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Feature Article

Team inclusion and empowerment among nursing staff in long-term care

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ABSTRACT

Team-based approaches to long-term care are increasingly part of the landscape in residential care facilities to improve staff performance and resident outcomes vis-à-vis empowering direct care staff. This study characterizes licensed and unlicensed nursing staffs' ($N = 95$) perceptions of inclusion as care team members by co-workers, supervisors and non-nursing clinicians. Further, we explored whether inclusion was correlated with heightened empowerment and its related dimensions using the Perception of Empowerment Instrument. Linear regression analyses revealed that levels of total empowerment, autonomy, responsibility and participation were associated with how included team members felt and by which members of the care team. These findings shed light on the potential importance of tailoring staff training to target specific team members to increase a sense of empowerment that aligns with the specific dimension(s) for a targeted group.

Introduction

America is growing older. The United States (U.S.) Census Bureau estimates that the number of adults aged 65 and older will nearly double between 2012 and 2050, reaching 83.7 million older adults, or 25% of the total U.S. population, by 2050.[1] Though disability rates among older adults have declined, it is still anticipated that more than half of individuals who turned 65 in 2016 will require some form of long-term services and supports; such care is typically utilized for an average of two years.[2] Older adults will require long-term services and supports for a variety of acute and chronic conditions, the most common being forms of cognitive impairment, including Alzheimer's disease and other dementias.[3] Within the U.S., over 5 million people currently live with some form of dementia and the prevalence of these diseases collectively is expected to rise with population growth, suggesting an increased need for care in residential long-term care (LTC) facilities, such as nursing homes and assisted-living facilities.[4]

Meeting the needs of this older adult population is immediate and growing and must include strengthening the LTC workforce. For over a decade, the Institute of Medicine has voiced the need to provide care to older adults via a well-trained and engaged workforce.[5] However, there are many challenges to ensure that the workforce can meet this demand for care. First, population growth among working age adults in the U.S. is projected to remain flat and, thus, result in widespread worker shortages.[6] Second, the LTC workforce commonly experiences high turnover rates. For example, in 2012, the median turnover rate for nurse aides in the U.S. was 52%, but has been documented as high as 100% in some facilities.[7,8] Therefore, it is essential not only to recruit and train workers for careers in LTC but also to retain them.

Numerous studies point to a variety of factors impacting turnover among the LTC workforce, and the LTC nursing (e.g., licensed nurses and nurse aides) workforce in particular. Such factors include a lack of respect from supervisors, a high and demanding workload, perceptions by staff of low-quality, as well as low pay and poor-to-no benefits.[8–11] Low job satisfaction has been one of the most frequently cited reasons why nursing staff in residential LTC facilities leave their jobs; moreover, the literature has revealed autonomy and empowerment as two of the most important factors influencing job satisfaction.[12] According to Kanter (1993), empowerment in the health care setting is defined as "the ability to get things done, to mobilize resources, to get and use whatever it is that a person needs for the goals he or she is attempting to meet" (p. 166).[13] Empowered employees feel control over their work and confident in their abilities to perform good care while believing that what they do impacts their organization.[14]

As empowerment of nursing staff, especially nurse aides, in LTC has been shown to improve both staff and resident experiences, part of the culture change shift from task-oriented to relationship-oriented care includes empowering hands-on caregivers. For example,

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Barry and colleagues found that certain empowerment practices such as rewarding staff led to fewer pressure ulcers and higher social engagement among residents, while other studies have found positive relationships between empowerment, job satisfaction, and turnover in LTC organizations.[15–18] Further, Cready et al. also reported higher job satisfaction for licensed nurses who worked with highly empowered nurse aides.[18]

