Job satisfaction and burnout among hospice nurses working on interdisciplinary teams: A multimethod study

Hillary Hamilton

University of Northern Iowa
JOB SATISFACTION AND BURNOUT AMONG HOSPICE NURSES
WORKING ON INTERDISCIPLINARY TEAMS:
A MULTIMETHOD STUDY

An Abstract of a Thesis
Submitted
in Partial Fulfillment
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ABSTRACT

This multimethod study examined three hypotheses and two research questions: (H1a) Interdisciplinary collaborative communication is positively related to hospice nurses’ experience of job satisfaction in the context of team-based care, (H1b) Interdisciplinary collaborative communication is negatively related to nurses’ experience of burnout in the context of team-based care, (H2) Interdisciplinary collaborative communication is negatively related to nurses’ intent to leave their organization, (RQ1) How does interdisciplinary collaborative communication influence hospice nurses’ experience of job satisfaction and burnout in the context of team-based care?, (RQ2) How does work site influence hospice nurses’ experience of job satisfaction and burnout in the context of team-based care?

Quantitative measures were used to explore hypotheses, and qualitative measures were used to explore research questions. Forty-six hospice nurses working primarily in hospice facilities, nursing facilities, or patients’ homes located in four Midwestern states completed the web-based survey that included consent information; demographic questions; and items for job satisfaction, burnout, intent to leave the organization, and interdependence and flexibility within interdisciplinary teams. All survey items excluding consent and demographics were measured using a five-point scale based on agreement where (1 = strongly agree and 5 = strongly disagree). Sixteen hospice nurses working primarily in hospice facilities, nursing facilities, or patients’ homes located in four Midwestern states participated in a semi-structured phone interview lasting approximately thirty minutes. All interviews were recorded and conducted after receiving
verbal consent. Interview questions focused on nurses’ experience with their organization, duties, communication and collaboration with their team, and feelings about their work experience.

I analyzed the quantitative data using correlation tests, which showed insignificant results for H1a, H1b, and H2. However, use of interdependence and flexibility within interdisciplinary teams was positively related to nurses’ experience of job satisfaction. This means that use of collaborative acts such as interdependence and flexibility within interdisciplinary teams was related to nurses’ experience of job satisfaction. In addition, use of interdependence and flexibility within interdisciplinary teams was negatively related to nurses’ experience of burnout. As such, use of interdependence and flexibility was related to nurses’ decreased experiences of burnout and intentions to leave their organization. These results provide broad insight into nurses’ work experience, whereas the qualitative interviews were used to provide depth and detail into nurses’ experiences and quantitative findings.

Using a thematic analysis, I analyzed qualitative data from which four themes emerged: relationships within teams, access and immediacy of communication, communication channels and technology, and location of work and time of work shift. Pertaining to RQ1, data indicated that interdisciplinary communication and collaboration impacted the quality-of-care nurses provided to patients, which in turn impacted their own satisfaction and experience of burnout. Pertaining to RQ2, data indicated that nurses communicated with different people depending on where care was provided, and they expressed more satisfaction when communication contributed to quality care for patients.
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Date ____________  Dr. Tom Hall, Chair, Thesis Committee

Date ____________  Dr. Melissa Dobosh, Thesis Committee Member

Date ____________  Dr. Catherine H. Palczewski, Thesis Committee Member

Date ____________  Dr. Jennifer Waldron, Dean, Graduate College
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CHAPTER ONE

INTRODUCTION AND LITERATURE REVIEW

In November 2020, the problem of burnout in healthcare workers captured public attention. Short staffed and overworked, healthcare workers are at the frontline against COVID-19. Social media posts, media interviews, and fictional series all commented on one thing: health care workers have seen more death in a week than normally seen in a year. However, death is the norm for some healthcare workers. Hospice workers face death every day as they provide care to terminal patients. Beresford (1993) stated that hospice’s “primary purpose is to work with the terminally ill and their families, to help them make most of the time that’s left, and to make their dying more comfortable, less frightening, and in every way more bearable” (p. 3). This career no doubt requires hospice care providers to be compassionate and empathetic towards their clients. However, it would also require strength to regularly face death, something that has disturbed many in the past year and led to experiences of burnout.

Employees in a variety of industries have long faced burnout, “a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with people in some capacity” (Maslach & Jackson, 1984, p. 134). However, in the past year it has been added to the World Health Organization’s (2019) “eleventh revision of the International Classification of Disease (ICD-11).” This classification depicts burnout as a significant health issue in need of treatment. Gormandy (2020) found that the condition is prevalent in many industries including social work, academia, law, retail, and healthcare. While the experience of
burnout may vary by industry, a 2020 Gallup poll indicated that 76% of employees in the United States experience job burnout at some time or another (Wigert, 2020). Specific to nursing, the National Nursing Engagement Report issued in 2018 stated that 15.6% of all nurses reported experiencing burnout, and 41% reported feeling “unengaged” (Brusie, 2019). This is problematic because burnout can lead to poor retention rates resulting in nurse shortages. Treating burnout is important to healthcare organizations’ ability to function, however the World Health Organization has not effectively addressed the issue.

While the World Health Organization labeled burnout as an occupational phenomenon rather than a medical condition, the classification itself focuses on symptoms of burnout rather than its contributors. This could negatively impact how the issue is addressed. Specifically, Maslach, an expert on burnout, has expressed hesitation regarding this classification stating that it encourages treatment of people rather than organizational change (Moss, 2019). Treating people rather than the organization itself is similar to treating symptoms of an illness, providing temporary relief rather than healing. Wigert and Agrawal (2018) found that organizational factors and coworker interaction actually cause and aggravate burnout. Specifically, factors such as autonomy, staffing and resources, and access to leaders within health organizations influenced nurses’ interactions with other staff and contributed to feelings of burnout (Brusie, 2019). For instance, Brusie (2019) found that inadequate staffing or lack of access to leaders negatively impacted collaboration and communication between coworkers and contributed to burnout among nurses. This study indicates that burnout is caused by organizational issues, not people. As such, treatment for burnout should target the
organization. While the previously identified organizational problems could be experienced in any healthcare setting, I focus on hospice care, an organization that requires a significant amount interaction between nurses and other staff to provide quality care in a variety of settings.

In this chapter, I explain contextual information pertaining to hospice as an organization. Then, I overview findings and common themes from previous literature, outline the methods used to complete this study, and explain data analysis procedures. Finally, I provide appendices including an interview guide and a list of hospices in Iowa that will be contacted for this study.

A Brief History of Hospice

Differentiating hospice care from palliative care provides a basis for understanding this study. It also provides a general organizational context for studying staff interaction as it relates to burnout. For this reason, I define and contrast hospice care and palliative care, provide a brief history of hospice care in the United States, and discuss hospice care’s current significance as an organization.

Hospice and palliative care are similar in that they focus on comforting patients rather than curing a disease. However, they are provided at different times. Specifically, hospice care begins after treatment for a disease has stopped and when patients have approximately six or fewer months to live. In contrast, palliative care may be provided at the time of diagnosis and treatment, or while patients have longer than six months to live. While hospice and palliative care are both forms of comfort care, hospice strives to provide autonomy and comfort to individuals with a terminal diagnosis. Beresford (1993)
stated, “to the greatest extent possible, hospice tries to give back to its patients’ independence and control over the daily events of their lives” (p. 4). In part, this goal is met through palliative care, which helps relieve discomfort caused by an illness (Beresford, 1993). It is important to understand that hospice and palliative care maintain differences, but palliative care is part of hospice. Exploring hospice’s history and current use further contextualizes the organization.

Cicely Saunders was the founder of the modern hospice as we know it today. Saunders opened the first modern hospice, St. Christopher’s, in 1967 at Sydenham, a suburb of London. In under a decade, this model of hospice travelled to the United States. As early as 1974, Florence Schorske Wald opened the United States’ first modern hospice at Branford, Connecticut. This hospice was small in size, first serving only 44 individuals; however, it was revolutionary in providing care for terminally ill people in the United States (Hevesi, 2008). Over time, hospice has grown so that by 2017, 1,350,000 people were provided with hospice care (National Hospice and Palliative Care Organization, 2018). Today, approximately 6,100 hospice programs exist in the United States and hospice services are available in hospitals, patients’ home, and hospice facility settings (National Hospice and Palliative Care Organization, 2020). As hospice has expanded in number and settings, more employees are needed to provide care.

Hospice commonly provides patients and their families with emotional, spiritual, physical, planning, and informational support. A wide range of professionals from different disciplines are employed in hospice organizations. Currently, hospice offers 3,096,700 jobs to nurses in the United States (Bureau of Labor Statistics, 2021). By 2022,
the United States as a whole is projected to have 3,318,700 available positions for nurses (Bureau of Labor Statistics, 2021). These statistics illustrate US hospice care’s expected growth and need for nurses. However, hospices do not rely on nurses alone. Rather, they utilize interdisciplinary teams to provide comprehensive care for patients. An interdisciplinary team is composed of members from different disciplines who must work together to provide care. A typical interdisciplinary team in hospice care includes physicians, nurses, psycho-social professionals, spiritual care providers, and social workers; teams may vary in size and include other professionals than those listed (Green, 2015; Wittenberg-Lyles et al., 2010). Further exploration of interdisciplinary teamwork aids in understanding communication and collaboration in hospice.

Interdisciplinary teams work together by collaborating and communicating. Bruner (1991) defined interdisciplinary collaboration as a process enabling the completion of goals that could not be met by one team member’s effort alone. Collaboration requires team members to act together and communicate about their roles and patients’ care plans. Interdisciplinary teams communicate about a variety of topics including goals, care plans, patient needs, and care providers’ roles and responsibilities. Communication between coworkers has also been found to impact employees’ job satisfaction and turnover intention (Cooiman, 2001). Investigating collaboration and communication between the nurse-team dynamic provides insight into hospice nurses’ experience of job burnout, while also exploring the issue as a contributing factor of hospice nurse turnover. However, it is first important to understand burnout as a concept before relating it to team interaction.
Burnout in Hospice and on Interdisciplinary Teams

Burnout is a contributor to turnover in most organizations; however, reasons for burnout vary by profession and individual. However, the condition can be identified through symptoms that employees experience: exhaustion, cynicism, and ineffectiveness (Maslach, 2017). Providing a brief description of the elements in relation to hospice care, reviewing the causes of burnout among nurses, and exploring factors contributing to the burnout builds a foundation for understanding burnout relating to interdisciplinary teamwork within hospice organizations.

Elements of Burnout

Elements contributing to burnout lead to distinct and negative feelings regarding work. Specifically, Maslach (2017) stated that exhaustion stems from stress, and this is often the first feeling experienced from burnout. This feeling could result from overwork or excessive emotion within hospice. With the current nursing shortage, hospice nurses are required to work longer hours and constantly face death. This could lead to feelings of exhaustion. Cynicism involves showing a negative, callous, detached response towards work (Maslach, 2017). This element appears from an overload of exhaustion and is used as a form of self-protection from negative feelings (Maslach, 2017). Hospice nurses who are emotionally affected by constantly dealing with death may choose to detach themselves from the situation to prevent burnout. Ineffectiveness pertains to a negative self-evaluation of incompetence and lack of achievement or productivity (Maslach, 2017). In regard to hospice, nurses experiencing burnout may feel unproductive and incompetent in their job. These elements indicate that individuals experience symptoms of burnout, but
burnout stems from work situations. Overviewing burnout in relation to nurses helps deepen understanding of the condition.

**Factors Contributing to Nurses’ Burnout**

Existing literature pertaining to nurse burnout focuses on three causes: working over the number of hours scheduled, lack of support, and team politics. Specifically, these issues increase nurses’ dissatisfaction with work, which contributes to feelings of burnout. Multiple studies identified insufficient staffing due to poor scheduling and staff cuts as stressful for nurses because it required them to work longer shifts and take on more patients (Castro, 2018; Hwang Koh et al., 2015; Smith & Porock, 2009). This created an unsafe work environment where staff were over tired and struggled to maintain their workload (Castro, 2018; Smith & Porock, 2009). In addition, understaffing required individuals to work longer hours, and this took time away from their home life or left them feeling drained and exhausted (Cain et al., 2017). Insufficient staffing took a physical toll on nurses, causing them to feel unsatisfied in their work and contributed to feelings of burnout. In addition to time interfering with providing care to patients and time spent at home, inadequate staffing also influenced interdisciplinary team support.

