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Developing and Sustaining Interprofessional Health Care:

Optimizing patient, organizational and system outcomes

RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers
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Contact Information

Registered Nurses' Association of Ontario
Healthy Work Environments Best Practice Guidelines Project
158 Pearl Street, Toronto, Ontario M5H 1L3

Website: www.rnao.ca/bpg

Developing and Sustaining Interprofessional Health Care:

Optimizing patient, organizational and system outcomes

Greetings from Doris Grinspun,

Chief Executive Officer, Registered Nurses' Association of Ontario

It is with great pleasure that the Registered Nurses' Association (RNAO) of Ontario releases this guideline, *Developing and Sustaining Interprofessional Health Care: Optimizing patients/clients, organizational and system outcomes.*

This is one in a series of best practice guidelines on healthy work environments developed by RNAO for the health-care community. The aim of these guidelines is to provide the best available evidence to support the creation of healthy and thriving work environments. These guidelines, when applied, will serve to support the excellence in service that health-care professionals are committed to delivering in their day-to-day practice. RNAO is delighted to provide you with this key resource.

We offer our endless gratitude to the many individuals and organizations who are making our vision for healthy work environment best practice guidelines a reality: the Government of Ontario for recognizing RNAO's ability to lead the program and providing generous funding; Dr. Irmajean Bajnok, Director, RNAO International Affairs and Best Practice Guidelines Programs, for her expertise and leadership in advancing the production of these guidelines; my co- chair Dr. Joshua Tepper and co-advisor Dr. Craig Jones for the many hours of critical deliberations, Development Panel co-chairs Dr. Stewart Kennedy and Dr. Rani Srivastava – for their superb stewardship, commitment and, above all, exquisite expertise. Endless thanks also to Program Manager Althea Stewart-Pyne who provided leadership to the process and worked intensely to see that this guideline move from concept to reality. Very special thanks to the best practice guideline's panel – we respect and value your expertise and volunteer work. To all, we could not have done this without you!

The nursing community and other health-professional partners – committed to, and passionate about excellence in clinical care and healthy work environments – have provided knowledge and countless hours essential to the creation, evaluation and revision of each guideline. Employers have responded enthusiastically by nominating Best Practice Champions, becoming Best Practice Spotlight Organizations®, implementation and evaluating the guidelines and working towards a culture of evidence-based practice.

Creating healthy work environments is both an individual and collective responsibility. Successful uptake of these guidelines requires a concerted effort by governments, administrators, clinical staff and others, partnering together to create evidence-based practice cultures. We ask that you share this guideline with members of your team. There is much we can learn from one another.

Together, we can ensure that nurses and all health-care providers contribute to building healthy work environments. This is central to ensuring quality patient care. Let's make health-care providers and the people they serve the real winners of this important effort!

Doris Grinspun, RN, MSN, PhD, LLD (Hon), O. ONT.
Chief Executive Officer
Registered Nurses' Association of Ontario

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How to Use this Document

This healthy work environment[G] best practice guideline (BPG) is an evidence-based document that focuses on developing and sustaining interprofessional[G] health care. It contains much valuable information, but is not intended to be read and applied all at once. We recommend you review and reflect on the document and implement the guidelines as appropriate for your organization at a particular time. The following approach may be helpful:

1. **Study the Healthy Work Environments Organizing Framework:** *Developing and Sustaining Interprofessional Health Care* was built on the Healthy Work Environments Organizing Framework, which was created to help users understand relationships among key factors in the workplace. Understanding the framework is critical to using the guideline effectively. We suggest you start your work with the guideline by reading and reflecting on the framework.

2. **Identify a focus:** Once you have studied the framework, we suggest identifying an area you believe needs attention to create a supportive environment for interprofessional health care.

3. **Read the recommendations and the summary of research for your focus:** Each major element of the model offers a number of evidence-based recommendations. The recommendations are statements of what nurses[G], organizations, and systems do, or how they behave, to provide a supportive, violence-free work environment for nurses. and other health-care providers. The literature supporting each recommendation is summarized briefly. We believe you will find it helpful to read the summaries to understand the "why" of the recommendations.

4. **Focus on the recommendations or desired behaviour most appropriate for you and your current situation:** Our recommendations are not meant to be applied as rules. Rather, they are tools to assist individuals, organizations and systems developing and sustaining interprofessional health care. In some cases there is a lot of information to consider. You will want to explore ideas and identify behaviours that need to be analyzed and perhaps strengthened for your situation.

5. **Start planning:** When you have selected a small number of recommendations and behaviours to work on, consider strategies to implement them. Make a tentative plan for what you might actually do to address the issues you are focusing on. If you need more information, you might wish to consult some of the material cited in the references.

6. **Discuss the plan with others:** Take time to get input on your plan from people it might effect, or whose engagement will be critical to success, and from trusted advisors, who will give you honest and helpful feedback on your ideas. This is an important phase for developing and sustaining interprofessional health care.

7. **Revise your plan and get started:** It is important to keep gathering feedback and adjusting your plan in response to it as you implement recommendations from this guideline. Developing and sustaining interprofessional health care is a lifelong quest; **enjoy the journey**.

*** Throughout this document, terms marked with the superscript symbol G ([G]) can be found in the Glossary of Terms (Appendix A).**

Purpose and Scope

Purpose:

This best practice guideline, *Developing and Sustaining Interprofessional Health Care: Optimizing patients/clients, organizational, and system outcomes* is intended to foster healthy work environments. The focus in developing this guideline was identifying attributes of interprofessional care[G] that will optimize quality outcomes for patients/clients[G], providers, teams[G], the organization and the system.

Scope:

This guideline identifies best practices to enable, enhance and sustain teamwork[G] and interprofessional collaboration, and to enhance positive outcomes for patients/clients, systems and organizations. It is based on the best available evidence[G]; where evidence was limited, the recommendations were based on the consensus of expert opinion[G].

Target Audience:

The target audience includes nurses and health-care professionals in all roles and practice settings, including interprofessional team members; non-nursing administrators at the unit, organizational and system level; clinical nurses; students; educators; researchers; policy makers and governments; professional organizations, employers, labour groups; and federal, provincial and territorial standard-setting bodies.

Guiding Principles and Assumptions

1. More effective teams produce better outcomes
2. Collaborative teams are more effective than individual health-care providers
3. Patients/clients are an integral part of interprofessional teams
4. The total expertise of team members is greater than the sum of its parts and produces better outcomes
5. Services are holistic and coordinated across the full spectrum of providers
6. The reward of improved patient/client outcomes is the best incentive for high-functioning interprofessional teams
7. There are ingrained power and status differentials that are discussed by the team to support effective team functioning
8. The power differential between health-care providers and between patients/clients needs to be acknowledged and addressed through policies
9. Financial frameworks and incentives advance interprofessional team-based health services

See **Appendix A** for a glossary of terms. See **Appendices B** and **C** for the guideline development process and process for systematic review[G]/search of the literature.

Summary of Recommendations

We have organized these recommendations according to the key concepts of the Healthy Work Environments Framework:

- System-based recommendations
- Organizational recommendations
- Individual/Team recommendations

System-Based Recommendations

1.0 System-wide partnerships

1.1 Leaders of key agencies (governments, academic institutions, regulatory bodies, professional associations, and practice-based organizations) collaborate to make interprofessional care a collective strategic priority.

1.2 Agencies in the health-care system strategically align interprofessional care with their other initiatives for healthy work environments.

1.3 Interprofessional care partnerships across organizations agree on an evidence-based approach to planning, implementation, and evaluation for joint activities.

2.0 Power and hierarchy in systems

2.1 Show willingness to acknowledge and share power across organizational boundaries by:

a. Talking about power: be open to constructive and courageous conversations that examine inequities, privilege and power differentials;

b. Building a collaborative inter-organizational environment by recognizing and understanding your power and its influence on others around you;

c. Creating balanced power relationships through sharing leadership, decision making, authority and responsibility;

d. Including diverse voices in collaborative decision making;

e. Sharing knowledge with each other, not withholding or hoarding information; and

f. Creating safe collaborative spaces where everyone feels welcome.

3.0 Academic organizations

3.1 Academic organizations build interprofessional care knowledge and competencies[G] into their curricula.

3.2 Academic organizations prepare students to work in interprofessional teams by:

a. Instilling values, skills and professional role socialization that will support interprofessional care;

b. Developing, implementing and evaluating education models that foster interprofessional values and skills; and

c. Enhancing educational and clinical opportunities for health professions to study and learn together.

4.0 Research recommendations

4.1 Researchers partner with decision makers to conduct research examining the impact of interprofessional care teams on both patient/client outcomes and on health-care teams[G].

4.2 Health research granting agencies develop and maintain a focus on Interprofessional care research priority areas.

4.3 Researchers use knowledge translation strategies to encourage action on research findings by funders, government, professional associations and regulatory bodies, as well as by unions, health-care organizations, educational institutions, study participants and other stakeholders.

5.0 Professional associations, regulatory bodies and unions

5.1 Professional associations, regulatory bodies and unions can support interprofessional care by:

a. Including it in legislation and policies for their members;

b. Working together to develop joint competencies and standards for interprofessional care;

c. Working together to add interprofessional care principles to approval standards for education programs; and

d. Including interprofessional care as a competency for licensure.

6.0 Accreditation[G] organizations

6.1 Accrediting bodies for organizations and education programs develop standards and performance indicators for interprofessional care.

7.0 Government

7.1 Governments can support the culture required for interprofessional care by:

a. Making interprofessional care a priority, and evaluating its impact; and

b. Providing health-care organizations with the fiscal resources required to develop, implement and evaluate interprofessional care.

Organizational Recommendations

8.0 Power and hierarchy in organizations

8.1 Organizations must acknowledge the impact of power and hierarchy by:

Identifying imbalances of power and making changes to equalize power and build mutually supportive, safe interprofessional workplaces.

8.2 Organizations need to engage and develop leaders at every level, including among their point-of-care health professionals, for successful interprofessional care.

Strategies for doing that include:

a. Developing interprofessional care champions/role models in different professions and programs; and

b. Offering leadership courses to introduce the concepts and competencies of interprofessional care and its management.

9.0 Operational supports

9.1 Organizations promote interprofessional care by developing a culture that expects collaboration and creates the operational supports it will need to succeed by:

a. Establishing human resources plans that allow dedicated time and coverage for staff to participate in interprofessional activities e.g. team development , a team charter (see **Appendix E, H**) and effective communication;

b. Designing buildings, spaces, programs and care pathways to accommodate and encourage interprofessional care; and

c. Considering shared spaces for patients/clients and team members to enhance opportunities for communication and innovation.

10.0 Competent communication

10.1 Organizations can support interprofessional care through enhanced communication by:

a. Establishing effective communication processes and tools to support collaboration and communication in teams, professions, with patients/clients and across programs and organizations;

b. Standardizing documentation and encouraging information sharing;

c. Adopting strategies to tackle issues such as "turf" protection and disrespectful communication; and

d. Creating a culture that promotes regular formal and informal communication among team members with team rounds and care conferences.

Individual/Team Recommendations

11.0 Supporting interprofessional team and care delivery

11.1 All health-care professionals, as well as volunteers and students, demonstrate their commitment to the principles of interprofessional care by:

a. Practising and collaborating with colleagues, patients/clients and families in a way that fosters respect, trust and understanding;

b. Understanding their roles and expertise, reflecting on their practice, being confident in their own abilities, and expertise, knowing the standards and boundaries of their practice and recognizing when it's time to turn to other team members; and

c. Developing communication and conflict-management skills.

12.0 Power and hierarchy in teams

12.1 Team members demonstrate their willingness to share power by:

a. Building a collaborative environment through recognizing and understanding power and its influence on everyone involved;

b. Creating balanced power relationships through shared leadership, decision making, authority, and responsibility;

c. Including diverse voices for decision making;

d. Sharing knowledge with each other, openly; and

e. Working collaboratively with patients/clients and their families to plan and deliver care.

13.0 Interprofessional education

13.1 Individuals develop skill and competency in precepting, mentoring and facilitating interprofessional learning.

Types of Evidence

EVIDENCE RATING	TYPE OF EVIDENCE
A	Evidence obtained from controlled studies, meta-analyses[G]
A1	Systematic Review
B	Evidence obtained from descriptive correlational studies[G]
C	Evidence obtained from qualitative research[G]
D	Evidence obtained from expert opinion
D1	Integrative Reviews[G]
D2	Critical Reviews[G]

Advisory Committee Members

Doris Grinspun, RN, MSN, PhD, LLD (hons), O.ONT.
Chief Executive Officer
Registered Nurses' Association of Ontario

Craig Jones, MD
Director
Vermont Blueprint for Health

Joshua Tepper, MD, FCFP, MPH, MBA
Vice President, Education
Sunnybrook Health Sciences Centre

Development Panel Members

Rani Srivastava, RN, PhD
Panel Co-chair
Chief of Nursing & Professional Practice
Centre for Addiction and Mental Health
Toronto, Ontario

Stewart Kennedy, MD, CCFP, MHA
Panel Co-chair, Past president
Ontario Medical Association
Toronto, Ontario

Salma Debs-Ivall, RN, MScN
Manager, TOH Models of Nursing & Interprofessional Patients/clients Care, The Ottawa Hospital
Ottawa, Ontario

Laurie Goodman, RN, BA, MHScN
Advanced Practice Nurse/Educator,
Toronto Regional Wound Healing Clinic
Dermatology Office of Dr. R. Gary Sibbald
Mississauga, Ontario

Scott Graney, MSW, RSW
Professional Practice Leader, Social Work
St. Joseph's Health Centre
Toronto, Ontario

Rozanna Haynes, RN
Professional Practice Specialist
Ontario Nurses' Association
Toronto, Ontario

Bonny Jung, PhD, BSc(OT)
Assistant Professor and Director of Program for Interprofessional Practice, Education and Research (PIPER)
McMaster University, Hamilton, Ontario

Kathleen Klaasen, RN, MN, GNC(C)
Chief Executive Officer
Saul and Claribel Simkin Centre
Winnipeg, Manitoba

Danielle Lubbers, BScN
University of Windsor, Thames Nursing Society
Windsor, Ontario

Patti McGillicuddy, MSW, RSW
Director, Professional Practice, Health Professions
University Health Network
Toronto, Ontario

Charmaine McPherson, RN, PhD
Associate Professor
School of Nursing
St. Francis Xavier University
Antigonish, Nova Scotia

Sheri Oliver, RPN
Manager, Education Initiatives
Registered Practical Nurses Association of Ontario
Toronto, Ontario

Hazel Sebastian, MA, MSW, RSW
Psychogeriatric Resource Consultant
St. Michael's Hospital
Toronto, Ontario

Gary Sibbald, MD, FRCPC, ABIM, DABD, Med
Professor Public Health, Medicine
Dalla Lana School of Public Health
University of Toronto
Toronto, Ontario

Judy Smith, RN, BScN, MEd(DE), ENC(C)
Geriatric Emergency Management Nurse (GEM)
Mackenzie Richmond Hill Hospital
Richmond Hill, Ontario

Eric Li, MA, BSc. Pharm.
Manager, Pharmacy Practice
Ontario Pharmacists' Association
Toronto, Ontario

Declarations of interest and confidentiality were made by all members of the Guideline Development Panel. Further details are available from the Registered Nurses' Association of Ontario.

Registered Nurses' Association of Ontario Best Practice Guideline Program Team

Althea Stewart-Pyne, RN, BN, MHSC
Program Manager
Registered Nurses' Association of Ontario
Toronto, Ontario

Patti Hogg, BA (Hons)
Project Coordinator
Registered Nurses' Association of Ontario
Toronto, Ontario

Marian Luctkar-Flude, RN, MScN
Research Assistant

Erica D'Souza, BSc, GC, DipHlthProm
Project Coordinator
Registered Nurses' Association of Ontario
Toronto, Ontario

Alice Yang, BBA
Project Coordinator
Registered Nurses' Association of Ontario
Toronto, Ontario

Kim English, RN, BScN, MN
Research Assistant

Stakeholder Acknowledgement

The Registered Nurses' Association of Ontario wishes to acknowledge the following for their contribution in reviewing this nursing best practice guideline and providing valuable feedback:

Marta Crawford, RN,BN,MN
Manitoba Health, Manitoba

Ruby Grymonpre, Pharm D, FCSHP
Professor and IPE Coordinator
University of Manitoba
Winnipeg, MB

Maria Casas, RN, GNC(C)
Director of Care
St. Joseph's Villa
Sudbury, Ontario

Val Johnston-Warren, RN, BScN, MN
Clinical Nurse Specialist
Grand River Hospital, Freeport site
Specialized Mental Health
Kitchener, Ontario

Dawn Burnett, PT, PhD
Director
Academic Health Council – Champlain Region
Ottawa, Ontario

Samantha Peck, Hon BA
Program Coordinator
Family Councils' Program, Self-Help Resource Centre
Toronto, Ontario

Sheila Driscoll, RN, BHA
Nursing Consultant
Ministry of Health and Long-Term Care
Barrie, Ontario

Julie Lapointe, PhD, OT(C), OT. Reg. (Ont.)
Research Analyst / Fellow
Canadian Association of Occupational Therapists
Ottawa, Ontario

Jennifer Harrison, RRT, BSc (Hons), BEd (Adult)
Professional Practice Advisor
College of Respiratory Therapists of Ontario
Toronto, Ontario

John Dick
Peer Support
Ontario Shores Centre for Mental Health Sciences
Whitby, Ontario

Ivan Silver, MD Ed
Vice President, Education
Centre for Addiction and Mental Health
Toronto, Ontario

Kelly Stadelbauer, RN, BScN, MBA
Executive Director
Association of Ontario, Midwives
Toronto, Ontario

Jane Paterson, MSW, RSW
Director Interprofessional Practice
Centre for Addition and Mental Health
Toronto, Ontario

Lily Spnajevic, RN, BScN, MN, GNC(C), CRN
Advanced Practice Nurse Geriatrics-Medicine
Joseph Brant Memorial Hospital
Burlington, Ontario

Ivy Oandasan, MD, CCFP, MHSc, FCFP
Associate Professor and Clinician Investigator
Department of Family and Community Medicine,
University of Toronto
Associate Director, Academic Family Medicine,
College of Family Physicians of Canada
Toronto, Ontario

Background to the Healthy Work Environments Best Practice Guidelines Project

Nurses are essential for achieving and sustaining affordable access to high-quality, timely health care for Canadians. Work environments that maximize health and well-being are essential for good nursing and the best patients/clients and organizational outcomes: those two realities are the drivers behind the Healthy Work Environment Best Practice Guideline Project.

