

System and Healthy Work Environment Best Practice Guidelines

JUNE 2016

Intra-professional Collaborative Practice among Nurses

Second Edition



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Intra-professional Collaborative Practice among Nurses

Second Edition

Greetings from Doris Grinspun, Chief Executive Officer, Registered Nurses' Association of Ontario



The Registered Nurses' Association of Ontario is delighted to present the second edition of the system and healthy work environment best practice guideline, *Intra-professional Collaborative Practice among Nurses*. Evidence-based practice supports the excellence in service that health professionals are committed to delivering every day, and we are very pleased to provide them with this key resource.

We offer our heartfelt thanks to the many stakeholders that are making our vision for clinical and healthy work environment best practice guidelines a reality, starting with Government of Ontario, for recognizing the Registered Nurses' Association of Ontario's ability to lead the program and for providing multi-year funding; Dr. Irmajean Bajnok, director of the RNAO International Affairs and Best Practice Guidelines Centre, Dr. Monique Lloyd, the associate director, and Althea Stewart-Pyne, program manager for their expertise and leadership. I also want to thank the chair of the expert panel, Barb O'Neil (Chief Nursing Executive and Chief, Interprofessional Practice and Organizational Development at Bluewater Health in Sarnia, Ontario) for her exquisite expertise and stewardship of this guideline. Thanks also to RNAO staff Patti Hogg, Anastasia Harripaul, Tasha Penney and Oliwia Klej for their intense work in the production of this new guideline. Very special thanks to the members of the RNAO expert panel for generously providing time and expertise to deliver a rigorous and robust evidence-based resource. We couldn't have done it without you!

Creating a healthy work environment is a central component of any health-care profession; working in a healthy environment enables nurses and other professionals and members of the care team to maximize the quality of outcomes for patients, clients and staff. Healthy Work Environments Best Practice Guidelines are designed to support health-care professionals in creating and maintaining positive environments for colleagues, patients and their families.

Successful uptake of best practice guidelines requires concerted effort by educators, clinicians, employers, policy makers and researchers. The nursing and health-care community, with their unwavering commitment and passion for excellence in patient care, have provided the expertise and countless hours of volunteer work essential to the development and revision of each guideline. Employers have responded enthusiastically by nominating best practice champions, implementing guidelines, and evaluating their impact on patients/clients and organizations. Governments at home and abroad have joined in this journey. Together, we are building a culture of evidence-based practice.

We ask you to be sure to share this guideline with colleagues from across all professions, because there is so much to learn from one another. Together, we must ensure that the public receives the best possible care every time they come in contact with us – making them the real winners in this important effort.

A handwritten signature in black ink that reads "Doris Grinspun". The signature is stylized and includes a long horizontal flourish at the end.

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

Table of Contents

How to Use this Document	5	BACKGROUND
Purpose and Scope	6	
Guiding Principles and Assumptions	7	
Summary of Recommendations	8	
Interpretation of Evidence	14	
Development Panel Members	15	
RNAO Best Practice Guideline Program Team	16	
Stakeholder Acknowledgement	17	
Healthy Work Environments Best Practice Guidelines Background	19	
Organizing Framework for the Healthy Work Environments Best Practice Guidelines	21	
Background Context: Guideline on Intra-professional Collaborative Practice among Nurses	24	

Individual/Team Recommendations	25	RECOMMENDATIONS
Organizational Recommendations	35	
External/System Recommendations	43	
Research Gaps and Future Implications	48	
Implementation Strategies	49	
Evaluating and Monitoring this Guideline	50	
Process for Review and Update of the Guideline	54	

REFERENCES	Reference List	55
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APPENDICES	Appendix A: Glossary of Terms	63
	Appendix B: Guideline Development Process	68
	Appendix C: Process for Systematic Review and Search Strategy	69
	Appendix D: Description of the Toolkit	73

How to Use this Document

This Healthy Work Environment^G Best Practice Guideline (BPG) is an evidence-based document that describes intra-professional collaborative practice among nurses. It offers much valuable information that is intended to be read and applied over time, in incremental steps for best results. We recommend you review and reflect on the document and implement the recommendations appropriate for your organization at a particular time. This approach may be helpful:

1. Study the organizing framework

Intra-professional Collaborative Practice among Nurses, Second Edition was built on the Healthy Work Environments Organizing Framework. The framework is designed 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 in your organization where you see a need to create a supportive environment for collaborative health care.

3. Read the recommendations and the summary of research for the area you're focusing on

Each 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, collaborative work environment. The literature supporting each recommendation is summarized briefly. Reading the summaries will help you understand the “why” of the recommendations.

4. Focus on recommendations or behaviour most appropriate for your situation

There is a lot of information to consider in this guideline. Our recommendations are not rules. They are tools to assist individuals, organizations and systems to develop and sustain intra-professional collaborative health care. Take time to explore the ideas, and then identify behaviour that needs to be analyzed and perhaps strengthened for your situation.

5. Start planning

When you have selected a small number of recommendations and particular behaviours to work on, consider strategies for making them happen. Make a tentative plan of what to do to address the issues you are focusing on. If you need more information, you might wish to consult some of the material in the references.

6. Discuss the plan with others

Take time to get input on your plan from people it will affect, those whose engagement is critical to success, and from trusted advisors who will give you helpful feedback. Consulting others is important for developing and sustaining collaborative health care.

7. Get started, then keep revising

Keep gathering feedback as you implement recommendations from this guideline and be responsive, adjusting your plan to reflect what you learn as you go. Developing and sustaining collaborative health care is a lifelong quest; **enjoy the journey.**

* **Terms throughout the document marked with the superscript symbol (^G) are defined in the Glossary of Terms (Appendix A).**

Purpose and Scope

Purpose:

A healthy work environment for nurses is a practice setting that maximizes the health and well-being of nurses, while ensuring the best possible outcomes for patients/clients, families, and the community, and improved organizational performance.

The goal of this best practice guideline is to strengthen collaborative practice among nurses, because effective collaborative practice is essential for working in health-care organizations.

In this guideline, we focus on collaborative practice amongst three types of nursing professionals – registered nurse (RN), registered practical nurse (RPN) and nurse practitioner (NP) – and explore what fosters healthy work environments for them, aware that collaboration must align with the needs of the patient or client.

To assist the review of the evidence on collaboration among intra-professionals these research questions were developed in consultation with the chair of the expert panel, the RNAO program manager, the University Health Network librarian and RNAO nursing research associates:

1. What physical/structural/policy components affect collaborative practice among nurses?
2. What cognitive/psycho/socio/cultural components affect collaborative practice among nurses?
3. What professional/occupational components affect collaborative practice among nurses?

(See HWE Model on pg. 21 for further details on terms)

Scope:

This best practice guideline was developed to assist nurses, nursing leaders, other health professionals and senior managers to enhance positive outcomes for patients/clients (individual/family/group/community), nurses, and the organization through intra-professional collaborative practice.

This guideline was based on the best available evidence and where evidence was limited, the best practice recommendations were based on the consensus of expert opinion.

This guideline identifies:

- best practices for intra-professional practice; and
- The organizational culture, values and relationships, and the structures and processes required, for developing and sustaining effective intra-professional nursing practice among nurses.

Target Audience:

This guideline is aimed at all categories of nurse in all roles and practice settings, including administrators at the unit, organizational and system level, clinical nurses, students, educators and researchers. It is also for use by policy makers and governments, professional organizations, employers, labour groups and federal, provincial and territorial standard-setting bodies.

Other health care professional groups that incorporate different categories of professionals may also find this guideline useful.

Guiding Principles and Assumptions

- All categories of nurses work together in a holistic^G model to facilitate continuity of care
- The College of Nurses of Ontario outlines the competencies for each category of nurse
- The respective environment is a factor that must be considered when guiding nursing assignments
- Respecting and understanding the roles of each nursing category facilitates effective intra-professional collaborative practice among nurses.
- Nursing assignments are guided by the acuity (stability, predictability, risk of negative outcome, and complexity) of the patient's/clients' condition.
- Nursing is based on relationships with patients or clients and team members.
- Effective teams produce better outcomes for patients/clients and team members.

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:

- Individual/team recommendations
- Organizational recommendations
- External/system recommendations

This 2nd Edition *Intra-professional Collaborative Practice among Nurses* (2016) replaces the RNAO BPG Collaborative Practice among Nursing Teams Guideline (2006).

We have used these symbols for the recommendations to indicate to the user how the guideline was updated based on the new evidence:

- ✓ No change was made to the recommendation as a result of the systematic review evidence.
- ⊕ The recommendation and supporting evidence were updated with systematic review evidence.

NEW A new recommendation was developed based on evidence from the systematic review.