Support was found to be a necessity to interdisciplinary collaboration, and lack of support contributed to nurses’ experience of burnout. Smith and Porock (2009) found that insufficient staff and time constraints limited the amount of support interdisciplinary teams were able to offer to each other, and this contributed to nurses’ frustration. Nurses value support in their interdisciplinary teams and are not necessarily opposed to offering support to other members. This indicates that team support was limited when there was
insufficient staff for the organization to effectively function. To address the staffing problem, nurses increased the amount of time they spent providing care while creating an unsafe work environment and limiting members’ time at home. This indicates that time working and support were related to staffing problems.

Politics within the team was less discussed in literature, but it was identified as a contributor to nurses’ dissatisfaction in interdisciplinary teams. Cain et al. (2017) and Castro (2018) found that team politics hindered interdisciplinary team collaboration and contributed to nurses’ dissatisfaction. Specifically, when nurses felt that their team was not supportive of each other and willing to work together, they perceived the team as less willing to collaborate. These studies reiterated the importance of staff support and identify collaboration as something that impacts nurses’ experience of satisfaction and burnout. This indicates that support in addition to having the time necessary to providing support is important to reduce nurses’ burnout and increase their satisfaction.

Influencers of Burnout in Interdisciplinary Teams

Literature discussed issues relating to time and organizational hierarchy as influencing interdisciplinary teams’ ability to collaborate, thus impacting burnout. Issues or processes that were time consuming or interrupted interdisciplinary team members’ normal work routines limited teams’ communication and collaboration. Specifically, staffing and location of work affected communication and collaboration in interdisciplinary teams. Smith and Porock (2009) found that providing home-based care was difficult when hospice was understaffed because it required teams to spend more time communicating with each other, and this pulled interdisciplinary team members
away from their other tasks. Obtaining support or approval of patients’ care plans was
time-consuming and hindered collaboration while also placing stress on team
relationships (Gilstrap & White, 2015). Specifically, nurses stated that they spent a lot of
time waiting for general practitioners’ approval and that they felt that general
practitioners did not understand end-of-life care (Gilstrap & White, 2015). This
perception was detrimental to communication and waiting for approval hindered
collaboration between healthcare providers. However, this finding also suggests that
healthcare hierarchy is an organizational issue.

Healthcare hierarchy influenced interdisciplinary collaboration and
communication. Specifically, vertical organizational hierarchies negatively impacted
communication and collaboration (Castro, 2018), whereas horizontal or flat hierarchies
facilitated team communication and collaboration (Aston et al., 2005). Mertens et al.
(2019) found that interdisciplinary teams sometimes misunderstood each other or faced
conflict due to organizational hierarchy issues. Specifically, some nurses refrained from
sharing observations with general practitioners because they felt that they were not
listened to and were criticized. This hindered collaboration because team members were
uncomfortable communicating with each other. In contrast, staff with identical rankings
in the healthcare hierarchy were more comfortable communicating with each other.
Wiegand (2012) found that nurses felt more comfortable speaking with other nurses than
with those who worked in other disciplines. In addition, Wiegand (2012) recommended
that interdisciplinary team members use debriefing, brainstorming, and humor to help
improve teams’ communication, working environment, and team building skills. These
studies indicate that vertical hierarchies hinder team collaboration, while flat hierarchies improve collaboration and can be facilitated through communication behaviors.

Literature indicates that interdisciplinary teams may struggle with communicating and collaborating because they either do not have the time to offer support, or they are uncomfortable interacting with individuals from different disciplines. In addition, literature has indicated lack of team communication and collaboration contribute to burnout among nurses. Addressing these organizational problems may help in decreasing burnout in the healthcare field, while also specifically addressing issues that hospice nurses face while working on interdisciplinary teams. However, literature also identified interdisciplinary teamwork as a contributor to nurse burnout.

**Burnout in Hospice Stemming from Interdisciplinary Teamwork**

A major influence on burnout, which can be both positive and negative, is working in interdisciplinary teams. This process requires individuals from different disciplines to collaborate while providing quality and comprehensive care to patients. Utilizing teams enables hospice organizations to better meet patients’ myriad and specific needs. Interdisciplinary teams are used to address complex problems, economize time spent providing care, and create care plans (Parker Oliver et al., 2005; Wittenberg et al., 2020). However, effective communication is crucial to interdisciplinary teamwork, as poor communication can result in miscommunication, information not being shared, and decreased quality of care for patients (Mertens et al., 2019; Pype et al., 2018; Wittenberg et al., 2020). As such, it is important for teams to effectively communicate and collaborate to provide hospice care. Literature regarding interdisciplinary collaboration
often used Bronstein’s (2003) model for interdisciplinary team collaboration to discuss teamwork. Overviewing the model provides a basis for understanding how hospice teams effectively engage in collaboration.

Interdisciplinary collaboration is a complex process impacted by team members’ interaction and communication. Bronstein (2003) developed a comprehensive model for interdisciplinary collaboration from four theoretical frameworks: multidisciplinary theory of collaboration, services integration, role theory, and ecological systems theory. The model describes interdisciplinary teams’ collaborative process, specifically identifying components and influencing factors of collaboration. Overviewing the model’s components and influencing factors increase understanding of interdisciplinary team collaboration.

**Components of the Interdisciplinary Collaboration Model**

Bronstein’s (2003) model for interdisciplinary collaboration is composed of five components: interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection on process. When used effectively, these components increase the likelihood of interdisciplinary teams providing quality care. It is important to note that presence of the components alone does not guarantee a positive collaborative experience; rather, this depends on members’ interaction. Each component is discussed in turn to better demonstrate the complexity of interdisciplinary team collaboration.

Interdependence refers to the idea that all team members rely on each other to effectively accomplish their goals and tasks. Kane (1980) stated that integrative teamwork requires individuals to collaborate while acknowledging that individuals
working together are dependent on one another. This indicates that interdependence is similar to or perhaps requires integrative teamwork. Interdependence is exemplified in hospice care when a physician relies on a nurse to give patients their prescribed medication, and a nurse relies on a physician to provide a correct prescription. Parker Oliver et al. (2005) found that social workers on interdisciplinary teams believed that their interdependent teamwork and team communication helped them provide quality care to clients and was part of their job description (Parker Oliver et al., 2005).

Interdependence requires work to be distributed among team members, which limits the amount of work any one team member has to complete. This could help prevent feelings of stress and burnout caused by feeling overworked.

Newly created professional activities require interdisciplinary team collaboration and enable teams to provide quality care, specialized to each patient. Activities include “collaborative acts, programs, and structures” (Bronstein, 2003, p. 300). Within palliative care, newly created professional activities could focus on patients’ care plans to provide specific care to each patient and better meet their individual needs. This component may take the form of “new structures, policies, and service delivery systems” that require individuals from different disciplines to work together with patients and their families while providing care (Bronstein, 2003). When effectively used, this component fostered interdisciplinary team collaboration to increase the quality-of-care patients received.

Flexibility extends interdependence by requiring members to go beyond the role and responsibilities required by their discipline. In the context of hospice care, Bronstein (2003) stated that flexibility requires role blurring among interdisciplinary team
members. Members are flexible when using knowledge gained from working with others in different disciplines to fulfill a need. This shows that collaborating as team increases members’ knowledge about all aspects of care, thus enabling individual team members to adapt to new or changing situations and better meet team members’ or patients’ needs. However, it also provides team members with enough knowledge to support other team members with tasks when needed; supportive team relationships help foster a positive work atmosphere and could help prevent or limit burnout.

Collective ownership of goals means that team members share responsibility for defining and reaching their goals. This component ensures that team members are working together and are unified. Smith-Carrier et al. (2015) studied interprofessional collaboration and found that having a shared vision for a patient facilitated collaboration within home based primary care. Similarly, Wittenberg et al. (2020) stated that interdisciplinary team members could improve collaboration when clearly defining goals, creating a shared vision, and agreeing on their mission. Having a shared goal unifies team members, helping them become cohesive as they fulfill different goals purposed to provide quality patient care.

Reflection on process requires team members to give attention to their collaboration and evaluate its effectiveness. This component improves communication by providing team members time to overview their past experiences to figure out what worked well and what could be improved in the future (Wittenberg et al., 2020). This component enables teams to identify their strengths and weaknesses, enabling them to become more effective in their collaborative process. However, Wittenberg et al. (2020)
also promoted members to consider interprofessional barriers and helping team members cope (p. 249). This statement indicates that reflection can also take form as support extended between team members. As previously stated in literature, support helps prevent feelings of dissatisfaction and burnout. This indicates that reflection can be used instrumentally not only to provide care but also to improve team members’ working experience.

Collaboration in hospice requires all team members to work together. The components demonstrated that team members are often involved in each other’s work, communicating about patients, tailoring care plans to patients’ specific needs, and unifying goals. While the presence of Bronstein’s (2003) components does not guarantee a positive work experience, their effective use helps facilitate quality care for patients and a supportive work environment. However, collaboration is also influenced by factors other than the previously discussed components.

Influencing Factors of the Interdisciplinary Collaboration Model

The collaborative process is influenced by a number of factors. Bronstein (2003) identified four influencers impacting collaboration: professional role, structural characteristics, personal characteristics, and history of collaboration. These influencers help determine whether team members have a positive or negative experience working together, thus impacting feelings of job satisfaction and burnout. It is important to note that influencers impact collaboration based on how they are used. Each previously identified influencer is discussed in relation to interdisciplinary team collaboration.
Professional role pertained to hierarchy, and this had the ability to facilitate or hinder collaboration. Specifically, maintaining a vertical hierarchy promoted division among team members and increased feelings of dissatisfaction (Mertens et al., 2019). In contrast, a flat or horizontal hierarchy helped all team members feel equal in status and facilitated communication and feelings of equality (Mertens et al., 2019). Teams value feeling equal in status to the extent that it increased their satisfaction within the team.

Structural characteristics of the hospice organization and interdisciplinary teams impacted team members’ communication and collaboration. For instance, Bronstein (2003) stated that administrative support, working autonomously, and scheduling manageable caseloads increased team members’ satisfaction with their job. This finding indicates that processes decided by the organization contributed to teams’ experience of satisfaction or stress. In contrast, team structures also impact interdisciplinary team communication. Wittenberg et al. (2020) stated that interdisciplinary team meetings facilitated communication between team members and helped them build rapport with one another. Interdisciplinary team members valued having a specific time and place to communicate with each other because it enabled them to build trust as a team. When used effectively, structural characteristics improve teams’ communication and collaborative experience, and this could be influential in preventing burnout among nurses.

Personal characteristics pertained to individual’s personalities and ability to build relationships. Characteristics such as loyalty, caring, and empathy were perceived as contributing to positive communication experiences among team members (Beate et al.,
2017). Specifically, these characteristics built a trusting and supportive environment, and this facilitated interdisciplinary team collaboration.

History of collaboration was perceived positively in literature. Mertens et al. (2019) stated that having a history of collaboration improved team members’ relationships and positively influenced their collaboration. Previously knowing and working with team members helped build team trust and provided a basis of experience on which to base future interaction. This helped create a positive work atmosphere characterized by supportive relationships.

Influencers facilitate communication and collaboration and contribute to feelings of job satisfaction when they provide team members with autonomy, equal decision-making power and voice to other members, establish rapport and trust within teams, and provide support and manageable caseloads. In contrast, influencers hinder communication and collaboration while also contributing to job stress and feelings of burnout when they limit communication between team members, reinforce a vertical hierarchy among members, overwork team members, and fail to provide support. These sources of burnout make clear that organizational change is important to promote satisfaction within hospice care.