Thus, to create a more stable and reliable workforce in LTC, efforts must be made to increase empowerment. There is evidence that participating on teams, including interdisciplinary teams, in LTC settings can lead to increased empowerment of nursing staff.[19–21] Further, the importance of quality teamwork in health care has been a subject of numerous studies citing improvements in job satisfaction, quality of care, patient safety and patient satisfaction.[22–28] Yet, to date, most findings demonstrating the benefit of team-based approaches come from acute care settings, where team-based, interdisciplinary care is not a novel concept but rather has been implemented as standard for years.[29] In acute care settings, highly-functioning and cohesive teams tend to produce more empowered clinicians, resulting in higher quality care.[25,30–32]

Lacking from the literature is an understanding of empowerment and the relationship with team-based approaches (or perceptions of teamwork) in contexts other than acute care, including LTC. The composition of acute care teams differs from that of teams in residential LTC settings. For example, a typical acute care health care team may include a surgeon, nurse, anesthesiologist, oncologist and radiation therapist; whereas the LTC team is comprised mostly of nurses, a social worker, activities director and therapists. More recently, mental health professionals and nurse aides have been invited on the team as their input has been deemed more valuable than before in light of the "culture change" movement in LTC.[59] While the composition may be different, there are certain aspects that are found in the literature that characterize functional teams in health care regardless of setting. From an organizational standpoint, there must be an appropriate culture, suitable leadership, relevant members and a clear purpose for the team. Individual contributions include trust, self-knowledge and commitment, while team processes must include coordination, communication, conflict management and cohesion, where team members feel a sense of belonging or inclusion.[33] Good teamwork must be encouraged by supervisors in order to increase empowerment among team members and teams work when all who have influence over a patient or resident's care are included on the team.[31,34]

An interdisciplinary team approach is an increasingly expected component of residential LTC. For example, U.S. Federal regulations that oversee care in residential LTC settings require interdisciplinary care planning, but not necessarily interdisciplinary teams. However, as LTC shifts from a task-oriented, medical model to relationship-oriented, patient-centered care, in addition to the increase in post-acute care, the use of care teams becomes more important and many LTC settings have switched to a team-oriented approach that reaches beyond the care plan.[35–39] The results have largely been positive when considering organizational performance and empowerment of team members.[37,39–41] Some studies, however, have shown that staff do not perceive teamwork at all, while others excluded nurse aides from the care team or considered them as "separate" from the rest of the team.[20,38,42–46] This suggests that non-inclusion (or its perception) of nurse aides as part of the care team can be a barrier to empowerment and work performance, despite the evidence that effective teams are inclusive of all members who influence resident care.

An adaptation of Rosabeth Moss Kanter's (1977) theory of structural power in organizations guided this study.[47] Kanter's theory posits that powerlessness is associated with structural job characteristics and that access to certain job-related empowerment structures affects employees in ways that enhance work outcomes. The empowerment structures involve opportunity structures, power structures and the structure of proportions. Participating on a team is an example of an opportunity structure where workers' growth in the organization can be accessed through increases in knowledge and skill, as well as the ability to participate in task forces or committees. She claims that teams can be used as a strategy for empowering workers. Kanter also considers an organization's awareness of worker contributions as an additional aspect of opportunity, including methods that impart a sense of value to employees (inclusion). Prior research using Kanter's model has shown that access to these power and opportunity structures can lead to increased job satisfaction, work effectiveness and participation in organizational decision making vis a vis empowerment.[48–50]

The purpose of this study was to characterize perceptions of inclusion or the extent one feels included as a team member by others (i.e., supervisors; co-workers; and other clinicians) among professional and paraprofessionals in nursing in LTC. Given emphasis on health care teams or inter-disciplinary care, a secondary goal was to explore if internal and external (department) inclusion was correlated with empowerment and its related dimensions. We hypothesize that, among professional and paraprofessional nursing staff, higher levels of inclusion by other team members will be associated with heightened empowerment.