INDIVIDUAL/TEAM RECOMMENDATIONS		TYPE OF EVIDENCE	STATUS
1.0 Nursing Collaborative Practice Individual/Team Recommendations	<p>Recommendation 1.1:</p> <p>Nurses develop an understanding of the roles, values and behaviours that support intra-professional collaborative practice by:</p> <ul style="list-style-type: none"> ■ learning about the attributes of supportive teams; and ■ demonstrating willingness to work effectively with others. 	IV	⊕
	<p>Recommendation 1.2:</p> <p>Nurses acquire and demonstrate the attributes of team work through:</p> <ul style="list-style-type: none"> ■ learning about the impact of interpersonal factors on the team; ■ team building activities; ■ demonstrating their commitment to the team; and ■ communicating effectively and openly, based on a clear understanding of their own roles scope of practice, and those of other team members. 	IV	⊕

INDIVIDUAL/TEAM RECOMMENDATIONS		TYPE OF EVIDENCE	STATUS
<p>1.0 Nursing Collaborative Practice Individual/Team Recommendations</p>	<p>Recommendation 1.3:</p> <p>Nurses initiate collaborative processes to improve patient/client outcomes, in particular when the acuity of the patient/client is increasing:</p> <ul style="list-style-type: none"> ■ in circumstances when a diagnosis has not been established, the patient should be assigned to an RN to ensure the continuity of care 	IV	+
	<p>Recommendation 1.4:</p> <p>Nurse managers model effective team behaviour and demonstrate power-sharing.</p>	IV	+
	<p>Recommendation 1.5:</p> <p>Nurses enhance the quality of work environments and improve outcomes for patients/clients by establishing processes and structures to promote intra-professional collaboration. Nurses should do this by:</p> <ul style="list-style-type: none"> ■ collaboratively establishing processes for shared decision-making in a variety of circumstances; and ■ introducing non-hierarchical, democratic working practices. 	Ia, IIb, IV	+
	<p>Recommendation 1.6:</p> <p>Nurses promote open, honest and transparent communication by</p> <ul style="list-style-type: none"> ■ promoting a culture of effective communication; and ■ establishing processes for verbal, written and electronic communication. 	IV	+
	<p>Recommendation 1.7:</p> <p>Nurses promote intra-professional collaborative practice by creating supportive learning environments and participating as mentors to students.</p>	Ia, IV	+

ORGANIZATIONAL RECOMMENDATIONS		TYPE OF EVIDENCE	STATUS
2.0 Nursing Collaborative Practice Organizational Recommendations	<p>Recommendation 2.1:</p> <p>Organizations develop strategies to encourage and enable effective teamwork.</p>	IV, V	+
	<p>Recommendation 2.2:</p> <p>Organizations build a transformational⁶ or relational⁶ leadership culture that provides clear policies and supports effective teamwork.</p>	Ia, IV	+
	<p>Recommendation 2.3:</p> <p>Organizations develop systems and processes that promote collaboration and continuity of patient/client care. They can do that by:</p> <ul style="list-style-type: none"> ■ implementing shared governance models that empower staff at all levels ■ supporting all nursing staff working to their full scope of practice; and ■ encouraging staff to engage in communities of practice for support and mentorship. 	IV	+
	<p>Recommendation 2.4:</p> <p>Organizations develop systems and processes to support nurses engaging in intra-professional practice. They can do this by:</p> <ul style="list-style-type: none"> ■ developing and providing intra-professional learning opportunities and evaluating effectiveness ■ developing competencies for intra-professional practice that are linked to performance appraisals ■ providing opportunities for feedback on intra-professional practice 	IIb	NEW

ORGANIZATIONAL RECOMMENDATIONS		TYPE OF EVIDENCE	STATUS
2.0 Nursing Collaborative Practice Organizational Recommendations	<p>Recommendation 2.5:</p> <p>Organizations develop outcome measures for evaluating the effectiveness of intra-professional collaborative practice. Those indicators could include</p> <ul style="list-style-type: none"> ■ patient/client and family experience and satisfaction; ■ nursing turnover rates, overtime, absenteeism, engagement and satisfaction; ■ infection rates, fall ratios, re-admission rates. ■ delayed or missed nursing interventions, gaps in continuity of care and caregiver, appropriate staff mix and skill levels; and ■ eliminating obstacles (e.g. broken or malfunctioning equipment, complacency) to evaluation processes. 	IIb	+
	<p>Recommendation 2.6:</p> <p>Organizations encourage and develop preceptors in order to make the intra-professional collaborative environment more welcoming for students and new staff. They can do this by:</p> <ul style="list-style-type: none"> ■ Assigning preceptors from the same class of nursing (e.g. RN student to RN preceptor) ■ selecting, assigning and supporting willing preceptors to work with students or new staff placed on the team; ■ informing preceptors of students' learning objectives and ensuring good communication between academic and clinical settings; and ■ reducing preceptors' caseloads to give them sufficient time to meet student nurses' learning objectives. 	Ia, IV	NEW
	<p>Recommendation 2.7:</p> <p>Organizations develop conflict management policies, practices and interventions by teaching and supporting managers and colleagues to address intra-professional relational challenges.</p>	IV	NEW

EXTERNAL/SYSTEM RECOMMENDATIONS		TYPE OF EVIDENCE	STATUS
3.0 Government Recommendations	<p>Recommendation 3.1:</p> <p>Governments promote sustainable intra-professional collaborative nursing by allocating funding for</p> <ul style="list-style-type: none"> ■ Intra-professional collaborative team development and evaluation initiatives; ■ nursing leadership development initiatives; ■ design, implementation and evaluation of approaches for safe and equitable workload; ■ technology to support team interaction; ■ staffing levels to provide person-centred models of care; and ■ recruitment and retention. 	IIb, IV	+
4.0 Research Recommendations	<p>Recommendation 4.1:</p> <p>Research is needed on how changing work structures affect intra-professional collaborative nursing in all health-care sectors.</p>	IIb, IV	+
5.0 Accreditation	<p>Recommendation 5.1:</p> <p>Health services accreditation bodies include evidence-based standards and criteria for collaborative intra-professional practice as part of their standards.</p>	IIb	✓

EXTERNAL/SYSTEM RECOMMENDATIONS		TYPE OF EVIDENCE	STATUS
6.0 Education	<p>Recommendation 6.1:</p> <p>Educators and educational institutions promote professionalism and intra-professional collaborative nursing and be role models of both. They can do this by</p> <ul style="list-style-type: none"> ■ introducing case studies that depict realistic team issues and scenarios (building the complexity along the continuum of the program); ■ focusing elective courses on teams and team functioning; ■ offering courses on respectful interaction and conflict resolution; ■ setting learning objectives focused on social and relational issues; ■ demonstrating collaborative teamwork during clinical placements; and ■ providing students with accurate information on role clarity and responsibilities of all members of the health-care team. 	IIb, IV	+
7.0 Nursing Professional/Regulatory	<p>Recommendation 7.1:</p> <p>Nurse professional and regulatory bodies (provincial and national) work together to help their members become more informed about their own and their colleagues' roles in the health system. They can do this by</p> <ul style="list-style-type: none"> ■ discussing roles and responsibilities associated with their education, skills and knowledge; and ■ promoting respectful, egalitarian relationships. 	IIb, IV	+

Interpretation of Evidence

Types of Evidence

Ia	Evidence obtained from meta-analysis ⁶ or systematic reviews ⁶ of randomized controlled trials, and/or synthesis of multiple studies primarily of <i>quantitative</i> research.
Ib	Evidence obtained from at least one randomized controlled trial ⁶ .
IIa	Evidence obtained from at least one well-designed controlled study ⁶ without randomization.
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study ⁶ , without randomization.
III	Synthesis of multiple studies primarily of <i>qualitative</i> research ⁶ .
IV	Evidence obtained from well-designed, non-experimental, observational studies, such as analytical studies ⁶ or descriptive studies ⁶ , and/or qualitative studies.
V	Evidence obtained from expert opinion or committee reports, and/or clinical experiences of respected authorities.

**The evidence chosen to support the recommendations has been identified as *types of evidence* in relation to the source or study type i.e. meta analysis, expert opinion etc. and does not reflect a hierarchical importance or strength of the evidence on which the recommendation is based.



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Stakeholder Acknowledgement

Part of the RNAO's guideline development process is a commitment to obtaining feedback from a variety of stakeholder reviewers⁶. These are individuals who have expertise in the guideline's subject, or represent organizations that will implement the guideline or be affected by it. Reviewers may be nurses from a wide range of practice settings and roles, other point-of-care providers, research experts, members of the interdisciplinary team, educators, nursing students, or patients/clients. Knowledgeable administrators, funders of health-care services and related associations are also consulted. Our aim is to gather expertise and perspectives from a diversity of health-care sectors, roles and geographic locations, including international regions. We want to acknowledge the following individuals for their own contribution in reviewing this best practice guideline:

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Stakeholder reviewers for RNAO guidelines are recruited in one of two ways. Some volunteer through a public call issued on the RNAO website (<http://rnao.ca/bpg/get-involved/stakeholder>). Others, key individuals and organizations with expertise in the guideline topic, are identified by the RNAO guideline development team and expert panel and are invited to participate.

Reviewers read a full draft of the guideline then submit their feedback on-line by completing a survey questionnaire. The stakeholders are asked these questions about each recommendation:

- Is this recommendation clear?
- Do you agree with this recommendation?
- Does the evidence support this recommendation?
- Does this recommendation apply to all roles, regions and practice settings?

This survey also includes opportunity to provide comments and feedback for each section of the guideline.

Survey submissions received are compiled and feedback is summarized by the guideline development team, and then reviewed by the expert panel, which, if necessary, modifies the guideline's content and recommendations to address the feedback. Our reviewers have consented to having their names and contact details published in this guideline.

Healthy Work Environments Best Practice Guidelines Background

Nurses are essential for achieving and sustaining affordable access to high-quality, timely health care for Canadians. Studies document the positive relationship between healthy work environments and the quality of patient/client care. A healthy work environment that maximizes health and well-being is essential for achieving the best outcomes for patients, clients and organizations.

A healthy work environment for nurses recognizes their professionalism and their ability to work autonomously and to lead. Healthy work environments are safe, collaborative and diverse, with reasonable workloads. But a healthy work environment is not easy to create, and there are many pressures – rising costs, pressure to increase productivity and 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). The report was submitted to the Ontario Ministry of Health and Long-Term Care in 2000 and approved by the Joint Provincial Nursing Committee (JPNC). The Healthy Work Environments Best Practice Guidelines Project was based on needs identified by the JPNC and the Canadian Nursing Advisory Committee (CNAC, 2002).

Guideline work began in July of 2003, when the Registered Nurses' Association of Ontario, with funding from the Ontario Ministry of Health and Long-Term Care, began a partnership with Health Canada's Office of Nursing Policy. From the beginning, we were committed to creating evidence-based guidelines, to ensure the best possible outcomes for nurses and their patients/clients, as well as for health care organizations and the system as a whole.

We found plenty of evidence on the relationship between nurses, work environments, patient/ client outcomes and organizational and system performance (Dugan et al., 1996; Estabrooks, Midodzi, Cummings, Rickers, & Giovannetti, 2005; Lundstrom, Pugliese, Bartley, Cox, & Guither, 2002). A number of studies have shown strong links between insufficient nurse staffing and adverse patient/client outcomes (ANA, 2000; Blegen & Vaughn, 1998; Cho, Ketefian, Barkauskas, & Smith, 2003; Kovner & Gergen, 1998; Needleman & Buerhaus, Mattke, Stewart, & Zelevinsky, 2002; Pearson 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 by reducing absenteeism, lost productivity, health-care costs for workers and costs arising from adverse outcomes (Aldana, 2001).

