Nurses' role in accomplishing interprofessional coordination: Lessons in 'almost managing' an emergency department team.

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Abstract

Aim: To describe how nurse coordinators accomplished day-to-day interprofessional coordination in an Australian emergency department team, drawing some lessons for the design of nurse coordinator roles in other settings.

Background: Previous studies have examined leadership *within* nursing teams, and there is a growing number of registered nurses employed as care coordinators. There is limited literature on how the day-to-day coordination of interprofessional teams is accomplished, and by whom.

Method: 19 semi-structured interviews with emergency department registered nurses, doctors and nurse practitioners analysed thematically.

Results: Three themes describe how coordinators accomplished interprofessional coordination: task coordination and oversight; taking action to maintain patient flow; and negotiating an ambiguous role.

Conclusion: Better-defined nurse coordinator roles with clearer authority and associated training are essential for consistent practice. However, accomplishing interprofessional coordination will always require the situated knowledge of the complex nursing-medical division of labour in the workplace, and the interpersonal relationships that are only gained through experience.

Implications for Nursing Management: The design of nurse coordinator roles must include the thorny question of 'who leads' interprofessional teams in the day-to-day coordination of tasks. New and inexperienced nurses may not have the necessary situated knowledge or interpersonal relationships to succeed. However, such roles offer an important development opportunity for future nurse managers.

Interprofessional Relations, Emergency Nursing, Leadership, Coordination

Background

Healthcare delivery requires the coordinated effort of an interprofessional team. Effective coordination involves the sequencing and timing of tasks to minimise delays, omissions and wasted effort (Kozlowski & Ilgen 2006). Coordination can be implicit through team members performing their roles in synchronicity, or explicit through verbal or written communication. Coordination occurs directly between individual team members (i.e. teamwork), but also requires the 'top-down' coordination of a team leader with oversight of the whole team's tasks (Reeves, Macmillan & Van Soeren 2010).

Clear team leadership is crucial for effective teamwork but it can be difficult to identify 'who leads' in an interprofessional team since each profession has its own management structure (Reeves, Macmillan & Van Soeren 2010; Smith et al. 2018). Previous studies examining nurse managers' roles focus on the nursing team only (Carthcart, Greenspan & Quin 2010; Duffield et al. 2019), and on 'leadership' and 'transformation', rather than day-to-day coordination (Wise & Duffield 2019). There a growing number of registered nurses (RNs) employed as care coordinators or 'navigators' where interprofessional coordination is central (Duffey 2017), but no studies on how these roles are performed. Thus, the extant literature on how the day-to-day coordination of interprofessional teams is accomplished, and by whom is limited (Allen 2014; Schot, Tummers & Noordegraaf 2020).

This paper explores how RNs undertook an interprofessional team coordination role in the Fast Track area of an Australian emergency department. Emergency department work is volatile, unpredictable and complex: patients usually attend without notice, with a wide spectrum of presenting complaints, possible diagnoses and levels of acuity (Jones, Shaban & Creedy 2015). As Nugus et al. (2011) describe, emergency workload is framed by an imperative to keep the endless stream of patients flowing through the department. Maintaining patient flow is critical to prevent department overcrowding (Sun et al. 2013), and to meet time-based performance targets. Drawing on interviews with emergency doctors, nurse practitioners (NPs) and RNs, we describe how front-line RNs placed in a coordinator role accomplished the day-to-day interprofessional coordination needed to keep patients flowing through the emergency department, and the challenges they faced. In doing so, the paper draws some lessons for the design and implementation of nurse coordinator roles in other settings.

Methods

This paper draws on emergency clinicians' own accounts of their teamwork practice and their perceptions of what helped or hindered effective coordination. Interviews were conducted as part of an explanatory sequential mixed methods study that explored team flexibly in response to dynamic workload demands (Wise et al. 2020). A time study first measured the tasks undertaken by RNs, NPs and doctors as they performed their everyday clinical work. The findings from this work observation phase informed the design of clinician interviews, the data presented here.

Study Site

The study was conducted in the emergency department of a metropolitan tertiary referral hospital in Sydney, Australia with an annual presentation rate of approximately 75,000 patients (AIHW 2021). The department was typical of others of its type in terms of the range of patients treated, models of care, and clinical roles (NSW Health 2017). There were 146 full-time equivalent RNs (including four NPs). In Australia, NPs have a protected title, require a Master's degree and have a legal mandate to autonomously diagnose, prescribe and refer for the patients and conditions within their scope of practice. There were 64.5 full-time equivalent doctors of whom 28.5 full-time equivalent (44%) were junior doctors on rotation through the hospital. The study was set in the 'Fast Track' area, dedicated to quickly treating and discharging patients with minor injuries and less complex medical conditions.

