

Effective Healthcare Departments: What Makes a Team?

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Research Article

ABSTRACT

What makes a good healthcare team? This article aims to identify and explore the organisational factors that contribute to the smooth functioning of a working team. The methodology adopted is based on qualitative surveys conducted in three contrasting departments. The results show that proximity between different occupational categories, the development of practices and shared values, shared decision-making and an effective communication system are all factors that foster cooperation within a department. A healthcare supervisor also plays a role in uniting and organising a team.

Keywords: Team coordination, Hospital, Quality, Communication

INTRODUCTION

For a long time, quality and patient safety were considered primarily to be a matter of knowledge, individual skills and specific medical expertise. However, it is now accepted and recognised that to deliver quality medical procedures and healthcare, and for patient safety, it is essential to have well-organised departments and teams and for everyone involved to be able to work together effectively.

The notion of the team appears to be a fundamental aspect of information exchange and sharing knowledge which are essential for quality in healthcare. Indeed, coordinating professionals in the health sector around the patient requires strong and constant cooperation ^[1]. Thus, patient records are intended not only for traceability but also as a multidisciplinary tool for facilitating dialogue about patients. This study therefore focuses on the team and how it is organised and functions. We will discuss the characteristics of a “good team” within three departments at two healthcare facilities and look at the ways in which the teamwork differs. These three cases illustrate examples of success and failure. The aim of this paper is to identify what makes an effective team in order to develop the management of healthcare teams.

METHODOLOGY AND FIELDWORK LOCATIONS

As part of a study for the French National Authority for Health, on the theme of management, HRM, and the quality of healthcare in hospitals, we visited a hospital centre (HC), an internal medicine department (IM with a capacity of 58 beds), an emergency department and a short-term hospitalisation unit (STHU with a capacity of 6 beds). This unit takes patients, mainly from the nearby emergency department, for a period of 24 to 48 h. In addition, we visited another institution, a “mutualist clinic” (MC) within an oncology department. Data was collected between the end of 2011 and the beginning of 2012 at the selected institutions. An in-depth case study methodology was used ^[2]. From the six in-depth case studies carried out, we selected three examples of departments with different operational structures, and notably a department where there was conflict, a well-functioning department, and a department where there was room for improvement.

Methodology

The methodology adopted in this study was essentially qualitative and inductive. The field investigation began with an exploratory survey. This pre-survey was based on data collected in two ways: interview and direct observation.

A first series of interviews (1 to 2 h), fully transcribed, was conducted among management and senior management staff who were particularly concerned about quality and human resources issues within their institution. The aim of these first interviews was to familiarise the authors with each setting (organisation, peculiarities, recent developments, etc.) and quality improvement policies in each establishment, based on experience of accreditation and certification procedures completed or in progress.

Following these initial interviews, we conducted exploratory observations within departments. Observation sequences were scheduled to reconstruct a full working week, which led us to be present on different days of the week and also at the weekend and nights. In total, nearly 120 h of observations were carried out in the selected departments. These early observations were fairly broad and aimed to establish the nature of the setting studied (use of space, layout of equipment, operational and organisational arrangements, etc.) and the daily activity of the unit (work content, distribution of tasks between the different occupational categories, knowledge and know-how applied by care teams, working relationships, professional interactions with patients and families, etc.). Finally, targeted interviews about the use of patient records (average duration 1 h 15 min – fully transcribed) were conducted with volunteers from the various professional categories within the healthcare team (**Table 1**).

Table 1. Professionals interviewed.

	Internal Department – IM	medicine	Emergency department and STHU	Oncology department – MC
	Not-scheduled		Not-scheduled	Scheduled
Healthcare assistant	2		4	3
Cleaning & maintenance orderly	2		2	3
Healthcare supervisor	1		1	1
Nurse	2		3	4
Doctor	2		3	1
Medical Secretaries	2		1	
Social worker	-		-	1
Psychologist	-		-	1
Total	11		14	14

The Fieldwork Locations

We selected the departments based on specific criteria (extent to which tasks are scheduled, role of technology in healthcare, composition of teams and diversity of patient profiles) in order to study three relatively different departments.

The characteristics of the teams identified in the review include: development of shared healthcare, team and organisational rules, team stability, interdependence, members' roles, the role of the healthcare supervisor, communication, and team spirit. All the information gathered was used to carry out a thematic, cross-sectional study of the three departments visited, resulting in the case analysis presented below.

RESULTS

The data collected helped to identify the way the departments were organised and to define working relationships with and between peripheral actors (doctors, the healthcare supervisor, care teams) focusing on work tasks and therefore approaches to coordination (**Table 2**). Examples of approaches to coordination within teams are given to show the results of analysing how teams function.

