doctor, even checking the internet for any up to date information on anything that they are not sure about so they could give

that information to the doctor. In order to avoid problems with the doctors, Thanga educates herself on any arising complication or problems with a resident before calling the doctor. She has experienced that when the doctor sees that the nurse is knowledgeable, he listens attentively and feels compelled to answer instructively.

According to Reynolds (2004), physicians are trained to make decisions about their clients' condition based on a variety of data received by the reporting healthcare worker. As a result a physician may become impatient with a nurse who is giving incomplete information, especially when he or she is in his office and maybe attending to one of his client at that time. It is therefore imperative that the nurse calling from the nursing home has complete information to divulge to the doctor before making the call. As final piece of advice Thanga added, "[The] Nurse needs to have and to show that level of competency in order to gain the doctors trust. The key is competency". She then gave suggestions for organized classes in nursing school where the doctors could be invited to attend. At these classes they should let nursing students or nurses know what is expected of them in the way of communication with the doctor, especially in LTC.

In sum: I strongly agree with Thanga when she says that nursing preparedness is the number one key to getting the doctors' attention. If the nurse gathers all of the pertinent information about the resident and also gain information from other sources before calling the doctor he will in no doubt be impressed and have no choice but to listen. However, in some emergent cases there is just no time to gain all the needed knowledge about what is going on at the moment. Sometimes just having the immediate information about the present condition in the given situation is all a nurse could gather at the time of the emergency, especially when the nurse is not the regular on the floor. In this situation the nurse really needs the patience and attention of

the doctor on the phone. Also, sometimes even if the nurse has all pertinent information she may feel that she is bothering the doctor by making the phone call.

In their study in 2010, Tjia et al. provided some recommendations from the nurses. In order to enhance communication between doctors and nurses, the study reported, "Nurses felt that physicians could contribute to improving nurse-physician communication by maintaining a professional demeanor and respecting nurses more" (p. 146). They also recommended that physicians recognize that the nurse often knows the patient well and be willing to work more collaboratively with the nurse. Nurses wished that physicians would call back more promptly and that they would listen to the nurses more when they do call.

Summary

The team leaders all gave their own accounts about their experiences in the role of team leader in LTC. However, common themes were found in their stories. They all felt that they were not prepared to work in LTC and did not receive sufficient orientation to practice as team leaders. They all agreed that nursing school had prepared them with basic skills and knowledge needed to practice as nurses. However, to practice as a *gerontology* nurse demands further training with a wider knowledge base on a more extensive orientation that is given when hired in LTC. They all felt some anxiety when starting their role as team leader which is normal because of all the responsibilities that come along with being team leader. Dominique, felt lucky that she was able to work for two years as a nurse on the floor before taking on the role as team leader. Jayson said even though he would have all the knowledge required to work as team leader only experience is his best teacher. They all like being team leaders in LTC and wish to stay in that

role but expressed the desire to practice more autonomously. However, the dominance of doctors in LTC poses a certain level of threat to their level of autonomy.

Ultimately, the one most important recommendation gained from this study is an echo of previous research. Namely, that nurses need preparedness if they are to deal with the pressures of LTCF work. Almost echoing what Thanga said in this study, one of the nurses in Tjia et al (2010) study said, "I think if you're prepared and have all the information needed when you talk to a doctor, it makes it go that much smoother" (p.146). Nurses in this study all agreed that they have to be well prepared before making the call by gathering all pertinent information. Also they must communicate clearly the reason for the call and what is needed from the doctor. Just like the participants in this study, the nurses in Tjia et al. (2010) said, nurses feel that it is important to be persistent, firm and professional with the doctor. One of the nurses said, "Remember that the safety of the patient is the most important thing" (p. 6).

IMPLICATIONS FOR NURSING EDUCATION

The previous section presented an examination of the themes found in the RN`s stories. This examination of themes was done in order to find answers to the research questions:

1. What are the experiences of registered nurses (RNs) working with medical doctors (MDs) in long-term care facilities (LTCFs) in Montreal?
2. How do they perceive/narrate their working relationship with the MD?
3. How do they perceive communication with the MD in a LTCF?

