Problems of the nursing teamwork

Health & Medicine, Nursing

In general, because of nature of MICUs with high work over load, high level of working stress, lack of mutual assistance and high sensitivity from being legally claimed if any mistakes occurred, nursing staff most of time unable to adjust themselves accordingly and refused any form of change faced during working shift (e. g. receiving patients while managing the unit works, receiving patients with preparing unit inventory, reassignments of patients after working with them and etc.). These findings were consistent with Ahmed and Abed (2016) who revealed that lowest mean score was being for the item of nurses make a plan to deal with changes in the workload, which had a median of 4. 00.

After the program implementation, nursing staff recognized that they have to compromise and changed their areas of assignment in order to pass effectively the change situations as well as they have to consider “ ourselves” instead of “ myself” during working together during the emergency situation. Additionally, they felt that they have the right to defend others if they had seen them encountered with the problems.

Given the observed NTW elements of the mutual trust dimension, the results of the study indicated that there were statistically significant differences between its elements during (pre, immediately post-program implementation and three months later) where obviously all items’ mean scores increased immediately post-program implementation compared to preprogram and relatively gained small decrease three months later. The results indicated that the majority of the study participants were observed highly not performing the element of “ refusing to be monitored by other staff if needed” followed by the element of “ asking other staff to confirm own work

related opinion” which increased post program implementation and relatively gained small decrease three months later.

It has been observed that, nursing staff were avoiding to interfere in each other’s work as they were rejecting anyone of them to investigate their patient’s file, ask them about any of their patient’s related clinical data, exiting their patient’s physical status and/ or checking their patient’s surrounding environment. They considered the previous actions as spying on their works in purpose of detecting and mistakes to report them to higher levels rather than improving them to avoid negative consequences. This case was in fact the worst within the nursing staff because it built a huge barrier that made them resistible in self-depending on each of them, self-reporting mistakes and collaborating with each of them at the hard times.

Researchers stated that mutual trust is the confidence that team members will complete their responsibilities. Without trust, team members expend time and energy protecting, checking and inspecting each other as opposed to collaborating (Kalisch, 2013 b). Trust has a critical influence on how individuals within a team will interpret other’s behaviors. Consequentially, teamwork behaviors such as performance monitoring and backup behaviors may be misinterpreted as team members keeping tabs on each other (Hamid & Mahmood, 2010).

Some of nursing staff has been observed by neglecting other work related opinions at the moments that require mutual consultation (e. g. timing of unit cleaning or disinfection). They most of time were afraid of being contradicted with each of their opinions leaving no space for sharing new

ideas and leaving a big gap between each of them the case that allow other staff to perceive themselves less valuable. Since trust, the professional bond, mutual respect, recognition of the other's work and collaboration are built through it (Carole, 2016). In the context of healthcare, the most prevalent elements include honesty, confidentiality, caring and showing respect (Carole, 2016).

Concerning the observed NTW elements of the shared mental model dimension, the results of the study indicated that there were statistically significant differences between its elements during (pre, immediately post-program implementation and three months later) where obviously all items' mean scores increased immediately post-program implementation compared to preprogram and relatively gained small decrease three months later. The results indicated that the majority of the study participants were observed highly not performing the element of " endorsing the tasks without forgetting any necessary information" followed by the element of " informing other staff what is expected from them in their assigned area" which increased post program implementation and relatively gained small decrease three months later.

Due to refusal of nursing staff for being observed or interfered by each of them, they missed to share the necessary information about patient's clinical condition and/or general working condition. They relayed on the assigned areas of every one of them that enable them to identify and collect data without initiating to inform others the necessary information as some nurses said at the moments of ending the shift and writing the endorsement sheet

by the on-charge nurse that “ it’s not my business to tell the on-charge nurse what was going on my case unless she asked my for that and she has to audit by herself my patient’s file to collect data needed and write down the endorsement sheet”. Consequently, not all endorsement sheet’s needed data were documented at the patient’s file and then sometimes were missed to be wrote down for endorsement.