Other reports and articles have documented the challenges of recruiting and retaining a healthy nursing workforce (CFNU 2013; Bauman et al., 2001). Some have suggested the nursing shortage is a result of unhealthy work environments (Dunleavy, Shamian, & Thomson, 2003; Grinspun, 2002; Shindul-Rothschild, Berry & Long-Middleton, 1996).

Achieving healthy work environments for nurses requires interventions aimed at underlying workplace and organizational factors (Lowe, 2004). Those could include efforts to improve communication, collaboration, decision-making, recognition and leadership and introducing new staffing models, (AACN 2002). These guidelines are designed to help bring about transformational change. We believe that focusing on creating healthy work environments will benefit not only nurses but other members of health-care teams as well. We also believe 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 maximizes the health and well-being of nurses, improves patient and client outcomes, increases organizational performance and benefits society.

THE REGISTERED NURSES' ASSOCIATION OF ONTARIO HAS PRODUCED TEN HEALTHY WORK ENVIRONMENTS BEST PRACTICE GUIDELINES:

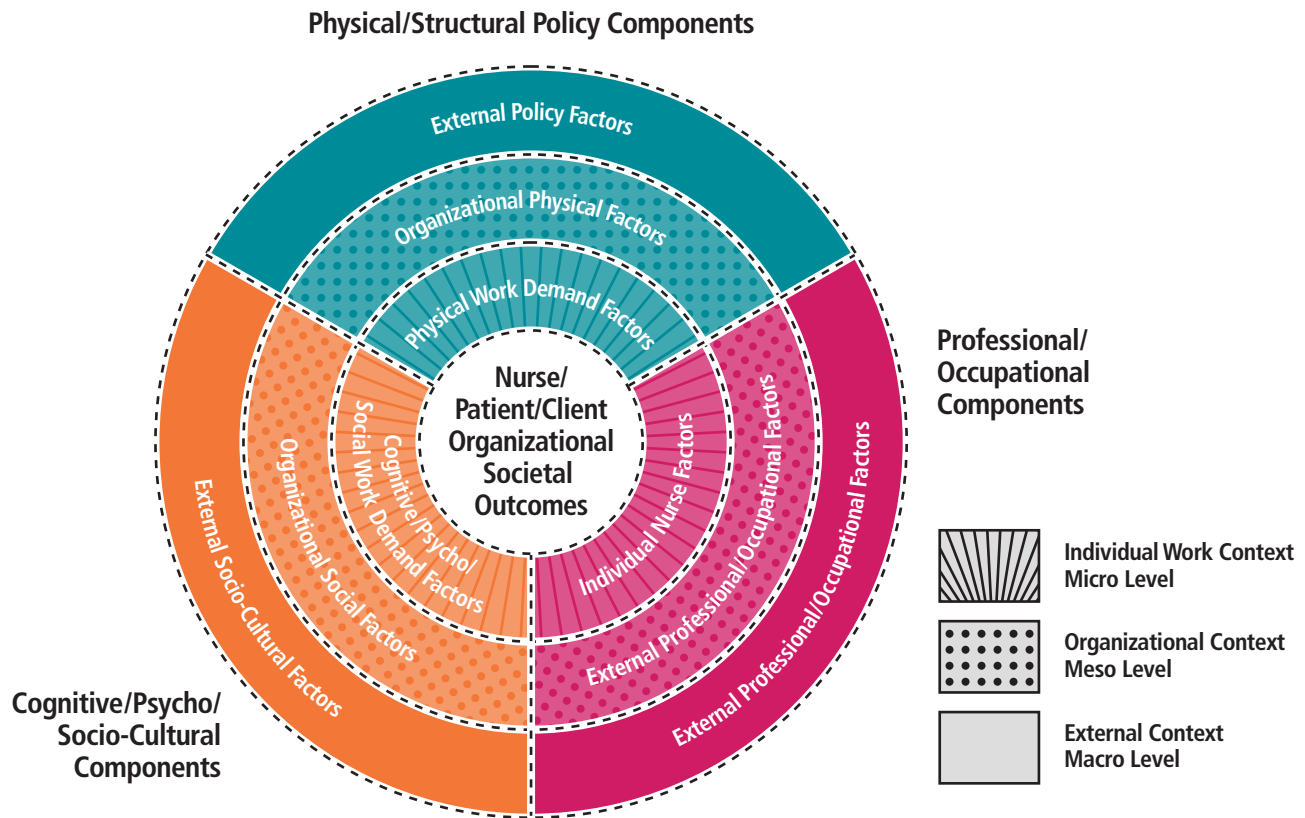
- Intra-professional collaborative practice among nursing teams*
- Developing and sustaining effective staffing and workload practices
- Developing and sustaining inter-professional health care: Optimizing patient/client, organizational and system outcomes
- Developing and sustaining nursing leadership*
- Embracing cultural diversity in health care: Developing cultural competence
- Managing and mitigating conflict in health-care teams
- Preventing and managing violence in the workplace
- Preventing and mitigating nurse fatigue in health care
- Professionalism in nursing
- Workplace health, safety and well-being of the nurse

*Second edition available



Organizing Framework for the Healthy Work Environments Best Practice Guidelines

Figure 1. Conceptual Model for Healthy Work Environments for Nurses – Components, Factors & Outcomesⁱ⁻ⁱⁱⁱ



HEALTHY WORK ENVIRONMENT BEST PRACTICE GUIDELINES

Healthy work environments are practice settings that maximize the health and well-being of nurses, and other health-care team members and improve patient/client outcomes, organizational performance and societal outcomes. They comprise numerous components – such as policy, physical demands and organizational design – and the relationships among them, making them complex and multidimensional. We have tried to capture the nuances and challenges of healthy workplaces in this illustration, in hopes mapping these concepts will be helpful as you develop, implement and evaluate your approach to enhancing nurses’ work environments.

In our model, the interdependence of individual, organizational and external system determinants is presented as three concentric rings. At their core are the beneficiaries of healthy work environments: nurses, patients/clients, organizations and systems, and society as a whole. The lines within the model are dotted, showing the synergistic interactions among all components of the model.

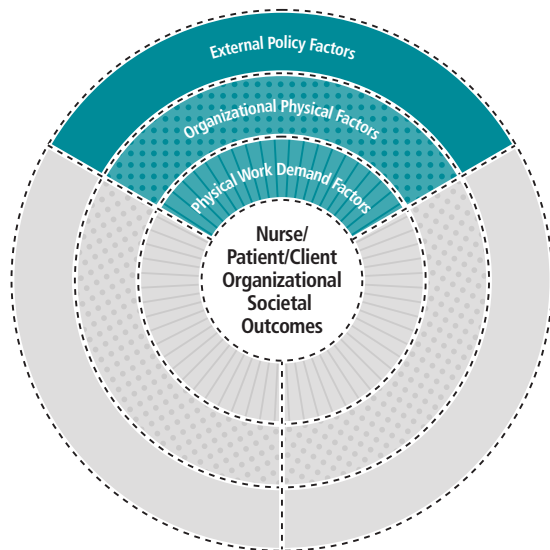
Those synergistic interactions among factors at every level are what mediate and influence individual experience, which is why interventions to promote healthy work environments must be aimed at multiple levels and components of the system – and indeed, at the system itself; they all come into play in determining whether a work environment is healthy.

The assumptions underlying the model are:

- healthy work environments are essential for high quality, safe patient/client care;
- individual, organizational and system-level factors determine whether a work environment is healthy ;
- factors at all three levels (individually or in combination) affect the health and well-being of nurses, the quality of patient/client outcomes, organizational and system performance, and societal outcomes;
- at each level, there are policy components, cognitive/psycho/social/cultural components and professional/occupational components; and
- Professional/occupational factors are unique to each profession, while the remaining factors are generic for all professions/occupations.

Physical/Structural Policy Components

Figure 1A. Physical/Structural Policy Components

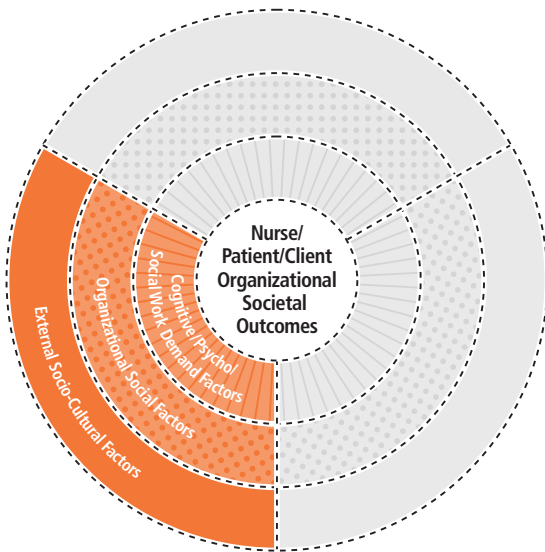


- For individuals, physical work demands include any requirement for physical capability and effort, such as workload, changing schedules and shifts, heavy lifting, exposure to hazardous or infectious substances and threats to personal safety.
- An organization’s physical environment includes both built and natural characteristics and structures and processes created to respond to the physical demands of the work. That includes staffing practices, flexible or self-scheduling, lifting equipment, occupational health and safety policies and security personnel.
- External policy factors include everything from the local health-care delivery model to funding and the legislative, trade, economic and political frameworks that shape society.

- 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, 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 Administration*, 5(2):12-16.
- iv Hancock, T. (2000). The Healthy Communities vs. “Health”. *Canadian Health Care Management*, 100(2), 21-23.
- 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
- vi Grinspun, D., (2000). Taking care of the bottom line: shifting paradigms in hospital management. In Diana L. Gustafson (ed.), *Care and Consequence: Health Care Reform and Its Impact on Canadian Women*. Halifax, Nova Scotia, Canada. Fernwood Publishing.
- vii Grinspun, D. (2010). *The Social Construction of Nursing Caring*. (Doctoral Dissertation, York University).