What do we mean when we speak of a healthy work environment? It's one which recognizes nurses' professionalism and their ability to work autonomously and to lead. Healthy work environments are safe, collaborative and diverse, and offer reasonable workloads. But a healthy workplace is not easy to create, and there are many pressures – from rising costs and calls for increased productivity, to the growing demands of an aging population – that can undermine it.

The idea of developing and widely distributing a guide for creating healthy work environments was first proposed in *Ensuring the Care Will Be There: Report on Nursing Recruitment and Retention in Ontario* (RNAO, 2000, submitted to the Ontario Ministry of Health and Long-Term Care [MOHLTC] in 2000 and approved by the Joint Provincial Nursing Committee [JPNC]). What has evolved from that, the Healthy Work Environments Best Practice Guidelines[G] Project, is based on needs identified by the JPNC and the Canadian Nursing Advisory Committee (CNAC, 2002).

The work began in July of 2003, when the Registered Nurses' Association of Ontario (RNAO), with funding from MOHLTC, began a partnership with Health Canada's Office of Nursing Policy to develop best-practice guidelines for creating healthy work environments for nurses. From the beginning, we were committed to creating evidence-based guidelines, to ensure the best possible outcomes for nurses, their patients/clients, organizations and the system as a whole.

We found plenty of evidence on the relationship between nurses, work environments, patients/clients outcomes and organizational and system performance (Dugan et al., 1996; Estabrooks, Midodzi, Cummings, Ricker, & Giovannetti, 2005; Lundstrom, Pugliese, Bartley, Cox, & Guither, 2002). A number of studies have shown strong links between nurse staffing and adverse patients/clients outcomes (ANA, 2000; Blegen & Vaughn, 1998; Cho, Ketefian, Barkauskas, & Smith, 2003; Kovner & Gergen, 1998; Needleman & Buerhaus, 2003; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002; Person et al., 2004; Sasichay-Akkadechanunt, Scalzi, & Jawad, 2003; Sovie & Jawad, 2001; Tourangeau, Giovannetti, Tu, & Wood, 2002; Yang, 2003). Evidence shows that healthy work environments yield financial benefits to organizations in terms of reductions in absenteeism, lost productivity, organizational health-care costs and costs arising from adverse patients/clients outcomes (Aldana, 2001).

Other reports and articles have documented the challenges of recruiting and retaining a healthy nursing workforce (CFNU 2011; Bauman et al., 2001). Some have suggested the nursing shortage is a result of unhealthy work environments (Dunleavy, Shamian, & Thomson, 2003; Grinspun, 2000; Grinspun, 2002; Shindul-Rothschild, Berry, & Long-Middleton, 1996). Strategies to enhance nurses' workplaces are needed to repair the damage of a decade of relentless restructuring and downsizing.

Achieving healthy work environments for nurses requires transformational change, with interventions that target underlying workplace and organizational factors (Lowe, 2004). We have developed these guidelines to bring about that change. Implementing them will make a difference for nurses, their patients/clients and the organizations and communities in which they practice. We anticipate that a focus on creating healthy work environments will benefit not only nurses but other members of health-care teams as well. We also believe that best practice guidelines can be successfully implemented only where there are adequate planning processes, resources, organizational and administrative supports, and appropriate facilitation.

A healthy work environment is…

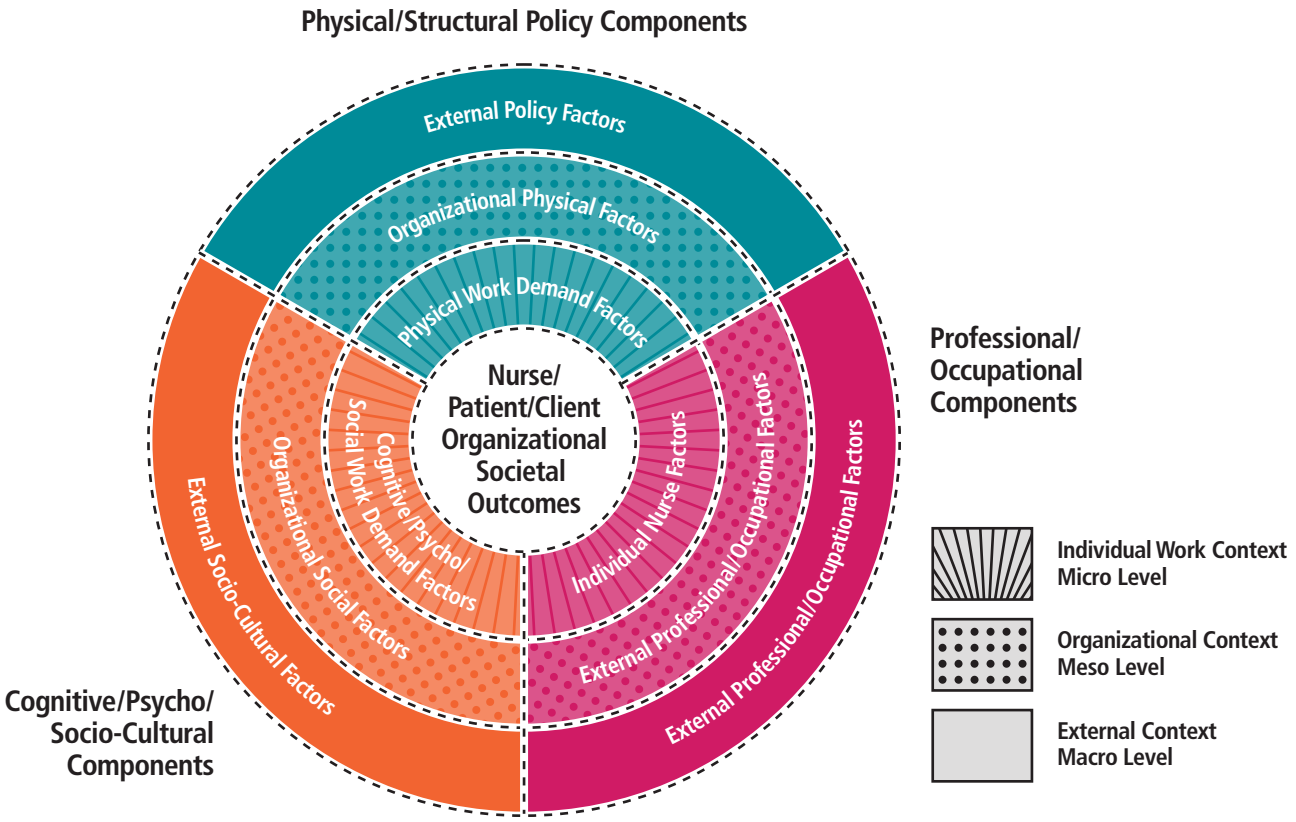
…a practice setting that maximizes the health and well-being of nurses, quality patients/clients outcomes, and organizational performance and societal outcomes.

THE PROJECT HAS PRODUCED NINE HEALTHY WORK ENVIRONMENTS BEST PRACTICE GUIDELINES

- Collaborative Practice Among Nursing Teams
- Developing and Sustaining Effective Staffing and Workload Practices
- Developing and Sustaining Nursing Leadership
- Embracing Cultural Diversity in Health Care: Developing Cultural Competence
- Professionalism in Nursing
- Workplace Health, Safety and Well-being of the Nurse
- Preventing and Managing Violence against Nurses in the Workplace
- Preventing and Mitigating Nurse Fatigue in Health Care
- Mitigating and Managing Conflict in Health-care Teams

Organizing Framework for the Healthy Work Environments Best Practice Guidelines Project

Figure 1. Conceptual Model for Healthy Work Environments for Nurses – Components, Factors & Outcomes[i-iii]



A healthy work environment for nurses is complex and multidimensional, comprised of numerous components and relationships among the components. A comprehensive model is needed to guide the development, implementation and evaluation of a systematic approach to enhancing the work environment of nurses. Healthy work environments for nurses are defined as practice settings that maximize the health and well-being of the nurse, quality patients/clients outcomes, organizational performance and societal outcomes.

The Conceptual Model for Healthy Work Environments for Nurses presents the healthy workplace as a product of the interdependence among individual (micro level), organizational (meso level) and external (macro level) system determinants as shown in Figure 1 the three outer circles. At the core of the circles are the expected beneficiaries of healthy work environments for nurses, patients/clients, organizations and systems, and society as a whole, including healthier communities. The lines within the model are dotted to indicate the synergistic interactions among all levels and components of the model.

The model suggests that functioning within the individual micro level is mediated and influenced by interactions between the individual and his/her environment. Thus, interventions to promote healthy work environments must be aimed at multiple levels and components of the system. Similarly, interventions must influence not only the factors within the system and the interactions among these factors but also influence the system itself.

The assumptions underlying the model are as follows:

- healthy work environments are essential for quality, safe patients/clients care;
- the model is applicable to all practice settings and all domains of nursing;
- individual, organizational and external system level factors are the determinants of healthy work environments for nurses;
- factors at all three levels impact the health and well-being of nurses, quality patients/clients outcomes, organizational and system performance, and societal outcomes either individually or through synergistic interactions;
- at each level, there are physical/structural policy components, cognitive/psycho/social/cultural components and professional/occupational components; and
- the professional/occupational factors are unique to each profession, while the remaining factors are generic for all professions/occupations.

i Adapted from DeJoy, D.M. & Southern, D.J. (1993). An Integrative perspective on work-site health promotion. Journal of Medicine, 35(12): December, 1221-1230; modified by Lashinger, MacDonald and Shamian (2001); and further modified by Griffin, El-Jardali, Tucker, Grinspun, Bajnok, & Shamian (2003)

ii Baumann, A., O'Brien-Pallas, L., Armstrong-Stassen, M., Blythe, J., Bourbonnais, R., Cameron, S., Irvine Doran D., et al. (2001, June). Commitment and care: The benefits of a healthy workplace for nurses, their patients/clients, and the system. Ottawa, Canada: Canadian Health Services Research Foundation and The Challenge Foundation.

iii O'Brien-Pallas, L., & Baumann, A. (1992). Quality of nursing worklife issues: A unifying framework. Canadian Journal of Nursing Administation, 5(2):12-16.

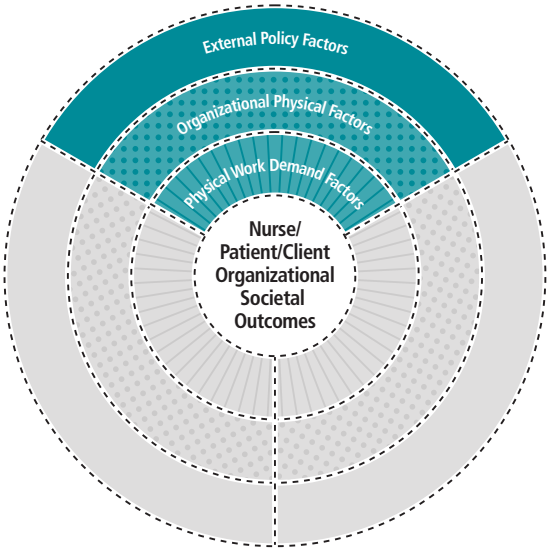
v Green, L.W., Richard, L. and Potvin, L. (1996). Ecological foundation of health promotion. American Journal of Health Promotion, 10(4): March/April, 270-281.

iv Hancock, T. (2000). The Healthy Communities vs. "Health". Canadian Health Care Management, 100(2), 21-23.

vii Grinspun, D. (2010). The Social Construction of Nursing Caring. (Doctoral Dissertation, York University).

Physical/Structural Policy Components

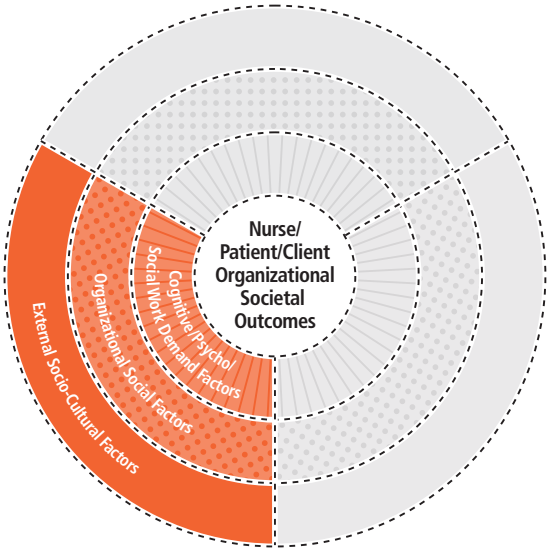
Figure 1A. Physical/Structural Policy Components



- At the individual level, the Physical Work Demand Factors include the requirements of the work which necessitate physical capabilities and effort on the part of the individual. schedules and shifts, heavy lifting, exposure to hazardous and infectious substances, and threats to personal safety.
- At the organizational level, the Organizational Physical Factors include the physical characteristics and the physical environment of the organization and also the organizational structures and processes created to respond to the physical demands of the work. Included among these factors are staffing practices, flexible, and self-scheduling, access to functioning lifting equipment, occupational health and safety policies, and security personnel.
- At the system or external level, the External Policy Factors include health-care delivery models, funding, and legislative, trade, economic and political frameworks (e.g., migration policies, health system reform) external to the organization.

Cognitive/Psycho/Socio-Cultural Components

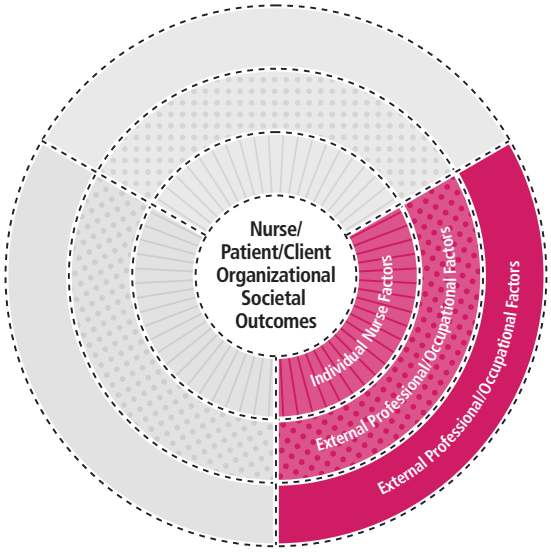
Figure 1B. Cognitive/Psycho/Socio-Cultural Components



- At the individual level, the Cognitive and Psycho-social Work Demand Factors include the requirements of the work which necessitate cognitive, psychological and social capabilities and effort (e.g., clinical knowledge, effective coping skills, and communication skills) on the part of the individual. Included among these factors are clinical complexity, job security, team relationships, emotional demands, role clarity, and role strain.
- At the organizational level, the Organizational Social Factors are related to organizational climate, culture, and values. Included among these factors are organizational stability, communication practices and structures, labour/management relations and a culture of continuous learning and support.
- At the system level, the External Socio-Cultural Factors include consumer trends, changing care preferences, changing roles of the family, diversity of the population and providers, and changing demographics – all of which influence how organizations and individuals operate.

Professional/Occupational Components

Figure 1C. Professional/Occupational Components



- At the individual level, the Individual Nurse Factors include the personal attributes and/or acquired skills and knowledge of the nurse which determine how she/he responds to the physical, cognitive and psycho-social demands of work. Included among these factors are commitment to patients/clients care, the organization and the profession; personal values and ethics; reflective practice; resilience, adaptability and self confidence; and family work/life balance.
- At the organizational level, the Organizational/Professional/Occupational Factors are characteristic of the nature and role of the professional/occupation. Included among these factors are the scope of practice, level of autonomy and control over practice, and intradisciplinary relationships.
- At the system or external level, the External Professional/Occupational Factors include policies and regulations at the provincial/territorial, national and international level which influence health and social policy and role socialization within and across disciplines and domains.

Background Context of the Guideline on Developing and Sustaining Interprofessional Health Care: Optimizing Patient, Organizational and System Outcomes

A work environment is healthy for nurses when it maximizes their health and well-being, as well as quality patients/clients outcomes and the organization's performance. Effective interprofessional teamwork is part of a healthy work environment.