Material and methods

Data Source. Data for this paper were taken from a larger IRB-approved study that investigated the impact of a standardized interdisciplinary team process based on the Eldercare Method.[35] The Eldercare Method is a systematic process of care for older adults in LTC settings that includes a behavioral health component. It is considered a "wrap-around" approach, where the goal is to involve everyone who cares for an individual in the LTC setting in order to improve care outcomes. This model seeks to impact residents, staff and the community as a whole via the creation of "Community Care Teams" inclusive of nurses, nurse aides, social work, and behavioral health among others.[35,36] The parent study sought to provide evidence for the effectiveness of this model on both residents and staff in 4 residential care facilities (skilled nursing and personal care) via staff questionnaires, as well as secondary data collected on the residents (e.g. Minimum Data Set; medication records; electronic health records. Results of the parent study have been reported elsewhere.[51]

The current study analyzed data from the staff questions only at time point one (pre-intervention). The staff survey was an online component of the study where staff anonymously completed a 34-item questionnaire that included questions concerning job title, job tenure, and intent to leave. The questionnaire also included the General Self-Efficacy Scale, perceptions of teamwork on the unit, and the Perception of Empowerment Instrument.[52,53] The survey was open to everyone on participating units ($N = 224$) among the 4 facilities. The variables of interest in this current study taken from the larger investigation include the following: selected characteristics of the sample in terms of work environment and job tenure, how included by key stakeholders the nurses and nurse aides felt as part of a health care team and perceptions of empowerment in their roles as nursing professionals and paraprofessionals in the LTC context.

Measurement

Work characteristics. The respondents answered questions concerning type of care unit (i.e., skilled or personal care), currently working in a memory support unit (yes or no); job tenure (3–6 months; 6–12 months; 1–2 years; 2–5 years; 5 or more years). These

responses allow for greater understanding of the sample with respect to the LTC work.

Inclusion as part of health care team. Respondents were asked about their level of being included as part of the health care team by their supervisor, co-workers and other clinicians as well as their overall perception of teamwork on the unit. These questions are detailed in Table 1, with response options ranging from 1: "strongly disagree" – 5: "strongly agree."

Empowerment. Respondents completed the Perception of Empowerment Instrument (PEI),[54] which measures overall empowerment and three dimensions of empowerment: autonomy, participation, and responsibility. Autonomy refers to an individual's perception of the level of freedom and personal control that he or she possesses and is able to exercise in performing job tasks. Participation measures perceptions of influence in producing job outcomes and the degree to which employees feel they have input into organizational goals and processes. Responsibility measures the psychological investment an individual has toward his/her job and the commitment he/she brings to the job. The scale includes 15 items (See Table 2) and response options included 1: "strongly disagree" – 5: "strongly agree." An overall empowerment score is calculated by summing all item responses, while the specific dimensions are based on summary of specific items per dimension.[53]

Sample

Of those invited to complete the survey, 158 staff members completed the survey (response rate of 70%) of which 144 indicated their position type (licensed/registered nurse; nursing assistant or aide; other). Of these, 95 individuals were nursing professionals (e.g., RN/LPN; $n = 36$) and nursing paraprofessionals (e.g., nursing assistant or nurse aide; $n = 60$), while the remaining varied in clinical and supportive roles (e.g., occupational therapy, nutrition therapy, administrative support staff). One of these respondents only completed the question about role and no other questions. Thus, these analyses included 95 nursing staff members in the sampled facilities ($n = 35$ licensed nurses and $n = 60$ aides).

Analyses

Data analyses were conducted using IBM SPSS Version 24. Descriptive statistics in the form of frequencies were calculated to characterize the work characteristics for the respondents. To address the primary study objective, frequencies and bivariate descriptive statistics were calculated for the empowerment measures (including dimensions) and inclusion as part of the care team. Spearman correlation was used to examine bivariate relationships between level of empowerment and inclusion perceptions (supervisor, co-worker, other clinicians, and teamwork on the unit). There were 4 linear regression analyses performed to identify independent predictors of heightened total empowerment, autonomy, responsibility, and participation according to perceived level of inclusion by each type of team member. Due to missing data of less than 10% of the PEI scores, data were imputed using mean scores so that PEI summary scores could be calculated.