Responsibility for direct patient care in Fast Track was divided between two role responsibilities: RNs, and doctors/NPs. Registered nurses assessed patients waiting first and had extended role responsibilities to order investigations (e.g. X-ray, pathology), medications and other supportive treatments to manage patients' symptoms. They also performed procedures and treatments delegated from the doctors and NPs, monitored waiting patients, and undertook the hospital admissions process. After the initial RN assessment, a doctor or NP undertook a clinical examination, ordered any further investigations, reviewed results, consulted colleagues, prescribed medications, performed any clinical procedures required, then admitted or discharged the patient. On each shift, an RN undertook the 'Fast Track coordinator' role. Coordinators did not have a patient load and oversaw the electronic waiting list. Coordinators were experienced emergency nurses who had completed an in-house training course. However, staffing challenges meant a less experienced RNs occasionally undertook the role. The doctor-in-charge in Fast Track (often a senior registrar) usually had a patient load.

Data Collection

Topics for the semi-structured interviews were based on the findings of work observation phase of the broader study on team flexibility (Wise et al. 2020) and included: the process of task delegation within the team; attitudes to RNs' extended role responsibilities; and perceptions of the NP role. Participants were also asked their perspective on why some shifts do not run smoothly in terms of team coordination, and what role the nurse coordinator and doctor-in-charge played in coordinating the team's tasks.

Interviewees were purposively selected from volunteers and stratified by role and clinical experience. Sample adequacy was achieved through data saturation, signalled by replication in the insights provided (O'Reilly & Parker 2013). Interviews were of between 20- and 50-minutes duration, audio-recorded, and transcribed verbatim. Quotations from doctors are coded as 'DR' in the text.

Analysis

Interview transcripts were thematically analysed using NVivo v11. Open codes were created by noting frequently recurring and evocative phrases, ideas and perceptions, then grouped into meaningful themes

in an iterative process (Taylor, Bogdan & DeVault 2015). A random selection of transcripts was recoded by a second researcher to test for consistency. Where there was disagreement in the coding the themes were discussed and refined. The primary researcher's prolonged exposure to the Fast Track environment during the work observation phase strengthened the interpretation of, and provided contextual understanding of the emergent themes. This researcher has a background in social research therefore did not share a professional identity with the participants, a common source of bias (Allen 2010). However, as an 'outsider' there was a potential for the researcher to misunderstand aspects of the complex working practices observed. This was managed by clarifying ambiguous practices with senior clinicians at the research site.

Ethics Approval

Ethics approval was granted by the hospital's Human Research Ethics Committee (HREC) (South Eastern Sydney Local Health District HREC Reference 14/144) and was ratified by the University of Technology Sydney HREC (Reference 2014000719).

Results

Table 1 gives a profile of the 19 clinicians who participated in an interview.

TABLE 1 HERE

Three themes emerged from the data to describe how Fast Track coordinators accomplished interprofessional coordination: task coordination; taking action to maintain patient flow; and negotiating an ambiguous role.

Task Coordination

In the fast-paced, often chaotic Fast Track environment a key benefit of the coordinator role was that they were not assigned a patient load and were usually located at their computer in the staff station, coordinating the team's tasks. Registered nurses' workload was driven by the completion of discrete tasks for multiple patients (those receiving treatment and waiting to be assessed) spread across several geographical areas (consultation rooms, two waiting rooms and unmonitored beds). This fragmented workload was compounded by shift changes and breaks, which meant the composition of the nursing team constantly changed. This made it difficult for doctors to identify to whom to delegate a task:

> *Nursing staff have these certain breaks, which frustrates medical staff because when they're trying to find the nurse, they can't find a nurse…or the nurse has changed over and then they don't know who's who ... so the medical staff go "I don't know who to tell!"* (NP4)

The coordinator helped overcome these challenges by acting as an intermediary in the delegation of tasks such as medication administration, wound care and other procedures. Rather than communicating directly with an RN, doctors and NPs notified the coordinator of the tasks to be completed for each patient who

delegated those tasks on. Interviewees noted that the coordinator was best placed to identify which RN had the capacity to complete the task in a timely manner and to an appropriate standard.