The Government of Canada, seeking to improve health care, assembled a working group of the provincial and territorial first ministers in 2012. This group was asked to integrate best practices for three priority areas: clinical practice guidelines, team-based health-care delivery models and health human resource management initiatives. Their report, *From Innovation to Action* (First Ministers' Health Care Innovation Working Group, 2013) highlighted the importance of team-based care delivery, using competencies developed collaboratively by health professionals.

Interprofessional care – comprehensive health services provided by multiple caregivers[G] working collaboratively – is important in all health-care settings to enhance health outcomes and patients/clients experiences, reduce costs and improve the work environment for all providers (First Ministers' Health Care Innovation Working Group, 2013).

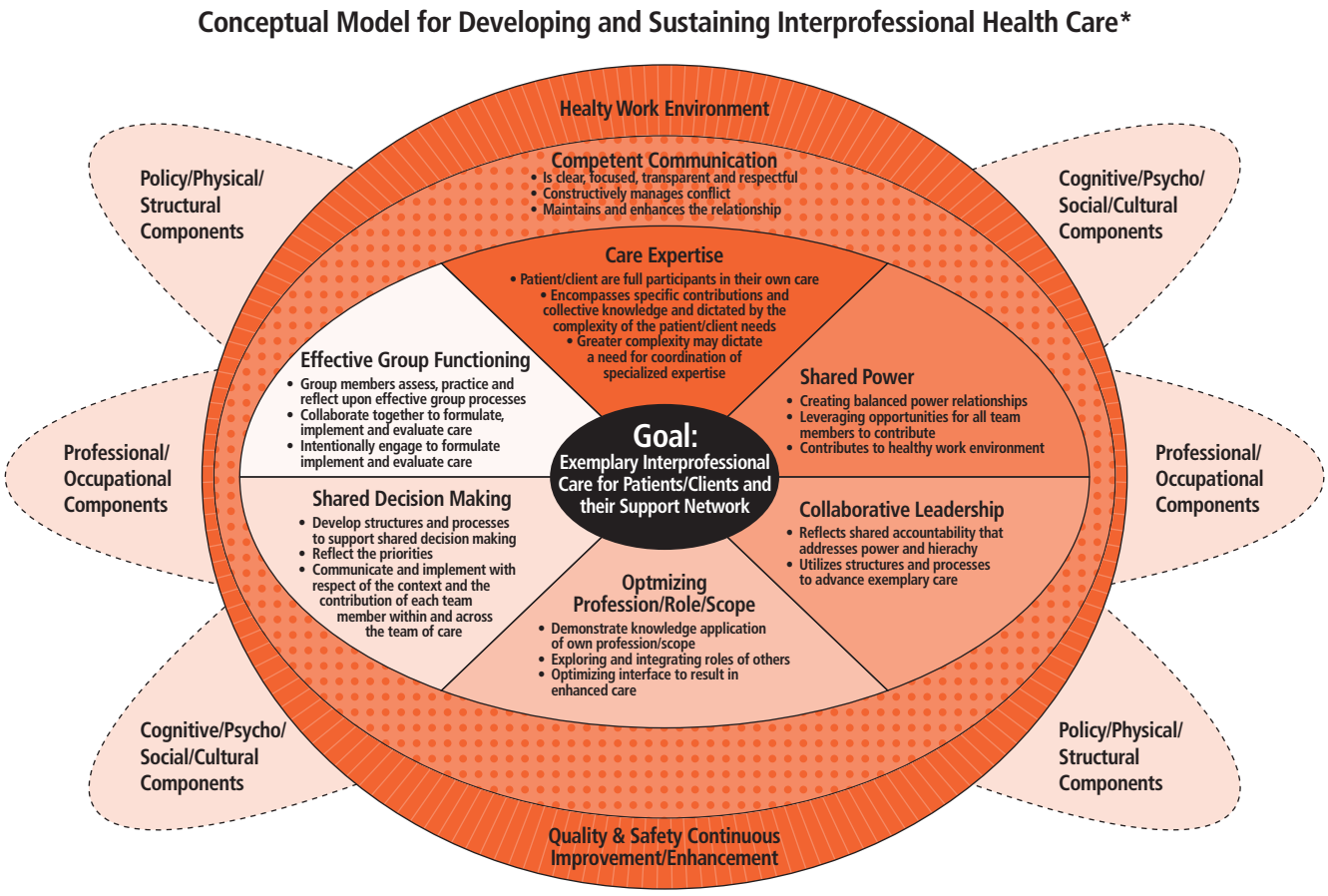
Despite the range of professionals involved, interprofessional care is not restricted to hospitals. It can be delivered in a variety of settings, sometimes, thanks to technological advances, by team members in multiple locations, which may be across town or hundreds of kilometers apart. Interprofessional teams work with patients/clients as they move across health-care sectors, whether that's from long term care to acute care, or in the community or at home. That's why good communication is a core competency of interprofessional teams. Patients/clients and their families' support networks are also integral to interprofessional care. The focus of this best practice guideline is to help you develop your role on your interprofessional team.

Interprofessional care was a response to a variety of changes, including increasingly complex patients/clients, limited resources, shifting demographics and changing laws, priorities and mandates. A number of regulated professions, including nurse practitioners, occupational therapists, pharmacists, dieticians and physician assistants, have initiated changes in scopes of practice and diversification of their skills to foster collaborative interprofessional practice and care.

> Interprofessional care is the provision of comprehensive health services to patients/clients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.
>
> (From Innovation to Action: The First Report of the Health Care Innovation Working Group, Council of the Federation,2012, p.14)

This guideline aligns with the first ministers' team-based care priority, which encourages health professionals to work to their full professional scope to better meet patient/client and community needs in a safe, competent, and cost-efficient manner (From Innovation to Action, 2012).

Figure 2. Conceptual Model for Developing and Sustaining Interprofessional Health Care



*Adapted from the National Competency Framework and the RNAO Model for Healthy Work Environments for Nurses

Overview of the Conceptual Model for Developing and Sustaining Interprofessional Care

Figure 2 presents a model developed by the "RNAO expert panel" based on the National Interprofessional Competency Framework (Canadian Interprofessional Health Collaborative (CIHC), (2010)) and the Registered Nurses' Association of Ontario Model for Healthy Work Environments for Nurses. In this model exemplary interprofessional care in a healthy work environment is a product of synergy among health-care teams, who demonstrate expertise in its six key domains, which are:

a. Care expertise;

b. Shared power;

c. Collaborative leadership;

d. Optimizing profession, role and scope;

e. Shared decision making; and

f. Effective group functioning.

The six domains are shown surrounded by an outer circle of expected benefits for the health-care team and the organization: a healthy work environment with enhanced quality and improved safety. The domains are supported by competent communication and the three foundational components of the healthy work environment model:

a. Policy, physical, structural;

b. Professional/occupational; and

c. Cognitive/psycho/social/cultural.

The six domains are fundamental for transforming work environments to a collaborative interprofessional environment, while the foundational components support and influence each domain to achieve the goal of exemplary interprofessional care for patients/clients and their support networks.

When interprofessional care has been successfully implemented and sustained, continuous improvement in quality and safety occur on three levels – for patients/clients, for interprofessional providers and for the organization and system.

Care Expertise

Interprofessional care requires collaboration between health-care professionals and patients/clients and their families and circles of care[G], in order to identify and take advantage of each professional's care expertise. Specific types of expertise may have to be sought out, depending on a patient's/client's needs. Effective use of different types of expertise can be reflected in measures of quality including improved long-term outcomes, quality of life and cost control.

A patient's/client's needs are determined by a collaborative interprofessional assessment, to identify what expertise is required. That assessment and the treatment goals and strategies it suggests be individualized for each patient/client and followed by a collaborative and coordinated effort to find the best expert for the patient/client.

At the organizational and system level, policies, practices and structures are in place enabling all health providers to optimize their scope of practice for the benefit of both the patient/client and themselves. To provide optimal expertise, a novice professional is encouraged to draw on the knowledge and support of an expert in the same profession (which speaks to the need for expertise versus the need for competence[G]).

The degree of care expertise needed is dictated by the complexity of a patient's/client's needs. The availability of expertise is affected by geographical location and local setting.

Shared Power

Shared power happens when each team member is open to letting others influence patients/clients care regardless of their educational or professional preparation (Orchard, Curran, & Kabene, 2009). Willingness to share power is a commitment to create balanced relationships through democratic practices of leadership, decision making, authority, and responsibility (D'Amour, Ferrada-Videla, San Martin, & Beaulieu, 2005b). Willingness to share power contributes to a healthy work environment where all team members, including the patient/client feel engaged, empowered, respected and validated (SJHC, 2009).

Collaborative Leadership

Collaborative leadership (also called reciprocal or shared leadership) is a people- and relationship-focused approach based on the premise that answers should be found in the collective (the team). According to Michael D. Kocolowski's 2010 paper, "Shared Leadership: Is it Time for a Change?", collaborative leadership has several characteristics, including:

COLLABORATIVE LEADERSHIP

- Reflects shared accountability that addresses power and hierarchy
- Utilizes structures and processes to advance exemplary care

a. Promoting a collective leadership process based on the belief that at different times and depending on the need, situation, and requirements, different people assume the leadership role and work is assigned based upon the skill requirement.

b. Structuring a learning environment that supports continuous self-development and reflection. The team members are encouraged to learn together and from each other, and to cultivate practices of open-mindedness, mutual trust, constructive feedback and viewing conflict as an opportunity for growth.

c. Supporting relationships that value honesty, mutual respect, expecting the best from others, and the ability to exercise personal choice. Collaborative leadership focuses on facilitating the ability of the team to live those values towards a shared vision that allows people to set common goals and direction.

d. Fostering shared power that implies shared responsibility and accountability for decision making and for learning. Power is found at the centre of the team rather than at the top of the hierarchy.

e. Practising stewardship and service (rather than focusing on personal power and control) to ensure the interests and needs of others are being served.

f. Valuing diversity and inclusiveness by respecting individual differences, which will result in freedom to learn together and exercising collective ownership.

Optimizing Profession, Role and Scope

Exemplary interprofessional care lets all team members work to their full scope of practice, and takes advantages of the synergies professionals working together can create. The Council of Federations (2012) identified the need for all health-care professionals to work to their full scope of professional capacity, while the National Interprofessional Competency Framework (CIHC, 2010) says practitioners must understand not only their roles but also those of other practitioners on the team. It also says practitioners must be able to articulate their roles, knowledge and skills and use effective listening skills with other team members. The British Columbia Competency Framework for Interprofessional Collaboration (2008) states all practitioners must respect each other's professional culture and values. The message is that old-fashioned professional "turf" wars have no place in interprofessional care; rather, overlapping scopes and roles are embraced as an opportunity to collaborate and advance the role of exemplary care for patients/clients and their support network.

Shared Decision Making

Shared decision making gives all team members, including patients/clients, the opportunity to contribute their knowledge and expertise, to arrive collaboratively at an optimal goal (Orchard et al., 2009). It requires respectful and trusting relationships among providers and between them and the patient/client. For shared decision making to work, everyone must recognize and respect each others' knowledge and expertise, regardless of occupation and formal position (Grinspun, 2007). Everyone must also accept that each team member has both the right and ultimate responsibility to share knowledge to contribute toward a patient's/client's plan of care (Orchard et al., 2009). Shared decision making also means, importantly, that each team member must be willing to accept responsibility for decisions.

Shared decision making is not appropriate in every situation. For example, in an emergency such as a code blue, a patient's/client's life depends on the person running the code, making decisions and directing the team quickly and decisively. However, where decisions are shared, all team members can participate in a review of their responses after an emergency is over. There are other situations in health care where some team members do not get to offer input. In those situations, transparency around decision making is very important. Team members can continue to feel valued and respected if they know in advance which decisions are shared and which are not. Collaboration is a continuum, from least collaborative, where team members are told what is happening without any opportunity for input, to most collaborative, in which teams can expect to co-create outcomes with maximum opportunity for input (D'Amour, Goulet, Labadie, Martín-Rodriguez & Pineault, 2008).

Shared decision making does not mean everything must be decided unanimously. Decisions may be made by one or more people, or by team consensus. What is important is that each member of the team, including the patient/client, has an appropriate opportunity to influence the plan of care (Edwards, Davies & Edwards, 2009). Quaschning, Korner, and Wirtz, (2013) suggest shared decision making is important to optimize patients'/clients' participation and enhance a high quality of care.

Effective Group Function

A health-care system that supports effective teamwork can improve the quality of patients/clients care, enhance patients/clients safety, and reduce workload issues that cause burnout among professionals (Oandasan & Reeves, 2005). We have adapted our definition of effective team functioning in interprofessional care from Ivy Oandasan and Scott Reeves (2005), who describe it as the successful interaction or relationship of an interprofessional health-care team who work interdependently to provide care for patients/clients. In the National Interprofessional Competency Framework (Canadian Interprofessional Health Collaborative (CIHC), (2010)), effective team functioning is one of the six competency domains, and its key competency is that "learners/practitioners understand the principles of team dynamics and group processes to enable effective interprofessional team collaboration" (p.11). The Conceptual Model for Developing and Sustaining Interprofessional Health Care uses the word *group* in the domains, rather than team, to draw attention to the importance of group process development and maintenance (see Figure 2).

To function effectively, interprofessional team members are expected to work collaboratively to formulate, implement and evaluate care and assess, practice and reflect on whether the group processes they have used were effective (CIHC, 2010, Oandasan et al., 2006).

In 2011, Adamson examined the empathy between members of interprofessional teams within a hospital environment. Findings from the study found interprofessional empathy was an important part of the relationships among interprofessional team members. Six themes emerged as critical to the development of effective and highly empathetic teams:

1. Engaging in conscious interactions;
2. Using dialogic communication;
3. Understanding each other's roles;
4. Appreciating personality differences;
5. Taking perspective; and
6. Nurturing the collective spirit.

The evidence also found accessibility, team building, overlapping scopes of practice, teachable moments, perception of workload, empathetic leadership, non-hierarchical work relationships and job security provided the necessary organizational supports to promote and sustain positive interprofessional relationships (Adamson, 2011).

Competent Communication

Competent communication – openness, honesty, respect for each other's opinions and effective communication skills – is part of all domains of interprofessional practice (Humphreys & Pountney, 2006). Team communication goals are achieved by sharing and responding to information in a timely manner, actively listening to other points of view, communicating clearly and succinctly, (Shaw, de Lusignan, & Rowlands, 2005) and using established processes and tools for sharing information (Mulkins, Eng, & Verhoef, 2005). Effective communication enhances interprofessional relationships and therefore patients/clients care and other work-related activities. Competent communication helps develop and sustain leadership and actively engages members of the team while demonstrating respect and professionalism (RNAO, 2007c).

Recommendations and Discussion of Evidence

External/System Recommendations

The following recommendations reflect physical/structural, cognitive, psychological, social, cultural, professional and occupational components of developing and sustaining interprofessional health care in the workplace that must be addressed at the external/system level to ensure best practice. The external systems factors contained in the recommendations include:

Physical/Structural Components:

- Health-care delivery models;
- Funding; and
- Legislation/Policy.

Cognitive/Psychological/Social/Cultural Components:

- Consumer expectations;
- Changing roles of family; and
- Diversity of population and health-care providers.

Professional/Occupational Components:

- Policies and regulations at the provincial/territorial, national and international levels that influence how organizations and individuals behave with respect to managing and mitigating conflict in the workplace; and
- Competencies and standards of practice that influence the behaviour/culture of team members.

1.0 SYSTEM-WIDE PARTNERSHIPS

RECOMMENDATION 1.1:

Leaders of key agencies (governments, academic institutions, regulatory bodies, professional associations, and practice-based organizations) collaborate to make interprofessional care a collective strategic priority.

RECOMMENDATION 1.2:

Agencies in the health-care system strategically align interprofessional care with their other initiatives for healthy work environments.

RECOMMENDATION 1.3:

Interprofessional care partnerships across organizations agree on an evidence-based approach to planning, implementation, and evaluation for joint activities.

Discussion of Evidence:

There are C, D and D1 types of evidence to support these recommendations.

The Registered Nurses' Association of Ontario Best Practice Guideline, "Managing and Mitigating Conflict in Health-care Teams" (2012) highlighted the importance of system-level collaboration, and coordinated legislative and regulatory reforms, to bring about overall change to the health-care system. That high-level collaboration is needed to develop, implement and evaluate interprofessional care because so many stakeholders and contexts will be affected by it. Some authors have spoken of the need for high-level collaboration across organizations, so they can work to set priorities, especially in terms of health innovation to strengthen health systems (Government of Ontario, 2010; McPherson, 2008). The final report tabled by the Government of Ontario's Interprofessional Care Strategic Implementation Committee (2010) stated:

"In Ontario, although interprofessional care (IPC) has gained a foothold at the grassroots level, a concerted, system-wide approach to its implementation is needed. Implementing interprofessional care, and establishing a firm base for interprofessional education (IPE), requires the commitment of a range of stakeholders, including regulatory bodies, health-care professional organizations, academic institutions, hospitals, insurers, community and support agencies, organized labour, researchers, patient consumer groups, government, crown agencies, health caregivers, educators, administrators, patients, and families"(p. 5)

Interprofessional care is an innovative way to strengthen health systems. Over the past decade, discussion in the literature has focused on the notion that such complex change requires deliberate collaborative efforts across organizational boundaries (Edwards & Di Ruggiero, 2011; McPherson, 2008, 2012; McPherson & McGibbon, 2010; McPherson, Kothari, & Sibbald, 2010; National Collaborating Centre for Determinants of Health, 2012). Such partnerships would work much like front-line collaboration by members of interprofessional teams, and allow for aligning interprofessional care with other strategic priorities.