Results

Work characteristics

Nearly half (48.4%) of the participants had worked at their current LTC facility for five or more years, while an additional 33.7% worked at the facility for 1–5 years. A majority provided skilled care (66.3%) and the remaining worked in personal care (33.7%). Most (55.3%) were not providing care in a supportive memory care unit.

Inclusion as part of a care team

Table 1 provides the participants' perceptions of level of inclusion as part of the health care team as afforded by their supervisor, their co-workers, or other clinicians as well as overall perception of level of teamwork. A high majority of the participants "strongly agree" or "agree" that their supervisor (71.2%) and co-workers (77.7%) include them as part of the health care team, while a lower proportion (41.5%) "strongly agree" or "agree" that other clinicians (e.g., psychologists, therapists, social workers) include them as part of the health care team. Over three-quarters of the participants (77.6%) believe there is good teamwork on the unit (i.e., "strongly agree" or "agree").

Associations between Inclusion, empowerment and related dimensions

Total Empowerment for the participants was, on average, 55.23 (SD: 7.57; range: 35–72), 17.51 (SD: 3.26; range: 12–20) for Autonomy, 17.98 (SD: 1.89; range: 12–20) for Responsibility, and 19.75 (SD: 4.10; range: 10–29) for Participation. Table 2 provides specific frequencies for each of the PEI items in addition to the sample means. There was high agreement with Responsibility items as the proportion strongly reporting to "agree" or "strongly agree" with statements ranged from 89.4% to 96.9%. The proportion of participants indicating that they "strongly agree" or "agree" with Autonomy items ranged between 41% and 62.1%, with the lowest proportion (41%) agreeing with the statement, "I am my own boss most of the time." Among the nursing-related participants 35.8%–58.9% "strongly agree" or "agree" with Participation items, which was the lowest of the three empowerment dimensions.

Each of the inclusion items were significantly correlated with Total Empowerment, Autonomy, Responsibility, and Participation (See Table 3 for detailed results). For example, having co-workers include the nurse or nurse aide as a care team member was significantly (positively) correlated with Total Empowerment ($r = 0.527$; $p < .01$), Autonomy ($r = 0.388$; $p < .01$), Responsibility ($r = 0.529$; $p < .01$), and Participation ($r = 0.419$; $p < .01$), and had the strongest correlation of all inclusion variables for Total Empowerment, Autonomy, and Responsibility. A perception of being included by a supervisor was also significantly correlated with Total Empowerment and all aspects, with the correlations being strongest with Total Empowerment ($r = 0.506$; $p < .01$) and Participation ($r = 0.492$; $p < .01$). Having

Table 1
Inclusion per nursing-related professionals and paraprofessionals ($n = 94$) (Likert: 1-"strongly disagree" – 5: "strongly agree").

Inclusion question	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Mean (SD; range)
My supervisor includes me as part of the health care team.	2.1%	1.1%	25.5%	48.9%	22.3%	3.88 (0.841; 1–5)
My co-workers include me as part of the health care team.	1.1%	2.1%	19.1%	46.8%	30.9%	4.04 (0.828; 1–5)
Other clinicians (psychologists, therapists, social workers) include me as part of the health care team.	5.3%	9.6%	43.6%	30.9%	10.6%	3.32 (0.975; 1–5)
Overall, I believe there is good teamwork on the unit.	4.3%	2.1%	16.0%	45.7%	31.9%	3.99 (0.978; 1–5)

Table 2
Empowerment item frequencies for nursing-related professionals and paraprofessionals ($n = 95$) (Likert: 1-"strongly disagree" – 5: "strongly agree").