Job Satisfaction Among Nurses and in Interdisciplinary Teams

Job satisfaction was another theme within literature that was similar or related to interdisciplinary team collaboration literature. Specific to healthcare, job satisfaction was impacted by factors including autonomy, similar beliefs and goals, and productivity.
Overviewing these topics provide better understanding of how they relate to healthcare providers’ job satisfaction.

**Autonomy as a Contributing Factor of Job Satisfaction**

Within the interdisciplinary team context, many elements of collaboration are valued and contribute to nurse satisfaction. Having autonomy or personal control within a situation increased nurses’ satisfaction and was linked to their willingness to stay at the organization (Cain et al., 2017; Ellis & Miller, 1993; Karlsson et al., 2019). Cain et al. (2017) found that autonomy allowed nurses to be more creative when providing care, and Karlsson et al. (2019) found that personal control was important to nurses because their jobs were subject to variability. This indicates that nurses liked the stability and creative allowance that autonomy provides. Providing interdisciplinary team members autonomy in their own tasks could help increase their satisfaction and prevent burnout.

**Unified Goals and Cohesiveness as Contributing Factors of Job Satisfaction**

Unifying goals within an interdisciplinary team positively impacts the collaborative process. Karlsson et al. (2019) found that interdisciplinary teams unified their goals by focusing them on patients’ needs and beliefs. While members had specific and different roles in providing care, focusing on patients’ needs and beliefs enabled members to share a broad goal; this encouraged interdependence and teamwork among members. In addition, unifying team goals to providing quality care for patients also increased nurses’ satisfaction (Cain et al., 2017; Karlsson et al., 2019). Specifically, nurses were more satisfied when they felt like they were providing quality care. However, nurses also valued team cohesion, which was facilitated by creating unified
team goals. These studies indicate that team unity facilitates collaboration, and this positively impacts nurse satisfaction.

Collaboration has the ability to influence team members’ opinions and feelings about teamwork. Interdisciplinary team members were dependent on team collaboration to ensure patient safety (Karlsson et al., 2019). For instance, team members offered support and advice to newly hired staff and offered help to those feeling stressed and overworked (Karlsson et al., 2019). This created a positive work environment where team members felt supported. In addition, teamwork that was characterized by supportive relationships helped members address sensitive or difficult patient issues (Cain et al., 2017). These studies highlight the importance of trust and support during the collaborative process to ensure its positive outcomes including satisfaction. Thus, collaboration built on team trust and mutual support increases members’ satisfaction and helps prevent or decrease feelings of burnout.

Productivity as a Contributing Factor of Job Satisfaction

Productivity and involvement in decision making contributed to team satisfaction. Coopman (2001) assessed productivity in terms of team members’ perception of being productive, making “good decisions quickly,” and completing many tasks (p. 269). Coopman (2001) found that productivity and involvement in the decision-making process contributed to overall satisfaction with the team, satisfaction with team communication, and desire to continue working on the team. Overall satisfaction with the team and desire to remain on the team was influenced by members’ perception of involvement in the decision-making process and willingness to listen (Coopman, 2001). This study indicates
that collaboration is important to members’ satisfaction with the team and its perception of team productivity. Perceptions of high productivity and involvement are related to satisfaction, meaning that it likely prevents feelings of burnout and intentions to leave the team or organization. Many factors contribute to nurses’ job satisfaction within the context of interdisciplinary teamwork. Although literature discussed autonomy most often, other factors such as unification of goals, cohesive collaboration, and productivity were also valued. These contributors increase the likeliness for interdisciplinary teams having a positive and satisfying collaborative experience.

Previous literature has explored interdisciplinary communication as well as nurse burnout and satisfaction stemming from various factors. However, results for previous studies have not identified a consistent relationship between communication, job satisfaction, and burnout among hospice nurses working on interdisciplinary teams, thus giving reason for continued exploration. Literature pertaining to communication in health care organizations focused on the provider-patient or the provider-care giver dynamics. This limited insight into other dynamics including those between interdisciplinary team members. In addition, literature did not address the settings where hospice care was provided by interdisciplinary team members. This presents a gap in the literature, giving reason for further exploration. To address this gap, I conducted a comprehensive examination of communication between interdisciplinary team members and the impact that work site (i.e. home-based care, hospice care facility, hospital) has on nurse’s job satisfaction, burnout, and turnover rates in Iowa. Previous literature led to the development of the following hypotheses and research questions.
H1a) Interdisciplinary collaborative communication is positively related to hospice nurses’ experience of job satisfaction in the context of team-based care.

H1b) Interdisciplinary collaborative communication is negatively related to nurses’ experience of burnout in the context of team-based care.

H2) Interdisciplinary collaborative communication is negatively related to nurses’ intent to leave their organization.

RQ1) How does interdisciplinary collaborative communication influence hospice nurses’ experience of job satisfaction and burnout in the context of team-based care?

RQ2) How does work site influence hospice nurses’ experience of job satisfaction and burnout in the context of team-based care?

Variable Definitions

For this study, each variable will be understood according to the definitions provided. Burnout indicates an individual’s lack of energy towards their profession or job (Quinn, 1996). Satisfaction refers to an individual’s satisfaction with their job or position within an organization. A team can be understood as a primary healthcare team which is a group of persons who share a common health goal and common objectives determined by community needs, to which the achievement of each member of the team contributes, in a coordinated manner, in accordance with his/her competence and skills and respecting the functions of others (World Health Organization, 1985).

Interdisciplinary hospice teams are better characterized by Kane (1980) through integrative teamwork, which posits that an individual’s ability to carry out their job is
dependent on other members. Collaboration is an interpersonal process allowing people to achieve goals that could not be done individually; these may include “interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection on the collaborative process” (Bronstein, 2003, p. 299). These definitions are foundational to understanding this study’s variables, and they are further addressed within the following content.

**Theoretical Grounding/ Background Information**

The collaborative communication variable relates to Bronstein’s (2003) model for interdisciplinary communication. This model will be used to understand interdisciplinary collaborative communication in this study. Bruner (1991) stated that interdisciplinary collaboration is an interpersonal process allowing goals to be reached that could not be done by individual professionals’ own work. This relates to the hospice interdisciplinary team, as much literature discussed members as reliant on one another. For instance, a nurse relies on a general practitioner’s prescription when delivering medication, and the general practitioner must trust the nurse to deliver the prescribed medication. In this instance, interdependence allows the professionals to achieve their goal of providing quality care for the patient. This shows that Bronstein’s (2003) model for interdisciplinary communication relates to Bruner’s (1991) definition of interdisciplinary collaboration.

Bronstein’s (2003) model for interdisciplinary communication is comprised of five components: interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection on process. Using all components helps
teams collaborate and effectively achieve their goal. Interdependence refers to professionals’ dependence on others to achieve a goal or complete a task. This relates to Kane’s (1980) definition of integrative teamwork stated that group members’ ability to fulfill their job requirements is dependent on other members. Interdependence could take form in “formal and informal time spent together, oral and written communication among professional colleagues, and respect for colleagues’ professional opinions and input” (Bronstein, 2003, p. 299). Newly created professional activities take form as “collaborative acts, programs, and structures that can achieve more than could be achieved by some professionals independently” (Bronstein, 2003, p. 300). Flexibility refers to the extensions of one’s interdisciplinary role and could resemble role blurring (Bronstein, 2003). Collective ownership of goals refers to “shared responsibility in the entire process of reaching goals including joint design, definition development, and achievement of goals” (Bronstein, 2003, p. 301). Reflection on process requires collaborators to take the time to reflect on their process and evaluate its effectiveness. This promotes improved, positive collaboration in the future.

Many factors influence interdisciplinary collaboration. Bronstein (2003) found that professional role, personal characteristics, structural characteristics, and history of collaboration impact the previously mentioned components of interdisciplinary collaboration. Professional role pertains to individuals’ “values and ethics of their social work position;” ideally, these should align or compliment other collaborators (Bronstein, 2003, p. 303). Personal characteristics is understood as the way collaborators perceive each other outside of their professional role (Bronstein, 2003). Structural characteristics
include “manageable caseload, agency culture that supports interdisciplinary collaboration, administrative support, professional autonomy, and time and space for collaboration to occur” (Bronstein, 2003, p. 303). History of collaboration regards colleagues previous experience working in interdisciplinary settings.

Previous literature on interdisciplinary collaboration in hospice care discusses the importance of these characteristics, as they impact the collaboration process. For instance, having previous experience working on an interdisciplinary team provides members with a foundation of collaborative skills. The influencers of interdisciplinary collaboration pertain to team-based hospice care, thus indicating that Bronstein’s (2003) model for interdisciplinary collaboration has the ability to increase understanding of interdisciplinary care team communication. The following section provides depth to the method of this study and measurement of variables.
CHAPTER TWO:

STUDY ONE QUANTITATIVE

Method

This study was purposed to identify relationships between interdisciplinary collaboration and communication, job satisfaction, burnout, and intention to leave the organization. The following hypotheses were best met using a quantitative approach to data collection and analysis. Quantitative methods were used to survey participants regarding their perception and emotions about working on interdisciplinary teams. The following chapter explains the participants, procedures, measures, instrumentation, and data analysis pertaining to study one.

H1a) Interdisciplinary collaborative communication is positively related to hospice nurses’ experience of job satisfaction in the context of team-based care.

H1b) Interdisciplinary collaborative communication is negatively related to nurses’ experience of burnout in the context of team-based care.

H2) Interdisciplinary collaborative communication is negatively related to nurses’ intent to leave their organization.

Participants

The studied population consisted of hospice nurses working on interdisciplinary teams. Data was collected from a purposive sample of hospice nurses working in four states in the Midwest. Survey data was collected over a five-month period from January to May 2021. The web-based survey collected data pertaining to hospice nurses’ job satisfaction, burnout, intention to leave their organization, and interdisciplinary team
collaborative experience. While 54 surveys were completed, only 46 were usable which restricted the reliability of results and conclusions but provided sufficient data to conduct a pilot study.

The frequency distributions for participants’ categorical demographics included gender, race, and setting. Participants reported the following gender distributions: 6.5% (n = 3) male, and 89.1% (n = 41) female. This sample represents an uneven distribution of participants regarding gender, where most participants were female. Pertaining to race and ethnicity, participants reported the following distributions: 89.1% (n = 41) White, 4.3% (n = 2) Hispanic or Latino, and 4.3% (n = 2) Asian. This shows that there is little diversity regarding race among the participants in this study.

Participants also indicated the setting they worked in most often where 26.1% (n = 12) hospice facility, 4.3% (n = 12) nursing home, and 67.4% (n = 31) patients’ homes. These findings represent an uneven distribution of participants surveyed regarding work setting. Participants reported working most often in patients’ homes, and the minority of participants reported working most often in nursing homes.

Table 1 reports the means, and standard deviations for participants’ ordinal demographics regarding tenure. The nurses participating in this study reported a tenure ranging from less than one year to more than sixteen years. Specifically, 4.3% (n = 2) nurses reported working for their organization less than one year, 15.2% (n = 7) reported working in their organization for one year, 52.2% (n = 24) reported a tenure of five years or less, 13% (n = 6) reported a tenure of ten years or less, 4.3% (n = 2) reported a tenure of fifteen years or less, and 8.7% (n = 4) reported a tenure of sixteen years or more. These
demographics represent a broad range of nurses’ experience in their current organization, although most respondents have worked five or fewer years thus indicating a relatively short length of organizational experience among respondents.

Nurses also reported the quantity of interdisciplinary teams they worked in where 28.3% (n = 13) one team, 50% (n = 23) five or fewer teams, 13% (n = 6) ten or fewer teams, 2.2% (n = 1) fifteen or fewer teams, and 4.3% (n = 2) sixteen or more teams. Table 1 reports the means, and standard deviations for teams. This indicates that most nurses have worked with five or fewer interdisciplinary teams, while the minority of nurses have worked with fifteen or fewer teams. These findings suggest that nurses do not switch teams often and likely have a history of working with the members in their team.