Some government policies support interprofessional models but others get in the way, including limited human resources planning, limited research funding, regulations and laws that create silos and payment methods that discourage collaboration (RNAO, 2012a). There is a critical need for decision makers to break down those barriers and develop the infrastructure to support interprofessional care. Promoting better understanding of the nature and benefits of interprofessional care would also help break down system barriers, and there is increasing pressure to link best practices in interprofessional care to accountability requirements (Canadian Health Services Research Foundation, 2006).

2.0 POWER AND HIERARCHY IN SYSTEMS

RECOMMENDATION 2.1:

Show willingness to acknowledge and share power across organizational boundaries by:

a. Talking about power: be open to constructive and courageous conversations that examine inequities, privilege and power differentials;

b. Building a collaborative inter-organizational environment by recognizing and understanding your power and its influence on others around you;

c. Creating balanced power relationships through sharing leadership, decision making, authority and responsibility;

d. Including diverse voices in collaborative decision making;

e. Sharing knowledge with each other, not withholding or hoarding information; and

f. Creating safe collaborative spaces where everyone feels welcome.

Discussion of Evidence:

There are B, C, D and D1 types of evidence to support this recommendation.

The notion of organizational power and hierarchy across the health-care system is well covered in the literature (D'Amour, Ferrada-Videla, San Martin, & Beaulieu, 2005a; D'Amour et al., 2005b; D'Amour & Oandasan, 2005; Islam & Zyphur, 2005; Hudson, 2002). Relationships among professions (Kenaszchuk, Wilkins, Reeves, Zwarenstein, & Russell, 2010), and across programs, organizations and sectors are contextual and embedded in socio-political-historical contexts, both past and present (Freyer et al., 2006; Hudson, 2006; McDonald, Davies, & Harris, 2009).

Orchard, Curran and Kabene (2005) addressed the importance of power sharing in their article on interdisciplinary collaborative professional practice. The authors claim that power imbalances between health professionals lead to a lack of sharing in decision making around patients/clients care. They also state that power imbalances within the health-care system and between the health-care system and patients/clients frequently lead to exclusion of patients/clients from the planning for, implementation of, and evaluation of their health care. They conclude that this leads to frustration amongst all parties who are not part of the decision making process (Jones, 2010).

Nevertheless, for everyone to be part of the decision making process, it is important that neither the health-care team members nor the patients/clients feel treated as inferior, by any member of the team. Working in an integrated way and allowing greater decision making power within a team is reported to build confidence, while also allowing for flexibility to alter the plan of care to meet the patient's/client's change in condition (Jones, 2010).

A recent qualitative case study (McDonald, Jayasuriya, & Harris, 2012) examining the influence of power dynamics and trust on inter-organizational multidisciplinary collaboration highlighted three key themes to power dynamics among health professionals: their use of power to protect their autonomy; power dynamics between private- and public-sector providers; and reducing dependency on other health professionals to maintain their power. These authors found that despite government policies supporting more shared decision making, there is little evidence

it is happening. The study concluded having primary and community-based health services delivered by different organizations adds another layer of complexity to interprofessional relationships (McDonald et al., 2012).

The Registered Nurses' Association of Ontario Best Practice Guideline, "Preventing and Managing Violence in the Workplace" (2009) recommended governments be role models for equity by eliminating hierarchies in the health ministry that put nurses in subservient roles. Collaboration across organizational boundaries remains challenging at the practitioner level due to issues of power and hierarchy. From a system wide perspective, the deliberate consideration of power and hierarchy by senior decision makers as they work across organizational lines is imperative (McPherson, 2008). This further supports healthy collaborative inter-organizational relationships as a base to create, align, and monitor evidence-informed policy mechanisms that support the interprofessional care endeavour.

To create a welcoming inclusive climate, the physical design of work stations needs to be considered. A qualitative study of interprofessional teams within three rural hospitals emphasized the importance of the work station design on collaboration and interprofessional care. The evidence showed the general physical environment to have a major influence on effective collaborative practiceĠThe poor designs that featured insufficient space and profession specific space were noted to contribute to communication barriers, frequent interruptions, and lack of privacy, while shared spaces where the health-care team sat together facilitated both social and professional discourse. Shared space can imply collective responsibility for the patients/clients outcomes (Gum, Prideaux, Sweet & Greenhill, 2012).

3.0 ACADEMIC ORGANIZATIONS

RECOMMENDATION 3.1:

Academic organizations build interprofessional care knowledge and competencies into their curricula.

RECOMMENDATION 3.2:

Academic organizations prepare students to work in interprofessional teams by:

a. Instilling values, skills and professional role socialization that will support interprofessional care;

b. Developing, implementing and evaluating education models that foster interprofessional values and skills; and

c. Enhancing educational and clinical opportunities for health professions to study and learn together.

Discussion of Evidence:

There are B, C, D and D1 types of evidence to support these recommendations.

There is a great deal of evidence that interprofessional education can effectively reduce barriers to collaborative practice and can promote competent communication (Abu-Rish et al., 2012; Cashman, Reidy, Cody, & Lemay, 2004; Curtis, 2008; Pinnock et al., 2009). Academic organizations play a key role preparing the health workforce for interprofessional care. There is sufficient evidence to support the proposition that interprofessional collaborative learning, helps practitioners and agencies work better together (Almas & Barr, 2008; Anderson, Manek, & Davidson, 2006; Hammick, Freeth, Koppel, Reeves, & Barr, 2007; Hayashi, et al., 2012). However, not all health professions accept that interprofessionalism is a critical component of undergraduate education. Supportive academic leaders will have to work with accreditation and regulatory bodies, professional associations, unions, governments and health-care organizations to bring about curriculum reform to support interprofessional care.

There have been significant global, national, and provincial efforts to advance education in interprofessional care in both academic and practice-based settings (e.g., Canadian Interprofessional Health Collaborative, 2010; McMaster University, 2012; University Health Network, 2012; University of British Columbia, 2012). Results from a quantitative pre-test post-test study at Gunma University Graduate School of Health Sciences in Japan suggest that the stage of study – first year university students compared to third year university students – as well as the style of educational delivery, may influence the students' attitude towards interprofessional education and care. The results demonstrated significant changes in attitudes; that is, the first-year students who participated in interprofessional education via the lecture style were negatively inclined, whereas the third-year students learning practice-style interprofessional education were positively inclined. These findings suggest that the program stage as well as the style of educational delivery may influence students' interprofessional attitudes (Hayashi et al, 2012).

Anderson and colleagues (2006) evaluated a workshop model for interprofessional education in acute care for students from eight professions. The model was accepted in the hospital, showing that hospital culture was becoming committed to education models that would bring together a wide range of students for interprofessional learning. The authors suggested the workshops they designed offered a practical, replicable model that can be sustained. The model helped students analyze their future interprofessional working responsibilities.

Another study examined a common curriculum for undergraduate health and social care education implemented in Norway in 1995, (Almas & Barr, 2008). Government policy had recommended a common core curriculum for undergraduate health and social work programs in all universities and colleges in Norway, with the belief collaboration in health-care education would improve collaborative practice and deliver more effective and efficient health care. All educational institutions adopted the common core, but some taught it separately to each professional group, while others offered it jointly for all or some of their relevant programs. The study found students with a common curriculum valued interprofessionalism more highly than those without. The study also demonstrated that students taught the common core in joint programs valued interprofessionalism more highly than those where it was taught separately. The authors suggested that those students taught together between professions valued their preparation for collaborative practice more.

Educational literature shows there are benefits for educators who plan and develop team-taught coursework collaboratively and monitor its impact. Several authors (Crow & Smith, 2003; Nevin, Thousand, & Villa, 2009) report on joint-teaching modules that suggest co- or team teaching has the potential to be a model for shared learning and collaboration. Co-teaching requires shared planning and reflection between the educators. Feedback from students

and tutors on the co-teaching process were positive and the authors stated co-teaching from different faculties enhances student learning and improves the effectiveness of teaching.

Educators at McMaster University and the University of Ottawa developed the Team Observed Structured Clinical Encounter (TOSCE) based on the National Interprofessional Competency Framework (CIHC 2010). TOSCE uses structured simulated team encounters to promote assessment and learning of interprofessional collaboration skills. The learners use the simulation to practice and gain skills and receive feedback on their performance. Validation work shows TOSCE is useful as a formative evaluation tool, and further research is focused on exploring its potential use as a summative tool (Marshall et al., 2008; Solomon et al., 2011).

Education that embeds essential attributes of interprofessional care is needed to advance nursing practice and interprofessional care. The partnerships between higher education institutions and health-care organizations promote interprofessional care and support a workforce that is educated to manage continuous change in service delivery (Howarth, Holland, & Grant, 2006).

4.0 RESEARCH RECOMMENDATIONS

RECOMMENDATION 4.1:

Researchers partner with decision makers to conduct research examining the impact of interprofessional care teams on both patient/client outcomes and on health-care teams.

RECOMMENDATION 4.2:

Health research granting agencies develop and maintain a focus on Interprofessional research priority areas.

RECOMMENDATION 4.3:

Researchers use knowledge translation strategies to encourage action on research findings by funders, government, professional associations and regulatory bodies, as well as by unions, health-care organizations, educational institutions, study participants and other stakeholders.

Discussion of Evidence:

There are B, C, D and D1 types of evidence to support these recommendations

Pursuing interprofessional care research is imperative to support evidence-based interprofessional practice. Clear recommendations for interprofessional care research priorities have been outlined in evidence-based documents, such as peer-reviewed literature and Registered Nurses' Association of Ontario healthy work environment best practice guidelines, for some time (CHSRF, 2007; CIHC, 2010; Cohen & Bailey, 1997; Curran & Orchard, 2007; Oandasan & Reeves, 2005;

RNAO, 2006). Because the body of knowledge on interprofessional care has been developed only over the past 15 years or so, more time is needed to examine its complexities, including developing a deeper understanding of it and of the frameworks we think will positively affect health outcomes.

Oandasan and colleagues (2004) outlined key research priorities for interdisciplinary education for collaborative patients/clients-centered practice in a report. The report states the highest priority be given to research that demonstrates the interdependency between interdisciplinary education and collaborative practice initiatives. The report also recommends major research granting agencies be approached to fund interdisciplinary education and practice initiatives in the future.

5.0 PROFESSIONAL ASSOCIATIONS, REGULATORY BODIES AND UNIONS

RECOMMENDATION 5.1:

Professional associations, regulatory bodies and unions can support interprofessional care by:

a. Including it in legislation and policies for their members;

b. Working together to develop joint competencies and standards for interprofessional care;

c. Working together to add interprofessional care principles to approval standards for education programs; and

d. Including interprofessional care as a competency for licensure.

Discussion of Evidence:

There are B, C, D and D1 types of evidence to support this recommendation.

The Canadian Interprofessional Health Collaborative (CIHC) put forth recommendations (including interprofessional care as a competency for licensure) specifically for organizations such as professional associations, regulatory bodies, and unions in their National Framework document (2010).

Reeves and colleagues, (2010) conducted a systematic literature review on interprofessional education and its effects on interprofessional practice and health-care outcomes. They found many provincial health professions' regulatory frameworks explicitly discuss interprofessional collaboration or practices. Regulators such as registrars and college boards need to focus on what elements must be demonstrated to show competence in interprofessional collaboration as part of licensing.

Whether interprofessional frameworks become part of quality assurance, continuing competence, or continuing professional development, regulators will find a competency framework useful in determining how to guide members to integrate interprofessional collaboration into their education and practice and how to work together as a group to address scope-of-practice issues (Reeves et al., 2010).

6.0 ACCREDITATION ORGANIZATIONS

RECOMMENDATION 6.1:

Accrediting bodies for organizations and education programs develop standards and performance indicators for interprofessional care.

Discussion of Evidence:

There are A1, B, C, D and D1 types of evidence to support this recommendation.

Several key sources confirm accreditation standards can directly influence what is taught in health education programs. In their systematic review, Reeves and colleagues (2010) made several observations on interprofessional education and its effects on interprofessional care and health-care outcomes. They suggested:

- Interprofessional education will need to be strengthened in health professional education accreditation programs.
- Accreditors will need to develop measures for interprofessional education in learners programs and practice.
- Accreditation Canada develops standards and measures for interprofessional care in its accreditation process.
- Organizations use a competency framework to guide them in developing interprofessional care (Reeves et al., 2010).

The Accreditation of Interprofessional Health Education (AIPHE) project, funded by Health Canada, was a national collaborative of eight organizations that accredit pre-licensure education for six Canadian health professions: physical therapy, occupational therapy, pharmacy, social work, nursing and medicine. One of the project's goals was to ensure the integration of interprofessional education standards into accreditation for the six participating professions to help create collaborative patient/client health and social care (AIPHE, 2011). In its report, the collaborative described the rationale for emphasizing interprofessional education, articulated guiding principles, and provided possible standards and examples of evidence, as well as a resource list for education programs (AIPHE, 2011).

The Registered Nurses' Association of Ontario Best Practice Guideline on Collaborative Practice among Nursing Teams (2006) specifically mentions accreditation bodies in its system-level recommendations on teamwork. (See recommendation 5.1. in that document).

7.0 GOVERNMENT

RECOMMENDATION 7.1:

Governments can support the culture required for interprofessional care by:

a. Making interprofessional care a priority, and evaluating its impact; and

b. Providing health-care organizations with the fiscal resources required to develop, implement and evaluate interprofessional care.

Discussion of Evidence:

There are C, D and D1 types of evidence to support this recommendation.

Several Registered Nurses' Association of Ontario Best Practice Guideline, focus on the importance of governments supporting guidelines (2006, 2007, 2009, 2012). Here again, government commitment is critical to interprofessional success. Unless governments set specific targets for interprofessional care, and assign funding for it, it probably will not happen (D'Amour & Oandasan, 2005). Successful interprofessional care will also need governments to work with other sectors in the system, such as academic institutions and health profession regulatory bodies to break down silos in professional education and practice, promote full scope of practice, and encourage effective use of all health-care providers (Interprofessional Care Strategic Implementation Committee Final Report, 2010).

Health policy from all governments (federal, provincial and territorial) affects practice, settings and ultimately patient/client and system outcomes. Government collaboration with other sectors is important for developing priorities and strategies and shaping public policy. Many government documents have made the case for collaboration in policy and planning (Currie, 2011).

Organizational Recommendations

The following recommendations are organized using the Healthy Work Environments framework, and reflect the physical/structural, cognitive, psychological, social, cultural, professional and occupational components of developing and sustaining interprofessional health care in the workplace that must be addressed at the Organizational level to ensure best practice. Organizational factors identified in the various components include:

Physical/Structural Components:

- Physical characteristics and environment of the organization (e.g. sleep rooms for all staff);
- Organizational structures and processes created to respond to the physical demands of work (e.g. decision making process regarding overtime and scheduling);
- Leadership support;
- Staffing practices; and
- Occupational health and safety policies.

Cognitive/Psychological/Social/Cultural Components:

- Organizational climate, culture and values;
- Cultural norms, especially those that foster support, trust, respect and safety;
- Communication practices;
- Labour/management relations; and
- Culture of continuous learning and support.

Professional/Occupational Components:

- Characteristics of the nature and role of nursing within the organization, including organizational policies that influence scope of practice, level of autonomy and control over practice; and
- Nurse intra- and interprofessional relationships within the organization.

8.0 POWER AND HIERARCHY IN ORGANIZATIONS

RECOMMENDATION 8.1:

Organizations must acknowledge the impact of power and hierarchy by:

Identifying imbalances of power and making changes to equalize power and build mutually supportive, safe interprofessional workplaces.

Discussion of Evidence:

There are A1, C, and D types of evidence to support this recommendation.

There are longstanding, often implicit, inequalities among professions, and between professionals and patient/client and their families. Organizations need to confront the problems caused by power and hierarchy by openly acknowledging it and discussing its impact on care and those who give it and receive it.

Healthy organizations empower and validate the contributions of all individuals and promote safe, equitable environments by fostering respect among all people. They also create opportunities for equitable communication, group interaction, and provision of care and shared decision making. Collaboration was seen as a partnership, characterized by the simultaneous empowerment of each participant whose respective power is recognized by all (D'Amour et al., 2005). Furthermore, such power is based on knowledge and expertise rather than functions or titles (Henneman, 1995). For example, if an environmental custodian, over the course of doing his/her duty, comes into contact with a patient/client, and through "chatting" with the patient/client receives information that they believe may be pertinent to that patient's/client's treatment, the custodian should in no way feel intimidated or afraid to share that knowledge (information) with the patient's/client's nurse or care-giving team. If the custodian works in an environment that is hierarchal and that uses top down approaches to interprofessional relationships and perceives that the treatment team may scorn him/her or accuse him/her of acting outside of their given hospital role, then s/he may feel that that they have neither the ability nor the opportunity to influence the course of events for the patient/client. As a result, if the custodian chooses not to share the knowledge with the team due to the above circumstances, then an organization is fostering unequal power relationships.

RECOMMENDATION 8.2:

Organizations need to engage and develop leaders at every level, including among their point-of-care health professionals, for successful interprofessional care. Strategies for doing that include:

a. Developing interprofessional care champions/role models in different professions and programs; and

b. Offering leadership courses to introduce the concepts and competencies of interprofessional care and its management.

