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Interprofessional collaboration: nursing moving towards teamwork in the care of the elderly

Colaboración interprofesional: Enfermería caminando hacia un trabajo en equipo en el cuidado del adulto mayor

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ABSTRACT

Objective: Describe and interpret the experiences of nurses with an expanded role in in-professional collaboration.

Material and methods: Descriptive-qualitative, exploratory study. Between May and October 2019, after signing the informed consent, an in-depth interview was intentionally conducted with 20 nurses with a minimum academic level of bachelor's degree, with diplomas, courses, specialty and/or master's degree, who had already been working for a minimum of 3 years in a service with attention to the elderly in public or private health institutions of 1st and 3rd level of care.

The interviews were transcribed and the thematic content data analysis proposed by De Souza and the phenomenological method was carried out, supported by the Atlas Ti Software.

Results: Two categories emerged: 1. Collaboration between nursing professionals: Guaranteeing continuity and quality of care, where the expanded role nurse collaborates with nurses of different levels of competence. 2. Interprofessional collaboration: moving towards teamwork, that is, it collaborates directly with health professionals in the care of the elderly when it is integrated into the geriatrics team. On the contrary, it is difficult to establish an interprofessional collaboration with internists and general practitioners.

Conclusions: The nursing professional is on the way to make their expanded role visible, without having to replace or carry out medical activities, but based on their established competencies to work collaboratively.

Keywords: Advanced Practice Nursing, Aged, teamwork, inter-professional collaboration, clinical work.

RESUMEN

Objetivo: Describir e interpretar las experiencias de las enfermeras con rol ampliado en la colaboración interprofesional.

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Materiales y métodos: Estudio descriptivo-cualitativo, exploratorio. Entre mayo y octu- bre 2019, previa firma del consentimiento informado, se realizaron entrevista a profundi- dad a 20 enfermeras de manera intencional con nivel académico mínimo licenciatura, con diplomados, cursos, especialidad y/o maestría, que ya estaban laborando mínimo 3 años en un servicio con atención al adulto mayor en instituciones de salud pública o privada de primero y tercer nivel de atención. Se transcribieron las entrevistas y se realizó el análisis de datos de contenido tipo temático propuesta por De Souza y método fenomenológico, apoyado del *software* Atlas Ti.

Resultados: Emergieron dos categorías: 1. Colaboración entre profesionales de enferme- ría: Garantizando la continuidad y la calidad del cuidado, donde la enfermera de rol am- pliado colabora con enfermeras de diferentes niveles de competencia. 2. Colaboración in- terprofesional: caminando hacia un trabajo en equipo, es decir, colabora directamente con los profesionales de salud en la atención del adulto mayor cuando está integrada al equipo de geriatría. Por el contrario, es difícil establecer una colaboración interprofesional con los médicos internista y médicos generales.

Conclusiones: El profesional de enfermería va en camino de hacer visible su rol ampliado, sin tener que suplir o realizar actividades médicas, sino en función de sus competencias establecidas para trabajar de manera colaborativa.

Palabras clave: Enfermera de Práctica Avanzada, Enfermera con Rol Ampliado, Anciano, colaboración interprofesional y trabajo en equipo.

INTRODUCTION

Interprofessional collaboration (IC) is the process by which groups of health and social care professionals work together to impact care (1) positively. It involves the regular interaction of knowledge, skills and experience of expert professionals, all of whom participate in decision-making (2) with shared responsibility for outcomes (3). This is important for the older adult (OA), given that the aging process, together with the presence of chronic diseases, gives rise to multiple complex needs, which become more acute with advancing age and need to be addressed comprehensively and effectively by a multidisciplinary team working collaboratively and interprofessionally (4), a strategy that is being implemented at the international level (5).

The Advanced Practice Nurse (APN), according to the International Council of Nursing (ICN)(6), is the professional with "expert knowledge, with complex decision-making skills and clinical competencies for expanded nursing practice whose characteristics are shaped by the context in which

they are accredited to practice." In 2018, PAHO published the Model for Expanding the Nursing Role in Primary Health Care (7), and in Mexico, the Permanent Nursing Commission (PNC)(8) its equivalent in the Mexican Framework of Competencies for Expanding the Nursing Role in the First Level of Care; both state to IC as a domain with specific competencies that the APN should have. Likewise, the figure of the Extended Role Nurse (ERN) was considered instead of the APN, which according to the PNC (8) is that nurse who has a postgraduate degree in nursing, training courses, work experience, which allows her to develop an advanced role with greater autonomy and participation within the health team", conceptual frameworks considered in this study.