Inclusion question	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Mean (SD; range)
Total empowerment (scoring range = 15–75)						55.23 (7.57; 35–72)
Autonomy (scoring range = 5–25)						17.51 (3.26; 12–20)
I have the freedom to decide how to do my job	2.1%	6.3%	35.8%	37.9%	17.9%	
I can be creative in finding solutions to problems on the job	0%	5.3%	40%	40%	14.7%	
I have a lot autonomy in my job	3.2%	3.2%	36.8%	41.1%	15.8%	
I make my own decisions about how to do my work	2.1%	7.4%	28.4%	51.6%	10.5%	
I am my own boss most of the time	10.5%	25.3%	23.2%	36.8%	4.2%	
Responsibility (scoring range = 4–20)						17.98 (1.89; 12–20)
I am responsible for the results of my decisions	0%	2.1%	8.4%	52.6%	36.8%	
I take responsibility for what I do	0%	0%	3.2%	33.7%	63.2%	
I am responsible for the outcomes of my actions	0%	0%	3.2%	33.7%	63.2%	
I am personally responsible for the work I do	0%	0%	4.2%	37.9%	57.9%	
Participation (scoring range = 6–30)						19.75 (4.10; 10–29)
I am often involved when changes are planned	4.2%	20%	38.9%	30.5%	6.3%	
I am involved in determining organizational goals	4.2%	20%	38.9%	30.5%	8.4%	
My input is solicited in planning goals	5.3%	18.9%	38.9%	29.5%	7.4%	
I am involved in decisions that affect me on the job	2.1%	7.4%	31.6%	42.1%	16.8%	
I am involved in creating our vision of the future	4.2%	20%	40%	31.6%	4.2%	
My ideas and inputs are valued at work	2.1%	8.4%	42.1%	36.8%	10.5%	

other clinicians (psychologists, therapists, social workers) include the nursing professional/paraprofessional as part of the health care team was significantly correlated with the Participation dimension of empowerment and was the most strongly correlated factor with Participation.

Tables 4–7 highlight linear regression models for Total Empowerment and dimensions of Autonomy, Responsibility, and Participation according to inclusion perceptions of the nurses and nurse aides. Belief that one's supervisor includes them as a member of the health care team was a significant and positive predictor of Total Empowerment and all dimensions, except Responsibility. In contrast, believing that one's co-workers include them as part of the health care team was a positive and significant predictor of empowerment and all dimensions, including Responsibility. A stronger belief that other clinicians include the respondents as part of the health care team was a significant positive predictor of Participation ($p = .02$). Lastly, the perception of teamwork on the unit significantly predicted higher Total Empowerment and Responsibility scores, but not Autonomy or Participation.

Discussion

This study explored the relationship between team inclusion and perceptions of empowerment among nursing staff in LTC facilities. To date, published research on clinical care teams in these settings has been minimal despite the increased emphasis on care teams in LTC organizations. More importantly, staff empowerment has a significant effect on overall quality of resident care.[54] The results of this study show a significant positive relationship between inclusion (e.g., perceiving to be included by one's supervisor, co-workers and other clinicians) and staff empowerment. This finding is particularly important given that high-functioning, inclusive health care teams can be developed through modeling and staff training programs.[43,55] Future work might focus on developing targeted tools and trainings to assist specified team members (supervisors, etc.) in their ability to include or engage subordinates or co-workers in caring for residents.

In this sample, average total empowerment scores were relatively high, as were scores on the Autonomy and Participation dimensions. An average score of 18 on the Responsibility dimension suggests that nursing staff in the sampled facilities were highly invested and psychologically committed to their jobs. However, the lowest proportion of respondents agreed with the statement, "I am my own boss most of the time", which contributed to a lower average Autonomy score. This is consistent with the highly-regulated and hierarchical nature of LTC nursing in the U.S., where much of the clinical care is dictated by Federal regulations that are then handed down to the nursing staff who are caring for residents. Additionally, while the average score for Participation was on the upper end of the scale range, a lower proportion of nursing staff agreed with the scale items compared with those for Autonomy and Responsibility. This suggests a perception of a lack of influence over job outcomes or having input into organizational goals, which is likely influenced by the for-profit, chain-affiliated characteristics associated with many nursing facilities.[3]

Nearly 75% of nursing staff felt included as part of the care team by co-workers and supervisors; however, less than half believed other clinicians considered them as care team members. Nursing staff who feel included by co-workers experienced higher empowerment on all dimensions of the measure, especially Autonomy and Responsibility and co-worker inclusion influenced all dimensions of empowerment in the predictive model. They might trust each other to get the job done and are psychologically invested in their work. Feeling included as a team member by supervisors was strongly correlated with the

Table 3
Pearson's Correlation of Inclusion and Empowerment.