> *Having someone who is that coordinating person, who is aware of the various tasks which their nursing staff are doing is very important, mainly because it's a central point of information. If you need certain things done in terms of medications given, it's easier to go through that one person because they know what everyone under them is doing. They can allocate it to whoever's is next free, or best able to do that task.* (DR1)

> *If there's five nurses running around, [the doctors] don't know who's who and what's what. So you need to identify yourself [as the coordinator] … you sit in that one spot at the in-charge computer, everyone knows who you are. Then the doctors can come and ask, "Can you do this? Can you do that?" and you can delegate it off to the other nurses…* (RN8)

The coordinator's role as an intermediary in task delegations helped avoid delays and omissions in care and to manage workloads within the nursing team. It was also observed in practice and confirmed in the interviews that team performance often broke down if the coordinator left their computer to 'help' with tasks themselves. With the doctor-in-charge usually taking a patient load, the coordinator was often the only team member with an overview of patients' care. Registered nurses were observed congregating around the coordinator's computer clarifying where each patient was in their journey, prioritising tasks to be completed, identifying patients to be admitted or discharged, and those at risk of breaching the time-based targets. These episodes occurred throughout the day: when handing over to the next shift, between breaks and at any time during the shift when the coordinator identified a need for the RNs to 'regroup'. One RN succinctly summarised the coordinator's functions to be "*prioritisation, coordination, and managing the queue*". In addition to task coordination, this required coordinators to take action to maintain the flow of patients through the emergency department.

Taking action to maintain patient flow

Taking action to maintain patient flow included chasing up nursing and medical staff for information about patients' care, prompting them to complete tasks to move the care process forward, and negotiating access to inpatient beds for admitted patients.

> *[As coordinator] I'm supposed to chase the doctor. What's the hold up with the patient's care? Chasing results and things like that. Also telling the nurse, "This patient is ready to go to the ward", or this patient needs prep for, say, a CT test.* (RN3)

Interviewees commented that less experienced nurses often found this proactive aspect of coordination difficult, especially when it involved challenging professional hierarchies or "*almost managing*" the team:

> *Rather than just passively waiting for direction from the doctors,* [coordinators need to be] *a little bit more proactive, so almost managing saying, "Right. What are you up to with this person? Do you need anything done*

with that?" Prompting the doctors and nurse practitioners to keep them flowing. So, the senior nurses who've got managing experience normally nail that. Some of the more junior ones, not so much. (NP3)

As this senior doctor explains, a 'good coordinator' anticipated what tasks doctors would require (including which investigations and symptomatic treatments should be ordered) and prompted less experienced RNs to complete those tasks to expedite the patient's journey:

A good coordinator understands doctors' practice and nursing practice, and how the two dovetail each other… They can then direct the less experienced nurses to get certain tasks done knowing that this will facilitate the doctor downstream, rather than waiting for the doctor to say "Can you do this"? So experienced coordinators anticipate what the patient will need and get things done prior to the doctor coming in. (DR3)

DR3's comment illustrates that experienced coordinators had a deep knowledge of the interdependence of medical and nursing roles that allowed them to anticipate which tasks doctors (or NPs) will require. This interprofessional knowledge extended to coordinators taking action in tasks traditionally performed by doctors to maintain patient flow, such as identifying patients who needed to be reviewed by a hospital specialist, or likely to be admitted for inpatient care.

If your coordinator is good at picking up on who needs to go to an acute bed and doing that quickly. If your coordinator has a good rapport with the doctors, then automatically they've already sorted out a whole lot of things because they are quite experienced, they know who needs to get a surgical review and they'll already be fast-tracking all of those things. If they're not on top of all of that, it can just delay after delay after delay, and I think that's when it starts to snowball. (RN6)

Unlike NPs, RNs did not have the authority to refer or admit patients, therefore coordinators used their "*rapport*" with hospital specialists and senior emergency doctors to expedite the review and admissions processes. There was also support from the doctors and nurses interviewed for coordinators to challenge, and even override doctors' decisions perceived to be holding up patient flow. Interviewees perceived that this reflected the egalitarian doctor-nurse relations in the emergency department, as well as the need for the oversight of the large number of junior doctors in the department.