Discussion of Evidence:

There are A1, C, and D types of evidence to support this recommendation.

Leadership can be exercised by different members of the team, at different levels and involves managing boundaries between: formal and informal roles, clinical roles, different professions, personal life experiences, professional experiences and the team environment (Chreim, Langley, Comeau-Vallee, Hug & Reay, 2013). Leaders and groups can learn to work more equitably through programs to develop strategies for addressing issues such as "turf" protection, bullying and disrespectful communication (Aksoy, Gurlek, Cetinkaya, Oznur, Yazici & Ozgur et al. 2004; Caplan, Williams, Daly, & Abraham, 2004; Naylor, Griffiths, & Fernandez, 2004; Sennour, Counsell, Jones, & Weiner, 2009).

In a Canadian study researching how leadership practices were exercised across interprofessional teams, Langly et al. (2013) identified that boundary work is fundamental to the practice of leadership in interprofessional teams. The authors found health-care leadership requires the management of fragile tension between reinforcing and eliminating professional boundaries, boundaries which are necessary but can also be problematic for teams Langly et al. (2013).

Leaders promote open dialogue and other measures for creating a more equitable workplace that include integrating training in cultural competencies and ethics to strengthen reflective, effective and respectful health-care relationships. Organizational leaders must ensure the allotment of resources to programs, teams and professions is transparent and balanced. This transparency in the allotment of resources can also contribute to a decreased sense of hierarchy (RNAO, 2007a, 2009, 2012).

Leadership can facilitate a team to realise high levels of collaboration, trust and respect. This creates an environment in which collective learning and increased responsibility thrive (Greenfield, 2007). These components together enable front-line staff or point-of-care leaders to take ownership of their service and to integrate the organising and delivery of services, and in doing so, improve health-care practice (Greenfield, 2007). Leaders at the point of care and throughout the organization can accelerate adoption of a culture that supports interprofessional care and practices by acting as role models and facilitators (Donahue, 2013). It is imperative that interprofessional health-care champions are developed throughout health-care organizations. Conclusions in the literature suggest that having individual champions who are role models and demonstrate an understanding of the concepts, competency and basic skills in the areas of interprofessional care result in a positive experience for team members and patients/clients (Curtis, 2008).

Support for ongoing interprofessional development is important to facilitate success of an interprofessional approach to care. To date, the types of leadership skills emphasized in leadership programs for point-of-care professionals include effective communication, project implementation, change management, interprofessional collaboration, research analysis and improving processes of care (Doran et al., 2012). Leadership development programs also focus on mentorship to build confidence and empower others (Doran et al., 2012). Team training and having strong team leaders or champions are critical to successful implementation and maintenance of the interprofessional approach to health care (Makowsky et al, 2009).

9.0 OPERATIONAL SUPPORTS

RECOMMENDATION 9.1:

Organizations promote interprofessional care by developing a culture that expects collaboration and creates the operational supports it will need to succeed by:

a. Establishing human resources plans that allow dedicated time and coverage for staff to participate in interprofessional activities e.g. team development and effective communication;

b. Designing buildings, spaces, programs and care pathways to accommodate and encourage interprofessional care; and

c. Considering shared spaces for patients/clients and team members to enhance opportunities for communication and innovation.

Discussion of Evidence:

There are A1, C, D and D1 types of evidence to support this recommendation.

Organizations that invest human, educational, and leadership resources toward interprofessional care may see direct benefits such as improved quality of care and safety. A systematic review of 14 studies exploring the role of teamwork and communication in emergency departments found moderate evidence that teamwork could improve access to care (Kilner & Sheppard, 2010). In addition, the study also demonstrated that staff were highly satisfied with their teamwork training and had positive attitudes toward teamwork and communication. When emergency staff prioritized the importance of teamwork and communication, they identified quality of care and safety as key concepts (Kilner & Sheppard, 2010). Furthermore, the study stated it was important to reduce team turnover to optimize growth of interdisciplinary teams. That, in turn, will increase adaptability to our rapidly changing health-care system (Kilner & Sheppard, 2010).

A semi-structured interview of 16 practitioners in an integrative care clinic was analyzed by coding for categories and themes (Mulkins et al., 2005). From the practitioners' perspectives, four central categories emerged as critical elements for effective integrative care teams:

1. Effective communication tools;
2. Personal attributes;
3. Satisfactory compensation; and
4. A supportive organizational structure.

The participants interviewed said the exemplary healing and working environments – achieved by strategies including weekly team meetings, common patient/client charts, standardized protocols, care and compassion toward teammates – fostered a nurturing atmosphere and were linked to improved patient/client outcomes (Mulkins et al., 2005).

Having the organizational commitment to design and support shared spaces was also noted to be a significant influence in an evaluation of interprofessional education that integrated social workers, community nurses and community officers (Curtis, 2008). The evaluation suggested that greater mutual understanding arose from co-location. As the team matured, members felt there had been an increased understanding of each other's roles and one noted outcome was that the delivery of care was enhanced. There was no evidence that any team members saw themselves as having higher status or importance than others; all were seen as having a vital part to play in sustaining team effectiveness and securing better outcomes. There was mutual respect among team members for each other's contributions. This study found three clear benefits of learning together and working together:

1. **Speed:** Undertaking tasks more efficiently was a result of an integrated approach.
2. **Flexibility:** the willingness to work differently and bend traditional professional boundaries to solve problems.
3. **Creativity:** a distinct aspect of teamwork that fosters opportunities to think about problems in a fresh way unencumbered by a legacy of 'this is the way we do things around here'. (Curtis, 2008).

10.0 COMPETENT COMMUNICATION

RECOMMENDATION 10.1:

Organizations can support interprofessional care through enhanced communication by:

a. Implementing effective communication processes and tools to support collaboration and communication in teams, professions, with patients/clients and across programs and organizations;

b. Standardizing documentation and encourage information sharing;

c. Adopting strategies to tackle issues such as "turf" protection and disrespectful communication; and

d. Creating a culture that promotes regular formal and informal communication among team members with team rounds and care conferences.

Discussion of Evidence:

There are B, C and D types of evidence to support this recommendation.

As patient/client care becomes increasingly complex, effective communication is essential for teams to function effectively. The evidence suggests having organizational factors such as interdisciplinary guidelines in place and clear role definition will support effective communication (Gulmans, Vollenbroek-Hutten, Van Gemert-Pijnen, & Van Harten, 2009). Similar findings were discussed in a study looking at teamwork and communication in the emergency department. These findings suggested that teamwork and communication play a role in four main areas in the emergency department:

improving patient/client satisfaction; improving staff satisfaction; reducing clinical errors and improving patient/client safety; and, facilitating access to care and admissions (Kilner & Sheppard 2010). This study recommended that organizations establish and support effective communication through the development of interprofessional teams, introduction of new team members, and specific training focused on teamwork for all members. Other findings in the study linked improved quality and safety of care to prioritizing the importance of teamwork and communication (Kilner & Sheppard 2010).

Team communication can also be enhanced through the provision of opportunities for formal (e.g. meetings) and informal gathering to gain an understanding of each other's roles and priorities (King & Ross, 2004). Team meetings benefit from a structured, active and integrative approach that includes procedures for negotiating, decision making and conflict management (Thylefors, 2012). Having effective communication processes and tools in place (Mulkins et al., 2005). Communication, motivation, commitment and enthusiasm contribute to team cohesion and a culture that supports effective interprofessional care (RNAO, 2006). Communication processes and tools include: integrated care pathways, weekly team meetings, common patient/client charts, standardized protocols, consistent scheduling of teams on the same shifts and standardized documentation (Mulkins et al., 2005).

Standardized documentation systems make interprofessional communication easier, encourage transparent decision making and promote evidence-based planning and care delivery. The evidence identifies effective documentation as having a positive effect on communication with patients/clients and the rest of the care team, leading to positive outcomes and an increase in provider satisfaction (Mulkins et al., 2005). Shared documentation in the form of care plans, evidence informed-practice tools and standardized charts provide easy access to patient/client information, for clinical decisions and planning by the interprofessional team (Prades & Borras, 2011).

Masso and Owen (2009) found that the use of common clinical assessment tools and development of protocols improved collaboration between providers, improved coordination and integration of care for patients/clients, and reduced duplication of services.

Interprofessional care plans have been identified as effective resources for improving teamwork, increasing the efficiency of care processes within an organization and decreasing risk of burnout for team members in hospital settings (Deneckers, Euwema, Lodewijckx, Panella, Mutsvari Sermeus et al, 2013). Teams can refine their expertise and improve outcomes by tailoring care plans to the specific needs of the individual patient/client. This lays the foundation for the development and fostering of a high performing team (Brennan, Butow, Marven, Spillane, & Boyle, 2011; Deneckers et al. 2013;Murchie, Campbell, Ritchie, & Thain, 2005).

Individual/Team Recommendations

The following recommendations are organized using the Healthy Work Environments framework and reflect physical/structural, cognitive, psychological, social, cultural and professional and occupational components of developing and sustaining interprofessional health care in the workplace that must be addressed at the individual level to ensure best practice. The individual factors that are identified in the various components include:

Physical/Structural Components

- Work demands;
- Work design;
- Work characteristics; and
- Workforce composition.

The Cognitive/Psychological/Social/Cultural Components

- Cognitive, psychological and social capabilities, and effort;
- Cultural competency;
- Gender;
- Working relationships – communication patterns, decision making, conflict resolution and member mentoring;
- Role clarity;
- Role strain;
- Emotional demands;
- Job security;
- Clinical complexity; and
- Clinical knowledge, coping skills communication skills.

Professional/Occupational Components

- Experience, skills and knowledge;
- Personal attributes;
- Communication skills; and
- Motivational factors.

11.0 SUPPORTING INTERPROFESSIONAL TEAM AND CARE DELIVERY

RECOMMENDATION 11.1:

All health-care professionals, as well as volunteers and students, demonstrate their commitment to the principles of interprofessional care by:

a. Practising and collaborating with colleagues, patients/clients and families in a way that fosters respect, trust and understanding;

b. Understanding their roles and expertise, reflecting on their practice, being confident in their own abilities, and expertise, knowing the standards and boundaries of their practice and recognizing when it's time to turn to other team members; and

c. Developing communication and conflict-management skills.

Discussion of Evidence:

There are C and D types of evidence to support this recommendation.

Practising and collaborating effectively on interprofessional teams requires individuals to demonstrate trust, respect, and knowledge of each team member's role. These are foundational competencies for interprofessional care and are highly valued by health-care providers (Marshall et al., 2008; St. Joseph's Health Centre, 2009). Along with these characteristics, it is important for team members, both as professionals and as integral parts of the team to self-assess (see **Appendix F**) and reflect on their practice (King, 2013).

It is important for all team members to participate in creating the systems and processes that support an interprofessional approach to care, and exchanging and applying knowledge is a key process of developing team care (shown in the conceptual model for developing and sustaining interprofessional health care, Figure 2). All health-care professionals should facilitate knowledge understanding on interprofessional teams. In a quantitative study, nurse practitioners in particular were identified as playing a crucial role in facilitating mutual understanding among members of newly formed teams (Quinlan & Robertson, 2013). Registered nurses were also identified as critical members of interprofessional teams, often holding great communication power and demonstrating effective knowledge exchange (Quinlan & Robertson, 2013).

Interprofessional collaboration depends on team members knowing their own role and scope of practice and having the confidence to provide knowledgeable input into care plans.

Following training and practical involvement in interprofessional program activities, physicians, nurses and other health professionals confirmed they felt more competent in their own roles, more knowledgeable about the role of others in the continuum of care of patients/clients, and more confident and motivated in performing their tasks and communicating with other interprofessional members (Quinlan and Robertson, 2013). Team members also demonstrate their commitment to interprofessional care by recognizing and respecting each other's roles and expertise (Oandasan & Reeves, 2005).

The effectiveness of any team depends on the ability of its members to solve problems and be accountable for their work, to overcome barriers (see **Appendix D**) and resolve conflict. Conflict in health-care environments has many sources. For example, the interdependent relationships of team members (including patients/clients and families) are

sometimes complicated by opposing interests, values, beliefs or interpersonal conflict (De Dreu & Van de Vliert, 1997). Failing to address interpersonal conflict can lead to bad relationships among co-workers, undermine safety and outcomes and disrupt the organization. Disagreements often result in anxiety, frustration and jealousy, and interpersonal conflict can leave people feeling angry, betrayed and frustrated (Bishop, 2004).

Having some understanding of conflict and how to manage it is important for the success of teams (RNAO, 2006) Research has shown relationship conflicts and task conflict[G] have different consequences. Relationship conflict produces negative emotional reactions (Jehn, 1995); when it's very high, individuals suffer frustration, tension and fear of being rejected by others on the team (Murnighan & Conlon, 1991). It also causes dysfunction in team work, diminishes commitment to team decisions and decreases organizational commitment (Jehn, Northcraft, & Neale, 1999). It raises communication problems on the team (Baron, 1991), job dissatisfaction (Jehn, 1995; Jehn, Chadwick, & Thatcher, 1997), and increases stress levels (Raymond, Simon, Steven, & James, 2000). However, not all conflict has negative outcomes; it can sometimes have benefits (De Dreu & Van de Vliert, 1997; Jehn, 1995; Jehn & Mannix, 2001).

Task conflict has different consequences: high levels of intense, prolonged conflict hurt individual and team performance, but moderate levels of task-related conflict can mitigate biased and defective group decision making (Brodbeck, Kerschreiter, Mojzisch, Frey, & Schulz-Hardt, 2002). The latter outcome is more likely where there is not also relationship conflict (De Dreu & Weingart, 2003a; Simons & Peterson, 2000), and when members discuss problems and debate their opposing views, beliefs and opinions in open-minded ways (De Dreu & Weingart, 2003; Tjosvold, 1998). Some studies show that on certain occasions, conflict may increase creativity and job quality in a group (Amason, 1996), and improve organizational effectiveness and development (Eisenhardt & Schoonhoven, 1990). Resolving conflict is critical to shared decision making and creating a supportive environment for interprofessional practice (SJHC, 2009).

12.0 POWER AND HIERARCHY IN TEAMS

RECOMMENDATION 12.1:

Team members demonstrate their willingness to share power by:

a. Building a collaborative environment through recognizing and understanding power and its influence on everyone involved;

b. Creating balanced power relationships through shared leadership, decision making; authority, and responsibility;

c. Including diverse voices in decision making;

d. Sharing knowledge openly; and

e. Working collaboratively with patients/clients and their families to plan and deliver care.

Discussion of Evidence:

There are A1, B, C and D types of evidence to support this recommendation.

The nature of health care gives rise to various issues of disagreement among team members, which is further exacerbated by the complex issue of power distribution (Janss, Rispens, Segers & Jehn, 2012). In health care, there is power

associated with positions and titles (hierarchies), and power based on knowledge and expertise (Henneman, 1995). In a systematic review conducted by Kendra and Seenandan (2012), gender inequalities were also identified as a contributor to power imbalances within the Canadian health-care system. Resulting power struggles were further correlated with a lack of interprofessional respect among nursing, medicine and allied health-care professionals (Kendra & Seenandan, 2012).

Janss and colleagues (2012) found that medical team members coordinate, cooperate, and communicate based on personal motivations and their perceptions of power. They suggest teams acknowledge and accept that conflicts linked to power exist and propose that teams participate in social and organizational training to mitigate the impact of this power? Or impact of these conflicts? This will foster improved team relations, highlight the need for greater understanding of motivational factors in teams, and set the foundation for respectful interactions.

Hills, Mullett and Carol (2007) further concluded that the successful implementation of a multidisciplinary or interprofessional approach to primary care requires moving away from physician-driven care. They suggest that this can only be achieved once there is a change in the underlying structures, values, power relations, and roles defined by the health-care system and the community at large, where physicians are traditionally ranked above other care providers.

Health-care workers are challenged to look for ways to share power with each other, and build positive working relationships that are appropriate to an organization's equality-seeking mandate and members' skills and abilities. By making a commitment to working together, health-care workers can build and maintain healthy organizations that empower and validate the contributions of all individuals. However, despite our most fervent efforts, we may never be able to eliminate power imbalances completely; that is because power is inherent in every relationship whether we like it or not. Yet, it is crucial that each one of us examine where our individual ideas of power come from, and consider how we exercise it with our professional colleagues, other health-care workers and our patients/clients. Recognizing our power and its influence on others around us is a first step towards promoting an egalitarian and collaborative team environment. Health- care workers need to start to envision human relations where power differentials are minimized, where people feel solidarity with others, where empathy outweighs personal interests, and where mutual aid and support are more important than status systems and systems of authority (St. Joseph's Health Centre, 2009).

The patient/client relies on health-care team members to use their knowledge and expertise to formulate the most effective treatment plan, customized to the patient's/client's needs. Power imbalances lead to a lack of shared decision making regarding a patient's/client's care (Orchard et al., 2009). When team members are willing to share power, they are contributing to a healthy work environment where all team members including the patient/client feel engaged, empowered, respected and validated. (St. Joseph's Health Centre, 2009).