	Total empowerment	Autonomy	Responsibility	Participation
My supervisor includes me as part of the health care team	0.506**	0.365**	0.322**	0.492**
My co-workers include me as part of the health care team	0.527**	0.388**	0.529**	0.419**
Other clinicians (psychologists, therapists, social workers) include me as part of the health care team	0.422**	0.226*	0.226*	0.494**
Overall, I believe there is good teamwork on the unit	0.436**	0.337**	0.387**	0.359**

* $p < .05$.
** $p < .01$.

Table 4
Linear regression analyses predicting total empowerment according to inclusion variables.

	B	SE	Beta	*t*	*p*
My supervisor includes me as part of the health care team**	0.337	0.819	0.260	2.841	.006
My co-workers include me as part of the health care team**	2.884	0.806	0.316	3.579	.001
Other clinicians (psychologists, therapists, social workers) include me as part of the health care team	1.313	0.677	0.168	1.939	.056
Overall, I believe there is good teamwork on the unit*	1.707	0.755	0.210	2.261	.026

Total R^2: 0.481, $p < .001$.
* $p < .05$.
** $p < .01$.

Table 5
Linear regression analyses predicting autonomy according to inclusion variables.

	B	SE	Beta	*t*	*p*
My supervisor includes me as part of the health care team*	0.861	0.426	0.222	2.021	.046
My co-workers include me as part of the health care team**	0.953	0.419	0.241	2.273	.026
Other clinicians (psychologists, therapists, social workers) include me as part of the health care team.	0.077	0.353	0.023	0.217	.828
Overall, I believe there is good teamwork on the unit	0.611	0.393	0.173	1.554	.124

Total R^2: 0.250, $p < .001$.
* $p < .05$.
** $p < .01$.

Table 6
Linear regression analyses predicting responsibility according to inclusion variables.

	B	SE	Beta	*t*	*p*
My supervisor includes me as part of the health care team.	0.257	0.231	0.114	1.110	.270
My co-workers include me as part of the health care team**	0.933	0.227	0.406	4.100	.000
Other clinicians (psychologists, therapists, social workers) include me as part of the health care team.	0.006	0.191	0.003	0.033	.974
Overall, I believe there is good teamwork on the unit*	0.427	0.213	0.208	2.002	.048

Total R^2: 0.347, $p < .001$.
* $p < .05$.
** $p < .01$.

Table 7
Linear regression analyses predicting participation according to inclusion variables.

	B	SE	Beta	*t*	*p*
My supervisor includes me as part of the health care team*	1.208	0.474	0.248	2.550	.013
My co-workers include me as part of the health care team*	0.997	0.466	0.201	2.139	.035
Other clinicians (psychologists, therapists, social workers) include me as part of the health care team**	1.230	0.392	0.290	3.139	.002
Overall, I believe there is good teamwork on the unit	0.670	0.437	0.151	1.533	.129

Total R^2: 0.414, $p < .001$.
* $p < .05$.
** $p < .01$.

Participation dimension of empowerment, which demonstrates a sense of having input into the organization and influencing resident care. This dimension of empowerment is exemplified by nursing staff becoming more involved in care planning, collaborative decision making, or simply being asked about a resident's status.[15,56] Further, supervisor inclusion significantly predicted all dimensions of empowerment, except Responsibility, which refers to the psychological investment one has with their job. Thus, this finding is contrary to prior research where having a supportive supervisor, especially for nurse aides, leads to higher levels of organizational commitment and lower levels of turnover.[57,58] This warrants further exploration of these relationships including, perhaps, discerning potential differences between the meaning of organizational commitment and having a psychological investment in the job.