The APN performs interventions in a collaborative and interprofessional manner in its daily work (9), achieving a better continuity of care, more personalized and focused on the OA, at the same time increasing the safety of care(10) and reducing admissions and morbidity in health institutions (11,12). However, in some countries, it has been affected by problems of authority, limited understanding of the roles, and responsibilities of others and the friction of professional limits (9,13). In Mexico, this situation is unknown, since although IC has been implemented (4,14), there are still few studies. Valdez et al.(15) and Galicia-Aguilar et al.(16) conducted studies with specialist nurses, who provide consultation to the OA, but only mention that the nurse participates in the multidisciplinary team. Therefore, the objective of this study is to describe and interpret the experiences of the Mexican ERN in IC for the care of the OA. The results aim to make the participation of the ERA visible so that decision-makers can implement strategies that favor their integration in multidisciplinary teams, with an impact on the improvement of comprehensive care centered on the OA.

MATERIAL AND METHODS

Qualitative exploratory-descriptive study (17). The participants were 20 nurses who met the inclusion criteria: minimum academic level of bachelor's degree with diplomas, courses, specialty and/or master's degree or doctorate, working for at least 3 years in public and/or private OA care services. The sampling technique was intentional through the heads of the health institutions that provide OA services and then by snowball sampling(17). A list of informants was drawn up and contacted by telephone to invite them to participate in the study, explaining its objective.

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The collection of information was carried out between May and October 2019 through a semi-structured interview with the following questions: What are the activities you carry out daily in the care of the elderly? and What are the activities you carry out with other professionals? The place was the participants' workplace during their working hours, with an average duration of 90 min, they were recorded and transcribed. The data were kept under a pseudonym. Significant situations of the study phenomenon were also observed and notes were taken.

The data analysis was of thematic content type according to De Souza(18) and simultaneously the phenomenological method was applied in four stages: 1) preliminary, 2) descriptive, 3) structural and 4) discussion of the results (19). The descriptive and structural stage was supported using Atlas ti *software*. 9(20).

In the previous stage, the researcher carried out reflexivity exercises. Descriptive stage: the transcribed interviews were imported into Atlas ti *software* and fluctuating reading was performed on two occasions. Afterwards, free coding was performed to achieve the protocol description of the experiences lived by the participants. Structural stage: a transversal reading was made of each code per informant, co-occurrence tables, Sanki diagrams and semantic networks were elaborated to identify the connection between codes. In order to identify saturation, a cross table of codes and documents was made, which makes it possible to visualize the recurrence with which each code is presented per participant. Finally, in the fourth stage, the findings were related to the conceptual framework and discussed with other research.

The scientific rigor complied with the criteria of credibility, confirmability, auditability and transferability (17). Regarding ethical considerations, we complied with the provisions of the Helsinki Declaration(21), the Belmont report (22) and the regulations of the General Health Law on health research (23). We had the favorable opinion of the CI/ENEO/114 Research Committee and the signature of the informed consent of each participant.

RESULTS

Fourteen nurses and six nurses between 28 and 57 years of age participated, working at the first and third levels of care in specialized geriatric areas, two with independent practice and one with nursing care (Table 1).

Table 1. Description of nurses with expanded role

PARTICIPANTE	Age	Genre	Maximum level of education	Service in which you work	*Labor Exp. (years)
1.NB	57	F	Elderly Nursing Specialty. Public Health	Elderly home in Hidalgo. Civil Association. Director	20
2.GRJ	46	F	Master's Degree in Gerontological Nursing.	Private practice. IHSM- MHA Health Center: Senior Citizen Groups. Chronic disease support group.	3
3.IAAP	39	M	Master's Degree in Educational Sciences. Diploma in chronic degenerative diseases.	Private practice. IHSM- MHA Health Center: Chronic Disease Clinic.	3
4.CAR	56	F	Diploma in Geriatrics Doctorate in Nursing Sciences.	University Home Nursing Service - NSNM Nursing Agency. CMN-Raza-IMSS	27
			Elderly Nursing Specialty. Master's degree in hospital administration.	NMC-Raza-IMSS. Floor manager. In the services	
5.CC	48	F		of pneumology, internal medicine, surgery therapy, general therapy, cardiac therapy, which are the main ones for older adults.	18
6.CLRE	44	F	Specialty in Nursing of the Elderly. Master's Degree.	NMC-Raza-IMSS. GERIATRMISS	5
JAZ	36	F	Master's Degree	HC-T-III-A-Portales. Chronic Disease Clinic	5
			Master's degree in service management health care. Diploma in Qi Gong for seniors	HC-T-III-A-Portales. Responsible for the Clinic of	
8.MD	47	F		Diabetes with senior self-help groups and other services.	8
9.MGAC	35	M	Master's Degree in Gerontology.	ISSSTE Family Medicine Clinic Nurse Consultation. Tlalpan.	4
10.SRO	38	F	Specialty in Nursing of the Elderly. Master's Degree.	Gerontological Geriatric Geriatric Nursing Clinic-HGG	3

Continúa...