Cognitive/Psycho/Socio-Cultural Components

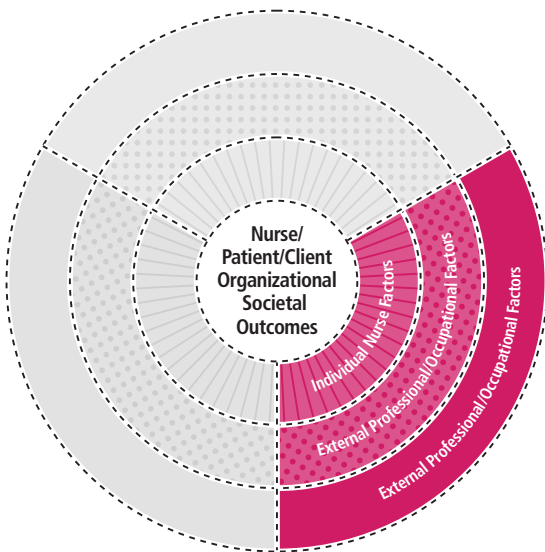
Figure 1B. Cognitive/Psycho/Socio-Cultural Components



- Individuals need cognitive and psycho-social work skills such as clinical knowledge, effective coping skills, and communication skills to function. Psycho-social and cultural factors that affect nurses include clinical complexity, job security, team relationships, emotional demands, and role clarity and role strain.
- An organization’s social factors are essentially its climate, culture and values. Organizational stability, communication practices and structures, labour-management relations and a culture of continuous learning and support shape social factors.
- External socio-cultural factors include consumer trends, changing care preferences, changing roles in families, the diversity of the population and of providers, and changing demographics – all of which influence how organizations and individuals operate.

Professional/Occupational Components

Figure 1C. Professional/Occupational Components



- The factors of individual nurses that affect the health of the work environment include the personal attributes, skills and knowledge that determine how she/he responds to the physical, cognitive and psycho-social demands of work. Those attributes include commitment (to his or her patient/client, organization and profession) and resilience, adaptability, self-confidence and the ability to maintain work/life balance. Knowledge and skills that influence the work environment include values and ethics and reflective practice.
- The organizational, professional and occupational factors that shape a healthy work environment are the nature and role of the profession or occupation. For nurses, they include their scope of practice, the level of autonomy they have over their practice, and the nature of their inter-professional 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: Guideline on Intra-professional Collaborative Practice among Nurses

Defining Intra-professional Collaborative Practice:

Nursing is a profession that requires effective inter-professional and intra-professional relationships to provide positive outcomes for patients/clients. Intra-professional practice occurs when multiple members of the same profession work collaboratively to deliver quality care within and across settings (College of Nurses of Ontario, 2014). This guideline focuses on the registered nurse^G (RN), the registered practical nurse^G (RPN) and the nurse practitioner^G (NP) working collaboratively to deliver safe effective care to diverse patient populations.

Collaboration is both a process and an outcome in which shared interest is addressed by key stakeholders. A key stakeholder is any party directly influenced by the actions others take to solve the issue. The collaborative process involves a synthesis of perspectives to better understand complex problems. A collaborative outcome is the development of integrative solutions provided by input from various parties (Gardner, 2005).

The terms **teamwork and collaboration** are used synonymously in the literature to express relationships between members of a team. Nurse-to-nurse intra-professional collaborative practice is complex in every setting, position, generation and experience (Bjarnadottir, 2011), and high-quality, collaborative, respectful relationships are vital for communication, interaction and positive outcomes for patients/clients and job satisfaction for nurses (Antoniazzi, 2011).

There are positive outcomes for patients/clients and health-care teams linked to effective intra-professional collaboration that can be achieved by building supportive resilient teams; fostering collegialism; improving the collaboration between new grads, managers, practical nurses, nurse practitioners, and registered nurses; and valuing respectful and effective communication between nurses (Bournes & Milton, 2009). Team work enables continuity of care giver as well as continuity of care as key pillars of safe patient/client care. In addition effective team work and role clarity enables critical decisions to be made that support assignment of the most appropriate category of nurse to care for a patient/client based on acuity (stability, predictability, risk of negative outcome, and complexity) of the patient's/client's condition.

With the mounting evidence of the importance of these relationships there is a need to examine the multiple factors relevant to intra-professional collaborative practice among nurses that need to be considered to foster healthy work environments, quality patient care and the retention and recruitment of nurses. The RNAO expert panel used the framework for healthy work environments to organize the recommendations within this guideline for intra-professional collaborative practice. As such you will find the recommendations address physical/structural and policy components; cognitive/psychosocial and cultural components; and professional components. The types of factors relevant at the individual/team, organizational, and external/system level are summarized in each section.

Individual/Team Recommendations

1.0 INDIVIDUAL/TEAM RECOMMENDATIONS

RECOMMENDATION 1.1:

Nurses develop an understanding of the roles, values and behaviours that support intra-professional collaborative practice by:

- learning about the attributes of supportive teams; and
- demonstrating willingness to work effectively with others.

Type of Evidence = IV

Discussion of Evidence:

Definition: Intra-professional collaborative practice

Multiple members of the same profession working together to deliver quality care (College of Nurses of Ontario, 2014).

As key members of the health care team, nurses are in a unique position to enhance team effectiveness and improve patient/client outcomes through strong intra-professional collaboration. Nurses can lead or participate in designing and implementing systems that support intra-professionalism by acquiring knowledge of the attributes and competencies of effective, intra-professional teams.

One moderate, cross-sectional study in a community hospital in Ontario found that knowing about the values and behaviour that support team work had a positive effect on unit cohesiveness and efficacy (Siu et al., 2008). The nurses in the study initially ranked their unit effectiveness and core self-evaluations as high without any intervention. This group demonstrated knowing values and behavior that supports team work. These core self-evaluations revealed the qualities they possessed to support team work which had a positive, direct, effect on both the professional practice environment and conflict management. It was also noted the quality of conflict management had a direct effect on unit effectiveness (Siu et al., 2008).

Nurses demonstrate willingness to work effectively with others

The literature shows that nurses who have a clear understanding of roles, responsibilities and competencies support and achieve intra-professional collaborative practice. To facilitate and participate fully in intra-professional collaborative practice nurses need to understand clearly their full scope of practice in the setting where they work, be secure within their professional team and communicate effectively (Eagar, Cowin, Gregory & Firtko, 2010), (Aper, Propp, Zabava Ford & Hofmeister, 2006).

How well nurses' work as a team can affect the quality of the care they provide. If there are communication issues or problems with interaction, patient/client care can be compromised. Intra-professional collaboration goes beyond improving work interactions for nurses to improving the care they provide to patients/clients.

RECOMMENDATION 1.2:

Nurses acquire and demonstrate the attributes of team work through:

- learning about the impact of interpersonal factors on the team;
- team building activities;
- demonstrating their commitment to the team; and
- communicating effectively and openly, based on a clear understanding of their own roles scope of practice, and those of other team members.

Type of Evidence = IV

TEAMWORK ATTRIBUTES^G

- | | | |
|-------------------|--------------------------|--------------|
| ■ Mutual Respect | ■ Open Communication | ■ Resilience |
| ■ Accountability | ■ Self-awareness | ■ Honesty |
| ■ Shared Planning | ■ Emotional Intelligence | ■ Enthusiasm |

Discussion of Evidence:

Interpersonal factors and commitment to the team

In a moderate, qualitative nursing research study “Work Engagement among Nurses in Relationally Demanding Jobs in the Hospital Sector,” Bjarnadottir states personal resources and interpersonal factors contribute to team building. One important resource of interpersonal factors is accountability – for behaviour and decisions, for ensuring proper charting is completed, and for assessing personal performance in relation to the expected outcomes of care. Interpersonal factors include communicating patient/client needs clearly and respectfully and showing enthusiasm. Being motivated and committed to work as a team member are also essential components in developing an effective and cohesive team that practices collaboratively (Bjarnadottir, 2011). An example of a team building activity is attending workshops together and being fully engaged in them. This activity demonstrates a commitment to team building (Kalb and O’Conner-Von, 2012).

A weakly rated 2011 mixed-methods study by France, Byers, Kearney, and Myatt, which explored critical care nurses’ perceptions of their work environment, found that along with commitment, interpersonal factors that play a key role in working intra-professionally include trust, respect and empowerment. They contribute to positive intra-professional practice and are critical components for a healthy working environment.

A moderate, cross-sectional study (Huynh, Alderson, Nadon & Kershaw-Rousseau, 2011) found registered nurses respect for the assessment skills of licensed practical nurses promoted collaboration. The same study found the most common organizational factors facilitating collaboration were leadership style, teamwork, and the equitable distribution of workload between registered nurses and licensed practical nurses.

Effective open communication

Open, effective communication is a key competency of a culture that supports effective teamwork (Garon, 2012). Communication has been identified as a key determinant of successful collaboration among nurses and a vital component in workplace health (Hartung & Miller, 2013). In her moderate, qualitative study Garon invited 33 registered nurses working in point-of-care or management positions in California to a focus group which explored nurses' perceptions of their personal ability to speak up and be heard in the workplace. The nurses said speaking up and being heard greatly improved job satisfaction, team work and patient/client safety.

Every person communicates in a style based on their knowledge, skills, experiences, cultural background, gender, education, language, values and assumptions and should be aware of the impact personal characteristics may have on communication (Garon, 2012). Effective communication requires team members to reflect and develop self-awareness of how they communicate with patients/clients and colleagues, who can help them, understand their personal and professional values (Barrett, Piatek, Korber & Padula 2009).

Understanding roles, scope of practice and teamwork

Role ambiguity can interrupt the effectiveness of a team and have a negative impact on job satisfaction. Nurses need to have and demonstrate role clarity to optimize the quality of patient/client care and patient/client safety (Oelke et al 2008).