Table 1

“Means, Standard Deviations for Participants’ Tenure and Teams”

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tenure</td>
<td>3.24</td>
<td>1.19</td>
</tr>
<tr>
<td>Teams</td>
<td>2.02</td>
<td>.97</td>
</tr>
</tbody>
</table>

Procedures

I collected the survey sample by contacting every hospice in four Midwestern states (see Appendices) and receiving participant consent first from the organization. Then, the hospice organization sent an informative email about the study to potential
participants. The email contained a link to the survey along with screening information for participation in the study. Individuals who met the requirements were then linked to the survey consent form where YES indicated a participant’s consent and desire to participate in the data collection process, and NO indicated that the person did not consent or wish to participate in the survey. Those who clicked YES were linked to the rest of the survey, which was completed entirely online. All participants were guaranteed confidentiality, and participants were offered entrance into a raffle for a $50 Amazon gift card for their participation. At the end of the survey, all participants were asked if they would like to also participate in the interview data collection process.

Instruments

Five-point scales where 1 = “strongly agree” and 5 = “strongly disagree” were used to measure job satisfaction, burnout, intent to leave, and team collaborative communication. All scales underwent principal components factor analysis with a promax rotation to assess variables and ensure validity. Only items with factors loading at .4 or greater were retained.

Job satisfaction presented on Table 2 was measured using two self-report scales with a total of nine items. Three items from Cammann’s et al. (1983) job satisfaction scale were used including “All in all, I am satisfied with my job.” In addition, six items from Price and Mueller’s (1986) job satisfaction scale were used including “I find real enjoyment in my job” (M = 1.70, SD = .70, Chronbach’s α = .91). All nine items loaded at .51 or higher on a single factor with an eigenvalue over Kaiser’s criterion of one (KMO = .90) accounting for 60.16% of variance.
Burnout presented on Table 3 was measured using Maslach’s Burnout Inventory (MBI) (Maslach & Jackson, 1984). This scale consists of three subscales: emotional exhaustion (M = 3.22, SD = .85, Chronbach’s α = .90), depersonalization (M = 2.25, SD = .22, Chronbach’s α = .75), and reduced personal (M = 1.67, SD = .33 Chronbach’s α = .68) (Maslach & Jackson, 1984). A sample item for emotional exhaustion is “I feel emotionally drained from my work” (Maslach & Jackson, 1984). A sample item for depersonalization is “I feel I treat some clients as if they were impersonal objects” (Maslach & Jackson, 1984). A reverse-coded sample item for reduced personal accomplishment is “I can easily understand how clients feel about things” (Maslach & Jackson, 1984). Nineteen items of the twenty-one that comprised burnout were retained. Of these, all items except for three loaded at .51 or higher (M = 7.14, SD = 1.17, Chronbach’s α = .90) with an eigenvalue of one or higher (KMO = .77) accounting for 66.59% variance; however, all factors were retained as they did not decrease the scale’s reliability.

Intention to quit presented on Table 4 was measured using three items from Colarelli’s (1984) self-report scale including “I am planning to search for a new job during the next twelve months” (M = 1.15, SD = .37, Chronbach’s α = .91). All three items loaded at .88 or higher on a single factor with an eigenvalue of one or higher (KMO = .73) accounting for 84.62% of variance.

Interdisciplinary collaborative communication was operationalized as interdependence and flexibility and measured using two subscales from Parker Oliver’s et al. (2005) Modified Index of Interdisciplinary Collaboration (MIIC). Perceptions of
interdependence presented on Table 5 were measured using eleven of the thirteen items from Parker Oliver’s et al. (2005) MIIC including “I utilize other professionals in different disciplines for their particular expertise” (M = 1.88, SD = .57, Chronbach’s α = .78). All eleven items loaded at .41 or higher on a fixed one-factor solution with an eigenvalue of one or higher (KMO = .73) accounting for 33.27% of variance. However, the one item that loaded at .32 was retained because it did not reduce reliability.

Perceptions of flexibility presented on Table 5 were measured using four of the five items from Parker Oliver’s et al. (2005) Modified Index of Interdisciplinary Collaboration (MIIC) including “I am willing to take on tasks outside of my job description when that seems important” (M = .75, SD = .23, Chronbach’s α = .57). All items loaded at .61 or higher on a fixed one-factor solution with an eigenvalue of one or higher (KMO = .63) accounting for 45.10% of variance. The low KMO score indicates that there may be other scales or items better suited to measure flexibility within interdisciplinary teams, although the four items were retained for the purpose of measuring flexibility in this study.
Table 2

“Scale Items” Satisfaction (SA-SD) 5 pt. scale

<table>
<thead>
<tr>
<th>Scale and Items (R indicates reverse-coded item)</th>
<th>Scale alpha</th>
<th>Scale mean (1-5) and standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Job Satisfaction</strong></td>
<td>.91</td>
<td>1.70 (.70)</td>
</tr>
<tr>
<td>I find real enjoyment in my job.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I like my job better than the average worker does.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am seldom bored with my job.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would not consider taking another job.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most days I am enthusiastic about my job.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel fairly well satisfied with my job.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All in all, I am satisfied with my job.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In general, I do not like my job. (R)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In general, I like working here.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3

“Scale Items” MBI (SA-SD) 5 pt. scale

<table>
<thead>
<tr>
<th>Scale and Items (R indicates reverse-coded item)</th>
<th>Scale alpha</th>
<th>Scale mean (1-5) and standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Burnout: emotional exhaustion</strong></td>
<td>.90</td>
<td>3.22 (.85)</td>
</tr>
<tr>
<td>I feel emotionally drained from my work.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel used up at the end of the work day.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel fatigued when I have to face another day on the job.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working with people all day is really a strain for me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel burned out from my work.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel very energetic. (R)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel I’m working too hard on my job.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel frustrated by my job.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working with people puts too much stress on me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel like I’m at the end of my rope.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(table continues)
<table>
<thead>
<tr>
<th>Scale and Items (R indicates reverse-coded item)</th>
<th>Scale alpha</th>
<th>Scale mean (1-5) and standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Burnout: reduced personal accomplishment</strong></td>
<td>.72</td>
<td>2.69(.24)</td>
</tr>
<tr>
<td>I can easily understand how clients feel about certain things. (R)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I deal very effectively with the problems of clients. (R)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel I positively influence other people’s lives through my work. (R)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can easily create a relaxed atmosphere with clients. (R)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel exhilarated after working closely with clients and their families. (R)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have accomplished many worthwhile things in my job. (R)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(table continues)
<table>
<thead>
<tr>
<th>Scale and Items (R indicates reverse-coded item)</th>
<th>Scale alpha</th>
<th>Scale mean (1-5) and standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Burnout: depersonalization</strong></td>
<td>.73</td>
<td>2.15(.34)</td>
</tr>
<tr>
<td>I feel I treat some clients as if they were impersonal objects.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I’ve become more callous toward people since I took this job.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I worry that this job is hardening me emotionally.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t really care what happens to some clients and families.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel clients blame me for some of their problems.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4

"Scale Items" Intention to Leave (SA-SD) 5 pt. scale

<table>
<thead>
<tr>
<th>Intent to quit</th>
<th>.91</th>
<th>1.15(3.65)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I frequently think of quitting my job</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am planning to search for a new job during the next 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If I have my own way, I will be working for this organization one year from now (R)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 5

"Scale Items" MIIC (SA-SD) 5 pt. scale

<table>
<thead>
<tr>
<th>Scale and Items (R indicates reverse-coded item)</th>
<th>Scale alpha</th>
<th>Scale mean (1-5) and standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interdependence</strong></td>
<td>.70</td>
<td>1.43 (.42)</td>
</tr>
<tr>
<td>I utilize other (non-nursing) professionals for their particular expertise.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I consistently give feedback to other professionals in my setting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionals in different disciplines in my setting utilize me for a range of tasks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teamwork with professionals from other disciplines is not important in my ability to help clients. (R)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The colleagues from other professional disciplines and I rarely communicate. (R)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The colleagues from other disciplines with whom I work have a good understanding of the distinction between my role and their role(s).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(table continues)
<table>
<thead>
<tr>
<th>Scale and Items (R indicates reverse-coded item)</th>
<th>Scale alpha</th>
<th>Scale mean (1-5) and standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>My colleagues from other disciplines make inappropriate referrals to me. (R)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can define those areas that are distinct in my professional role from that of professionals from other disciplines with whom I work.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I view part of my professional role as supporting the role of others with whom I work.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My colleagues from other disciplines refer to me often.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooperative work with colleagues from other disciplines is not a part of my job description. (R)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My colleagues from other professional disciplines do not treat me as an equal. (R)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My colleagues from other disciplines believe that they could not do their jobs as well without my professional discipline.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(table continues)
## Scale and Items (R indicates reverse-coded item)

<table>
<thead>
<tr>
<th>Scale and Items (R indicates reverse-coded item)</th>
<th>Scale alpha</th>
<th>Scale mean (1-5) and standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Flexibility</strong></td>
<td>.58</td>
<td>1.71(.44)</td>
</tr>
<tr>
<td>I am willing to take on tasks outside of my job description when that seems important.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am not willing to sacrifice a degree of autonomy to support cooperative problem solving. (R)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I utilize formal and informal procedures for problem-solving with my colleagues from other disciplines.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The professional colleagues from other disciplines with whom I work stick rigidly to their job descriptions. (R)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colleagues from other disciplines and I work together in many different ways.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Data Analysis

This study used quantitative procedures to analyze and understand data. Specifically, quantitative data were gathered from an online survey of hospice nurses working on interdisciplinary teams. Demographics regarding tenure, work site or setting, team involvement, and sex were obtained. The proposed hypotheses looked for a
relationship between the independent and dependent variables. Separate bivariate correlation tests were used to look for a relationship between nurses’ job satisfaction and team communication and job burnout and team communication. Another correlation test was used to look for a relationship between nurses’ job satisfaction, burnout, and job site. Correlation tests indicated the strength and type of relationship present between variables. This information provides broad insight into which variables are most significant to influencing hospice nurses’ job satisfaction and burnout.

Results

All quantitative data were analyzed using the Statistical Package for Social Sciences (SPSS) to answer the study’s hypotheses. Hypothesis 1a predicted that interdisciplinary collaborative communication is positively related to hospice nurses’ experience of job satisfaction in the context of team-based care. Two bivariate correlation tests were used to look for a relationship between the independent variables (interdependence, flexibility) relating to the dependent variable (job satisfaction).

Interdependence and flexibility were weakly related to job satisfaction. The first Pearson product-moment correlation test presented in Table 6 looked for a relationship between team interdependence and nurses’ job satisfaction during interdisciplinary team communication $r(45) = .15, p = .334$. The second correlation test presented in Table 7 looked for a relationship between team flexibility and nurses’ job satisfaction $r(44) = .26, p = .091$. While the relationship was in the hypothesized direction, it was not significant.
Table 6

“Pearson Correlation for Interdependence and Job Satisfaction”

<table>
<thead>
<tr>
<th>Interdependence</th>
<th>Pearson Correlation</th>
<th>Job Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interdependence</td>
<td>1</td>
<td>.147</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td></td>
<td>.334</td>
</tr>
<tr>
<td>N</td>
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</tr>
<tr>
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</tr>
<tr>
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<td>.334</td>
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<tr>
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Table 7

“Pearson Correlation for Flexibility and Job Satisfaction”

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<tr>
<th>Flexibility</th>
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<tr>
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<td>.091</td>
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<tr>
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Hypothesis 1b predicted that interdisciplinary collaborative communication is negatively related to nurses’ experience of burnout in the context of team-based care. Two bivariate correlation tests were used to look for a relationship between the independent variables (interdependence, flexibility) relating to the dependent variable (burnout). Interdependence and flexibility were weakly related to burnout. The first correlation test presented in Table 8 looked for a relationship between team interdependence and nurses’ experience of job burnout $r(45) = -.19$, $p = .209$. The second correlation test presented in Table 9 looked for a relationship between team flexibility and nurses’ experience of job burnout $r(44) = -.24$, $p = .114$. Although the relationship was in the hypothesized direction, it was not significant.