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11.HER	35	M	Specialty in Nursing of the Elderly. Master's Degree.	Coordination of Geriatric Nursing Clinic-INNSZ	10
12.DM	38	M	Specialty in Nursing of the Elderly. Master's Degree in Thanatology.	Sector 5 Geriatrics-INNSZ.	7
13LHD	34	F	Specialty in Nursing of the Elderly. Master's Degree.	Internal Medicine-Geriatrics-HGM	6
14.ABM	31	M	Bachelor of Science in Nursing. Specialty: Neurological Nursing.	Wound Nursing Clinic-INNNN.	9
15.MCF	38	F	Bachelor of Nursing. Diploma: Take care of me. Specialty: Wounds. Stomas and burns. Master's degree.	Wound Nursing Clinic-INNNN.	9
16.ALI	37	F	B.S. in Nursing and Home Nursing Care Specialty.	Wound Nursing Clinic-INR.	8
17.MSGR	53	F	Bachelor's Degree in Nursing. Master's Degree	Chief Consultant of Catheter, Wound and Elderly Clinics-INR.	20
18.BET	46	F	Elderly Nursing Specialty. Master's Degree	Head of Orthopedic Geriatrics Service-INR.	20
19.MAR	48	F	Master's degree.	Head of Nursing Education -INR.	25
20.ANC			Bachelor of Science in Nursing Diploma in geriatrics, cardiology and one in research.	Gerontological Geriatric Nursing Clinic-HGG	
	27	M			3

Source: the authors, 2022

IHSM: Institute of Health of the State of Mexico; NSNM: National School of Nursing and Midwifery; NMC: National Medical Center; GeriatrMISS: Geriatrics Program of the Mexican Institute of Social Security; HC-T-III-A: Health Center T III A; MHA: Ministry of Health and Assistance.

*Work experience (years): Refers to the years in which the ERN has worked in assistance, teaching and research in the care of the elderly, in some cases simultaneously, in health institutions and independent practice or free practice of the profession.

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The data analysis resulted in two categories: 1) Collaboration among nursing professionals: ensuring continuity and quality of care, and 2) Interprofessional collaboration: moving towards teamwork.

1. Collaboration among nursing professionals: Ensuring continuity and quality of care

The ERN at the tertiary level of care coordinates nurses of different academic and experience levels, from a nursing technician to the head nurse, to provide continuity and quality of care for specific health problems:

> *...if there is an admission, it is assessed by Lázaro, who is the specialist...then, in collaboration, we interview the patient and the caregiver...and we agree on the plan, we notify the chief what therapy will be given... (LHD).*

> *... if we find or detect that this patient has delirium, we refer directly to the nurse and we say specificities (DM).*

They also make referrals from the OA to the nursing clinics:

> *... there are skin [nursing] clinics, catheters, if we detect a patient that requires this care, then we refer to the clinic.... (SRO).*

> *The consulting is in neurological nursing, there is also wound and stoma nursing... we work as a team, we refer patients. We focus a lot on the prevention of pressure injuries, which is what most commonly harms our neurological patients (ABM).*

They also act as consultants at the request of non-specialist nurses:

> *... the [nursing] graduates, ... ask us for support, they say: "I have a patient with delirium, another who has just fallen, I don't know what to do...". (HER).*

2. Interprofessional collaboration: moving towards teamwork

The ERN works collaboratively with a variety of health professionals, as a specialist in the geriatrics service, in private practice, in the Nursing Clinic or as a member of the geriatrics team.

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Both in the first and third level of care, the ERN in the Nursing Clinic or in private practice with the support of laboratory studies or screening scales identifies health problems of the OA and refers him/her to other professionals, such as the geriatrician, neurologist, pulmonologist, and all contribute to the improvement of the patient:

> *this care is interdisciplinary... when a patient comes in with an injury, we send him to nutritional support. If I see that the wound is infected, I take a culture and send it to Neuroinfecto, and they determine which antibiotic. Then we can manage the wound without any risk... (MCF).*

> *... if he has a cognitive disorder, we will refer him to the geriatrician with an interconsultation, ... if he needs an evaluation by a neurologist, pulmonologist, so that we all contribute to his care...(NB).*

Participants working in tertiary care institutions with multidisciplinary geriatric teams have the opportunity to participate in the assessment, diagnosis, planning and evaluation of care with the geriatric physicians, the social worker and the nutritionist:

> *... we work with the multidisciplinary geriatric team; there is the geriatric physician together with the residents, nutritionist, social worker and me as a nurse, we work by interconsultations, ... if a patient has delirium, dementia, then the whole team goes to assess ... I comment on what I found ... and they [the geriatric physicians] make the adjustments. (CLRE).*

> *... the geriatrics geriatrimss team is made up of a physician, nurse, social worker and dietician. Together we see what is going to be done in case the family member does not cooperate, the patient is not doing well... (CC).*