Nurse managers could reduce or eliminate role ambiguity and role conflict on the unit with clear policies outlining roles, and clear values related to patient care such as continuity of care giver, continuity of care, and a model of primary nursing care, (Wu & Norman, 2006), which would assist managers, resource nurses and point-of-care nurses in making decisions about care giver assignments. It would also help them understand the distinct contributions each category of nurse provides through their knowledge and skills.

To support the understanding of roles, nurse educators could use case scenarios depicting various roles and the needs of patients along the continuum of care to assist all nurses and inter-professional teams to identify their roles and further educate team members on their scopes of practice. The scenarios should demonstrate working together to contribute knowledge and skills to patient/client care in a process of continuous communication and shared decision making (RNAO, 2014). This could help nurses gain an understanding of their profession and develop an ability to articulate their knowledge and contributions as a profession and as part of the team (Burgess & Purkis, 2010).

Nurse practitioners and teamwork

In a 2011 moderate, participatory action study, Burgess and Purkis sought to provide a brief history of the nurse practitioner role from a Canadian and British Columbia perspective (using the participative action research methodology) and report the study findings particular to the effects of collaboration on nurse practitioner role integration. They studied 17 nurse practitioners and looked at the effects of collaboration on the integration of nurse practitioners in two health authorities in British Columbia. The study found nurse practitioners held a strong commitment to the team and valued each member's unique contribution. The nurse practitioners said collaboration among the nurse-team fostered autonomy and allowed them to create new relationships and enhance patient/client care. This collaboration further enhanced teamwork and the group demonstrated a sense of team spirit, mutual respect, sharing and trust.

Burgess and Purkis (2011) also concluded there is a political aspect to the nurse practitioner role, and nurse practitioners rely on collaborative relations to advance integration of their role. As a philosophy, collaboration denoted nurse practitioner commitment to egalitarian power relations, whereby all team members were valued for their unique and significant contributions to decision-making. As a practice, collaboration signified the enactment of this philosophy, in which nurse practitioners fostered and modeled the sharing of knowledge and expertise. Collaboration fostered nurse practitioner autonomy to explore new practice approaches, cultivate new partnerships, and be responsive to clients and communities. And nurse practitioner autonomy enabled them to construct innovative collaborations to advance primary health care practice. In this way, collaboration and autonomy had reciprocal effects, in which the nurse practitioners were enabled to more fully enact their roles.

In order to work collaboratively, nurse practitioners foster and model the sharing of expertise within the team, and demonstrate a commitment to egalitarian power relationships (Burgess & Purkis 2011).

Scope of practice and teamwork

Scope of practice^G is a term used across health-care that describes the “who, what, where, when, why, and how” of nursing. The term has various definitions, and so is used widely but inconsistently, which has contributed to role ambiguity (RPNAO, 2014). The ambiguity associated with overlapping scopes of practice leads to confusion not only among health-care professionals, but also patients/clients and by extension the public (Malloch & Ridenour, 2014).

Confusion surrounding scope of practice can lead to frustration and conflict among nurses and negative outcomes, particularly in medication administration, patient/client allocations and workload (Eagar, Cowin, Gregory, & Firtko, 2010).

A moderate, qualitative comparison study from Australia explored nursing team communication and scope among 30 prepared registered nurses and “enrolled” nurses, who study for 12-18 months and receive a certificate. Participants reported concerns on being bullied, stressed and harassed as a result of confusion surrounding scope of practice. The potential for negative patient/client outcomes in the areas of medication administration, patient/client allocation and workload was of equal concern (Eagar et al 2010).

To support effective team work and avoid conflict and negative consequences for the intra-professional team and its patients, nursing team members should clearly understand their roles and scope (Eagar et al 2010). Nurse Managers can provide additional support for effective teamwork by conducting regular reviews of factors that contribute to effective teamwork and job satisfaction for nurses (Hayes, Bonner & Pryor, 2010).

RECOMMENDATION 1.3:

Nurses initiate collaborative processes to improve patient/client outcomes, in particular when the acuity of the patient/client is increasing.

Type of Evidence = IV

Discussion of Evidence:

In the past 20 years patient/client care has become increasingly complex. The complexity of a patient/client’s condition influences the nursing knowledge needed to provide appropriate care – a more complex patient/client situation and less stable environment increase the need for consultation (College of Nurses of Ontario, 2014).

Within the context of intra-professional practice, nurses and nurse managers role model safe quality care through patient/client assignments that reflect the most appropriate care provider based on patient/client acuity and a model of care enabling one primary patient/client care lead, continuity of care giver and continuity of care. Respecting and understanding the contributions of everyone on the intra-professional team facilitates nurses practicing to their full scope, enhances collaboration and leads to improved client outcomes (College of Nurses of Ontario, 2014). Patient/client assignments need to be based on level of patient/client acuity (stability, predictability, risk of negative outcome, and complexity), within the context of a model of primary nursing care, continuity of care giver, continuity of care and collaborative practice. Experienced nurses develop skills to collaborate and assess the potential success of nursing interventions before approaching a situation.

Duddle and Boughton noted in an explanatory study, with a weak methodological design (2007) that intra-professional relationships among nurses are very complex and collaboration in this group is fundamental to patient/client care. Intra-professional relationships are especially critical when nurses are communicating patient/client information, planning care or during procedures and at times of increased patient/client acuity.

RECOMMENDATION 1.4:

Nurse managers model effective team behaviour and demonstrate power-sharing.

Type of Evidence = IV

NURSE MANAGER ATTRIBUTES

- Approachable
- Emotional Intelligence
- Honesty
- Affirming behaviours
- Appropriate communications
- Respect
- Open Communication

(Rouse, R.A. Al -Maqbali, M.2014)

Discussion of Evidence:

Working environments today put many demands on relationships, so building resilient teams is essential. Managers are leaders, and their behaviour is critical to creating work environments that foster high-quality patient/client care while meeting the demands of their organizations (Udod 2012). Nurse Managers need to be mentors, providing guidance and professional training according to staff needs (Bjarnadottir, A. 2011).

Using a strong, qualitative study, University of Saskatchewan researcher Sonia Udod looked at how hospital nurse managers exercise power. She found that because nurse managers play a critical role in modifying nurses' work environments, nurses seek connections with them. Where nurses were not engaged, managers depended on institutional practices and nurses resisted them. However, in settings where managers shared power and treated nurses as collaborators, patient outcomes improved (Udod, S.A. 2012).

Sharing power is willingness and a commitment to create balanced relationships. This can be accomplished through democratic practices of leadership, decision-making, authority and responsibility. Nurse Manager's can support intra-professional collaboration by:

- establishing clear values related to quality of patient/client care
- leveraging opportunities for all team members to contribute
- creating balanced power relationships
- establishing a safe environment for diverse opinions to be expressed and
- consider the various points of views from care providers. (RNAO, 2013).

To support intra-professional collaboration among nurses, nurse managers should recognize their own power and cultivate qualities that facilitate power-sharing, which include open communication, conflict management, and an effective leadership style (Cilliers & Terblanche, 2010).

Open communication

One strong, descriptive, qualitative study that sought to understand communication patterns of nurse managers identified workplace processes that can help or hinder managers' ability to set a positive tone and stay connected with staff. It recommends ways to strengthen communication and overcome disconnects. They include lots of communication, whether it is spoken, written, and electronic or by social media (although generational differences should be considered when choosing a mode of communicating, to reach people in ways they're comfortable with). It is also important to be visible and to schedule regular time with staff, such as doing rounds with them (Hartung & Miller, 2013).

In a similar, moderately rated qualitative study (Garon, 2012) explored the perceptions of staff registered nurses and managers about nurses' ability to speak up and be heard in the workplace. The results of this study identified nurse managers as important in creating a communication culture where nurses felt safe to voice their thoughts. Garon also found communication from the nurse manager was best for creating a healthy work environment, when viewed as honest, and completed face to face on a regular basis (Garon 2012).

Conflict management

Nurse Managers need to support staff use of conflict-management strategies by modeling open and honest communication. Using a moderate, correlational study design, Morrison (2008) found that understanding how levels of emotional intelligence and conflict skills correlate can improve interpersonal relationships and help maintain a healthier work environment.

A qualitative study, with a weak methodological design, by St-Pierre (2012) found that visibility of nursing managers have a direct impact on how they are perceived as being an active member of the team. The study also reported that managers' visibility affects what information was reported to them and the use of appropriate communication by nurses. However, one of the study's key conclusions was that managing aggression or conflict is not the sole responsibility of managers; individuals at all levels should be involved, as appropriate.

Effective Leadership

Formal access to power through leadership is critical for building processes to promote and sustain nurses' control over practice (MacPhee, Wardrop, & Campbell, 2010). The critical need for power-sharing among management and nurses is discussed repeatedly in the literature. A moderately rated descriptive study by Scherb et al (2011) looked at how staff nurses and nurse managers rated their actual and preferred involvement in decisions on unit governance and leadership and collaboration or liaison activities. Staff nurses perceived themselves as less involved in decisions than their managers felt they were.

Scherb et al, concluded achieving greater staff nurse involvement in decisions would require a change in traditional staff nurse and nurse managers' roles and expectations. But the authors cautioned that staff nurses will need professional development if they are to be more involved in decision making. At the same time, organizations will need to assist and support nurse managers to develop the style, comfort, and skills that enable shared decision making.

A cross sectional study in Oman, using a weak methodological design, asked 1,526 nursing professionals what they felt were essential leadership skills for nursing managers. Results showed nurses wanted managers who were approachable and whose behaviour was affirming and collaborative. Appropriate tone and listening were essential for improving nurses' self-esteem and improved patient/client outcomes. Participants did not like managers whose critical behaviour was seen as emotionally demeaning and discouraging and they did not appreciate those who spoke harshly, showed favouritism or disciplined nurses publicly (Rouse & Al-Maqbali, 2014).

RECOMMENDATION 1.5:

Nurses enhance the quality of work environments and improve outcomes for patients/clients by establishing processes and structures to promote intra-professional collaboration. Nurses should do this by:

- collaboratively establishing processes for shared decision-making in a variety of circumstances; and
- introducing non-hierarchical, democratic working practices.