As a result of the themes that emerged during the study, certain implications were identified such as the need to address the inclusion of communication courses in the nursing curriculum; availability of a well-structured orientation program in the workplace; the need to improve team

leaders' and doctors' relationship and communication styles. A look at how team leaders could be best supported will also be presented.

Implication for Education

All of the participants stated that they experienced some form of anxiety in their early experiences as a team leader. They expressed appreciation for the training and experiences obtained in nursing school and clinical practice. Nevertheless, they felt that even though they were given the basic education, they were in no way prepared to work in LTC and especially not prepared to communicate with the doctors in LTC. The RNs also expressed that most of their clinical experiences in nursing school were anxiety provoking which sometimes hindered their learning and they were not given the hands on experience of communicating with the doctors in the clinical setting. This added to their sense of insecurity when they started in LTC. Even with experience some of them still express anxiety when having to communicate with doctors, especially by phone, when the doctor is one they do not work with all of the time.

Poor communication among health care professionals accounts for one of the most common causes of error in health care (Tschannen, et al, 2011). The challenges healthcare institutions face regarding communication and collaboration between nurses and physicians must be addressed in two ways. First, the education system needs to embrace the concept of inter-professional education and ensure it becomes a part of every nursing and medical student's curriculum. Second, hospitals need to initiate an in-service process to educate and train current practicing nurses and physicians in the skills of effective communication techniques. This can be done through team training and simulations focusing on inter-professional communication, allowing opportunities for nurses and physicians to work together (Tschannen et al, 2011). As

was seen in this study, when nurses and physicians worked together on a solution to a problem, collaboration emerged and communication became more equal between the two groups.

Fagermoen (1997) states "A core characteristic of nursing as a practice discipline is that its practitioners work in close and continuous relationships with patients who are both vulnerable and partially or totally dependent on the nurse for the maintenance of their basic needs in coping with health deficiencies" (p. 434). It's easy to care for people whom we like and with whom we naturally identify. It's altogether different when caring for patients and families with challenging behaviours.

Therefore, the development of the desired and required competence in nursing students is paramount, as the knowledge, skills and ethical grounding of the practitioners directly affect the quality of care provided. Also, nurses are expected to be self-directed learners and be able to reflect on their practice and consequences of that practice (Martyn, Terwijan, Kek & Huijser (2014). It is important for nurses to be ready to meet the future challenges in healthcare. Therefore, nursing students must be equipped with essential 21st century critical thinking skills and self-directed learning tools that will enable them to become creative problems solvers.

Now with the ever increasing aging population, nursing curriculum should include more courses on aging and include more stages in LTC. The introduction of Problem Base Learning (PBL) in the nursing school curriculum might be a strategic way to encourage team work and foster nurse`s competence when trying to integrate in the health care setting as team leaders. This strategic form of learning entails that students work in groups and use problem cases or scenarios to define their own learning objectives (Wood, 2003, p. 328). Subsequently, they do

independent self-directed study before returning to the group for discussion and refining of their acquired knowledge.

According to Ehrenberg and Häggblom (2006), PBL encourages self-conducted individualized learning and the student's own responsibility for learning. It is reported in the literature that this kind of learning also supports the personal and professional growth of the students. The students will use their experience from their clinical setting as a starting point towards problem solving and critical analyses. This will enable nurses to increase the way they integrate theory with practice. Since this practice of PBL is already being used in medical school and also taking roots in nursing education, maybe this method of learning could also be used as a training tool to encourage communication between doctors and nurses.