Key Messages

- Greater equality is a precondition for good social relations.
- Power can be covert or overt, subtle or blatant, hidden or exposed.
- Each person must reflect on the impact of how his/her power affects his/her relationship with others.
- The goal in any relationship is to limit power differential between people.
- Each team member has power. Team members exercise their power differently. However, some team members have more power than others. Those who have power over the work of others may abuse their power through the control of how others work. Those who feel disempowered may practice their power through the use of passive or overt resistance.

- People who have power must take responsibility for the negative impacts of their actions on disadvantaged people, whether these actions are intentional or not.

(St. Joseph's Health Centre, 2009)

Actions that Support the Practice of Power Sharing

- Rotate the Chair of team meetings
- Include appropriate team members and patients/clients in treatment discussions (include diverse voices)
- Share knowledge with each other
- Validate each other's work experiences, or at least talk about them
- Create safe spaces where everyone feels welcomed
- Have constructive and courageous conversations
- Share roles and responsibilities between all team members, regardless of education or professional preparation
- Talk about power: power is recognized by everyone when we have discussions and conversations about inequality, privilege and power differentials

(St. Joseph's Health Centre, 2009)

13.0 INTERPROFESSIONAL EDUCATION

RECOMMENDATION 13.1:

Individuals develop skill and competency in precepting, mentoring, and facilitating interprofessional learning.

Discussion of Evidence:

There are A, C, and D types of evidence to support this recommendation.

Organizations need committed and enthusiastic individuals to be competent and skilled champions of interprofessional care and interprofessional education. Educating people in interprofessional care helps them overcome barriers to collaborative practice and promotes competent communication (Banez, et al., 2008). Teams that learn together produce better patient/client outcomes (Reeves & Reeves, 2008). As organizations increasingly offer interprofessional learning opportunities to students, various types of professionals will need to be trained in facilitation, preceptorship and mentorship (CNA, 2004). All employees are expected to contribute to the professional development and learning of students in their own and other professions. Individuals can take part in educating students by letting them shadow them on the job, participating in orientation, offering student placements, and becoming a preceptor or mentor (HFO, 2007; Curran & Orchard, 2007).

Research Gaps and Future Implications

The Registered Nurses' Association of Ontario expert panel, in reviewing the evidence for this guideline, identified the following priority research areas. These areas have been broadly categorized into practice, outcomes and health system research (see Table 1).

Table 1: Priority Practice, Outcomes and Health System Research Areas

CATEGORY	PRIORITY RESEARCH AREA
PRACTICE RESEARCH	Establishment of a standardized assessment and documentation tool for use by interprofessional teams in clinical practice
	Contextualize the interprofessional team across the various sectors
	Impact of communication technologies and ease of access to information on the interprofessional team
OUTCOMES RESEARCH	The value of integrating patient/family as part of the interprofessional team
	Impact of interprofessional-based care on in-patient length of stay
	Influence of interprofessional teams on staff satisfaction
	Impact of interprofessional education on professional practice and specific clinical outcomes
	Effectiveness of various devices utilized for pressure redistribution/offloading in diabetic foot ulcers
HEALTH SYSTEM RESEARCH	Health economic evaluations of interprofessional care strategies

The information in Table 1, although in no way exhaustive, is an attempt to identify and proritize the critical amount of research that is needed in this area. Many of the recommendations in the guideline are based on quantitative and qualitative research evidence. Other recommendations are based on consensus or expert opinion. Further substantive research is required to validate the expert opinion. Increasing the research evidence can impact knowledge that will lead to improved practice and outcomes using an interprofessional approach to the delivery of patient care.

Implementation Strategies

Implementing guidelines at the point of care is multifaceted and challenging; it takes more than awareness and distribution of guidelines to get people to change how they practice. Guidelines must be adapted for each practice setting in a systematic and participatory way, to ensure recommendations fit the local context (Harrison, Graham, Fervers & Hoek, 2013). Our *Toolkit: Implementation of Best Practice Guidelines (2nd ed.)* (RNAO, 2012b) provides an evidence-informed process for doing that.

The *Toolkit* is based on emerging evidence that successful uptake of best practice in health care is more likely when:

- Leaders at all levels are committed to supporting guideline implementation;
- Guidelines are selected for implementation through a systematic, participatory process;
- Stakeholders for whom the guideline is relevant are identified and engaged in the implementation;
- Environmental readiness for implementing guidelines is assessed;
- The guideline is tailored to the local context;
- Barriers and facilitators to using the guideline are assessed and addressed;
- Interventions to promote use of the guideline are selected;
- Use of the guideline is systematically monitored and sustained;
- Evaluation of the guideline's impact is embedded in the process;
- There are adequate resources to complete all aspects of the implementation.

The *Toolkit* (RNAO, 2012b) uses the "Knowledge-to-Action" framework (Straus, Tetroe, Graham, Zwarenstein & Bhattacharyya, 2009) to demonstrate the process steps required for knowledge inquiry and synthesis. It also guides the adaptation of the new knowledge to the local context and implementation. This framework suggests identifying and using knowledge tools such as guidelines, to identify gaps and to begin the process of tailoring the new knowledge to local settings.

The Registered Nurses' Association of Ontario (RNAO) is committed to widespread deployment and implementation of our guidelines. We use a coordinated approach to dissemination, incorporating a variety of strategies, including the Nursing Best Practice Champion Network®, which develops the capacity of individual nurses to foster awareness, engagement and adoption of BPGs; and the Best Practice Spotlight Organization® (BPSO®) designation, which supports implementation at the organizational and system levels. BPSOs focus on developing evidence-based cultures with the specific mandate to implement, evaluate and sustain multiple RNAO best practice guidelines. In addition, we offer capacity-building learning institutes on specific guidelines and their implementation annually (RNAO, 2012b, p.19-20).

Information about our implementation strategies can be found at:

- Registered Nurses' Association of Ontario (RNAO) Best Practice Champions Network: http://rnao.ca/bpg/get-involved/champions
- RNAO Best Practice Spotlight Organizations: http://rnao.ca/bpg/bpso
- RNAO capacity-building learning institutes and other professional development opportunities: http://rnao.ca/events
- RNAO's nursing order sets as a tool to facilitate BPG implementation, please email BNOS@rnao.ca.

Evaluation & Monitoring of Guideline

Organizations implementing the recommendations in the Healthy Work Environments Developing and Sustaining Interprofessional Health Care Best Practice Guideline are encouraged to consider how the implementation and its impact will be monitored and evaluated. Table 2 is based on a framework outlined in the *Toolkit: Implementation of best practice guidelines (2nd ed.)*, (RNAO, 2012b) and illustrates some specific indicators for monitoring and evaluation of this guideline.

Table 2: Example of Indicators for Monitoring and Evaluation

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME	MEASUREMENT
Objective	To evaluate the organizational supports that enables the health-care team to develop and demonstrate effective interprofessional practices.	To evaluate organizational inteprofessional processes and behaviour related to the conceptual model.	To evaluate the impact of implementation of the guideline recommendations in various clinical settings.	To measure and monitor indicators of structures, processes and outcomes.
Organization/ Unit	Specific plans in the organization to implement the Developing and Sustaining Interprofessional Health Care guideline. Structures consistent with recommendations related to organizational supports are evident in the organization such as: ■ Processes for coordination of care	Communication mechanisms established and used such as: ■ Remote access, open forums, shared documentation. Workload measurement tools in place and used appropriately to plan interprofessional staffing Systems for monitoring results of	Organizational outcomes such as ■ Metrics for quality ■ Sick time ■ Stability of leadership staff ■ Retention rates	Human Resources Statistics, staff satisfaction survey, over time hours, staff turnover, sick time, retention of nursing and health-care staff in all roles.

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME	MEASUREMENT
	■ Processes and technology to facilitate continuous communication and access to information ■ Professionals working to full scope of practice ■ Shared governance through governance committees	effective coordination and delivery of care e.g. patient/staff satisfaction		
Individual Teams	Availability of education and supports for the six domains of interprofessional competencies: 1. Care expertise 2. Shared power 3. Collaborative leadership 4. Opitmizing professional/ role/scope 5. Shared decision making 6. Effective group functioning	Individuals in all roles demonstrate interprofessional competencies related to each of the 6 domains as outlined in the guideline Regular performance appraisal carried out including self assessment Leadership behaviour is assessed as part of performance appraisal	Interprofessional team outcomes such as ■ assessment of quality of learning experience ■ satisfaction with learning experience ■ demonstration of interprofessional competencies in communication and quality of care	An Inventory of Quantitative Tools Measuring Interprofessional Education and Collaborative Practice Outcomes (2012)

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME	MEASUREMENT
Patient/ Client	High quality Interprofessional care plans are in place	Ongoing monitoring of effects of interprofessional team care processes and decisions on patients/ client, resource allocation and quality Processes for patients/clients to provide feedback on care are explained to patients/client and accessible	Patient/client satisfaction with interprofessional team care Documented patient/client feedback on care Number of unresolved patient/client care issues	Satisfaction with Nursing Care Questionnaire (Eriksen, 2005) Patient length of stay Readmission rates
Financial			Recruitment and retention cost savings Sick time cost savings Overtime cost savings	

Process for Reviewing and Updating the Healthy Work Environments Best Practice Guidelines

The Registered Nurses' Association of Ontario proposes to update the Healthy Work Environments Best Practice Guidelines as follows:

1. Each Healthy Work Environments best practice guideline will be reviewed by a team of specialists (Review Team) in the topic area to be completed every five years following the last set of revisions.
2. During the period between development and revision, Registered Nurses' Association of Ontario Healthy Work Environments project staff will regularly monitor for new systematic reviews and studies in the field.
3. Based on the results of the monitor, project staff may recommend an earlier revision plan. Appropriate consultation with a team of guideline development members, comprising original panel members and other specialists in the field, will help inform the decision to review and revise the guideline earlier than the five-year milestone.
4. Six months prior to the five-year review milestone, the project staff will commence the planning of the review process by:

   a) Inviting specialists in the field to participate in the Review Team. The Review Team will be comprised of members from the original panel as well as other recommended specialists.

   b) Compiling feedback received and questions encountered during the dissemination phase as well as other comments and experiences of implementation sites.

   c) Compiling relevant literature.

   d) Developing a detailed work plan with target dates and deliverables.

5. The revised guideline will undergo dissemination based on established structures and processes.

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Appendix A: Glossary of Terms

Accreditation: The act of accrediting or the state of being accredited, including the granting of approval to an institution of learning by an official review board after the school has met specific requirements.

Circle of Care: The expression includes the individuals and activities related to the care and treatment of a patient. Thus, it covers the health-care providers who deliver care and services for the primary therapeutic benefit of the patient. It also covers related activities such as laboratory work and professional or case consultation with other health care providers. Retrieved from http://www.ic.gc.ca/eic/site/ecic-ceac.nsf/eng/gv00223.html

Collaborative practice: A joint venture or cooperative endeavour that ensures a willingness to participate. This relationship involves shared planning and decision making, based on knowledge and expertise rather than on role and title.

Collaborative Relationship/Practice: is defined as a joint venture or cooperative endeavour that ensures a willingness to participate. This relationship involves shared planning and decision making, based on knowledge and expertise rather than on role and title (Henneman, Lee & Cohen, 1995).

Competence: The quality or ability of a registered nurse to integrate and apply the knowledge, skills, judgments, and personal attributes required to practise safely and ethically in a designated role and setting. Personal attributes include but are not limited to attitudes, values and beliefs (CARNA, 2006; NANB, 2005).

Competencies: Statements about the knowledge, abilities, skills, attitudes and judgments required to perform safely within the scope of an individual's nursing practice or in a designated role or setting (CRNBC, 2006b).

Correlational studies: Studies that identify the relationships between variables. There can be three kinds of outcomes: no relationship, positive correlation or negative correlation.

Critical reviews: A scholarly article based on a review of the literature on a particular issue or topic, which also includes the author's considered arguments and judgments about it.

Evidence: Evidence is information that comes closest to the facts of a matter. The form it takes depends on context. The findings of high-quality, methodologically appropriate research provides the most accurate evidence. Because research is often incomplete and sometimes contradictory or unavailable, other kinds of information are necessary supplements to, or stand-ins for, research. The evidence base for a decision is the multiple forms of evidence combined to balance rigour with expedience while privileging the former over the latter (Canadian Health Services Research Foundation, 2006).

Expert opinion: The opinion of a group of experts based on knowledge and experience, and arrived at through consensus.

Health caregivers: Regulated and unregulated health-care providers, personal support workers, caregivers, volunteers and families who provide health care services at the organizational, practice and community levels.

Health-care team: In health care, the most common types of teams are management teams and care delivery teams, which are the focus of this guideline. These teams can be subdivided by: Patient population (such as geriatric teams); Disease type (such as stroke teams); or Care delivery settings (such as primary care, hospital and long-term care), (CHSRF, 2006).

Healthy work environment: A healthy work environment for nurses is a practice setting that maximizes the health and well-being of nurses, quality patient outcomes and organizational performance.

Healthy work environment best practice guidelines: Systematically developed statements based on best available evidence to assist in making decisions about appropriate structures and processes to achieve a healthy work environment (Fields & Lohr, 1990).

Integrative reviews: The integrative process includes the following component: (1) problem formulation; (2) data collection or literature search; (3) evaluation of data; (4) data analysis; and (5) interpretation and presentation of results. Retrieved from http://www.findarticles.com/p/articles/mi_ga4117/is_200503/ai_n13476203

Interprofessional: Teams made up of different professions working together to reach a common goal and share decision making to achieve the goal. The goal in health care is to work in a common effort with individuals and their families to enhance their goals and values. An interprofessional team typically includes one or more physicians, nurses, social workers, spiritual advisors, personal support workers and volunteers. Other disciplines may be part of the team, as resources permit and as appropriate (Ferris et al., 2002).

Interprofessional care (IPC): Provision of comprehensive health service to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.

Interprofessional education (IPE): Process by which two or more health professions learn with, from and about each other across the spectrum of their life-long professional educational journey to improve collaboration, practice and quality of patient centered care (Centre for Advancement of Interprofessional Education, 2002).

Nurses: Refers to registered nurses, licensed practical nurses (referred to as registered practical nurses, in Ontario), registered psychiatric nurses, and nurses in advanced practice roles such as nurse practitioners and clinical nurse specialists.

Meta-analyses: The use of statistical methods to summarize the results of several independent studies, thereby providing more precise estimates of the effects of an intervention or phenomena of health care than those derived from individual studies (Clark & Oxen, 1999).

Patients/clients: Recipient of nursing services. This includes individuals, family members, guardians, substitute caregivers, families, groups, populations or entire communities. In education, the patient may be a student; in administration, the patient may be staff; and in research, the patient may be a study participant (CNO, 2002; Registered Nurses Association of Nova Scotia, 2003).

Qualitative research: A method of data collection and analysis that observational, rather than quantitative. Qualitative research uses a number of methods to obtain observational data, including interviewing participants to understand their perspectives or experiences.

Systematic review: Using a rigorous scientific approach to review all the data and evidence on a question. (National Health and Medical Research Council, 1998). Systematic reviews establish where the effects of health care are consistent, where research results may be applied across various populations and health-care settings, and where differences in treatment and effects may vary significantly. The use of explicit, systematic methods in reviews limits bias (systematic errors) and reduces chance effects, thus providing more reliable results upon which to draw conclusion and make decisions (Clarke & Oxen, 1999).

Task conflict: Task process conflicts occur when determining how task accomplishment should proceed, who's responsible for what, and how things should be delegated (Jehn & Mannix, 2001).

Team: A number of persons associated together in work or activity. (Merriam-Webster on line Dictionary. Retrieved from http://www.m-w.com/cgi-bin/dictionary)

Teamwork: That work which is done by a group of people who possess individual expertise, who are responsible for making individual decisions, who hold a common purpose and who meet together to communicate, share and consolidate knowledge from which plans are made, further decisions are influenced and actions determined (Brill, 1976).

Appendix B: Guideline Development Process

The Registered Nurses' Association of Ontario (RNAO) has made a commitment to ensure that nursing best practice guidelines are based on the best available evidence. The Registered Nurses' Association of Ontario Nursing Best Practice Guideline *Developing and Sustaining Interprofessional Health Care: Optimizing patients/clients, organizational and system outcomes* (2013) is the culmination of the Registered Nurses' Association of Ontario expert panel's work in integrating the most current and best evidence to ensure the validity, appropriateness and safety of the guideline recommendations and supporting evidence.