Type of Evidence = Ia, IIb, IV

Discussion of Evidence:

Processes and Structures

Clear and effective processes and structures provide opportunities for intra-professional collaboration. Morning rounds and team meetings promote face-to-face interaction and collaboration among nurses and other members of the health-care team. These forums have facilitated knowledge exchange, continuity of care and patient/client care planning for decades. They have also served in subtle ways to build teams and interpersonal relationships (McFetridge, Gillespie, Goode & Melby, 2007).

Mentorship shows promise in building interpersonal relationships and intra-professional collaboration. Results of a weakly rated, quasi-experimental (pre-post design) study that followed 92 mentor-mentee teams over three years in an academic-hospital partnership indicated positive results for staff satisfaction, mutual respect, a culture of support and improved patient/client outcomes in the pressure ulcers and falls. The mentors not only engaged in supporting fellow nurses but also assisted with enhancing the overall work environment for RNs (Latham, Hogan & Ringl, 2008).

A strong systematic review conducted by Pearson, et al., (2006) concluded team functioning can be improved by involving staff in developing and implementing unit policies and processes, such as principles for patient/client assignment, incorporating values of primary nursing care, and continuity of care giver, and of care. When a process is tailored to individual unit needs and combined with mentoring and coaching, it can promote a positive change in staff attitudes toward team structure, leadership, situation monitoring, mutual support and communication (Vertino, 2014).

Establishing processes for shared decision-making in a variety of circumstances

Conclusions in a systematic review conducted by Pearson et al. (2006) suggest that team functioning and collaboration can be improved by involving staff in the development and implementation of processes, structures and policies, such as scheduling practices, unit councils and occupational safety policies that impact day to day functioning.

Consistent with previous findings in the literature St-Pierre (2012) stressed the importance of developing processes with strategies to guide individuals on how to discuss issues with colleagues. They include meeting with all parties, addressing issues without delay and keeping the process as informal as possible. These strategies are important for staff satisfaction and were identified as factors influencing nurses' decisions on whether to resign (Estryn-Behar et al. (2007).

Introducing non-hierarchical, democratic working

The term “control over nursing practice” describes nurses' influence on decisions that affect their practice. Having control is associated with professional practice environments that result in nurse satisfaction and higher-quality patient outcomes (Weston, 2008).

A moderately rated cross-sectional survey of 456 registered nurses from five hospitals by Jessica Castner and colleagues identified that nursing autonomy over practice, nurse self-management, and shared governance are essential in enhancing the teamwork skills and behaviour of nurses. The results of this study provided a preliminary understanding of control over practice as a variable to be addressed in policy, practice and research on enhancing teamwork. The study also said that downplaying organizational power structures and incorporating non-hierarchical, democratic working practices (such as leadership, situation monitoring, mutual support, and communication) were crucial steps for enhancing patient safety (Castner, Ceravolo, Foltz-Ramos & Wu, 2013).

Similar positive results were also identified in Schraeder et al., 2008 by nurses utilizing the model of primary care as affording nurses' control over their practice and satisfaction. The study reported nurse case managers contributed to their patients'/clients' care by pro-actively identifying and reporting changes that had the potential to affect their patients'/clients' outcome. The nurse case manager in the study spent time to understand the patients'/clients' holistically beyond their acute stage, tailoring health education to meet the patients'/clients' needs, and following up with patients' including test and lab results (Schraeder, C., et al. 2008).

RECOMMENDATION 1.6:

Nurses promote open, honest and transparent communication by:

- promoting a culture of effective communication; and
- establishing processes for verbal, written and electronic communication.

Type of Evidence = IV

Discussion of Evidence:

Promoting a culture of effective communication

Communication is central to human interaction. Without it, people cannot relate to those around them, build relationships or make their needs and concerns known. Effective communication processes allow decision makers to access information required to make decisions for patients, themselves and their team (Casey & Wallis, 2011).

All nurses need to develop skills in active listening and use processes that support “clear, competent communication” – defined as openness, honesty and respect for the opinion of others, and a key competency for effective teamwork (RNAO, 2013).

Establish processes for verbal, written and electronic communication

Point-of-care nurses are at the hub of the communication process. Their work demands effective methods for communicating patient/client assessment, documentation, details of treatment and care; methods which allow them to handle sensitive information in a transparent yet confidential manner (Casey & Wallis, 2011).

Promoting a culture that allows nurses to speak up and be heard (i.e. through unit-based councils, staff meetings and managers with open-door policies (Garon, 2012), can promote and strengthen positive communication and a healthy workplace environment (Hartung & Miller, 2013).

RECOMMENDATION 1.7:

Nurses promote intra-professional collaborative practice by creating supportive learning environments and participating as mentors to students.

Type of Evidence = Ia, IV

ATTRIBUTES OF MENTORS

- Approachable
- Good coach
- Communicates openly
- Respectful
- Understands others' perspectives
- Shares experience
- Active listener

Discussion of Evidence:

Student placement and intra-professional collaborative practice

Several studies have identified the importance of supportive learning environments for developing intra-professional collaborative practice. Andrews' weakly rated qualitative study found that many factors affect whether a student has a positive placement; the attitude of the manager, how prepared their mentors were and whether preceptors were aware of their students' learning objectives (Andrews et al. 2006).

A cohort study with a weak methodological design by Borch found the mentor's views of their own ability and satisfaction in the role can be a support for students if the mentors are prepared (Borch, Athlin, Hov & Sorensen Duppils, 2013).

A strong systematic review by Pearson et al 2006, sought to identify the best available evidence on the effect of team characteristics that create a healthy work environment, supported the idea that negative relationships with clinicians inhibited students' learning (Pearson, et al, 2006). This is important for the nursing profession as positive clinical placement experience is related to high job satisfaction, and therefore potentially improves retention (Wu, L. & Norman, IJ (2006).

To build team cohesion and attract and retain nurses, organizations need to consider the additional workload on experienced nurses asked to mentor new nurses and managers need to be prepared to support them in that work. Experienced nurses also need to refresh and review their knowledge and skills in anticipation of the graduate's innumerable questions (Ballem & McIntosh 2014).

Organizational Recommendations

2.0 ORGANIZATIONAL RECOMMENDATIONS

RECOMMENDATION 2.1:

Organizations develop strategies to encourage and enable effective teamwork.

Type of Evidence = IV, V

Discussion of Evidence:

Intra-professional collaboration needs to be supported by organizational strategies and structures that allow nurses to participate fully in collaborative work. Creating support structures and strategies shows the organization values collaborative practices and teamwork. Those strategies and supports include recognizing the importance of teams, launching performance development processes and giving teams paid time to meet in a suitable, accessible location. Funds for educational programs on team functioning are crucial for effective teamwork (MacDavitt, Chou & Stone, 2007; Kalisch, Xie & Ronis, 2013).

Support from the organization for intra-professional development amongst nurses is important for aligning micro (e.g. staff education), meso (e.g., shared governance) and macro (e.g., health policy legislation) system supports, including enhancing competencies, developing effective work environments and providing intra-professional educational opportunities (MacDavitt, Chou & Stone, 2007).

Organizations that invest in education and provide incentives towards collaborative practice may see direct benefits related to teamwork, professional development, staff satisfaction and improved outcomes for the patient/client (Kalisch et al., 2013). A literature review, quasi-experimental studies with weak methodological design, supported by expert panel, confirm organizations also benefit from developing and consistently tracking outcome measures on the impact of collaborative teams on patient/client care and quality of work life (Vertino, 2014; Kalisch, Xie & Ronis, 2013; Kalisch & Lee, 2011).

RECOMMENDATION 2.2:

Organizations build a transformational^G or relational^G leadership culture that provides clear policies and supports effective teamwork.

Type of Evidence = Ia, IV

Discussion of Evidence:

Supporting a leadership culture

Group cohesion, collaboration and effective conflict management all showed significant positive associations with relationally focused or transformational leadership. There are five evidenced-based transformational leadership

practices: building relationships and trust, creating an empowering work environment, creating a culture that supports knowledge development and integration, leading and sustaining change, and balancing the positive outcomes for patients/clients and nurses (Cummings et al., 2010); (Hunt, Corazzini, & Anderson, 2014); (RNAO, 2013).

A moderate systematic review (Cummings et al., 2010) examined the relationship between various styles of leadership and outcomes for the nursing workforce and their work environments. The cumulative evidence reported in the review found distinctive differences between relational and task-focused leadership styles. Relationally focused also known as transformational leadership practices led to more encouraging outcomes including group cohesion than did task-focused leadership styles – including dissonant leadership, management by exception, transactional, instrumental and laissez-faire approaches. Specifically, relational leadership was linked to greater role clarity, team functioning, and reduced conflict and ambiguity. The authors concluded leadership styles that use *participative decision making* support intra-professional collaboration.

Participative decision-making

Participative decision-making and strong leadership is supported by a moderate, participatory action-research study that looked at nurse-leader shared decision making around workload issues. The study concluded effective work relationships among teams of staff and frontline leaders contributed to successful outcomes, but relationships between teams and operations leaders made the biggest difference (MacPhee et al., 2010).

Organizations need to assist and support nurse managers to develop the style, comfort and skills that enable participative decision-making with staff nurses. Staff nurses also need to be supported to become actively involved in decision making (Scherb et al., 2011). A moderately rated qualitative study on the experience of coaching nursing managers found that participants moved from being defensive to strong personal and leadership awareness during this transformative period (Scherb et al., 2011). Participants sought leadership roles with significantly more self-authorization, while being aware of and managing their personal and organizational boundaries.

Developing clear and consistent policies

The moderate systematic review by Cummings et al (2010) found team functions improved when leaders involved staff in developing and implementing of policies and the policies were clear and implemented consistently. Pearson et al (2006) came to the same conclusion using their strong systematic review.

Organizations can help leaders realize high levels of collaboration including utilization of clear policies, by assisting them to develop their leadership characteristics, starting with an evaluation of the leadership development needs of managers, charge nurses, clinical educators and point-of-care nurses (Hunt et al, 2014).

Leadership culture

Once the needs of the nursing staff are identified, supports and education should be put in place by the organization to promote transformational leadership practices and retain leaders.