In order to implement this kind of student-centered learning environment nursing educators must be willing to move away from the more traditional way of teaching. This kind of learning suggests that PBL therefore, enables the student to enter the health profession with thought processes that are developed to a higher level. Implementing this kind of learning strategy throughout the nursing curriculum would benefit nurses entering the health care system and especially nurses entering the profession as team leaders, as they will have already developed a level of competency needed to work in LTCFs as team leaders. It is well noted that team leaders need to be problem solvers and able to make good clinical judgement.

However, researchers Allen, Donham and Bernhardt (2011) advise us that their literature review of the practice of PBL does not provide concrete evidence of its effectiveness on student learning outcomes.

The results of this study clearly suggest the importance of effective communication between doctors and nurses for the safe care of residents. There is therefore implication for students to be introduced to the medical team in the clinical setting and be encouraged to communicate with the doctors. This may help them with the organization of what information is relevant and pertinent to share with the doctors, which in turn may encourage effective communication between doctors and nurses.

However, in order to fully function as autonomous team leaders, nurses need to be empowered and to learn techniques of being assertive when in communication with members of the medical team. Nurses must feel that they possess the level of competency and confidence needed to perform in the role of team leader. These findings adequately imply that the practice of communication between doctors and nurse should begin in nursing school.

Implications for the LTC Institutions

The results of this study suggest that changes are needed within the institutions of the LTCFs in the way orientation is done and the length of the orientation given. In the LTCF the nurses received a total of eight days as compared to six weeks in acute care hospitals in Montreal. A team leader assumes a great number of responsibilities when he or she takes up practice in a LTCF. Therefore the orientation program should be a well-structured, organized and planned program and should be more extensive. The nurse should be given an appropriate length of orientation time to ensure that he/she obtains the required amount of knowledge and skills needed to perform the required responsibilities as team leader. It is therefore imperative that the preceptor has the knowledge and skills required to perform a successful orientation so that the new nurse is not left with feelings of insecurities. The preceptor must possess a strong clinical

background, strong leadership and good communication skills, and be able to impart that knowledge effectively to others.

Also, since all of the nurses stated that they did not feel prepared to practice as team leaders in LTC when they started, it is safe to conclude that nurses should be offered courses in leadership as well as how to communicate with doctors in order to be experts in their field of practice as team leaders. All of the participants hold a college degree in nursing and are practicing in the capacity of team leader but have never had any formal teaching on how to be a team leader or on how to communicate with the doctor. Nurses should take responsibility for their professional development by further educating themselves in areas where there is a lack of education. It would be to their benefit and the benefit of their patients or residents to seek courses or workshops that will help them gain the education needed to enhance their communication skills.

It is also highly recommended that LTC institutions develop and fund courses in leadership and on how to take on the role of team leader which should include how to communicate with the doctor. Courses may include having doctors' participation. Taking on the role of team leader could be very stressful and intimidating especially for a new nurse who has little or no experience in nursing. In LTC the majority of the team members are PABs who have been working for long time and feel that they have a command of the unit. Consequently when a new nurse shows up on the floor some may think that they can take the opportunity of testing their limits.

However, it is important and necessary to have the full participation of all members of the team for everything to go well and the proper care be given to the residents. This is even more difficult for the nurse who is a *float nurse* (a nurse who works on different floors). It is a difficult

task to have to reorient oneself on a constant basis. Every floor has its own culture and the team leader has to learn a different culture every time she goes to a different floor. The team has to be welcoming and accepting of the role of the team leader in order for all to go smoothly. There is also the responsibility of making sure the appropriate care is given to the residents which include communicating with the doctors. It therefore is the role of the nurse manager (head nurse) to help with the integration of a new team leader to the floor and the nurse rely on the support of the head nurse, which in my own observation is sometimes not present. As nurse managers influence the attitude of their staff it is very important that the staff knows that the team leader is being supported by the head nurse.