The emergency nursing staff are a different breed to ward nurses. They're more willing to challenge any levels of hierarchy within the system if they think it's in the patient's best interest. So, they're empowered in that way to say "I disagree with what you are doing" … having that sort of support from nursing staff is something that is different from a lot of other environments within the hospital. (DR1)

Taking action to maintain patient flow required coordinators to have high levels of clinical experience, a deep understanding of medical and nursing roles, and be willing to challenge professional hierarchies. That it also relied on a 'rapport' between coordinators and individual doctors underscores the ambiguity in their authority to undertake such actions.

Negotiating an ambiguous role

Interviewees were clear what a 'good coordinator' *should* do in coordinating tasks and taking action to maintain patient flow, but the role's remit and authority was ambiguous. One consequence was that coordination was performed inconsistently from shift-to-shift.

> … *everybody runs it slightly differently so I think that's confusing as well for the doctors because there's no kind of real set path. They might have worked out there two days ago and it was running pretty differently to how it is running today, for instance.* (RN1)

To overcome this ambiguity, some interviewees noted that the coordinator had to *"identify themselves"* (RN8) and clarify how team coordination would work that day:

> *You have to have someone who is really headstrong to say, "Look, this is how it's gonna run today" … "I'm coordinating. Everything needs to come through me. You need to tell me what the patient needs. And they need any medications or anything, come and tell me, I'll delegate that."* (NP4)

Another consequence of role ambiguity was that coordinators must constantly negotiate their authority to take the actions needed to maintain patient flow. Specifically, it was not clear whether their "prioritisation" function extended to setting doctors' priorities, for example selecting which patient on the waiting list should be seen next. Some of the doctors supported this approach, one noting *"…if* [the coordinator] *says this person is more clinically relevant to be seen first, I'll respect that and I'll go and see the patient*" (DR5). However, three of the RNs and one of the doctors interviewed commented that the coordinator did not have a clear mandate to prioritise doctors' tasks, and some who had attempted it had *"…rubbed people up the wrong way"* (RN1). To compound this ambiguity, the doctor-in-charge role in Fast Track was also performed inconsistently. Some took control of patient flow, some focussed solely on direct clinical care, while others worked collegially with the coordinator.

> *The coordinator is in theory supposed to decide who gets seen next and the priorities of what's happening. But I think the senior medical officer sometimes takes on that role depending on who it is. But the nurse in charge should almost be running the place like a manager.* (DR4)

DR4's advocating that the coordinator should *"almost be running the place like a manager*" highlights the role's ambiguous mandate and mirrors the language of "*almost managing*" used by NP3. With both the coordinator and the doctor-in-charge negotiating ambiguous roles, interviewees commented that effective interprofessional coordination relied on their clinical experience and the quality of the working relationship between the two:

> *Good team coordination comes from stability in terms of experienced leadership. I think the seniority of the coordinator and the [doctor-in-charge] for Fast Track has enormous influence on that. If you've got a very pro-active, approachable emergency physician and when their relationship with the coordinator is a cordial and fantastic one, the flow of the department is so much better, even when it's super busy.* (NP2)

Discussion

This study provides insight into the day-to-day coordination of an interprofessional healthcare team. Like similar roles described in Australian (Grover, Porter & Morphet 2017; Nugus & Forero 2011) and British emergency departments (Vezyridis & Timmons 2014), a front-line RN was responsible for day-to-day coordination. In the busy, often chaotic environment, coordinators acted as an intermediary in task delegation and as a central point of communication to prevent delays and omissions in patient care. The coordinator was the only team member with an overview of the team's tasks, monitoring the electronic waiting list and checking patients' progress against the time-based performance targets (Vezyridis & Timmons 2014), and negotiating patients' trajectories through the department and on to the next stage of their journey.

Patient trajectories are underpinned by formal pathways illustrated in models of care diagrams and written into organisational protocols, but are accomplished through the relational processes of teamwork and top-down coordination that adapt to dynamic workload conditions (Allen 2018; Boiko et al. 2020). Negotiating patient trajectories, to achieve 'flow' in emergency departments is notoriously difficult (Boiko et al. 2020). It involves harnessing the teams' skills to respond to complex and unpredictable patterns of patient demand while constantly under time pressure. As Carthcart, Greenspan & Quin (2010) argue, the knowledge and skills to accomplish this type of work are situated in the workplace context and only accrued through experience. Ekström & Idvall's (2015) study of newly qualified RNs found their lack of experience in performing and prioritising tasks for themselves made it difficult to coordinate the work of others in the nursing team. In the present study, clinicians perceived that effective interprofessional coordination required a deep understanding of the complex nursing-medical division of labour (i.e. the tasks of each role and their interdependence) and how that division must adjust to dynamic workload conditions (Burtscher & Manser 2012). Such situated knowledge was even more salient for coordinators as they negotiated an ambiguous role.