In a longitudinal, qualitative case study researching management turnover in nursing homes its relation to quality of care and how staff responds to turnover, Hunt et al (2014) said support for leaders should include education on the components of leadership, decision making, coaching, team-building and conflict resolution.

RECOMMENDATION 2.3:

Organizations develop systems and processes that promote collaboration and continuity of patient/client care. They can do that by:

- implementing shared governance models that empower staff at all levels
- supporting all nursing staff working to their full scope of practice; and
- encouraging staff to engage in communities of practice for support and mentorship.

Type of Evidence = IV

Discussion of Evidence:

To provide nurses with a venue to address issues affecting practice, organizations should support unit-based shared governance councils, co-chaired by a front-line nurse and a member of the leadership team (Wright, Mohr & Sinclair, 2014; Latham, Hogan, & Ringl, 2008). A shared governance model has been linked to improved workplace environments and collaboration (Latham et al., 2008). Focusing on nursing autonomy over practice, nurse self-management, and shared governance is an essential practice for organizations to enhance teamwork among nurses (Castner et al., 2013).

A Canadian mixed-methods^G research study (Oelke et al., 2008) on scope of practice and team effectiveness found considerable overlap in tasks and role ambiguity, not only in nursing but across other disciplines as well. The weakly rated study found lack of role clarity among health-care professionals can contribute to duplication of effort, under-utilization of scarce human resources, tension in the workplace, less-than-ideal inter-professional relationships and potential to establish staff/provider mix models that do not optimize quality of patient care or patient safety (Oelke et al., 2008).

Confusion in scope of practice among categories of nurses can also result in some nurses feeling a lack of respect, which resulted in feelings of stress and being bullied and harassed.

Understanding the roles and scopes of practice of all nurses, and adhering to them along with other related policies, in staffing decision making can reduce intra-professional conflict between nurses (Eagar et al., 2010).

RECOMMENDATION 2.4:

Organizations develop systems and processes to support nurses entering intra-professional practice. They can do this by:

- developing and providing intra-professional learning opportunities and evaluating effectiveness
- developing competencies for intra-professional practice that are linked to performance appraisals
- providing opportunities for feedback on intra-professional practice

Type of Evidence = IIb

Discussion of Evidence:

Many different supports and processes contribute to the promotion and success of intra-professional practice in health-care organizations. Because intra-professional nursing teams function in complex, high-pressure situations and environments, organizations need to recognize the need for systems and processes to ensure appropriate staff-mix, staffing levels, and for developing collaborative practice.

Support systems and processes

Supports such as scheduling tools, procedures, policies, the model of care, medical directives, plans of care, best practice guidelines, care pathways, assessment tools, preprinted order sets and protocols for staff, all assist nurses in intra-professional work (CNO, 2014).

Systems are also needed to support mentorship, professional development, evaluation, collaboration and high-quality delivery of care, including orientation for novice nurses and others new to the practice environment. Ontario has the *New Graduate Guarantee Program*, a provincial initiative designed to support newly graduated registered nurses and registered practical nurses by providing them with a full-time job opportunity – one example of programs for new nurses (Ballem & MacIntosh, 2014), (Latham, Hogan, & Ringl, 2008).

Organizations should ensure new nurses get a full orientation before joining the intra-professional team; doing so, according to one comprehensive qualitative descriptive study, has a positive impact on how nursing teams function (Andrews 2013). Nurses should not be given independent patient assignments before they have completed orientation – and even then they should be in a long-term mentorship program.

According to a quasi-experimental (pre-post design) study with a weak methodological design, nursing mentorship programs led staff nurses to be more supportive of colleagues and enhanced the overall work environment for nurses (Latham et al., 2008). Organizations have a responsibility to ensure new employees have supports in place after orientation, including a mentor (Ballem & MacIntosh, 2014).

Implementing education and training for nurses who are or would like to be mentors should include content on providing constructive feedback, role modeling and information on how to develop critical thinking skills (Latham, et al. 2008); (Wright, Mohr & Sinclair, 2014).

RECOMMENDATION 2.5:

Organizations develop outcome measures for evaluating the effectiveness of intra-professional collaborative practice. Those indicators could include

- patient/client and family experience and satisfaction;
- nursing turnover rates, overtime, absenteeism, engagement and satisfaction;
- infection rates, fall ratios, re-admission rates;
- delayed or missed nursing interventions, gaps in continuity of care and caregiver, appropriate staff mix and skill levels; and
- eliminating obstacles (e.g. broken or malfunctioning equipment, complacency) to evaluation processes

Type of Evidence = IIb

Discussion of Evidence:

Measurement and evaluation are essential for ensuring care is of acceptable quality, and organizations need to be prepared to provide sufficient resources for thorough, timely evaluations and to remediate problems. Fowler, Hardy and Howarth (2006) conducted a weak pre-post quasi-experimental test of collaborative care, which they defined as supporting and ensuring the delivery of safe and quality care to patients, while at the same time enhancing professional satisfaction and professional development opportunities for nursing staff.

The results of the Fowler et al, 2006 study concluded that organizations need to develop valid, consistent outcome measures and use them to evaluate the impact of teams on patient/client care and quality of work life. Measures frequently used for these evaluations include patient/client satisfaction, staff satisfaction and length of waiting lists.

RNAO and the Ontario Ministry of Health and Long-term Care have on-line resources to help promote a healthy work environment. More information is available on the RNAO website: <http://rnao.ca/search/content/HWE> and MOHLTC website: <http://www.health.gov.on.ca/en/pro/programs/hhrsd/about/environments.aspx>.

RECOMMENDATION 2.6:

Organizations encourage and develop preceptors in order to make the intra-professional collaborative environment more welcoming for students. They can do this by:

- Assigning preceptors from the same class of nursing (e.g. RN student to RN preceptor)
- selecting, assigning and supporting willing preceptors to work with students or new staff placed on the team;
- informing preceptors of students' learning objectives and ensuring good communication between academic and clinical settings; and
- reducing preceptors' caseloads to give them sufficient time to meet student nurses' learning objectives

Type of Evidence = Ia, IV

Discussion of Evidence:

Students and intra-professional collaboration

Student nurses need support as they move into intra-professional practice. A moderately rated qualitative study asked student nurses immediately prior to graduation what they were expecting at their first job. The students were looking forward to supportive work relationships and a collaborative approach to patient care (Andrews, 2013). However, in a weakly rated systematic review Morrow (2009) examined the literature on new grad transition in Canada and found students' expectations contrasted greatly with their actual experiences of ongoing lack of support and negative experiences with other registered nurses (Morrow, 2009).

Morrow suggests that how well new graduates transition into the workforce affects team effectiveness, recruitment and retention of graduate nurses and patient safety, thus transforming episodic challenges into chronic system issues. Organizations can no longer ignore the difficulties in retaining new graduates, and nurse managers need to investigate why teams continue to marginalize new nurses, and work to end it (Morrow, 2009).

Influence of preceptors

Organizations can provide support to students to be part of the collaborative team by assigning preceptors to integrate students into the practice environment and promote psycho-social supports for student placement within teams (Morrow, 2009). Preceptors can set the tone for students' views of intra-professional collaborative practice. A strong qualitative study found RNs could either promote or block access to knowledge and team acceptance of the students, which influenced the quality of their learning experience (Brammer, 2006b). Similarly, in another weak qualitative study about students Andrews (2006) reported that placements were influenced by the attitude of the ward manager. Managers can foster an environment where the cultural norms foster trust and respect (Henderson et al., 2006) and promote a culture that is supportive of continuous learning and collaboration (Brammer, 2008; Brammer, 2006b, Morrow, 2009).

For their part, preceptors are an important part of whether students have a positive experience, but they are often unprepared for their role and unaware of students' learning objectives (Andrews et al., 2006). The study said communication between academics and the clinical setting should be improved (Andrews et al., 2006). Another study found that mentoring new grads can strain the workload and expertise of RNs, but those challenges are largely ignored by organizations and create barriers to collaboration (Ballem & MacIntosh, 2014).

A moderate interpretive methodology study by Vallant and Neville (2006) sought to understand the interaction between student nurses and nurse clinicians. The study found that when nursing students had negative experiences with clinicians, learning was inhibited and collaboration was compromised. Conversely, when students felt clinicians were participating actively and positively in the relationship, their learning was enhanced. Positive experiences left students feeling nurtured and accepted. A moderate phenomenological study by Blum & Gordon (2009) examining the experiences of preceptorship from the point of view of students, found the latter valued a welcoming presence, empathy, patience, encouragement of growth and therapeutic communication from other nurses.

A moderately rated qualitative study exploring the experience of nurse preceptors found that daily routines and the prioritization of patient care governed their ability to precept; collegial support for the preceptor was important to create supportive, collaborative environments for the students and previous precepting experiences guided their strategies and techniques (Carlson, Pilhammar & Wann-Hansson, 2010).

Key components of successful models of preceptorship include reduced turnover of staff and establishing relationships (Henderson, Twentyman, Heel & Lloyd, 2006). Registered nurses act as gate-keepers to their area, unit, department or floor, monitoring and supervising students in the practice setting (Chang, Russell, & Jones, 2010). Student nurses need positive relationships with nurse clinicians to be successful and feel a sense of belonging to the team (Vallant & Neville, 2006). Precepting is a complex function with multiple challenges (mainly lack of allocated time for it) (Carlson et al., 2010). RNs need better preparation as preceptors to improve the learning experiences of students and their transition into the working environment (Brammer, 2006a).

RECOMMENDATION 2.7:

Organizations develop conflict management policies, practices and interventions by teaching and supporting managers and colleagues to address intra-professional relational challenges

Type of Evidence = IV

Discussion of Evidence:

Conflict management and collaboration

To provide guidance and handle intra-nurse conflict effectively, managers need conflict-resolution competencies. St-Pierre (2012) studied nurse-to-nurse aggression from the perspective of nursing managers in a weakly rated qualitative, ethnographic study. The participants managed aggression between nurses by tending to issues regularly, empowering staff, providing staff with the right tools to address issues promptly, and by accessing support themselves (such as human resources) when they needed help to deal with incidents. St-Pierre concluded managing aggression is not solely the responsibility of managers, but should involve the aggressor, peers, the human resources department and unions.