Table 8

“Pearson Correlation for Interdependence and Burnout”

<table>
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</table>
Table 9
“Pearson Correlation for Flexibility and Burnout”

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Hypothesis 2 predicted that interdisciplinary collaborative communication is negatively related to nurses’ intent to leave their organization. Two bivariate correlation tests were used to look for a relationship between the independent variables relating to interdisciplinary team collaborative communication (interdependence, flexibility) and the dependent variable (intent to leave the organization). The first correlation test presented in Table 10 looked for a relationship between team interdependence and nurses’ intention to leave their organization $r(45) = -.04$, $p = .787$. The second correlation test presented in Table 11 looked for a relationship between team flexibility and nurses’ intention to leave their organization $r(44) = -.27$, $p = .072$. While the relationship between variables was in the hypothesized direction, it was not significant. More depth to these findings is provided in the following section.
Table 10

“Pearson Correlation for Interdependence and Intent to Leave”

<table>
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</table>

Table 11

“Pearson Correlation for Flexibility and Intent to Leave”

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Discussion of Findings

This study sheds light on interdisciplinary team communication and collaboration in the context of Covid-19. Specifically, this study provides insight into hospice nurses’ experience of job satisfaction, burnout, and intention to leave their organization. The following content provides explanation and reasoning for the study’s results.

The survey results did not yield significant findings; thus, none of the hypotheses were supported. However, weak relationships were identified between the independent and dependent variables. Specifically, increased use of interdependence and flexibility in interdisciplinary teams was weakly related to an increase in nurses’ job satisfaction. This means that increased use of communicative collaborative behaviors such as interdependence and flexibility likely result in increased job satisfaction among nurses. In addition, increased use of interdependence and flexibility in interdisciplinary teams was weakly related to a decrease in nurses’ experience of burnout and intention to leave their organization. While the relationship between variables followed the predicted direction, the lack of significant results suggests that the study was flawed and is a limitation of this study. It is likely that something other than interdisciplinary communication and collaboration is related to hospice nurses’ experience of job satisfaction and burnout and perhaps contribute to high nurse turnover rates and the nursing shortage previously discussed.

This study provided insight into hospice nurses’ experience of job satisfaction, burnout, and intention to leave their organization. The study results indicate that nurses experience feelings attributed to job satisfaction, burnout, and intent to leave; however,
these feelings were not related to collaborative communication practices. The insignificance of the findings from the quantitative data can be explored more in depth through the qualitative analysis.
CHAPTER THREE:
STUDY TWO QUALITATIVE METHOD AND ANALYSIS

Method

This study was purposed to better understand hospice nurses’ perceptions of collaboration and communication among interdisciplinary team members in addition to exploring how worksite impacts hospice nurses’ communication and collaboration with other interdisciplinary team members and influence job satisfaction, burnout, and intention to leave their organization. The following research questions were best met using a qualitative approach to data collection and analysis. Specifically, qualitative methods were used to interview participants about their work experience with interdisciplinary team members and work site. The following chapter explains the participants, procedures, and data analysis employed in this study.

RQ1) How does interdisciplinary collaborative communication influence hospice nurses’ experience of job satisfaction and burnout in the context of team-based care?

RQ2) How does work site influence hospice nurses’ experience of job satisfaction and burnout in the context of team-based care?

Participants

In total, sixteen hospice nurses (3 = male, 13 = female) working on interdisciplinary teams participated in the phone interviews. Participants worked in the following locations: two individuals worked in a hospice facility, and fourteen individuals worked as traveling hospice nurses in nursing facilities and in patients’ homes. Tenure of employment with the hospice ranged from six months to 37 years, with
only one nurse employed less than one year. As such, data from the interviews were
gathered from individuals with a wide range of experience working on an
interdisciplinary team in their hospice organization.

Procedures

The primary researcher developed the interview guide from previous qualitative
studies focusing on job satisfaction and burnout as well as interdisciplinary collaboration
and communication. In addition, some questions were inspired by current events and
issues such as Covid-19 and trends in hospice care. Throughout the interview protocol
and during interviews, questions were designed to ask for nurses’ experiences in the form
of examples (i.e. Tell me about a positive experience that you have had with team
communication.). After establishing interview protocol, the primary researcher received
IRB approval for this project. Over the course of five months from January to May 2021,
the primary researcher spent eight hours interviewing participants over the phone. All
interviews were audio recorded and ranged in length from thirty minutes to forty-five
minutes with a median time of thirty minutes. All interviews were transcribed verbatim,
yielding 141 pages of single-spaced transcript. Names were replaced with pseudonyms,
and all location identifiers were removed during the analysis. In addition, to using the
data for this thesis project, the primary researcher prepared a report, which was
distributed to the organizations participating in the study.

Qualitative data were gathered from interviews conducted over the phone.
Interviews provide insight into participants views and feelings pertaining to feelings
about team communication, team collaboration, and worksite. All interviews were
recorded and transcribed, which the primary researcher read and reread to increase familiarity with data. The primary researcher used open coding by searching broadly for recurring themes throughout the data. This enabled the researcher to categorize data. Next, axial coding was used to identify relationships between the categories to identify themes within the data. This information provides depth to the quantitative data.

Data Analysis

Interdisciplinary team collaboration has been extensively researched in the past; however, the outbreak and global spread of Covid-19 has radically changed organizational life in hospices and provides even more reason to continue research of interdisciplinary teams. While this study was conceptualized before the outbreak of Covid-19, it would be foolish not to acknowledge the pandemic’s impact on communication and collaboration within interdisciplinary teams and its impact on nurses’ job satisfaction and burnout. Therefore, all interview data should be contextualized as experienced during the pandemic and specifically between January and June, a time frame during which a vaccine was created and distributed.

Four themes emerged from the data that impacted hospice nurses’ work experience: relationships within teams, access and immediacy of communication, communication channels and technology, and location of work and time of work shift. These themes highlighted nurses’ agency and efficacy as impacting their experience of job satisfaction and burnout. Discussing these topics in depth provides understanding of how hospice nurses’ work experience as an interdisciplinary team member varies by organization and in the context of Covid-19.
Building Relationships Within the Interdisciplinary Team

Covid-19 has dramatically changed how teams provide care and interact. Specifically, Covid-19 safety rules created over the past year have restricted face-to-face interaction, physical contact, and even access to patients. This has limited nurses’ sense of agency in providing care and has challenged interdisciplinary teams to learn how to care for patients while still abiding by Covid-19 guidelines. Nurses participating in this study emphasized the importance of the team relationship while providing care before and since Covid-19. Specifically, building close relationships with team members characterized by support, timely feedback, and validation has provided nurses with a sense of agency while caring for hospice patients, and this contributed to nurses’ feelings of satisfaction in their job.

While all participants discussed team relationships, five nurses discussed the importance of building strong team relationships to promote team cohesion, support individual members, and to provide better care for patients. Specifically, participants discussed relationship-building practices as sharing personal stories that led individual members to working in hospice and spending time together doing non-work-related activities. One nurse described social events within the organization as something that helped team members get to know each other and facilitated relationship growth. Specifically, the events included wedding celebrations, baby showers, and happy hours. These events enabled team members to get to know each other outside of work and separate from their role in the organization. In another hospice, nurses and their directors met for monthly dinners to get to know each other and check in on emotional wellbeing.
These dinners took place outside of the workplace, but they were more oriented to work-related discussion and emotions experienced while working. However, the dinners were also reported as promoting relationship growth within the organization. Since the outbreak of Covid-19 the monthly dinners were canceled and have been reported as missed by nurses who would like to continue having social times with their director. This shows that nurses desire to have relationships and connection with others in their workplace. Relationships enabled team members to know each other as individuals outside of their organizational role, and this facilitated relationship growth, and promoted cohesion within teams and coordination when providing care.

The practices discussed indicate that building relationships on an interdisciplinary team occurs through getting to know a person and spending time with them at work and outside of work. As such, building relationships as an interdisciplinary team is wholistically done, acknowledging a person as an individual and as an organizational member. Nurses appreciated this kind of relationship because it provided them with space to acknowledge and understand each other separate from work and reinforced the team identity by constructing tight-knit, supportive relationships.

Four nurses expressed appreciation for the support provided by their team because they felt it improved the quality of care given to patients and supported their own personal well-being. Participants discussed providing informational and emotional support as practices that improved the team experience and reduced feelings related to burnout. Specifically, these forms of support guided nurses in how to care for patients during a global pandemic and helped protect them from stress.
Nurses provided information support by updating specific team members of a patient’s condition or needs when they pertained to that member’s role. For instance, a music therapist might update a nurse about a patient’s response to a session. This would help the nurse know how a patient is feeling and perhaps give them some direction in providing care that will comfort the patient. Nurses also used informational support by discussing Covid-19 updates and practices to reduce the spread of the virus; this helped alleviate team members’ fear of contracting and spreading the virus. While informational support gave nurses direction in how to provide care, it also provided them with reassurance about fear pertaining to Covid-19. In addition to informational support, nurses also reported emotional support within their team.

Emotional support involved acknowledging feelings and being present in real time with another individual. Specifically, interdisciplinary team members provided emotional support by taking time to check in with each other periodically on stress levels, difficulties, or emotions experienced while providing care and from members’ personal lives. Many nurses expressed increased stress from the spread of Covid-19 and safety restrictions limiting physical proximity and interaction between the interdisciplinary team and with patients. Nurses expressed feeling isolated within their workplace and from others on their team. One nurse specifically expressed a need for emotional support while providing care and support for patients. The nurse stated,

You don't see a lot other than patients who need you. You don't see a lot of people who are there to uplift you. One of the social workers and I have made meetings with each other, just little phone calls to each other several
times a day, just to check in on what our stress levels are and acknowledge it. Then we take some breaths together and we go on about our day, and that’s one of the ways we’ve learned to cope with just the stress.

This example shows that nurses experience stress while providing care for patients and try to find ways themselves to manage the feeling. While the nurse believed these phone meetings helped in coping with stress, they did not reduce the amount of stress experienced. Informational and emotional support helped nurses cope and manage stress. Nurses also expressed appreciation for those who made an effort to check in with them either daily or weekly about their stress and mental health. Nurses who discussed having supportive team members also expressed appreciation for their team generally more often than those who did not.

The findings indicate that taking time to check in and offer informational or emotional support helped nurses manage stress (a factor of burnout) and promoted appreciation for their interdisciplinary team. However, the support was not discussed as something that promoted job satisfaction. This indicates that further action needs to be taken to not only help nurses manage their stress but also provide alleviation of the burnout symptoms. Another way that nurses felt more supported was through having access to team members when needed.

Immediacy and Access to Team Members

Having access to team members and immediacy in communication was discussed as important to nurses’ job satisfaction because it provided them with the agency necessary to provide care for hospice patients. Three nurses reported access and immediacy as
important to providing care, something that was discussed as improving team member’s satisfaction at work. One nurse specifically discussed immediate feedback from the physician. The nurse stated,

Today I was at my visit, and the patient had uncontrollable anxiety, so I sent a text message in our secure chat to the doctor. He messaged back within minutes and gave me answers to help the patient immediately. My patient never waited for relief, and I absolutely love that because the nurses are the middlemen, but patients are looking to us. We want to help them, but we have to wait for a doctor's approval.

This statement indicates that nurses need immediate feedback from physicians to care for patients because they are unable to do some things without approval. As such, the nurse is a “middleman” but is still viewed as in charge by the patients. Having immediate feedback enabled this nurse to provide more immediate care for patients and helped nurses feel that they had the power to help patients. This scenario highlights interdependency between interdisciplinary team members and patient care. Specifically, interdependence was necessary in caring for patients and helped nurses fulfill their role on the team. This shows that nurses valued the sense of efficacy they had when able to immediately fix a problem. In contrast, nurses who did not have immediate feedback from team members expressed dissatisfaction with their team experience. As such, interdependency provided nurses with a sense of efficacy that enabled them to provide immediate care for patients.
Nurses expressed frustration at team members and leaders who did not answer their phone or ignored communication from nurses. This created miscommunication and confusion when providing care for patients that slowed down care. One nurse expressed frustration about a habitual lack of communication with their nursing director. The nurse stated,

I can speak for the rest of my nurses as well. We just tend to get a “call you back” [when contacting the director of nursing] but then no call back. They also play ignorant to emails that have been sent because they haven’t read their email. So yeah, it makes my job much more stressful.