Ambiguity in the coordinator's remit was matched by a lack of clarity in the doctor-in-charge role, with both performed inconsistently. In establishing the coordinator role, the department had not confronted the difficult question of 'who leads' the Fast Track team (Reeves, Macmillan & Van Soeren 2010; Smith et al. 2018). Clinicians understood that effective coordination meant running the place *like* a manager, without the attendant title or status of a manager. Tasked with *almost managing* the coordinator must be assertive with doctors, but it was unclear whether task coordination extended to the prioritisation of doctors' work. Likewise, coordinators were expected to expedite the referrals and admissions process to maintain patient flow (Vezyridis & Timmons 2014), without formal authority to do so. Reflecting what Svensson (1996) describes as a 'negotiated order' between doctors and nurses, RNs deploy their negotiation skills to persuade, challenge and influence doctors' decisions. This task was made easier in the emergency department by egalitarian doctor-nurse relations (Nugus et al. 2011), though did not necessarily extend to negotiations with other hospital specialists.

In addition to coordinators' workplace experience and negotiation skills, well-established interpersonal relationships between the coordinator and the doctor-in-charge facilitated interprofessional coordination. Clark & Greenawald's (2013) study of interprofessional team leadership at the most senior level emphasised the importance of personal and professional relationships between leadership 'dyads' (i.e. medical and nursing directors), developed over time while serving in front-line clinical roles. Evidence from the emergency department finds interpersonal relationships between front-line leadership dyads to be equally important for day-to-day coordination. These findings add to the growing body of evidence on the importance of stability in team membership for developing the interpersonal relationships needed for effective coordination in healthcare teams (Burtscher & Manser 2012; Rydenfält, Odenrick & Larsson 2017; Wise et al. In Press).

As intermediaries in the healthcare process, front-line nurses have always borne responsibility for interprofessional coordination, essential work that is largely 'invisible' (Allen 2014). The proliferation of boundary-spanning Advanced Practice Nurses and coordinator roles demonstrates that nurses are increasingly called on to deploy these coordination skills in a formal capacity, helping patients negotiate their journey through fragmented healthcare systems. The lack of role clarity and uncertain authority is persistently found to hamper the sustainability, consistency and effectiveness of such roles (Duffey 2017; Roche et al. 2013). Better-defined roles with clearer authority and associated training are essential, including tackling the difficult question of 'who leads' interprofessional teams the day-to-day coordination of tasks (Reeves, Macmillan & Van Soeren 2010).

Limitations

The tasks undertaken by RNs placed in a coordinator role in this study are similar to those described in other emergency departments (Grover, Porter & Morphet 2017; Vezyridis & Timmons 2014). However, the coordination challenges in maintaining patient flow, and the egalitarian culture means the specific nature of interprofessional coordination may not be transferable to other healthcare settings. That said, some generalisable lessons on the importance of role clarity, situated knowledge and interpersonal relationships needed for accomplishing interprofessional coordination may be drawn to guide future research and practice in this under-studied area.

Conclusion

Giving nurse coordinators responsibility to overcome the weight of historical doctor-nurse relations without sufficient authority, consigns them to the unenviable status of 'almost managers'. Such roles need a clearer mandate to take action in tasks traditionally performed by doctors, and to challenge professional hierarchies. However, accomplishing interprofessional coordination in practice will always require the situated knowledge of the complex nursing-medical division of labour, and interpersonal relationships only gained through workplace experience.

Implications for Nursing Management

The design and implementation of nurse coordinator roles must tackle the thorny question 'who leads' in the day-to-day coordination of tasks, and realistic expectations of what can be achieved in these roles. Appointment to coordinator roles must also consider the candidate's experience of the specific context since inexperienced nurses or those new to the workplace are unlikely to have the situated knowledge or interpersonal relationships need to accomplish interprofessional coordination effectively. That said, interprofessional coordination roles offer an important development opportunity for future nurse managers.

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