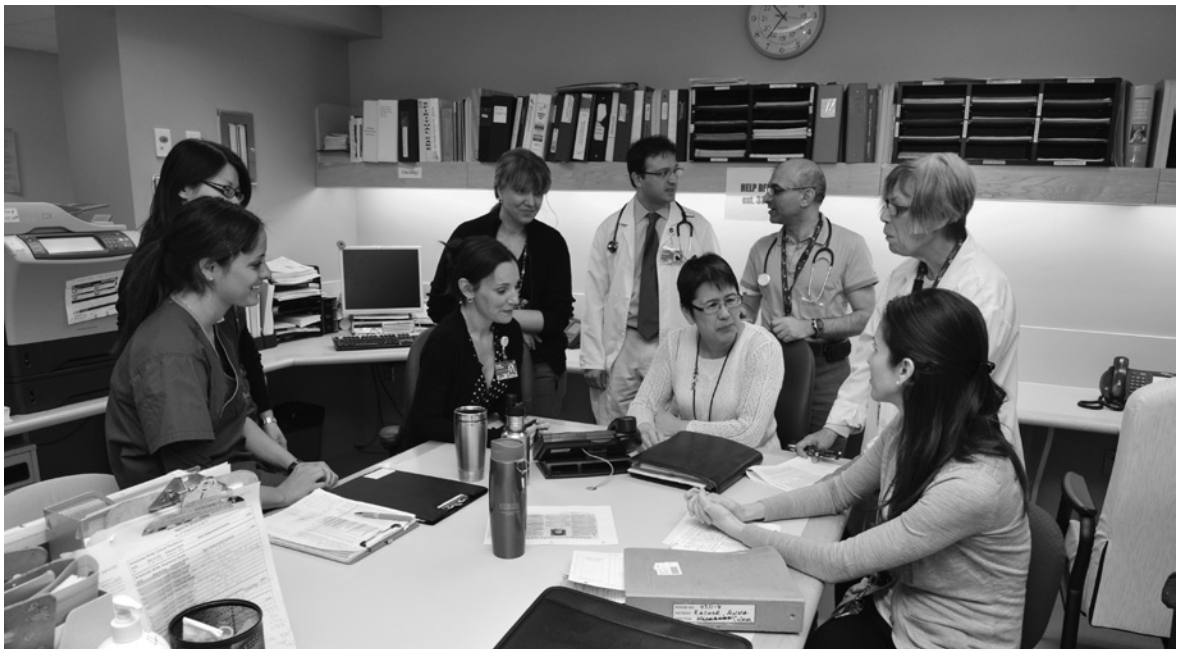
The expert panel consists of health-care professionals with expertise in practice, research, policy, education and administration from various practice areas. The expert panel was supported by an Advisory Committee consisting of senior health-care executives from the hospital, provincial government and not-for-profit settings.

A systematic review of the evidence was based on the purpose and scope of the guideline and supported by three clinical questions. The systematic review captured relevant literature and guidelines published between 2002 and 2013. The following research questions were established to guide the literature review:

How does interprofessional care within organizations and systems lead to optimal patient/client satisfaction and health outcomes?

How does interprofessional care within organizations and systems lead to provider satisfaction, effective team functioning and integration of care?

How does interprofessional care within organizations and systems lead to effective organizational and system outcomes?



Appendix C: Process for Systematic Review/ Search Strategy

Search Strategy:

A comprehensive literature search was conducted from September to November 2011 by a University Health Network (UHN) librarian in the following health-related electronic databases: Embase, PsychInfo, Medline, Cochrane (SR), Cochrane (CCRCT), and CINAHL IP.

English-language systematic reviews, guidelines and primary studies were included if they were within the scope of the clinical questions and published between 2002 and 2011. There was no preference on the basis of research design; both qualitative and quantitative primary studies of various designs were included. An additional search was conducted from September to October 2013 to include studies published to September 2013.

Inclusion Criteria:

- Abstracts in English
- French articles
- Literature published 5-11 years
- Grey literature
- International studies
- Business literature

Exclusion Criteria:

- Articles on interprofessional education curriculum
- Other languages unless the abstract is in English and French
- Older than 11 years
- Grey literature older than 5 years

Search Terms Identified Included:

- Interdisciplinary
- Multidisciplinary
- Interprofessional
- Team
- Team work
- Leadership
- Virtual teams

- Enablers to interprofessional collaboration
- Barriers/challengers to interprofessional collaboration
- Interorganizational Collaboration
- Core competencies of interprofessional collaboration
- External Drivers to interprofessional collaboration
- Relationships between professionals
- Interaction patterns of interprofessional collaboration
- Shared Leadership of interprofessional collaboration
- System enablers to interprofessional collaboration
- Regulatory bodies to interprofessional collaboration
- Social Paradigms and interprofessional collaborationPower and Interprofessional Care
- Hierarchy and interprofessional collaboration
- Communication and interprofessional collaboration
- Team boundaries and interprofessional collaboration
- Articles from Zwarenstein
- Articles from Ivy Oandasan
- CIHC
- Patient Safety & interprofessional collaboration
- Medical Error
- Health Disparity
- Diverse Health Care Teams
- Circle of Care
- Quality Assurance Literature
- Context Specific Issues and Team Work
- Team Effectiveness
- Peer Support Model

Two research associates (master's prepared nurses) independently assessed the eligibility of studies according to established inclusion and exclusion criteria. The Registered Nurses' Association of Ontario Best Practice Guideline program manager working with the expert panel, resolved disagreements.

A final summary of literature findings was completed. The comprehensive data tables and summary were provided to all panel members. In January 2013, the Registered Nurses' Association of Ontario expert panel convened to revise and achieve consensus on guideline recommendations and discussion of evidence.

Search Results:

A total of 6128 abstracts were independently screened for inclusion/exclusion by two Masters Degree prepared nurses for the three questions: question 1 (2389 abstracts), question 2 (477abstracts), and question 3 (3262 abstracts). No relevant guidelines were found on this subject and therefore not included in this review. Upon completion of the independent review, 472 articles were included for full-text relevance review. Of these 472 articles, 248 articles were subsequently excluded. The remaining 224 articles were independently reviewed for methodological quality and data extraction. Upon completion of the review for quality, 88 full-text articles were excluded. The remaining 138 studies were included. Given the diversity with respect to research design across the included studies, a variety of instruments were used to assess methodological quality as directed by the Registered Nurses' Association of Ontario See Figure 4).

Figure 4. Instruments Used to Assess Methodological Quality

The following resources were used to guide the critical appraisal of the articles reviewed:

- Qualitative Studies

  Critical Appraisal Skills Programme (CASP): "10 questions to help you make sense of qualitative research" (Public Health Resource Unit England, 2006)

- Quantitative Studies

  Effective Public Health Practice Project Quality Assessment Tool for Quantitative Studies (Effective Public Health Project, 2009)

- Systematic Reviews:

  Assessment of Multiple Systematic Reviews (AMSTAR) (Shea et al., 2007)

Articles were subsequently categorized based on relevance to research questions. The reviewers discussed relevant themes arising from the literature. A summary of evidence was provided to the guideline development panel for feedback and revisions as appropriate. As such, the final report represents the culmination of this work and the shared findings of reviewers and the guideline development panel.

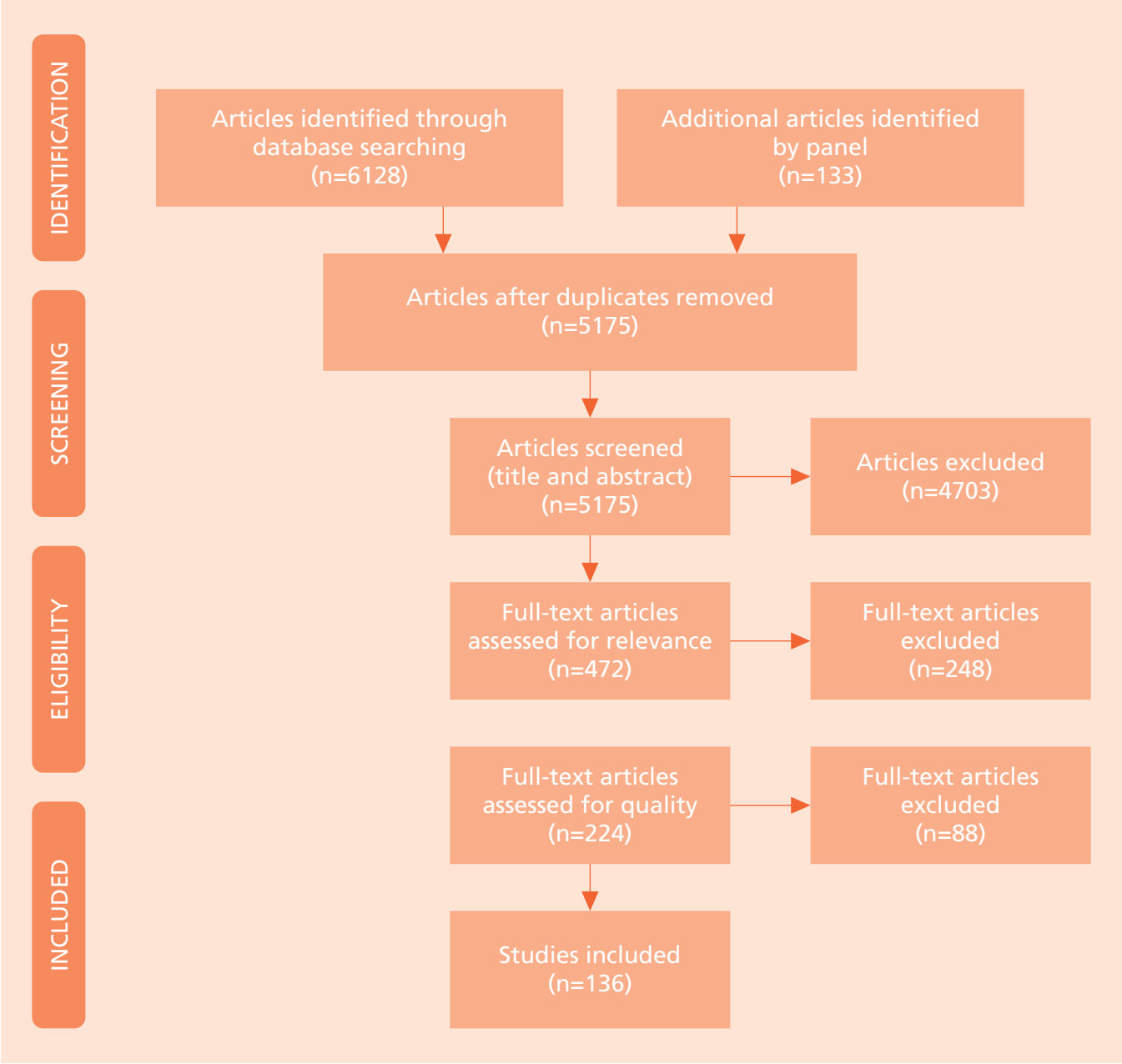
Results:

A review of the extracted data for each of the three research questions suggested five general themes: (1) effective models of IPC; (2) interventions to enhance IPC; (3) tools to enhance IPC; (4) facilitators of IPC; and (5) barriers to IPC.

Article Review Process Flow Diagram

The following flow diagram of the review process for guidelines and articles is adapted from D. Moher, A. Liberati, J. Tetzlaff, D.G. Altman, & The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *BMJ 339,* b2535, doi: 10.1136/bmj.b2535

A complete Bibliography of all articles screened for inclusion is available at



Appendix D: Enablers and Barriers to Interprofessional Care

CATEGORY OF FACTORS	ENABLERS	BARRIERS
INTERPERSONAL	■ Mutual respect[1-4] ■ Shared commitment to improving care[1] ■ Personality of team members[2, 5] ■ Understanding of roles/role clarity[2, 3, 5-9] ■ Perception of quality of patient/client care[10] ■ Perceptions of collaborative relationships[11] ■ Nurse-physician relationships[12, 13] ■ Nurse-physician communication[13] ■ Teamworking[14] ■ Characteristics of therapists[2, 15] ■ Characteristics of collaboration[15] ■ Communication[4, 14, 16-19] ■ Role awareness[14] ■ Professional and personal development[3, 14] ■ Leadership[20, 21] ■ Common core knowledge ■ Interpractitioner trust[2, 3] ■ Equitable power relations[22, 23] ■ Sense of belonging/ownership[22] ■ Professional ethics[17] ■ Inclusive/shared language use[9]	■ Interdisciplinary rivalry[24, 25] ■ Lack of mutual respect[26] ■ Lack of understanding of mutual roles[25] ■ Lack of experience with IPC[25] ■ Poor provider relations[27, 28] ■ Role conflict[4, 7, 29] ■ Communication failures[9, 27, 30, 31] ■ Nurse-physician relations[11, 26, 32] ■ Inequitable power relations[22, 31, 33] ■ Professional boundary infringements[4, 33] ■ Identity issues[4, 23] ■ Different approaches to patient/client care[9, 31, 33] ■ Professional language differences[9, 34] ■ Perceived lack of organizational support[33] ■ Group stereotypes[26] ■ Attitudinal barriers[27]

CATEGORY OF FACTORS	ENABLERS	BARRIERS
ORGANIZATIONAL	**Interventions/Processes/Structures** ■ Daily interdisciplinary team rounds[18, 35-39] ■ Weekly interdisciplinary team rounds[40] ■ Interprofessional team rounds after clinic[41] ■ Interdisciplinary action groups/projects[23, 42, 42-44] ■ Interdisciplinary case conferences[43, 45] ■ Daily interdisciplinary team meetings[46] ■ Weekly multidisciplinary team meetings[5, 47] ■ Monthly multidisciplinary team meetings[18] ■ Dedicated time for team meetings[13, 48] ■ Review/discussion of patient/client documentation[9] ■ External facilitators[18] ■ Multidisciplinary education[49-53] ■ Interprofessional education[54] ■ Multidisciplinary facilitation[50] ■ Multidisciplinary performance improvement teams[49, 50, 55] ■ Interdisciplinary quality improvement teams[8, 56-59] ■ Interdisciplinary complication reviews[46] ■ Training local champions[60] ■ Multidisciplinary morbidity & mortality rounds/death review[61, 62] ■ Multidisciplinary process redesign[63] ■ Self-assessment audits[62] ■ Pre-operative team briefings[64-66] ■ Clear lines of communication[1] ■ Use of quality/feedback information[67]	**Interventions/Processes/Structures** ■ Fee structure[24] ■ Liability issues[24] ■ Organizational and practice structures[3, 6, 27] ■ Organizational culture[19, 71] ■ Ill-defined hierarchy[27] ■ Degree of therapist involvement in referral & assessment process[15] ■ Different gateways to same patients/clients profile[29] ■ Role of hospital executive board[29] ■ Physician-driven care[22] ■ Conflicts in schedules and roles[31] ■ Building layouts hindering interaction[31] ■ Lack of time for teambuilding[31] ■ Responsibility overload[27] ■ Absenteeism[31] ■ Constraining rules and regulations[31] ■ Authority (disagreement about decision making)[68] ■ Lack of training in IPC[25]

CATEGORY OF FACTORS	ENABLERS	BARRIERS
ORGANIZATIONAL	■ Practice characteristics (physical layout, same working hours)[2, 5] ■ Characteristics of the environment[4, 15] ■ Referral process[15] ■ Business policies[15] ■ Time[4, 68] ■ Supportive organizational structure[5] ■ Institutional leadership[69] ■ Mission clarity[70] ■ Supportive/flexible structures[22] ■ Teamwork culture[71-73] ■ Communication training[69, 74] ■ Teambuilding training[48, 75-79] ■ Client-centered care[17, 22] ■ Building on existing relationships[23] ■ Providing opportunities for formal & informal contact[5, 23, 47] ■ Evidence-informed decision making[17] ■ Integration of allied health professionals into healthcare teams[2, 3] ■ Integrated management systems[80] ■ Authority(agreed upon leadership and decision making)[68] ■ Education(shared values and goals)[68] ■ Patient/client needs[68] ■ Knowledge[68] ■ Resources[68] **TOOLS** ■ Daily rounds forms[74] ■ Clinical/integrated care pathways[81, 81-92]	■ Education[68] ■ Patient needs[68] ■ Knowledge[68] ■ Resources[68] ■ Time[68] **TOOLS** ■ Time constraints[85] ■ Challenging to learn to use integrated care pathways[86] ■ Care pathways that are not a multiprofessional record of care[104] ■ Variability in development & use of clinical protocols & guidelines[29] ■ Health policy[29]

CATEGORY OF FACTORS	ENABLERS	BARRIERS
ORGANIZATIONAL	■ Interdisciplinary practice guidelines/protocols[5, 6, 21, 55, 92-94] ■ Common clinical information systems[47] ■ Common patientchart[5] ■ Computerized data tools[95] ■ Multidisciplinary discharge planning tool[96] ■ SBAR communication tool[97] ■ Tailored survivorship care plans[98] ■ Documentation templates[99] ■ Consultation and collaboration guidelines[1] ■ Organizational standards of behaviours[97] ■ Interdisciplinary team-developed checklists[44, 100] ■ Multidisciplinary audit tools[101] ■ Standardized orders and medication charts[55, 94, 102] ■ Effective communication tools[5, 37, 47] ■ Business policies[15] ■ Electronic medication administration records[103] ■ Computerized order sets[58] ■ Multidisciplinary audit tool[101]	

CATEGORY OF FACTORS	ENABLERS	BARRIERS
SYSTEMIC	■ Social variables and community contacts[15] ■ Satisfactory compensation[5] ■ Health policy[29] ■ Reinforcement of partnerships between higher education institutions & health & social care institutions[14] ■ Access[17] ■ Strong national leadership[24] ■ Interdisciplinary education[24]	■ Unstable funding arrangements[105] ■ Funding models that discourage collaboration[25] ■ Political environment[15] ■ Inconsistent government policies[25] ■ Limited health human resource planning[25] ■ Legislation and regulations obstructing professions full scope of practice[106] ■ Underutilization of health human resources[106] ■ Regulatory/legislative frameworks that create silos[25] ■ Governance/ organizational conflicts[31]

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Appendix E: Example of Team Charter

Team Charter Example

Interprofessional Care Members

Provide expert advice to surgical team using interdisciplinary approach.