Table 2. Organisational structure and approach to coordination within departments.

	HC- Internal medicine (IM)	HC-Emergency- STHU	Oncology (MC)
Organisational structure	Doctors mistrust the way the department is organised as it was not chosen by them but decided by the former team; they demand more clinical time; they are critical of the time spent on administrative tasks (encoding of action taken) and above all the removal of the position of coordinating nurse.	Encoding of action taken is delegated to administrative assistants (day) and care assistants (night); doctors complain about administrative tasks, the burden of writing and rewriting the same data in different formats.	Teams appreciate the organisational structure, especially with the presence of the general practitioner recruited 4 years ago. This guarantees more medical presence for nurses while allowing oncologists to be less present in the department.
Approaches to coordination	Professional relations are characterised by power: hierarchical cooperation with delegation of duties; lack of cognitive proximity between stakeholders which hampers genuine exchange, creating a divide between doctors, nurses and care teams.	The way work is organised is a barrier to exchange within this department although this is facilitated by regular and daily contacts with the healthcare supervisor.	Proximity and ease of exchange between teams, within teams and between healthcare and medical practitioners. Oncologists visit the department 3 times per week. Oncologists and the general practitioner often share information by phone to plan an admission, discuss a patient's situation, etc.

Approaches to Cooperation within Teams

In the IM, a departmental reorganisation and a doubling of bed capacity had reinforced a feeling of having to work fast and being “against the clock» in care teams. Cooperation could be perceived as impossible or difficult in such an environment where working conditions had deteriorated and the pace of work in particular had increased. Moreover, a more accentuated division of responsibilities had made sharing tasks between nurses and healthcare assistants potentially more confrontational. During the day, nurses and healthcare assistants worked separately and not in pairs. Maintenance and cleaning orderlies and healthcare assistants did not work in pairs either. “I always try to see the healthcare assistants but...they do what they have to do, and we do what we have to do” (maintenance and cleaning orderly).

In the HC emergency department, nurses and healthcare assistants worked in pairs when assigned to receive patients. The rest of the tasks were shared in a traditional way between the different professional categories. However, teams had the peculiarity of being pooled between the STHU and emergency department (with the exception of doctors: three of them were assigned to the STHU). This organisational approach allows for mutual replacements: “we are all interchangeable”, explained one staff member. These terms seemed to be appreciated by all professionals because “it stops us falling into a routine”. Moreover, in this department, there was no dedicated night team. Every six weeks, staff had to work five nights for a period of about fifteen days. According to the head of department, this practice is positive because “the night time routine is toxic to teams” (unusual atmosphere, disconnection with the day shift, lack of training and supervision, etc.). However, this alternation can be more difficult for paramedics – “the nights come often” – although they also pointed out the advantages – “we are at home more often than at work”. These organisational approaches encourage cooperation within the extended team. In this regard, many forms of informal mutual assistance could be identified between the staff of two units. These forms of cooperation, described as “a helping hand”, were also observed within the same unit. For example, the day crew may stay on at work a little longer than planned in order to support the night team when it “takes over”.

At the MC, there was a closeness and easy exchange between the teams, within teams, and between care and medical teams. The general practitioner helped promote an organisational approach within the department, based on cooperative coordination, involving all healthcare teams. These teams demonstrated a genuine desire to share patient information, a commitment to learning and a lack of resistance to implementing programmes to improve the quality of healthcare. The study found that doctors take account of the opinions of the patient, the patient's representative if they cannot express themselves, the patient's family, the causes of illness and the opinion of the multidisciplinary team (social worker, psychologist, etc.). There was therefore a real commitment to finding all the information for the good of the patient.

How the Teams Function?

In the department at the IM, the absence of a healthcare director in the institution meant that the healthcare supervisor was responsible for organisational problems. This had caused exhaustion which may explain why one supervisor was on sick leave. At the height of the conflict, staff, one third of the department, went to see the head of human resources and the hospital director. In the opinion of the current supervisor, “it was extremely harsh and we didn't

know anything about it”, the harm was obvious because they were traumatised by what had happened, “This move came about all of a sudden” [3]. We would describe this team as dysfunctional.

Cooperation between STHU and emergency team members helps to maintain a sense of job satisfaction within the team. The various emergency professionals expressed their contentment with working in a department in which healthcare is varied and offers them the opportunity to be “versatile”. The quality of the team’s work was recognised collectively on the basis of a number of shared indicators. Thus, professionals pointed out that in “their” department, patients were admitted and assessed extremely quickly (“from the first bell”). The same goes for their care, which can begin without these patients having to spend time in the waiting room. The performance of “their department” was regularly compared to that of other emergency services departments and characterised positively. We call this team a pretty good team.