This statement shows that the nurse feels that their director chooses not to communicate with them. While lack of communication within the team was discussed as frustrating for different nurses, this instance shows that when lack of communication is perceived as purposeful, it contributes to stress, a factor of burnout and restricted the nurse’s sense of efficacy. Specifically, nurses expressed dissatisfaction with lack of communication because it limited their ability to take care of patients’ needs. Other nurses reported poor communication with their nursing director but acknowledged that the director was often busy. These nurses did not mention experiencing stress, although this does not mean that the feeling was not experienced. This indicates that having access to team members and immediate feedback impacts nurses’ perception of communication and ability to provide patient care.

Communication is important within the interdisciplinary team because members are interdependent and cannot always act without approval from others. Immediate access
and feedback from team members was important to providing care and was appreciated by nurses because it enabled them to do their job and provided them with a feeling of efficacy in being able to address patients’ needs. In contrast, lack of communication was perceived negatively and contributed to nurses’ stress, a factor of burnout, because it hindered nurses from providing patients with quality care, something that was discussed as linked to job satisfaction. Beyond having access to team members and leaders, nurses reported appreciating when leaders listened and validated their input. These findings highlight sense of efficacy as important to nurses’ experience of satisfaction and burnout. Specifically, ability to provide care for patients impacted nurses’ sense of job satisfaction and burnout. Team communication and collaboration impacted nurses’ agency in providing care, thus showing that patient care was most influential to nurses’ work experience.

Listening and validation were behaviors that facilitated a positive team experience and decreased negative experiences contributing to burnout. Specifically, three nurses reported appreciation when a leader or doctor listened to their input and took it into consideration. In one instance, a nurse commended their boss for listening to a patient and their family’s complaint about a bed delivery. Specifically, a bed was delivered to a patient’s home, but it came without sheets, and no one was present to move the patient into the bed. The family was upset because they thought that hospice would provide the sheets and would be present to move the patient. The nurse reported that they brought this complaint up with their boss, and the boss responded humbly and listened. The nurse stated,
I took care of the situation. And I noticed in their [the boss’s] personality, that they didn't get defensive. What they said was, and I wanted to see if she'd say it, because I actually thought it myself, the things that the patient was saying, were valid things. And I noticed what they said, “well, I'm gonna take that into consideration, because those are actually valid points.”

The nurse went on to say that they respected their boss for this response because it is important to provide care for patients and listen to their concerns rather than being prideful or rejecting a concern. This example shows that validation can positively impact nurses’ feelings about communication. In this example, the nurse described taking care of the situation by making the bed with sheets and helping the patient into the bed. These acts both demonstrate caring for a patient where the bed delivery alone only highlighted the patient’s lack of agency. In this situation, the nurse valued caring for the patient and appreciated their leader’s validation and consideration of the situation. Besides listening, the healthcare hierarchy was another factor contributing to the nurse’s feelings.

Nurses appreciated validation from those who ranked higher in the organizational hierarchy because it gave them credibility as a healthcare professional and made them feel appreciated within the organization. In contrast, another nurse discussed dissatisfaction when leaders did not listen to those on interdisciplinary teams. Specifically, a nurse raised a concern to their director stating that many individuals on their team were planning on leaving the organization because of stress. The director listened to the nurse’s concern but took no action and according to the nurse devalued the
concern. The nurse stated that the director “sat there and patted my hand, essentially, and said, Oh, it'll be okay. Everything's great. Thank you for talking to me.” The nurse felt this instance exemplified poor communication that devalued the nurse by limiting their agency in providing care and minimizing their concerns. Communicative situations such as this contribute to nurses’ dissatisfaction with their job and could lead to experiencing burnout symptoms.

The findings indicate that nurses feel validated in their organization when individuals with higher ranking on the organizational hierarchy listen to their input and concerns and take them into consideration. This increased nurses’ satisfaction and promoted positive perceptions of the leader’s skills. In contrast, listening to a concern but neglecting to take it into consideration or act on the concern led to nurses feeling devalued in their organization and contributed to experiences of dissatisfaction and even lower retention. The findings showed that agency was important to providing patient care and nurses’ job satisfaction. Specifically, when leaders validated and acted on patients’ or nurses’ input, nurses felt that they had more agency in providing patient care. In contrast, when leaders did not take nurses’ or patients’ input into consideration, nurses experienced dissatisfaction with their work. Besides listening and validation, nurses’ job satisfaction and burnout were also impacted by communication channels used within teams.

**Technology and Face-to-Face Communication Channels**

Nurses communicated with their interdisciplinary teams through a number of channels: email, text message, phone call, video conference, and face-to-face. Each of
these channels was used strategically. In addition, nurses expressed mixed feelings about the channels used and explained that while all the channels have always been used, face-to-face communication has been utilized less since the outbreak of Covid-19 in compliance with social distancing guidelines. Explaining how interdisciplinary teams used each channel and how they felt about the channel increases understanding of communication between nurses and their team members in the context of a global pandemic.

Email was used primarily for one-way communication, and nurses reported that they received approximately 80-100 emails per day in the form of patient or organizational updates or reports. These emails were usually sent to specific team members who needed the information to provide care. One nurse described email as necessary to provide quality care; however, eight nurses stated that email hindered team communication because members received so many emails that they were easy to lose or were unable to respond to them all. In addition, nurses stated that emails were time consuming to compose and did not easily enable immediate feedback, clarification, or follow up questions. As such, email restricted nurses’ sense of efficacy when they needed feedback from a team member to provide care for patients.

These responses indicate why emails were used primarily for one-way communication. In addition, nurses reported four reasons for lack of email responses: (1) team members intended to respond but were likely interrupted and thought they would respond later but forgot, (2) communication systems became bogged down with an overload of emails and resulted in missing emails, (3) nurses prioritized caring for
patients and only responded to emails at the end of the day, and (4) team members were lazy and did not prioritize communication with others. While these perceptions may not reflect reality, it is important to note that nurses who perceived a lack of email communication as intentional also described overall team communication and team leadership as poor. This reinforces the finding that nurses appreciate access to team members and leaders in addition to their immediate feedback. Lack of these things contributes to experiencing factors of burnout. These findings indicate that nurses experience information overload from receiving too many emails each day and felt that this hindered their team’s communication.

Phones were used mostly for two-way communication between team members and included phone calls and text messages. Nurses reported that phones were used to attend remote team meetings to ask specific team members questions, and to provide updates regarding a patient’s status. While nurses perceived these channels as facilitating quality care for patients, they did express some dissatisfaction with each channel.

Phone calls hindered communication when too many calls were made or received in voicemail. One nurse stated, “It feels like I can’t get anything done from having too many interruptions, but at the same time they’re necessary to give proper care, and it is good to have a group to work with because you never feel alone.” This statement indicates that having too many phone calls can hinder nurses from completing their own tasks, but phone calls were needed to provide quality care and provided nurses with a sense of connection with team members and prevented feelings of aloneness. As such, phone calls were perceived positively unless nurses felt that their work was interrupted
and hindered from receiving too many calls. In addition, nurses discussed the importance of phone calls to providing patient care. In fact, phones seemed to be tools that connected nurses with their team members and provided them with agency to meet patients’ needs. These findings differ from those pertaining to text message communication.

Text messaging hindered communication because it made providing feedback difficult and caused miscommunication at times. One nurse explained,

Talking is the best because it is two-way, and you can make sure that people received the message the way that it is intended. Texting might look like oh, she is angry in the text but if she is not angry, it's just how she types. We need to go back to the old-fashioned way — talking to and call them because sometimes texting emailing, then you assume one thing because it's one way. When calling you get you get to ask for feedback; Hey, what did you mean by that is Oh, I didn't mean it that way.

This nurse expressed that text messaging is not always an appropriate form of communication between members because it can result in miscommunication. The nurse identified feedback and follow up questions as communicative tools that help reduce miscommunication. While these could be used when texting, the nurse felt that they could be used with more physical ease and immediacy over phone call. This indicates that communication channels should be selected strategically with feedback needs in mind. Another communication channel, face-to-face, also enabled immediate feedback.

Face-to-face communication was used least often and even less in the past year during the pandemic. Use of this channel varied depending on where care was provided.
One nurse explained that face-to-face communication had always been rare because care was often provided in different locations (i.e., patients’ homes and various facilities), and team members visited patients at different times of the day. Teams who provided care in patients’ homes were often traveling and could not communicate face-to-face. In contrast, nurses who worked in one facility such as a hospice house reported more use of face-to-face communication because they were in close proximity to other team members. These findings indicate that face-to-face communication was used based on nurses’ location of work and proximity to other team members. As such, close proximity as a team made face-to-face communication more convenient than through other channels. While face-to-face communication was the least often used channel, it was perceived positively. In fact, all nurses who commented on satisfaction with face-to-face communication indicated that they preferred this channel to other technologically based channels. Specifically, nurses stated that they liked seeing their team members and found that talking in person was easier than communicating by other channels and specifically text-message. One nurse stated, “I’m much better talking in person than texting a whole situation… I find it much easier to just talk in person.” This statement depicted talking as physically easier than texting. Another nurse described talking as direct and effective, and this comment indicates that the nurse perceived other channels as less direct and effective. These findings indicate that nurses like the ease, directness, and connection provided by face-to-face communication.

Video conferences were primarily used for team meeting purposes that facilitated communication and collaboration to provide quality patient care and emotional support
for nurses. Specifically, video conferences were reported by many nurses as held daily for morning meetings to discuss new admissions, patient care plans for that day or schedules, immediate needs, and deaths. Nurses often had these meetings from home before leaving to care for patients. Video conferences were also held weekly for interdisciplinary team meetings in which the whole team including the physician was present. Feelings about the morning meetings and interdisciplinary team meetings were mixed. While some thought they were helpful, others felt like they took too much time. Overviewing communication that took place over videoconference provides insight into interdisciplinary communication and collaboration and nurses’ perceptions of the channel.

Videoconference facilitated communication between team members who were in different locations and provided nurses the opportunity to collaborate with each other. Specifically, one nurse stated, “If I have too many patients to see in a day, another nurse volunteers to help.” It is important to note that there was more than one nurse on this team, and collaboration between nurses and other team members was not discussed as occurring through video conference. However, the channel enabled nurses to discuss their schedules and created space to plan collaboration. While nurses discussed how they used videoconference, they did not report satisfaction or dissatisfaction with this channel. Rather, they discussed their feelings pertaining to team meetings.

Nurses had mixed feelings about team meetings. Many nurses reported their satisfaction and appreciation for the meetings because they were necessary to provide quality care. Specifically, nurses mentioned using meetings to ask specific questions
about patients, discuss patient reports, offer each other emotional support, create schedules and care plans, and build relationships with team members. However, nurses also described the meetings as taking too long and including information that was either unnecessary or redundant. One nurse stated that their team meeting lasted an hour and a half and included too much unnecessary information; the nurse stated,

There was a lot of storytelling, which is not necessary in a meeting like that, and it's annoying for the people that don't need to know the story. So, I guess I would like a little more pertinent information but also proper training and reining in of a storyteller. Also, sometimes you hear the same thing over and over again, which that's not necessary either.

This statement indicates that nurses’ feelings about meetings depended on their orientation to tasks or relationship building. The nurse valued their time and wanted the meetings to only include information relevant to providing patient care. However, the nurse discussed in the quotation seemed to value relationships and used team meetings to build relations. While meetings are necessary and could be used to build relationships and offer support, nurses generally wanted them to be short to enable them to start working with patients sooner. As such, those who reported having short daily meetings seemed more satisfied than those who had daily meetings lasting an hour or more.