Though less than half of the respondents felt included by other clinicians, the data revealed the strongest correlation with the Participation dimension when nursing staff did feel included on the care team by other clinicians. Further, Participation was the only dimension of empowerment predicted by inclusion by other clinicians, exemplifying the culture change movement in LTC, which includes employing interdisciplinary teams to increase patient-centered care and minimizing the hierarchy within organizations.[59] These data mirror the research on culture change, where true culture change can be difficult to attain due to challenges with staff who are resistant to altering the way things have always been done in addition to the inherent complicated dynamics associated with interdisciplinary teams.[60,61] However, when nursing staff feel a part of a high-functioning, inclusive team, they are more committed to the organization and feel an overall sense of empowerment and a more empowered nurse or nurse aide is less likely to leave the organization.[16,61]

Results of this study support Kanter's theory of structural empowerment, where inclusion by certain care team members leads to increased investment in the job and beliefs that nursing staff can influence organizational goals and care outcomes. This study suggests

practical implications for enhancing empowerment among care team members in LTC. Specifically, simple participation in team-based care processes are necessary but may not be sufficient to create positive change in perceptions of empowerment among nursing staff. Rather, nursing staff empowerment and its dimensions are influenced by feelings of inclusion specific to the quality and characteristics of interactions with different types of team members. This critical link between the nature of team member interactions and the perception of empowerment has implications for how LTC organizations might structure interdisciplinary team collaboration among staff in order to create truly empowered workers.

In order to understand the full implications of the findings of this study, it is important to consider the context of the growing body of literature related to fostering effective interdisciplinary collaboration.[62] Within this body of literature, it is well established that teams function best when there is an intentionality in providing interdisciplinary care team members with training in interdisciplinary collaboration, as well as providing the team as a whole with clear goals, standardized structure, strong leadership and time. These structures and resources are necessary to enhance collaboration and effectiveness within teams in order to improve worker effectiveness and lead to higher quality care.

Limitations

While the results of this investigation add to the limited literature on team inclusiveness and empowerment in LTC, there are several limitations that should be considered. The cross-sectional nature of the design limits the ability to determine causation. It is equally as likely that more empowered staff actively become part of care teams. The end result being the challenge of improving overall staff empowerment with team inclusion serving as one example of attaining this goal. Future longitudinal investigations are warranted to determine causality.

Additionally, as with any secondary data analysis, the data in this study were collected with differing objectives. A study designed specifically to examine this research question would likely include additional measures, particularly those related to turnover, job satisfaction and resident outcomes. Further, given the historical nature of healthcare teams, where nurse aides are often not included, it was surprising to discover that initial analyses revealed no significant differences on Inclusion and Empowerment scores between nurse aides and those of licensed nurses. This, in addition to the small sample size, precluded us from exploring any differences that may have existed between licensed and unlicensed staff in this sample. The extent of participation in the culture change movement for the sampled facilities was not measured to determine whether the nursing staff perceptions reported here could be an artifact of organizational culture. These potential biases support future exploration of these relationships using a larger sample size and including variables associated with measuring culture change. Despite these limitations, the results of these analyses indicate a role for team inclusion in efforts to empower nursing staff in LTC organizations and discourage the use of a “one-size fits all” approach for staff training.

Conclusion

The results of this study revealed that levels of empowerment among interdisciplinary care team members are associated with whether or not individuals feel included as part of the team and by whom. As interdisciplinary teams continue to become more commonplace and integrated into LTC settings, it will be important to address this issue to create truly empowered care teams. It is likely that inclusive and empowered care teams will lead to higher job satisfaction and staff retention and, ultimately, higher quality care for LTC consumers.

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Declarations of interest

None.

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