At the MC, the teams comprised a nurse and a healthcare assistant, who are supported by a cleaning and maintenance orderly during the day. Working in pairs gives mutual support and helps make work more enriching. Working in the oncology department was motivating for healthcare assistants. Similarly, the cleaning and maintenance orderlies had a very positive perception of their work and felt that they contributed to patient comfort and the quality of healthcare. All cleaning and maintenance orderlies said they preferred working in both areas of the oncology department – “it is more interesting, you feel like you're part of the team, you help patients to get up, to change positions...” This team could be described as a very good team.

The Unifying Roles of the Healthcare Supervisor and Doctor

At the IM department, the healthcare supervisor was striving to instil a sense of team spirit even though an apparent lack of resources for solving problems tended to generate internal conflicts. The supervisor’s ability to create a group dynamic was called into question. With the help of the senior health officer, she tried to create a link between the members of the team.

In the emergency department, the healthcare supervisor was striving to inspire the same team spirit but faced difficulties due to the way the department is run. Staff “spun” between handling emergencies and the STHU and alternated between night and day shifts. “Sometimes some team members do not see each other for a month”. The healthcare supervisor had implemented two strategies to try to overcome these difficulties: compulsory attendance – even on their days off – at a staff meeting scheduled for every two months; and introduction of a handover booklet for staff to share. In addition, the healthcare manager – whose office was located close to the STHU – visited the emergency rooms and the STHU several times a day, primarily to review “the bed situation”. This offered her the opportunity to be in direct contact with all staff on the team.

At the MC, the healthcare supervisor played a critical role in establishing quality assurance procedures in the oncology department. Through her involvement, she had succeeded in uniting everyone involved in the department around this approach and placing the quality of patient care and patient comfort at the centre of all concerns. Staff recognised the key role the health care supervisor played in improving the quality and organisation of healthcare tasks. She was perceived more as a facilitator and consultant than a pure decision-maker or controller. The healthcare supervisor acted as an intermediary between management, the Quality unit and the oncology department.

DISCUSSION

Three discussion points arise from these results: team structure and distribution of tasks; communication and reducing distances in working relations; and the mediating role of the healthcare supervisor.

Team Structure and Distribution of Tasks

Analysis of the cases studied shows that the way a team organises its work and conducts relations is determined by the way the department is organised and medical authority.

In the model of a good team, hierarchical control has been replaced by establishing unity of purpose and values. The team involves cleaning and maintenance orderlies by giving them some responsibility and by actively including them in decision-making. This involvement positively affects feelings of value in cleaning and maintenance orderlies, increasing their motivation, satisfaction and pride. In taking this approach, the oncology department has reduced negative behaviour in orderlies which can be a source of dysfunction and generate additional costs due to demotivation. The department can also secure their cooperation, increase their productivity and improve the quality of healthcare. Conversely, a lack of perceived closeness (in the IM department) can be seen as a cause of conflict and poor quality. Thus, as the Gheorghiu and Moatty report points out “a more pronounced division of work has in many cases made task sharing between nurses and healthcare assistants potentially more confrontational” [4].

Our results indicate that role descriptions, particularly for doctors, are not always adapted. It is not the doctor's role to supervise or to lead; their main role is to share their experience and knowledge, to analyse patient records and explain medical instructions during staff meetings, thus fostering cognitive proximity. A lack of exchange is badly perceived by teams and creates a divide between doctor and care team. The role of the healthcare supervisor is also often misunderstood by teams and must be legitimised (IM). Wallick shows that the healthcare supervisor's effectiveness depends significantly on whether senior management is committed to developing the supervisor's skills so that they can perform this HR role fully [5].

Making Tasks Meaningful through Communication

Comparison of the three departments shows that the larger a department becomes, the more cohesion is weakened if teams do not find new ways to cooperate and more time for discussion [6]. Verbal handovers, staff meetings, and weekly overview meetings are the only ways healthcare staff can liaise with each other. Exchanges within networks outside of the department also strengthen group cohesion by involving specialists (psychologists, etc.). These two forms of liaison combined facilitate coordinated action. Patient records and the information they include should encourage communication between team members [7]. However, it is not so much writing as communication that is important [8]. Most exchanges are verbal and relatively formalised (handover, staff meetings).