1. JOB DESCRIPTIONS:

- **Chair:** Oversees overall operations of the program
  Responsible for team function
  Ensures the timelines are met
  Makes an executive decision in times of crisis situation
- **Facilitator:** Rotating position
  Creates agenda
  Organize meetings
  Outlines immediate issues for discussion and facilitates meetings
  Keeps discussions on track
  Ensures that the meetings start on time
- **Data collector:** Voluntary task
  Taking minutes
- **Resource person:** Research coordinator for outcome measures, advise on data collection and analysis, assistance with pictorials and models if needed

2. ROLE DEFINITION

Role of RN in care team is to provide expertise in nursing roles and responsibilities:

- Provision of quality care by developing nurses´ expertise in management of surgical patients/clients
- Utilize current evidence and tools related to interprofesssional care
- Developing prevalence studies
- Disseminating and integrating of research findings into practice and facilitating change by promoting nursing best practices related to surgical care
- Educating and empowering nursing staff
- Participates in research projects
- Liaise with team members as appropriate

Role of Social Worker in care team is to provide expertise in:

- Supporting family, patients/clients and circle of care in obtaining services, resources required to optimize patients/clients health

Role of OT in surgical care team is to provide expertise in:

- Use of modalities
- Assistive devices
- Complementary therapies (such as footwear recommendations)
- Promoting functional independence including ADL and IADL

Role of Physiotherapist in surgical care team is to provide expertise in:

- Recommendations on positioning patients/clients (specifically focusing on promotion of healing and prevention of skin breakdown and joint contractures)
- Improving the mobility of the patient/client in bed and out of bed.

Role of Physician in surgical care team is to provide expertise in:

- The management of post-op care
- Assist in educating the team regarding optimal post-op care

Role of Dietitians in surgical care team is to provide expertise in:

- Expertise in Clinical Nutrition
- Based on evidence-based literature and best-practice, provide appropriate intervention.
- Determine appropriate protein, calorie and micronutrient requirements based on individual needs
- Liaise with Registered Dietitian team to collaborate on best practices.

Role of the researcher/evaluator in surgical care team is to provide expertise in:

- Facilitate effective interprofessional surgical care practice through a review of current research findings and determine the gaps for further research to improve patient/client care quality.
- Contribute in the development of an environmental scan to determine what supports and resources are needed internally and externally for an effective interprofessional community of practice.
- Guide the tracking and monitoring of the evaluation data for the interprofessional care initiative, and will guide the development of a Program Logic Model.
- Develop a sustainability plan for the continuation of interprofessional communities of practice.

Working Together:

- Open communication
- Trust and commitment
- Expertise
- Accountability in knowledge transfer and application
- Dynamic
- Be transparent
- Respect different opinions

- Mediate and compromise when necessary
- Attend meetings with focused agenda and be on time
- Share and work towards common master plan
- Take info back to team
- Set timelines, agreed by consensus

Management Support:

- Commitment for resources
- Priority/operational goal
- Representation on committees

3. ENHANCED COMMUNICATIONS:

- Who makes decision

  a. Minimum required for decision making 50% of membership

  b. In stalemate situations- defer to person with expertise

- Maintain time lines- leader's accountability
- Executive decisions

  a. In difficult situations – role of chair or/delegate is to provide situational leadership

  b. When violation of conduct – chair makes decision based on team's feedback

- Frequency of communications
  Team meetings to occur monthly
  E-mail communication in between meetings as necessary
  Transparency (documents posted for everyone to read)

4. CORE VALUES (refer to Registered Nurses' Association of Ontario, Best Practice Guidelines model for interprofessional care)

5. EXPECTATIONS/IMPACT OF THE TEAM

EXPECTED OUTCOME – identify clear indicators using Registered Nurses' Association of Ontario, Best Practice Guideline on interprofessional care as a guide

6. CONFLICT RESOLUTIONS – utilize Registered Nurses' Association of Ontario, Best Practice Guideline on managing conflict

7. AUTHENTICITY (true to self/others)

8. EDUCATION (refer to surgical care plan)

Evaluation (refer to program logic model and Registered Nurses' Association of Ontario Best Practice Guideline on interprofessional care)

Appendix F: Interprofessional Competency Framework Self-Assessment

[Adapted from the CIHC National Competency Framework (2010) and the Registered Nurses' Association of Ontario conceptual model for developing and sustaining interprofessional health care (2013)]

Interprofessional Competency Framework Self-Assessment Tool

The Registered Nurses' Association of Ontario Conceptual Model for Developing and Sustaining Interprofessional Health Care describes the competencies required for effective interprofessional collaboration. Six competency domains highlight the knowledge, skills, attitudes and values that together shape the judgments that are essential for interprofessional collaborative practice. These domains are:

- Care expertise
- Shared power
- Collaborative leadership
- Optimizing profession, role and scope
- Shared decision making
- Effective group functioning

The six domains are shown surrounded by an outer circle of expected benefits for the health-care team and the organization: a healthy work environment with **enhanced quality and improved safety**. The domains are supported by **competent communication** and the three foundational components of the healthy work environment model:

- Policy, physical, structural
- Professional/occupational
- Cognitive/psychosocial/cultural

This self assessment survey allows you to reflect on your areas of strength in collaborative practice and areas that you may wish to strengthen. Please indicate how well you believe you perform each of the following indicators.

EXAMPLE: COMPETENCY	NEVER	RARELY	SOMETIMES	ALMOST ALWAYS	DOES NOT APPLY
Indicator #1				✔	
Indicator #2			✔		

1. Care Expertise

Interprofessional care requires collaboration between health-care professionals and patients and their families and circles of care in order to identify and take advantage of each person's care expertise. To support interprofessional practice, learners/practitioners are able to:

INDICATOR	NEVER	RARELY	SOMETIMES	ALMOST ALWAYS	DOES NOT APPLY
Support the participation of patients/clients, their families, and/or community representatives as integral partners alongside health-care personnel					
Share information with patients/clients (or family and the community) in a respectful manner and in such a way that it is understandable, encourages discussion, and enhances participation in decision making					
Ensure that appropriate education and support is provided to patients/clients, family members and others involved with care or service					
Listen respectively to the expressed needs of all parties in shaping and delivering care or services					
Conduct a collaborative interprofessional assessment to identify what expertise is required and then individualize for each patient/client					
Coordinated effort to find the best expert for the patient/client					

INDICATOR	NEVER	RARELY	SOMETIMES	ALMOST ALWAYS	DOES NOT APPLY
Patients/Clients are full participants in their own care					
Include specific contributions and collective knowledge as dictated by the complexity of the patient's/client's needs					

2. Shared Power

Willingness to share power is a commitment to create balanced relationships through democratic practices of leadership, decision making, authority and responsibility. To support interprofessional practice, learners/practitioners are able to:

INDICATOR	NEVER	RARELY	SOMETIMES	ALMOST ALWAYS	DOES NOT APPLY
Leverage opportunities for all team members to contribute					
Create balanced power relationships					
Establish a safe environment to express diverse opinions					
Consider points of view of all care providers					

3. Collaborative Leadership

Collaborative leadership (also called reciprocal or shared leadership) is a people- and relationship-focused approach based on the premise that answers should be found in the collective (the team). To support interprofessional practice, learners/practitioners collaboratively determine who will provide group leadership in any given situation by supporting:

INDICATOR	NEVER	RARELY	SOMETIMES	ALMOST ALWAYS	DOES NOT APPLY
Work with others to enable effective patient/client outcomes					
Advance interdependent working relationships among all participants					
Facilitation of effective team processes					
Facilitation of effective decision making					
Establish a climate for collaborative practice among all participants					
Co-create a climate for shared leadership and collaborative practice					
Apply collaborative decision making principles					
Integrate the principles of continuous quality improvement to work processes and outcomes					
Share accountability that addresses power and hierarchy					
Utilize structures and processes to advance exemplary care					

4. Optimizing Profession, Role and Scope

Exemplary interprofessional care lets all team members work to their full scope of practice and takes advantage of the synergies professionals working together can create. To support interprofessional practice, learners/ practitioners are able to:

INDICATOR	NEVER	RARELY	SOMETIMES	ALMOST ALWAYS	DOES NOT APPLY
Describe their role and others'					
Recognize and respect the diversity of other health and social care roles, responsibilities, and competencies					
Perform their own roles in a culturally respectful way					
Communicate roles, knowledge, skills, and attitudes using appropriate language					
Consider the roles of others in determining own professional and interprofessional roles					
Access others' skills and knowledge appropriately through consultation					
Consider the roles of other in determining own professional and interprofessional roles					
Integrate competencies/roles seamlessly into models of service delivery					
Demonstrate knowledge application of own profession/role/scope					
Explore and integrate roles of others					

5. Shared Decision-Making

Shared decision-making gives all team members, including patients, the opportunity to contribute their knowledge and expertise, to arrive collaboratively at an optimal goal. To support interprofessional practice, learners/practitioners are able to:

INDICATOR	NEVER	RARELY	SOMETIMES	ALMOST ALWAYS	DOES NOT APPLY
Recognize and respect each other's knowledge and expertise, regardless of occupation and formal position					
Willing to accept responsibility for decisions					

6. Effective Group Function

A health-care system that supports effective teamwork can improve the quality of patient care, enhance patient safety, and reduce workload issues that cause burnout among professionals. To support interprofessional practice, learners/practitioners are able to:

INDICATOR	NEVER	RARELY	SOMETIMES	ALMOST ALWAYS	DOES NOT APPLY
Understand the process of team development					
Develop a set of principles for working together that respects the ethical values of members					
Effectively facilitate discussions and interactions among team members					
Participate, and be respectful of all members' participation, in collaborative decision making					

INDICATOR	NEVER	RARELY	SOMETIMES	ALMOST ALWAYS	DOES NOT APPLY
Regularly reflect on their functioning with team learners/ practitioners and patients/clients/ families					
Establish and maintains effective and healthy working relationships with learners/ practitioners, patients/clients, and families, whether or not a formalized team exists					
Respect team ethics, including confidentiality, resource allocation, and professionalism					
Collaborate and engage together to formulate, implement and evaluate care					
Assess, practise and reflect upon effective group processes					

7. Competent Communication

Competent communication – openness, honesty, respect for each other's opinions and effective communication skills – is part of all domains of interprofessional practice. To support interprofessional practice, learners/ practitioners are able to:

INDICATOR	NEVER	RARELY	SOMETIMES	ALMOST ALWAYS	DOES NOT APPLY
Establish team work communication principles					
Actively listen to other team members including patients/ clients/families					

INDICATOR	NEVER	RARELY	SOMETIMES	ALMOST ALWAYS	DOES NOT APPLY
Communicate to ensure common understanding of care decisions					
Develop trusting relationships with patients/clients/families and other team members					
Effectively use information and communication technology to improve interprofessional patient/client/community-centered care					
Is clear, focused, transparent and respectful					
Constructively manages conflict					
Maintains and enhances the relationship					

Review and reflect on the score you have given yourself. The scores reflecting "rarely" and "never" in any particular domain may be areas you wish to develop further. Having completed your self assessment, it is recommended that you discuss your results with your mentor or a trusted colleague in your team.

Appendix G: Description of the Toolkit

Best Practice Guidelines can only be successfully implemented if there are adequate planning, resources, organizational and administrative supports and appropriate facilitation. In this light, the Registered Nurses' Association of Ontario, through a panel of nurses, researchers and administrators, has developed the *Toolkit: Implementation of Best Practice Guidelines (2nd ed.)*(2012b). The *Toolkit* is based on available evidence, theoretical perspectives and consensus. We recommend the *Toolkit* for guiding the implementation of any Healthy Work Environment Best Practice Guideline in health-care organizations.

The *Toolkit* provides step-by-step directions to individuals and groups involved in planning, coordinating and facilitating the guideline implementation. These steps reflect a process that is dynamic and iterative rather than linear. Therefore, at each phase preparation for the next phases and reflection on the previous phase is essential. Specifically, the *Toolkit* addresses the following key steps, as illustrated in the "Knowledge to Action" framework (RNAO, 2012b; Straus et al., 2009) in implementing a guideline:

1. Identify problem: identify, review, select knowledge (Best Practice Guideline).
2. Adapt knowledge to local context:
   - Assess barriers and facilitators to knowledge use; and
   - Identify resources.
3. Select, tailor and implement interventions.
4. Monitor knowledge use.
5. Evaluate outcomes.
6. Sustain knowledge use.

Implementing guidelines in practice that result in successful practice changes and positive clinical impact is a complex undertaking. The *Toolkit* is one key resource for managing this process. The *Toolkit* can be downloaded at http://rnao.ca/bpg.

Appendix H: Charter Statements

Patient/Client Expectation

As a patient/client in Ontario, I expect my health care to be provided by various health caregivers who respect me and the health-care choices I make. My caregivers seek to know my health experience and are prepared to work with me across settings to combine their knowledge and skills to meet my health goals.

Caregiver Commitments

As a health caregiver in Ontario, in supporting the interprofesssional vision,

1. I will seek to know the experience of those I care for, respect and strive to understand their needs, and work with them to develop their care plans that acknowledge their choices,
2. I will understand my role and understand the role and expertise of other health caregivers,
3. I will inform those who are caring for patients/clients with me about the care I am providing to them,
4. I will ask questions, communicate to be understood, seek input and listen respectfully to generate options for care,
5. I will be aware of how my own behaviour and attitudes impact interprofessional care and how I actively foster a culture of collaboration, and
6. I will acknowledge that there are limits to what I know and will continue to learn from others so that care can be better integrated and guided by the best possible ideas.

Leader Commitments

To meet patients/clients expectation and enable caregiver commitments in Ontario, as health system leaders,

1. We will align our language, processes, structures and resources to foster an interprofesssional culture,
2. We will create opportunities to collaborate within and across sectors to integrate interprofesssional care into practice, education, policy and research,
3. We will measure and evaluate our interprofessional care initiatives to know what is being achieved, and
4. We will continuously improve interprofessional care in the health-care system by identifying, promoting and implementing practices that make a difference to patient/client care.

Interprofessional Care Strategic Implementation Committee Final Report 2010

http://www.healthforceontario.ca/UserFiles/file/PolicymakersResearchers/ipc-final-report-may-2010-en.pdf

Endorsements

Ontario Association of Social Workers
L'Association des travailleuses et travailleurs sociaux de l'Ontario

December 17, 2013

Doris Grinspun RN, MSN, PhD, LLD(hon), O.ONT.
Chief Executive Officer
Registered Nurses' Association of Ontario (RNAO)
158 Pearl Street
Toronto, ON
M5H 1L3

Dear Dr. Grinspun,

The Ontario Association of Social Workers (OASW), the voice of social workers in Ontario, is pleased to endorse RNAO's timely Healthy Work Environment Best Practice Guideline- *Developing and Sustaining Interprofessional Health Care: Optimizing patient, organizational, and system outcomes.* With its robust evidence-based focus on enhancing interprofessional health care, this best practice guideline will greatly strengthen the outcomes for clients and for all members of the interprofessional team.

We were delighted to have social work represented on the expert guideline panel through Scott Graney, Patti McGillicuddy and Hazel Sebastian, and are thrilled to have been a part of this groundbreaking work. The guideline is directly related to our mandate of advocating for the improvement of social policies and programs directly affecting social work clients and social work practice. The recommendations addressing individual and team practice, organizations, and the system will enable both our members and our association to work towards a creating a strong culture of interprofessionalism within our health-care system.

Ontario's Social Workers are committed to having the healthiest clients/patients and the best health-care system, and we believe the *Developing and Sustaining Interprofessional Health Care: Optimizing patient, organizational, and system outcomes* guideline will help us to achieve these goals.

Best regards,

Kate Power, MSW, RSW
President, OASW

January 10, 2014

Doris Grinspun RN, MSN, PhD, LLD(hon), O.ONT.
Chief Executive Officer
Registered Nurses' Association of Ontario (RNAO)
158 Pearl Street
Toronto, ON M5H 1L3

Dear Dr. Grinspun,

On behalf of the Board of Directors of the Ontario Society of Occupational Therapists (OSOT), I am pleased to write to communicate the Society's endorsement of the RNAO's evidence-based Healthy Work Environment Best Practice Guideline- *Developing and Sustaining Interprofessional Health Care: Optimizing patient, organizational, and system outcomes.*

OSOT is the professional association of over 3800 Ontario occupational therapists. The Society promotes and develops the profession of occupational therapy to participate as a valued profession in health care teams across the continuum of care in Ontario's health care system. Occupational therapists (OTs) work with clients whose ability to do what they need and want to do has been compromised by injury, illness or disability. Their work and contribution to the Ontarians' health and our health care system is magnified in the context of effective interprofessional care. To this end, RNAO guideline is directly related to our mandate of working closely and collaboratively with other members of the health care team for better client outcomes. We were pleased to have an occupational therapy perspective included amongst the guideline development process through Bonny Jung's membership on the expert guideline development panel.

The rigorous process RNAO uses in guideline development has resulted in a set of evidence-based recommendations related to individual and team practice, organizations and the system that will influence healthy teamwork among all professions. Ontario's Occupational Therapists are committed to having the healthiest clients/patients and the best healthcare system. This guideline will be a valued resource and support our members to continue making positive contributions to interprofessional team work.

Sincerely,

Christie Brenchley

Christie Brenchley
Executive Director

Notes

Notes

INTERNATIONAL AFFAIRS & BEST PRACTICE GUIDELINES

TRANSFORMING NURSING THROUGH KNOWLEDGE

Best Practice Guidelines

DECEMBER 2013

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Ontario