Several researchers' examinations of nurses' perceptions of autonomy reveal that although nurses thought they are expected to practice autonomously they receive little support for doing so. Consequently "nurse mangers must provide opportunities for nurses to develop and maintain exquisite competence; must communicate trust; and most of all, must empower nurses to function autonomously" (Kramer & Schmalenberg, 2003, p. 15). Key findings and results of the study by Kramer and Schmalenberg (2003) illustrate the importance of the involvement of nurse managers in the role of nurses performing autonomously in the clinical setting. In order for nurses to practice autonomously they must feel that they possess that level of competence.

Competence is a prerequisite to autonomy, which means that the nurse knows that he or she has the knowledge to perform certain task or skill as well as the ability to divulge certain information to patient and family and the health care team regarding their patients' care. Consequently, nurse managers are responsible for providing opportunities for nurses to keep up their knowledge base. In so doing they are thereby providing empowerment and fostering

leadership. Creating workshops and professional development opportunities could be the driving force for change.

In his study "The hidden curriculum", Nelson (2012) implies that nursing educators and employers are having a fight about who should be educating nurses and making them ready for work in hospitals and community. Nursing employers claim that nurses are ill prepared, and not well trained and ready for work. Hospital administrators feel that they should not have to train nurses who have already been trained in school, while nursing educators claim that they do everything to produce well trained nurses in all fields of nursing. Nursing educators state that they prepare life-long learners who have the theory and skills needed to practice in any nursing environment. Nelson further claims that it is time to break the "deadlock once and for all" and come up with new models that will make practice-based learning positive and programs responsive to the needs of the system now and in the future (p.5). There has to be a new approach to developing clinical skills and professional identity.

As a nurse educator I want students to be mentored by practitioners who embody the desired knowledge, skill and professional values and in agreement with Nelson, (2012), I suggest an orientation program consisting of mentors who are highly functional. Therefore, colleges, universities and institutions must work in partnership to accomplish this goal. In order to solve the nursing shortage and to produce professionally skilled individuals with practice-based experience, new approaches are to be developed. The current reality is that educators focus on creating patient-centered professionals who are competent and reflective and could function in the fast-paced and, at times down right chaotic health care system.

Almost all of the time nursing students are sent to a clinical setting with instructors who do not work in the institution and therefore do not know the setting. Therefore, when a nurse is hired in an institution, caution is taken to place the new nurse with preceptors who are chosen by the institutions' administration on the basis that they are competent, efficient, are equipped with mentoring skills and can work with the added pressure of mentoring a new nurse.

Implications for Further Research

The data obtained from the six participants support some of the findings in the literature and provide some new knowledge as well. The study suggests the importance of effective communication between doctors and nurses and has the opportunity for raising questions that could provoke serious discussion. The study also suggests the strong influence that the medical team has in the healthcare system and in the health care environment. Furthermore the study suggests the importance of good team leadership. The relationship between doctors and nurses was also explored revealing that the doctor who works with a nurse on a regular basis, who is a part of the team, has built and established a trusting relationship, and is the ideal partner for the team leader nurse. The nurses admitted that building this kind of relationship had always a rough start and it took a while to achieve but it was an accomplishment that they were happy with when it was arrived at. Their challenge remains communicating with a doctor who is on call and who does not know the nurse and/or the residents.

Telephone conversation is a mode of communication that takes place between nurses and doctors on a regular basis since the physician is not in the LTCF most of the time. Therefore nurses have to be well prepared before calling a doctor on call. There need to be further research on this topic since the literature in this area is scarce. The team leaders all said they were not trained and had no previous experience as team leaders in LTC except for their eight days of

orientation. This can be an area to explore to see if team leaders need some kind of special training before taking on the role as team leaders. Also it is important to hear the doctors' point of view on communication between doctors and nurses. Therefore this is also an area to be explored. In addition, the nursing curriculum should be re-evaluated and clinical teachers' perspectives explored on allowing nursing students to communicate with doctors in the clinical setting.

This study provided new qualitative data on team leadership. This needs to be explored to find out how team leaders work effectively with their team and with the doctors to provide safe care to residents in LTC. This study also resonates well with that of Kramer and Schmalenberg (2003) and confirms that further research on autonomy be done so that the differences between clinical and professional autonomy and control over practice are made clear.