Although the rules defined within teams provide a framework for action, they can also cause a sense of action being meaningless, especially in the case of absent management and a lack of sharing. Conversely, exchange between people based on sharing healthcare tasks promotes accountability. Healthcare practitioners discuss before consulting the protocols and any doubt or hesitation is removed by consulting the protocols. Verbal exchanges and physical proximity are crucial. The protocols might set out how to do something but discussions with doctors will explain why. It is the why that brings meaning and gives sense to what is done.

The case of the HC illustrates a reality experienced by many departments. In practice, each doctor had a specific approach to their work and valued specialisation and clinical time more than discussion time and coordination within care teams. The healthcare supervisor questioned whether organisational rules could influence the behaviour of doctors who (along with the care teams) were convinced that changes to the department's organisational structure and an increase in administrative tasks had decreased their clinical time. Consequently, they did not adhere to the rules. These findings are consistent with those of Chřdotel and Krohmer who argue that rules play a decisive role in "defining a clear and shared guideline, establishing a facilitating structure and clear division of roles" [9].

Organisational and individual choices, such as pooling teams, working in pairs, and more consistent doctor presence and involvement in teams, will only be successful if the facilitating conditions are in place. We found that teams do not work well if too many external constraints disrupt the collective commitment to the patient. The best tool for regulating this could be workplace discussion as "discussion enables a manager to restore meaning to work" [10]. Discussions need to be managed in the event of immediate managers, namely healthcare supervisors, failing to resolve problems. Managed discussions should make it possible to regulate an activity jointly by facilitating clear expression of the difficulties, negotiation of rules, and building compromise [11]. In the MI department, the team's difficulties and constraints were discussed in a working group set up to develop a service charter. This shows that effective communication that develops values and helps create meaning requires a suitable organisational size, a shared tool such as patient records, and doctors who facilitate coordination by communicating with the team.

The Healthcare Supervisor – A Mediating Role

In this context, alongside other factors, the healthcare supervisor helps regulate the way healthcare units function. The integral role of the healthcare supervisor is that of what Crozier calls the influential outsider [12]. This role can facilitate the negotiation of rules between different stakeholders. Indeed, the role of supervisor comes into its own mainly in mediation. This is particularly the case in meetings, where they may speak to defend the point of view of a member of a care team. They may also call some doctors to order to make sure they comply with the rules defined in the department (to sign prescriptions for example). As highlighted in the report by Gheorghiu and Moatty, mediation and monitoring positions have multiplied (in the appearance of the healthcare supervisor), simultaneously with the development of regulatory procedures and direct cooperation (protocols) [4].

The healthcare supervisor at the MC acted as an intermediary between management, the Quality unit and the oncology department. She fulfilled a coordinating role intra- and inter-departmentally within the oncology service. This legitimised Quality procedures in the eyes of medical teams and strengthened their collective motivation, which was focused on the well-being of patients. The nature of the relationship between doctors and healthcare workers has been marked by the development of the role of healthcare supervisor. As Nobre points out, "the effect of this is that a rigid, hierarchical structure bearing the stamp of paternalism is replaced by a cooperative relationship that reduces differences in status and challenges the medical sphere" [13]. We have shown that it is the healthcare supervisor's role to foster the

relationship between doctors and care teams, by focusing on the way the department is organised, and respect for common rules. The healthcare supervisor is more than just a mediator, they also become organisers. The study by Dumas and Ruillier showed that “the healthcare supervisor is the person who helps employees fulfil their work duties” [14]. Managerial activity therefore includes supporting the team and giving recognition. The role of the healthcare supervisor as a leader thus requires an ability to motivate, lead and develop people.

CONCLUSION

The hospital environment, at least in large establishments, favours specialisation and high levels of expertise over cross-team approaches and coordination skills. We have shown that cohesion between doctors and care teams promotes efficiency and facilitates coordination between medical and care teams. Teamwork involves adopting good coordination practices. These practices require team members to form new closer working relations within a context of formal rules of communication and respect for organisational rules. Everyone has a part to play in this coordination but there needs to be a leader, such as the healthcare supervisor, who organises and manages the work. Depending on the structure of the department and how remote the doctors are, a general practitioner can play this pivotal role and forge the links between doctors and care teams.

More informal factors contribute to building team spirit. Our results show that support among colleagues fosters trust and a positive atmosphere at work. Finally, our results highlight a number of areas of tension or where extra care is needed, signs of deterioration in the working climate and team spirit and the quality of teamwork.

The cases studied highlight problems and failures in cooperation, but also successes. In the case of the MC, the contribution of a resource such as the general practitioner has improved the organisation. The legitimacy of the healthcare supervisor as an organiser and someone who comes up with solutions, supported by Management, is also a driving force in team dynamics.

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