However, this is not the case with general practitioners at the first level of care and internists at the third level. Only with some physicians does the ERN have the confidence to express their impressions about the health problems of the OA:

> *... The specialist nurse, specifically with the internal medicine physician, has no communication; they communicate with the physician [geriatrician], who is attached to the geriatrics service. (CC).*

> *... only some general practitioners you can say to them: "hey, doctor, I see the patient's feet are bad" because you have confidence...(IAAP).*

DISCUSSION

With regard to the first category, it was evident that collaboration between nurses flows at different levels of competence, according to P. Benner (24): beginner, advanced beginner, competent, effective and expert to provide care in accordance with the health requirements and to meet the needs of the OA; the latter level being that of the ERN who indicated and provided specialized care in hospitalization services, referred the older adult to nursing clinics and was also a consultant to non-specialized nursing personnel.

The above coincides with what is reported by Fougére et al.(12) who point out that the ERN is in charge of formulating the plans and their implementation for lower level nurses; and when the OA condition is not within their scope of action, they refer it to other specialist nurses (25) to provide continuity and quality of care. It is also in line with other research showing that the ERN in several countries act as a consultant to hear their expert opinion by professionals in their own discipline(11,12), especially nurses of lower academic levels(9).

Specifically, it is noted that ERN works collaboratively among nurses because they share professional identity and the same profession(26); simplifying communication, counteracting misunderstandings about roles, fostering trust and respect, while at the same time they feel greater freedom and authority(27). This makes it possible to provide specialized, continuous and quality care at each stage of the process carried out during the care of the OA by the entire nursing team(28).

With regard to the second category, it is important to note that in tertiary care institutions, the ERN assigned to multidisciplinary geriatric teams fully exercises its expanded role, participating directly with all members in the assessment, diagnosis, planning and evaluation of care, as evidenced in various studies (11,29). This is due in part to the fact that each member is assigned his or her role, uses a similar interprofessional language (13,29) and attaches the same importance to what the physician prescribes as to the care of the nurse provides, which makes each member feel equally valued(4,13) within the team. Likewise, it was found that the ERA supported by laboratory studies or titration scales collaborates with other health professionals through the referral of the OA. These findings coincide with those of Morrilla et al.(11) and Boman et al.(9) who found that the ERN indicates diagnostic tests, interprets, makes clinical judgments, and subsequently,

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in an environment of trust and good communication between physicians and nurses, the physicians approve the observations, suggestions and opinions of the nurses, accepting the patient referral, managing to streamline the care of the OA (11,16). This validates the ERN competencies proposed by the ICN(6), PAHO(7), PNC of Mexico (8) and other studies(11).

On the contrary, the lack of teamwork impedes the visibility of interprofessional competencies and hinders collaboration, as is the case between the ERN and internists and general practitioners, with whom it is difficult to establish an exchange of opinions. According to various research studies, this is due to three factors, which coincide with the findings of this study: 1) a traditional hierarchical model still prevails with leadership centered on the physician who does not listen to the nurse's opinion(9,30) 2) to the passivity of nurses, assuming that the information they handle on the patient is of minor importance for healing (2) and 3) because some physicians are reluctant to share responsibility for patient care with other disciplines, possibly because they are unaware of what they can contribute to the care of the elderly(31).

Thus, IC, understood as the periodic interaction of knowledge, skills and experience of expert professionals working as a team to provide comprehensive care to patients(2), as in the case of the elderly, is reflected in the continuity and quality of care provided and, at the same time, in the reduction of morbidity and mortality in this age group (11,12).

CONCLUSIONS

The nursing professional is on the way to making his expanded role visible in terms of working collaboratively among nursing professionals and other professionals. This becomes more evident when integrated into the multidisciplinary geriatric team, where they have the opportunity to participate directly with health professionals throughout the care process. However, the role of the ERN is still not recognized or taken advantage of the ERN role, especially by general practitioners and internists. Therefore, it is necessary and indispensable to make the competencies of the ERN visible in order to avoid conflicts in teamwork, which hinder their collaboration and prevent them from providing continuity and quality of care to the OA.

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Limitations of the study

Participants from the second level of care were not included, as well as ERN from the third level of care of the Institute of Security and Social Services for State Workers (ISSSSW).

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Authors' contribution to the article

Virginia Reyes Audiffred (VRA), Zoila Esperanza Leitón-Espinoza (ZELE)

Introduction: (VRA) and (ZELE); methodology: (VRA) and (ZELE); results: (VRA) and (ZELE); analysis and discussion: (VRA) and (ZELE); original draft: (VRA) and (ZELE); final draft and presentation: (VRA) and (ZELE); conclusions: (VRA) and (ZELE).

All authors have read and accepted the published version of the manuscript to be published and agree to be responsible for its accuracy and completeness.

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