Taking into account that there was only one male participant in the study and there is limited research on male nurses' involvement in nursing, this should also be considered an area for further research. This may help to explore and identify any specific needs and if they differ from those of female nurses/team leaders. It may also provide valuable data that will enable educators to identify what kind of support is needed. Since it is a well-known fact that males are still underrepresented in the nursing profession, it would be very interesting to hear their perspectives. An important identification is that all of the participants in the study came from diverse cultural background as is the case of the nursing culture today. Nursing students are made up of diverse ethnic groups. This could be another area of research to look at their experiences and transfer of knowledge.

Limitations

Even though this was a small sample study it gave insights into the experiences of nurses as team leaders and their perceptions of their relationship with the doctors with whom they work. However, there are some limitations to the study. One important limitation is that all of the nurses were from the same LTCF where the researcher works as an educator. And even though the researcher explained before the interview that her role at that time was one of researcher and not educator, it is possible that the participants may have withheld some information that could have been important to the study

The participants were all from CEGEP level of nursing and therefore the results cannot be generalized to nurses with a higher level of education like one holding a baccalaureate or master's degree. Despite these limitations, this research study has provided rich data that may be helpful to nursing educators. It may help educators to better understand the experiences of nurses working as team leaders in LTC so they could best support them in the transition from students to team leaders as well as the nurses coming from another clinical background to integrate into LTC as team leaders. This could help to decrease the level of anxiety of the nurses but most importantly may help with the re-evaluation and planning of the nursing curriculum and also with on-the-job-training. Also, I did not include physicians in the study which might have limitations to the conclusions that can be drawn about physicians-reported barriers to nurse-physician communication. Some studies have been done on education of physicians-patients communication but studies on physician-nurse communication are scarce. Further study is needed to assess physician responses to these findings.

Future Directions

Effective nurse-physician communication is essential to promote excellence in resident care. The two professionals must realize that teamwork is the key to effective communication. If each professional recognizes and respects the difference in the role each of them plays this will allow for equal amount of respect for each other's role and for each other. A well-structured nursing curriculum that offers a solid educational background to nurses is paramount to their approach to the profession. In the same way a well-structured and organized orientation program is essential to the success of nurses in their role as team leaders. Sufficient time should be allowed in the orientation to facilitate the knowledge base needed to feel comfortable to begin practice as a team leader. As the shortage of nurses in the health care system is rising the need to train more efficient and autonomous leaders in nursing is becoming more evident.

Furthermore, with the aging Canadian population and the need to place more people over the age of 75 in LTCFs, it is imperative that nursing educators rethink the nursing curriculum to accommodate more educational courses in gerontology and include more stages in LTCFs. These courses should also include communication with doctors. The literature reveals that, in the near future more nurses will be taking up practice in LTC as older nurses go on retirement. Also noted is that gerontology nursing is becoming more popular and is attracting more nurses than before. Nurses therefore need to develop skills on how to work in LTC like, how to manage staff, how to communicate with the doctors and how to be more autonomous as they lead as team leaders.

The nurses in this study identified well one of the perceived barriers to communication and collaboration with the doctor as nurses' unpreparedness when calling the doctor and also feeling of being hurried when communicating by phone with a covering doctor. As a nurse

educator in LTC I am witness to this fact. I have had complaints from both sides. The doctors complaining that the nurses are not giving complete information when they call and the nurses complaining that the doctors do not take the time to listen.

It is evident that clear communication is associated with improved quality of care and patient/resident outcomes. All of the participants expressed the desire to practice autonomously but the dominance of the doctors poses a threat to this. "The nursing curriculum must change to enhance professional nurse autonomy by changing from an emphasis on training to education, from technique to understanding, from a focus on content to one that endorses autonomous decision making and finally from ritualistic thinking to one that embraces inquiry" **(**Wade, 1999, p. 316).