Videoconference was primarily used to hold team meetings, and thus fostered interdisciplinary team communication and at times collaboration. While nurses did not report negative perceptions of videoconference, they did report both positive and negative perceptions of team meetings. Team meetings were necessary to provide care but were
time consuming, and sometimes used to share unnecessary information. As such, team meetings were perceived as important but ineffectively used at times. Another factor that influenced nurses’ perceptions of communication and collaboration were time and place of work.

**Communication and Collaboration Influenced by Shift and Location of Work**

Communication and collaboration with others and individual responsibilities varied by shift (day or night) and the location of nurses’ work. The location and time in which nurses worked seemed dependent on their own personality and they type of interaction they desired with patients. Shift and location of work also influenced who nurses communicated with and how they interacted with their interdisciplinary team. Explaining the different contexts in which nurses worked provides a basis to understanding nurses’ perceptions of communication and collaboration within their teams during Covid-19.

Nurses either worked a day or night shift, and this depended on location of work. Those who worked in patients’ homes did not work night shifts; however, nurses were on call at night in case an emergency situation arose with a patient that needed their immediate attention. In contrast, hospice facilities such as hospice houses did have nurses who specifically worked on night shifts by caring for patients and their families. These nurses did not interact with interdisciplinary teams but did interact with other RNS and were in charge of all things going on or needed within the facility. One nurse stated “We're in one hallway and are interdependent on one another. We work together the whole time.” This nurse went on to describe their interdependence with other night shift
nurses stating, “It’s a yin-yang type situation where one excels in clinical mastery of certain things. One excels in the discussion, the most emotive part, and you kind of balance each other out.” This example indicates that night shift nurses work interdependently to provide care like interdisciplinary teamwork discussed in previous research. As such, ability to provide care was important to nurses’ satisfaction. These findings also show that time of work shift depends on location of work and influenced with whom nurses interacted.

When working in a facility, nurses interacted with staff from that facility and their own team. They also reported doing more paperwork. One nurse described caring for patients in different nursing facilities negatively because it created extra documentation work and communication needs; the nurse stated that in facility care, “I have to schmooze with the administrators and the home directors, and they all want to report every time I go. And then I have to call families and give them updates. And there's just a lot more I feel like I do, a lot of duplicate documentation along the way.” These descriptions portrayed being a traveling nurse working in different facilities negatively because it required communication with hospice and the facility in which the patient was living. In this context, the nurse did not perceive communication as beneficial for the patient’s care. Rather the nurse viewed communication as redundant and keeping them from caring for patients. This indicates that communicating with nursing facility staff in addition to hospice staff and patients’ families was perceived as limiting nurses’ agency and ability to provide care, and this produced feelings of dissatisfaction and experiences of burnout.
Nurse satisfaction with communication varied by time of shift, location of work, and purpose of communication.

Nurses working in patients’ homes interacted with their interdisciplinary team but reported communicating more with family by educating them on how to provide care. Nurses working in patients’ homes described the experience positively because they perceived this care as increasing patients’ quality of care and personal happiness. One nurse stated, they preferred providing care in patients’ homes because they’re typically happier and it’s much simpler, in all honesty, teaching family members how to care for their loved ones because nobody loves them like they do. And you have a smaller and more dedicated group, not to put down nurses and nursing homes, but they are very regimented in their daily grind. However, nurses have to be more detailed in educating families how to care for a patient and provide a lot of visual, detailed instruction about meds.

This quote indicates that the nurse based their preference off of the patient’s happiness so that even when the nurse had to educate families more, it did not contribute to feelings of dissatisfaction. In addition, the nurse felt that those working in nursing homes were so regimented that the quality of care they provided to patients suffered. This indicates that patient outcomes contribute to hospice nurses’ satisfaction with communication done while working.

From the data, it seemed that nurses based their work experience off their patient’s quality of care, satisfaction, and happiness. When working in a facility, nurses
described the experience negatively because it required more verbal communication and
documentation with other care providers, and this was not perceived as helping or caring
for the patient. In contrast, nurses perceived working in patients’ homes positively even
when required to communicate and collaborate more with patients’ family by providing
education and instruction in how to care for the patient. This was likely reported
positively because nurses perceived the education as beneficial to the quality of care
provided to the patient. In addition, nurses working on the night shift at a hospice care
facility did not work on an interdisciplinary team but did report working with other
nurses or CNAs. These experiences were perceived positively because nurses worked
together to meet patients’ needs. This indicates that nurses’ perceptions of team
communication and collaboration vary based on shift and location of work and whether
communication and collaboration are perceived as influencing the quality of patients’
care. However, satisfaction and burnout were impacted by nurses’ agency and ability to
provide care.

Discussion of Findings

This study provided depth to hospice nurses’ experience at work and what it looks
like to provide care for patients in the context of interdisciplinary teams and Covid-19.
The qualitative data indicated that providing care was important and highly valued by
hospice nurses, and communicative collaboration was an essential part of this process.
Four themes pertaining to interdisciplinary team communication emerged from the data
as contributing to nurses’ ability to provide care which influenced their job satisfaction
and burnout: building relationships within the interdisciplinary team, immediacy and
access to team members, technology and face-to-face communication channels, and communication and collaboration influenced by shift and location of work. Discussing the qualitative data in relation to the research questions shows how themes relate and provides deep understanding of nurses’ perceptions of team communication.

Research question one asked, “How does interdisciplinary collaborative communication influence hospice nurses’ experience of job satisfaction and burnout in the context of team-based care?” Findings indicated that hospice nurses communicate continuously throughout the day with their teams. Nurses often described their agency and efficacy to provide patient care as important to their perception of work, and communication within the team impacted nurses’ ability to provide care, thus influencing their experience of satisfaction and burnout. Specifically, building relationships by spending time together outside of work and offering information and emotional support in teams helped nurses care for patient’s changing and individual needs; it also helped nurses cope with stress, a symptom of job burnout. Having access to team members and receiving immediate feedback in which nurses felt they were being listened to facilitated communication and positive feelings such as connection and appreciation for the team.

Nurses’ feelings pertaining to burnout stemmed from one-way communication overload. Specifically, nurses felt that they received so many emails, phone calls, and text messages that they were unable to respond or spent too much time communicating with team members, which limited nurses’ agency and prevented them from providing quality care to patients. These findings indicate that team communication impacts nurses’ ability to do their job, and quality of care provided influences nurses’ job satisfaction and
experience of burnout. Specifically, communicative collaboration seemed to help battle feelings contributing to burnout and facilitative feelings of job satisfaction. Another factor influencing team communication was time or shift and location of work.

Research question two asked, “How does work site influence hospice nurses’ experience of job satisfaction and burnout in the context of team-based care?” Findings indicated that nurses worked in a variety of locations. While two nurses reported working only in one hospice facility, the other nurses reported traveling to provide care in patients’ homes and various nursing facilities. The nurses that worked in the hospice facility primarily communicated face-to-face and described team communication as direct and effective. The facility also had a 2-1 patient to nurse ratio, and nurses reported experiencing less stress from nursing shortages or overworking in this context. In contrast, nurses who traveled throughout the day to provide care primarily communicated with their teams through technologically based channels. Nurses reported feelings of stress stemming from an overload of one-way communication and stated that they often used phone call and text message to contact team members as needed because these channels were used with more immediacy and for two-way communication.

Nurses experienced stress from communication with staff working in nursing facilities and who were not members of the hospice organization. This communication was not perceived as contributing to patient care. Rather, nurses described it as double documentation and as an organizational requirement. Nurses also reported increased communication with patients’ family members when providing care in patients’ homes. In this context, nurses provided education and demonstration in how to care for patients.
This communication was a source of satisfaction among nurses because it was perceived as directly benefitting a patient’s outcome.

These findings indicate that communication varies by worksite, and nurses’ job satisfaction and experience of burnout symptoms depend on patient care more than location of work. While worksite varied among nurses, all nurses expressed the importance of communicating with whomever they were working with. This indicates that collaborative communication is important to providing care and supports the idea that communicative collaboration contributes to nurse satisfaction and prevents burnout because it enables nurses to have agency and provide quality care for patients. While this study provided deep insight into nurses’ perceptions of their work, it is beneficial to overview these findings alongside those from Study One. The following chapter works to connect findings from Study One and Study Two to provide more thorough and comprehensive insight into nurses’ perception of their work.
CHAPTER FOUR:

DISCUSSION

This project was created to examine the relationship between communicative collaboration and hospice nurses’ experience of job satisfaction, burnout, and intent to leave their organization. Within this study, collaborative communication was operationalized as behaviors of interdependence and flexibility. However, previous literature has discussed and examined other behaviors of communication collaboration such as newly created professional activities, collective ownership of goals, and reflection on process. While the quantitative results of Study One and the qualitative results of Study Two were previously and individually discussed, it is important to understand the findings together as two parts of one project. As such, the following content connects the two individual studies. Specifically, overviewing the quantitative findings and qualitative findings together provides depth to this examination that can be used to better understand the project’s limitations and to identify ideas for future research.

Study One resulted in findings that lacked significance. However, the relationships between variables were as predicted meaning that it is likely for hospice nurses to experience increased job satisfaction and decreased burnout and intention to leave the organization when their interdisciplinary team engages in collaborative communication. One explanation for the lack of significant findings could be the operationalization of collaborative communication. Within this study, collaborative communication was measured as behaviors of interdependence and flexibility. However,
previous studies have addressed organizational relationships, history of working together, and newly created activities among other things. This in combination with the qualitative findings from Study Two suggests that the operationalization of collaborative communication was too simplistic.

Study Two delved deep into nurses’ perception of their work experience and specifically used examples of communication and collaboration to better understand behaviors that contribute to hospice nurses’ experience of job satisfaction and burnout in the context of interdisciplinary teamwork. The findings from this study indicated that nurses derived satisfaction from feeling that they were able to do their job by providing patients with quality care. As such, nurses desired agency within their job. In contrast, nurses expressed feelings of inefficacy and stress when they felt unable to provide quality care to patients. The qualitative findings indicated that communication and collaboration within interdisciplinary teams provided nurses with agency. Specifically, behaviors such as immediate feedback and access to team members provided nurses with the ability to provide immediate and individualized care for patients. In addition, collaborative communication behaviors such as informational and emotional support not only facilitated patient care but was also instrumental in helping nurses cope with feelings of stress and in alleviating symptoms of burnout. As such, collaborative communication seemed function by alleviating feelings of burnout rather than contributing to them.

While collaborative communication was not related to nurses’ job satisfaction, it provided nurses with the agency to provide quality care to patients, and this was important to nurses’ perception of their work experience. Synthesizing the findings from
Study One and Study Two provides deeper insight into how nurses experienced and understood the relationship between variables in this project. Together, these studies findings indicate that nurses find satisfaction in providing care for patients. Collaborative communication within teams helps alleviate symptoms of burnout rather than contributing to burnout as an experience. These findings highlight the project’s limitations and helps in identifying avenues for future research.

Implications

Discussing this project’s implications and limitations provides insight into the result of project and creates avenues for future research. This study contributed theoretically of the field of Communication Studies by providing deep insight into nurses' perception of their communication and collaboration with interdisciplinary team members while providing hospice care during Covid-19, a context that remains relatively unstudied but has changed communication and interaction between all people around the world, thus warranting continued exploration. Findings from Study One were insignificant, and it is likely that there was a problem in how collaborative communication was operationalized. Based on the qualitative findings, it is likely that collaborative communication helped in alleviating burnout rather than contribute to the experience. This is further discussed in the limitations and ideas for future research.

Regarding practical implications, this project provided insight into nurses’ communication and collaboration with their team members. Specifically, the study has shown that while nurses do experience symptoms of burnout from their work, they are also satisfied with their jobs and use interdisciplinary collaboration practices including
interdependence and flexibility. This project also helped in identifying and highlighting challenges pertaining to providing care during a global pandemic, communication issues within teams, and communication and collaboration practices that help nurses cope with symptoms of burnout or that lead to a satisfying work experience. These findings are important as they can be used to provide education and led organizational change that supports nurses and hopefully decreases experiences contributing to feelings of burnout and intentions to leave their organization. Despite these implications, this study contains limitations that may be addressed in future research.