One suggestion I would like to make is that of the introduction of Nurse Practitioners (NPs) in LTCFs in Montreal. "Nurse practitioners (NPs) are registered nurses with additional educational preparation and experience who possess and demonstrate the competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within their legislated scope of practice" (Canadian Nurses Association [CNA], 2006, p.19, as cited in Canadian Nurses Association, Fact Sheet). In LTC the role of the NP as a member of the primary health care team, is that of a clinician, collaborator, case manager, coordinator, counsellor, communicator and educator.

Bryant-lukosius, DiCenso, Browne and Pinelli (2004) state that "Advanced practice nursing (APN) represents the future frontier for nursing practice and professional development" (p. 520). For this reason continued development of APN is of paramount importance for society

and the nursing profession, even though there are still many challenges to the successful implementation of NPs.

This practice is in place already throughout the province of Ontario. Since most Nurse practitioners were staff nurses before becoming a NP they really understand the nurses' role. I think this could be one of the ways to bridge the gap in communication between doctors and nurses in LTC since the NPs will be working with the doctors and more with the nurses. As was reported by the nurses in the study, they sometimes feel that their input is not valued or acted upon which gives them the sense that there is a lack of collaboration between them and the doctors. The addition of NPs to the team may be a positive one for nurses as well as for the physicians, as a higher level of collaboration has been reported between MDs and NPs and between NPs and nurses than between MDs and nurses. Nevertheless, communication with a resident's nurse should be especially useful because the nurse is the one at the bedside with the resident and family and knows the resident very well (Vazirani et. al., 2005).

According to the literature not many LTCFs employ NPs and in Quebec there are not yet any NPs in any LTCFs. Hopefully this will change in the near future as I believe having NPs in LTCFs will improve nurse/doctor communication, help decrease the transfer of residents to acute facilities and thereby reduce the cost of health expenditures. Having NPs in nursing homes has helped addressed critical issues in LTC, such as the increasing proportion of older resident with complex health problems, limited physician services, inadequate quality of care, and escalating healthcare costs (Ploeg et al, 2013, Ryden et al, 2000 & Mueller et al, 2014). Collaborative efforts between doctors and nurses are becoming more and more important as the medical care becomes more complex. This is important for achieving positive outcomes for patients/residents (Vazirani et al., 2005). In this time of a shortage of nurses, interventions to improve physicians-

nurse collaboration are needed, because such collaboration is advantageous for physicians, nurses and patients. Tjia et al. summarized this aim most succinctly when they stated, "Interventions to improve the effectiveness of communication in LTC setting must target both nurses and physicians to create a culture that facilitates effective communication with improved patient safety and healthcare quality as the ultimate goal" (2010, p.9).

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Appendix A

INVITATION LETTER TO REGISTERED NURSES (RNs) OF A LTCF IN MONTREAL QUEBEC

RE: Research Study: "IDENTIFYING LEARNING NEEDS TO ENHANCE COMMUNICATION SKILLS BETWEEN DOCTORS (MDS) AND NURSES (RNS) IN LONG-TERM CARE FACILITIES (LTCFS) TO DELIVER SAFE CARE TO RESIDENTS"

Dear X,

As part of a requirement of a M.A. in Educational Studies in the Department of Education of Concordia University, I am undertaking a research study: "Identify learning needs to enhance communication skills between Medical Doctors (MDs) and registered nurses (RNs) in long-term care facilities (LTCFs) for the safe delivery of care to the elderly (residents)". I am writing to you to invite you to participate in the study. The purpose of this study is to understand the experiences of RNs in building communicative, collaborative and trusting relationship with MDs. Participation is voluntary and participants' identity will be kept confidential and protected by pseudonym.

The study will consist of one individual interview with 6 RNs and is expected to take 45-60 minutes. The interview will be audiotaped and transcribed for your revision. Your identity will not be disclosed in the findings. Only I, the researcher, will know your identity. Any details that may identify you will be excluded from the data. You maintain the right to withdraw from the study at any time. I hope to conduct the interview at your convenience and at a place mutually agreed upon.

This study has received approval from the Concordia University Human Research Ethics Committee and the LTCF's Research Ethics committee. It is my hope that this study will contribute to nursing and medical education.

Thank you for considering this request. If you have any questions or concerns, please feel free to contact me at 450.681.8068 or 514.738.4500. ext. 2192 or email mardougl@hotmail.com.

I look forward to hearing from you.

Marilyn Richards-Douglas

Appendix B

CONSENT TO PARTICIPATE IN

IDENTIFYING LEARNING NEEDS TO ENHANCE COMMUNICATION SKILLS BETWEEN DOCTORS (MDS) AND NURSES (RNS) IN LONG-TERM CARE FACILITIES (LTCFS) TO DELIVER SAFE CARE TO RESIDENTS

I understand that I have been asked to participate in a research project being conducted by Marilyn Richards-Douglas for the purposes of completing the requirements of her MA degree in Educational Studies. Marilyn Richards-Douglas is a graduate student of Concordia University*(Tel.* 450.681.8068 or 514.738.4500. ext. 2192 or email mardougl@hotmail.com) and she is conducting this study under the supervision of professor Arpi Hamalian, department of Educational Studies of Concordia University.

A. PURPOSE

I have been informed that the purpose of the research is to examine the communication experiences of nurses working with doctors in LTCFs. The main goal of the study is to identify the ways nurses collaborate and communicate with the doctors in order to deliver safe care to residents and to understand the experiences and perceptions of the nurses from their own perspective. The results of the study will be used to make recommendations for inclusion of lessons in the nursing curricula during the years of education and training for qualification for their professional degrees. I understand that the data collected will not be used to impact the actual day to day practice of the participants in any way.

B. PROCEDURES

I understand I will be interviewed once, for a period of 45 to 60 minutes. The interview will be audio-taped and will be conducted at a place and time mutually agreed upon by the research and myself. The interview will take place in Montreal, during September, October and if needed November 2015. My real name will not be used in the write-up of the study: a pseudonym will be given to me and every effort will be made to keep my name confidential. Only the researcher will know my real identity. The interview will be transcribed by the researcher and shared with me for accuracy. The interview transcription should be returned to the researcher within two weeks of its receipt. The sharing and the return of the transcription will be by e-mail or by post or in person as arranged and agreed upon between the researcher and I. After the study is completed all the audio tapes and notes from the interviews as well as transcripts will be safely stored in the home of the researcher, in a locked cabinet with an alarm system, and electronic data will be password protected and stored on the computer of the researcher. All data will be deleted from the computer and the paper copies will be shredded after five years. I will have access to the completed thesis document through Concordia's Spectrum Research Repository (open Access).

C. RISKS AND BENEFITS

I understand that the risks to me as a participant in the study are minimal or non-existent. In the unlikely case, when in the course of the interview session incidental findings are discovered, the researcher has an obligation to inform the participant and/or the relevant authorities (in case of incidental findings of a criminal nature for example).

The benefits may be that my story will be used to better understand the experiences of nurses working with doctors in LTCFs. The results of the study may ultimately help improve nursing education in the future by including best communication practice lessons in the curricula.

D. CONDITIONS OF PARTICIPATION

- I understand that I am free to withdraw my consent and discontinue my participation at any time without negative consequences.
- I understand that my participation in this study is CONFIDENTIAL (i.e., the researcher will know, but will not disclose my identity).

I HAVE CAREFULLY STUDIED THE ABOVE AND UNDERSTAND THIS AGREEMENT.
I FREELY CONSENT AND VOLUNTARILY AGREE TO PARTICIPATE IN THIS STUDY.