Limitations and Future Research

Discussing this study’s limitations provides insight into understanding the findings and generates ideas for future research. Limitations from Study One and Study Two are discussed together, as qualitative findings helped inform the lack of significant findings in Study One. Future research ideas are discussed following each individual limitation.

First, there were uneven distributions of nurse demographics (i.e., gender, tenure, worksite). Obtaining a sample with an even distribution of demographic information may provide increased insight into differences among nurses’ experiences that may be dependent on gender, tenure in an organization or even as a hospice nurse, and place that care is provided.

Second, a small sample size limited the generalizability and reliability of results. Obtaining a larger sample would increase generalizability of results beyond the four states from which participants were recruited. The small sample size may also have
contributed to the poor reliability score for the MIIC’s subscale for flexibility. Obtaining a larger sample size is a starting point to addressing poor reliability scores.

Third, the survey results were insignificant perhaps due to a problem in how collaborative communication was operationalized. Specifically, interdependence and flexibility were measured as collaborative communication behaviors and measured as input variables that contributed to burnout. However, findings from the qualitative interviews suggest that collaborative communication help in alleviating symptoms of burnout. In addition, the qualitative findings indicate that personal ties, immediacy in feedback, and using appropriate communication channels are important to collaborative communication and should be considered and operationalized in future studies.

Fourth, this study was also limited in generalizability because data was gathered during a global pandemic and focused on obtaining deep insight rather than breadth of information. Even during the period of gathering information, Covid-19 restrictions and rules have changed significantly meaning that nurses’ guidelines for providing care and organizational rules pertaining to patient and staff safety have likely changed and will continue doing so. As such, these findings are limited to provide understanding specific to the time of data collection. Future studies may explore interdisciplinary communication and collaboration during the whole of the Covid-19 pandemic or even its long-lasting impacts on care provided in hospice organizations. Continued research of interdisciplinary team communication and collaboration is important as the United States remains in a nursing shortage and battles Covid-19.
REFERENCES


Moss, J. (2019, December 11). Burnout is about your workplace, not your people. *Harvard Business Review*. https://hbr.org/2019/12/burnout-is-about-your-workplace-not-your-people?fbclid=IwAR3thkioIHOY-1XWCFc8fvGtGiNOMU22Tzn2RrMhz8gE0c1gWCDebYC4Thc


My name is Hillary Hamilton, and I am a student enrolled in the University of Northern Iowa's Graduate Communication Studies program. I would like to invite your hospice organization to participate in a research project that I am conducting. My research focuses on interdisciplinary team communication and collaboration. Specifically, I am interested in the relationship between interdisciplinary team communication and collaboration on hospice nurses’ job satisfaction and burnout.

I am conducting a multimethod study that includes an online survey and phone or video conference interviews. In addition, I am specifically looking for participation from hospice nurses working on interdisciplinary teams. Participants may choose to be involved in either the survey and/or the interview. The survey takes approximately 15 – 20 minutes to complete, and the interview will take approximately 30 minutes.

Data from this study will enable me to complete my thesis. It will be shared with my thesis committee and kept on file at the University of Northern Iowa. In addition, I would like to share my findings with each participating hospice in the form of a result report and best practices document. These can be used to tailor communicative practices within teams with the hope that it will improve hospice nurses’ job satisfaction and minimize their experiences of burnout.

If you are interested and would like to know more, or if you have questions or concerns, please email me at the address below.
APPENDIX B

PHONE INVITATION TO PARTICIPATE

Hello. My name is Hillary Hamilton, and I am a student enrolled in the University of Northern Iowa's Graduate Communication Studies program. I am currently working on a study pertaining to hospice nurses’ experience of burnout and job satisfaction related to interdisciplinary team communication and collaboration. My hope is that this study will enable me to create a best practices document that will provide some guidance in how to increase nurses’ job satisfaction and decrease their experiences of burnout.

Currently, I am recruiting participants, and I am looking for hospices that would allow me to gather data within their organization. I would like to invite your hospice organization to participate in this research project. Would you be interested in talking a bit more about this opportunity and its benefit to your organization?

(If yes)

This is a multimethod study that includes an online survey and phone or video conference interviews. I am specifically looking for participation from hospice nurses working on interdisciplinary teams. Participants may choose to be involved in either the survey and/or the interview. The survey and interviews each take approximately 30 - 45 minutes to complete.

Data from this study will enable me to complete my thesis. It will be shared with my thesis committee and kept on file at the University of Northern Iowa. In addition, I would like to share my findings with each participating hospice in the form of a result report and best practices document. These can be used to tailor communicative practices
within teams with the hope that it will improve hospice nurses’ job satisfaction and minimize their experiences of burnout.

If you choose to participate, I would appreciate your help in recruiting participants. Specifically, I was hoping that you would consider forwarding my recruitment email to employees within this hospice organization. If there is a way to send this email only to hospice nurses with experience working on interdisciplinary teams, that would also be helpful.

Is there anything else that you would like to know about this study?

(If yes, answer questions.)

(If no, provide contact information.)

Could I leave my contact information with you?

(If yes.)

My name is Hillary Hamilton. My phone number is 641-344-1328. My email address is hamilhab@uni.edu

Could I also have your contact information?

(If they provide more than one contact.)

What is the best way for me to reach you?

Thank you for your time. Goodbye.
Hello,

You are invited to participate in a research project conducted by Hillary Hamilton. I am enrolled in the University of Northern Iowa's Graduate Communication Studies program.

I am conducting a survey of hospice nurses working on interdisciplinary teams. The survey takes about 10 - 20 minutes to complete, and it can be done online. Participants of the web-based survey are offered the opportunity to enter a raffle for a $50 Amazon gift card. If you are interested, please click the link below. If you have questions or concerns, please email me at the address below.

I am also conducting interviews with hospice nurses working on interdisciplinary teams. Interviews last approximately 30 - 45 minutes and will be done over the phone or through video conference. If you are interested or have questions or concerns, please email me at the address below.

Sincerely,

Hillary Hamilton

hamilhab@uni.edu
### “Scale Items” Demographic Information

<table>
<thead>
<tr>
<th>Race</th>
<th>Which of the following best describes your racial or ethnic background?</th>
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</thead>
<tbody>
<tr>
<td>American Indian or Alaska</td>
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<tr>
<td>Native</td>
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<tr>
<td>Asian</td>
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<tr>
<td>Black or African American</td>
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<td>Hispanic or Latino</td>
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<tr>
<td>Native Hawaiian or Pacific</td>
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<td>Islander</td>
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<tr>
<td>White</td>
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<tr>
<td>Other. Please specify</td>
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<table>
<thead>
<tr>
<th>Gender</th>
<th>Which of the following genders do you associate with?</th>
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<tbody>
<tr>
<td>Male</td>
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<td>Female</td>
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<td>Transgender</td>
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<td>Gender neutral</td>
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<td>Other. Please specify</td>
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<tr>
<th>Tenure</th>
<th>How many years have you worked at your current place of employment?</th>
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<td>1</td>
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<td>5 or less</td>
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<td>10 or less</td>
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**Independent and Dependent Variables**

The following variables will be presented on a 5-point scale.

For the following items, please indicate your agreement using the scale where 1=strongly disagree and 5= strongly agree.

*“Scale Items” Satisfaction (SA-SD) 5 pt. scale*

<table>
<thead>
<tr>
<th>Scale and Items (R indicates reverse-coded item)</th>
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</thead>
<tbody>
<tr>
<td><strong>Job satisfaction</strong></td>
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</table>
I am seldom bored with my job.
I would not consider taking another job.
Most days I am enthusiastic about my job.
I feel fairly well satisfied with my job.
All in all, I am satisfied with my job.
In general, I do not like my job. (R)
In general, I like working here.

“Scale Items” MBI (SA-SD) 5 pt. scale

<table>
<thead>
<tr>
<th>Scale and Items (R indicates reverse-coded item)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnout: emotional exhaustion</td>
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<tr>
<td>I feel emotionally drained from my work.</td>
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<tr>
<td>I feel used up at the end of the work day.</td>
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<td>I feel fatigued when I have to face another day on the job.</td>
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<td>Working with people all day is really a strain for me.</td>
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<tr>
<td>I feel burned out from my work.</td>
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<td>I feel very energetic. (R)</td>
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<td>I feel I’m working too hard on my job.</td>
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<tr>
<td>I feel frustrated by my job.</td>
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<tr>
<td>Working with people puts too much stress on me.</td>
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<tr>
<td>I feel like I’m at the end of my rope.</td>
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</table>
| Burnout: reduced personal accomplishment | I can easily understand how clients feel about certain things. (R)  
I deal very effectively with the problems of clients. (R)  
I feel I positively influence other people’s lives through my work. (R)  
I can easily create a relaxed atmosphere with clients. (R)  
I feel exhilarated after working closely with clients and their families. (R)  
I have accomplished many worthwhile things in my job. (R) |
| Burnout: depersonalization | I feel I treat some clients as if they were impersonal objects.  
I’ve become more callous toward people since I took this job.  
I worry that this job is hardening me emotionally.  
I don’t really care what happens to some clients and families.  
I feel clients blame me for some of their problems. |

**“Scale Items” Intention to Leave (SA-SD) 5 pt. scale**

| Scale and Items (R indicates reverse-coded item) | I frequently think of quitting my job  
I am planning to search for a new job during the next 12 months |
If I have my own way, I will be working for this organization one year from now (R)

**“Scale Items” MIIC (SA-SD) 5 pt. scale**

<table>
<thead>
<tr>
<th>Scale and Items (R indicates reverse-coded item)</th>
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<tbody>
<tr>
<td><strong>Interdependence</strong></td>
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<tr>
<td>Flexibility</td>
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Indicate your willingness to participate in an interview. (YES) (NO)
APPENDIX E

INTERVIEW GUIDE

Before beginning the interview, review the interview process and purpose. Remind participants that their answers are voluntary, that they can refuse to answer and question or choose to end the interview at any point, and that the interviews are recorded. Ask participants to state, “I [State your name] consent to participating in this interview and recognize that my participation is voluntary. Then, provide introductions including your name and why you are conducting the study, and begin the interview.

1. Could you walk me through a typical day of your job including what you do and who you interact with?
   a. What issues or topics of communication typically arise in a day at work?
   b. How does your work vary on a daily basis?

2. How long have you worked as a nurse with this hospice?
   a. Why did you decide to work with this hospice?
   b. Do you have previous nursing experience? (If so, where and how long/tenure)
   c. What is one thing you appreciate at this hospice? (Ask for experience)
   d. What is one thing you wish would improve in this hospice? (Ask for experience)

3. I understand that you work on an interdisciplinary team. Can you tell me what this experience generally is like?
   a. How long have you worked with interdisciplinary care teams in general?
b. How many teams have you worked with? (Identify if they have all been at their current place of employment).

c. Do you work with more than one team at a time?

4. How many members are on your team, and what roles do they fill?
   a. How long have you worked with your interdisciplinary team?
   b. How would you describe the leadership on your team?
   c. How often do you see the members on your interdisciplinary team?

5. How would you describe the team’s communication?
   a. What is one thing that helps your team communicate?
   b. What is one thing that hinders your team’s communication?
   c. If you could improve one thing about your team’s communication, what would it be?
   d. Tell me about a positive experience that you have had with team communication.
   e. Tell me about a negative experience that you have had with team communication.

6. I can only imagine that you experience a lot of emotion in this line of work. Can you tell me how your emotions impact you work?
   a. How has Covid-19 impacted the emotion you feel pertaining to your position?

7. How has Covid-19 affected your team’s work experience?
   a. How has your work experience changed from the Covid-19 pandemic?
b. How has the Covid-19 pandemic affected your team’s communication?

(Ask for experience)

8. Is there anything else that you would like to share or that you feel I should know about your work experience?