NAME (please print) _____

SIGNATURE _____

If at any time you have questions about the proposed research, please contact the study's Principal Investigator, Marilyn Douglas, Concordia University, 450.681.8068, 514.738.4500 ex. 2192 or mardougl@hotmail.com or Faculty Supervisor, Professor Arpi Hamalian, Department of Educational Studies, Concordia University, 514.848.2424 ex.2014 or ahamalian@education.concordia.ca

If at any time you have questions about your rights as a research participant, please contact the Research Ethics and Compliance Advisor, Concordia University, 514.848.2424 ex. 7481 ethics@alcor.concordia.ca

Appendix C

Consent form for contacting research participants

I, _____ (Print full name)

agree to be contacted by Marilyn Richards-Douglas, the researcher for the study

"Identifying learning needs to enhance communication skills between doctors (MDs) and nurses (RNs) in long-term care facilities (LTCFs) to deliver safe care to residents" to schedule the interview.

Contact information:

Telephone number: _____

Home address: _____

_____

E-mail address: _____

Signature: _____

Date: _____

Appendix D

Demographic Data

Name: _____

Gender: _____

Title: _____

Country of birth: _____

Number of years living in Canada: _____

Educational status: _____

Length of time as an RN_____

Length of time as RN/team leader in LTC: _____

Do you work part or full time in the LTCF: _____

Appendix E

Interview

IDENTIFYING LEARNING NEEDS TO ENHANCE COMMUNICATION SKILLS BETWEEN DOCTORS (MDS) AND NURSES (RNS) IN LONG-TERM CARE FACILITIES (LTCFS) TO DELIVER SAFE CARE TO RESIDENTS

INTRODUCTION

1. Introductions
2. Review purpose of interview
3. Explain the interview mechanics:
    - 45-60 minutes maximum in length
    - Will occasionally check the clock and the tape recorder

4. Interview process:
    - Allow you to talk about your observations and experiences with the MD
    - My role is to listen and if needed to prompt from my check-list of questions to ensure that all necessary areas are covered
    - Please ask for clarification if needed

5. Reassurance regarding confidentially
    - Specific content of the questionnaire and taped interview are confidential
    - Content is only for the use of the research team
    - When using names of residents or colleagues, please use fictitious names.

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Appendix F

Research and interview questions

Introductory questions:
-Tell me about your educational background?
-How long have you been working as a registered nurse?
-How long have you been working in LTC?
-Is nursing your first job and is working in LTCF your first job as a nurse?
-How has nursing school prepared you for practice in a LTCF?
-When you started working in LTC how did you feel about practicing as a team leader?

Primary Research Question 1: How do MDs and RNs communicate with one another to provide safe care to residents in LTCFs in Montreal?
Secondary Research Questions: What is the purpose of MD-RN communication related to the work of your facility? Please elaborate
-Tell me about what you learnt in nursing school about communication with the MD?
-Did you feel prepared or do you feel this is a skill that you had to develop over time?
-How often do you communicate with the MD? Please identify the ways of communication.
-What do you feel are the most important outcomes of MD-RN communication practice?

Primary Research Question 2: How do you perceive your working relationship with the MD?
Secondary Research Questions: Tell me about your experience as team leader, what is that like?
- Let us talk about the kind of autonomy needed to practice as team leader in a LTCF?
- Do you feel that you have been given that kind of autonomy?
- Tell me about other experiences you had with working with and communicating with the MD
- How has your experience as RN/team leader enhance your working relationship with the MD
- Describe your working relationship with the MD you work with most of the time as compared to the ones you do not work with all of the time.

Primary Research Question 3: How do you perceive your communication with the MD in LTCF?
Secondary Research Questions: -Describe some of your challenges face when communicating with the MD.
-Give me some examples of positive or negative experiences.
-How did your experiences change over time?
-Can you tell me about barriers to MD-RN collaborative practice that you have encountered or of which you are aware?
-What do you think could be done to reduce or eliminate barriers to collaborative practice?
-What educational strategies would you recommend be included in RN-MD education that would enhance communication/collaboration between the two profession.