A moderate study by MacPhee et al., (2010) used participatory action research to examine the links among structure, process and outcomes in shared decision making on workload issues (such as safe staffing assignments). The authors found that while effective relationships among nursing teams contributed to successful outcomes such as nurses feeling their wants were understood and responded to. The nature of relationships with nurse managers or other leaders made the biggest difference for nurses. Good relationships with nurse managers made nurses feel shared decisions on scheduling worked better for them. Furthermore, the study found ineffective communication led to conflict and was related to past trust and respect issues arising from nursing power dynamics (MacPhee et al., 2010).

Handling conflict effectively is essential for collaborative practice, and both staff nurses and managers must have conflict-resolution skills and understand the art of relationship management when dealing with other people's emotions (Morrison, 2008). Therefore, conflict-management practices and interventions specific to the sector or work environment are required (Losa Iglesias & Becerro de Bengoa Vallejo, 2012).

While conflict cannot be avoided in teams, it is important that team members understand how to manage it. By ensuring that all staff are educated on harassment policy, the code of conduct and conflict management, organizations can support effective team functioning. (Wright, Mohr, & Sinclair, 2014; Hunt, Corazzini, & Anderson, 2014).



External/System Recommendations

3.0 GOVERNMENT RECOMMENDATIONS

RECOMMENDATION 3.1:

Governments promote sustainable intra-professional collaborative nursing by allocating funding for:

- Intra-professional collaborative team development and evaluation initiatives;
- nursing leadership development initiatives;
- design, implementation and evaluation of approaches for safe and equitable workload;
- technology to support team interaction;
- staffing levels to support person-centred models of care; and
- recruitment and retention.

Type of Evidence = IIb, IV

Discussion of Evidence:

Team development and evaluation:

Governments need to openly support nursing participation in collaborative team work through the development of structures and processes that promote and reward collaborative practice.

Government funding to enhance team development and evaluation is not often perceived as a priority but evidence demonstrates that nursing autonomy over practice and self-management as well as shared governance, are essential targets for enhancing teamwork skills and behaviour (Castner et al., 2013). Implementing interventions to improve teamwork in nursing is associated with positive patient outcomes (Kalisch et al., 2007). Another weakly rated literature review reported the positive impact that effective teamwork has on patient/client outcomes, organizational effectiveness, overall health-care delivery and the quality of nursing work life (MacDavitt, Chou & Stone, 2007).

One moderate quasi-experimental study looked at the impact of a multi-component intervention designed to enhance teamwork and staff engagement on patient/client falls, patient/client satisfaction, staff assessment of teamwork on the unit, and vacancy and turnover rates. It found the intervention increased teamwork and was associated with a reduction in patient/client falls and an increase in patient/client satisfaction (Kalisch et al., 2007).

In another moderate quasi-experimental study by Vertino (2014), the question was whether a structured team training initiative provided to inpatient nursing staff would improve staff attitudes toward teamwork. Researchers found the customized team-training initiative, combined with mentoring improved communication and teamwork skills among health-care professionals and were associated with significant increases in team structure, leadership, situation monitoring, mutual support and communication (Vertino, 2014).

Interventions to improve teamwork among nurses are associated with positive team outcomes and positive patient/client outcomes (Latham et al, 2008; Kalisch et al, 2007; Kalisch et al, 2013; Vertino, 2014). Government funding is needed to ensure organizations can build strategies for effective intra-professional practice.

Professional nursing leadership development:

Leadership development is critical for building capacity in nursing leaders. Strong nursing leadership is essential for a healthy work environment. Barrett and colleagues found that cohesive team functioning and a positive workplace culture was contingent on the unit nurse leader (Barrett et al, 2009). Establishing intra-professional collaboration requires strong nursing leadership at all levels of the organization, but especially at the point-of-care (RNAO, 2012). The absence of strong leadership in teams contributes to a lack of shared vision among employees, which hinders communication, undermines quality of care and limits system capacity (Hunt et al, 2014). Strong nursing leadership on the ward is linked to positive job satisfaction for nurses, successful outcomes and nurses having autonomy and control over their practice (Duffield, Roche, O'Brien-Pallas, Catling-Paull, & King, 2009). Government funding is needed to support organizations and individuals to develop effective management and leadership skills that enhance nurse satisfaction, recruitment, retention, and healthy work environments (Cummings et al., 2010; St-Pierre, 2012; Cilliers & Terblanche, 2010).

Design, implement and evaluate approaches for equitable workload:

The most common organizational factors facilitating intra-professional collaboration were leadership style, teamwork (as the primary model of care delivery), and the equitable distribution of workload among both RNs and LPNs (Huynh et al, 2011). The leadership role of nurse managers is critical to influencing nurses' job satisfaction and a positive work environment through workload assignment. A key element for nurse managers is having the capacity to increase staffing to acceptable levels, ensuring there are sufficient support workers and allied staff, and generally being able to decrease workloads, which in turn improves job satisfaction and retention. Government funding is needed to ensure ongoing understanding of the facilitators and barriers of an equitable workload. Also to ensure staffing resources are available for replacement and workload redistribution (Duffield et al., 2009).

Technology and processes to support team interaction

A 2013 moderate qualitative study by Paulsen, Romoren, and Grimsmo explored organizational and cultural obstacles to collaboration between six nurses in acute care and nine in municipal (community) care in the discharge of frail elderly patients/clients from hospital to local care in Norway. While the hospital nurses provided ample notice of the patients/client about to be discharged, municipal nurses felt the discharge was premature and the process did not provide the information they needed (Paulsen et al., 2013). The municipal nurses described having to collect the information they needed to organize adequate community care informally, by contacting several people in the hospital, which led to conflict and inaccuracies (Paulsen et al., 2013). They also reported that families and patients/client had received inaccurate information from the hospital about the community services provided.

To avoid that kind of disconnect, governments need to fund the development and use of technology that would improve the exchange of information among nurses across organizations. The expert guideline development panel suggests hand-held devices for nurses to improve communication among nurses and other health-care providers.

Recruitment and retention

Recruitment and retention of nurses is critical in today's dynamic and complex health care workplace. Priority should be given to strategies for integrating new nurses to the team, promoting accessible leadership, quality preceptorship and mentorship models, and the integration of face-to-face team strategies within a supportive team and organizational environment. Further funding is needed to more clearly understand the relationship between new graduate nurse engagement in collaborative practice and retention (Pfaff, Baxter, Ploeg, & Jack, 2014).

4.0 RESEARCH RECOMMENDATIONS

RECOMMENDATION 4.1:

Research is needed on how changing work structures affects intra-professional collaborative nursing in all health-care sectors

Type of Evidence = IIb, IV

Discussion of Evidence:

Although there has been significant discussion and work on identifying what needs to happen in the workplace to maximize intra-professional collaboration among nurses, the achievement of a cohesive team of individuals practicing to their full scope has proved challenging for many organizations (St Pierre, 2012). Additional research will increase our understanding of how to attain and sustain healthy working environments for collaborative teamwork, and quality patient care (Castner et al., 2013).

5.0 ACCREDITATION

RECOMMENDATION 5.1:

Health services accreditation bodies include evidence-based standards and criteria for collaborative intra-professional practice as part of their standards.

Type of Evidence = IIb

Discussion of Evidence:

Research has shown a positive relationship between patient/client safety and staff collaboration. For example, interventions to improve teamwork in nursing are associated with positive patient/client outcomes (Kalisch et al., 2007). In a weakly rated quasi-experimental study, Kalisch and colleagues linked the benefits of collaboration to a reduced number of falls on a 41-bed medical oncology unit. The authors also reported that establishing a collaborative relationship sustained a positive, healthy work environment for staff and patient/client satisfaction, having the team reduced the staff turnover rate, improved morale and reduced injuries (Kalisch et al 2007).

Canada's principle accreditation organization, Accreditation Canada, recognizes the importance of collaboration and communication as essential components of safe patient/client care, but they are not required organizational practices (ROPs) (Accreditation Canada, 2014). Because the accreditation process promotes change, making collaborative nursing practice a ROP would drive its broad adoption across the country.

6.0 EDUCATION

RECOMMENDATION 6.1:

Educators and educational institutions promote professionalism and intra-professional collaborative nursing and be role models of both. They can do this by:

- introducing case studies that depict realistic team issues and scenarios (building the complexity along the continuum of the program);
- focusing elective courses on teams and team functioning;
- offering courses on respectful interaction and conflict resolution;
- setting learning objectives focused on social and relational issues;
- demonstrating collaborative teamwork during clinical placements; and
- providing students accurate information on role clarity and responsibilities of all members of the health-care team.

Type of Evidence = IIb, IV

Discussion of Evidence:

Students learn as much by observation as they do from lectures and texts. Instructors should emphasize collaboration to optimize learning and facilitate student-patient engagement (Austria et al., 2013). This is particularly important once students are out of the classroom. One study found that when educators and clinical mentors collaborate to reduce the gap between theory and practice, the quality of student nurses' clinical experience improves, which is related to high job satisfaction later (Wu & Norman, 2006).

More collaborative learning benefits students in other ways as well. One moderate qualitative study shows that when students learn in a collaborative environment, they experience decreased anxiety, increased confidence, and task efficiency (Austria et al, 2013). Using a weakly rated, action research study, Russell and colleagues found that intra-professional collaborative learning enabled students to learn the essence of nursing, time management skills, interpersonal communication skills, critical thinking and self-confidence (Russell et al., 2011). As well, patients/clients were satisfied with the care they received by students learning and working collaboratively (Austria et al., 2013).

However, it takes work to offer students a collaborative environment. Preceptors of nursing students require collegial support to create a supportive learning environment. Collaboration with physicians, clinical teachers and auxiliaries can support preceptors; the absence of cooperation limits the nurses' success (Carlson et al., 2010).

7.0 NURSING PROFESSIONAL/REGULATORY RECOMMENDATIONS

RECOMMENDATION 7.1:

Nurse professional and regulatory bodies (provincial and national) work together to help their members become more informed about their own and their colleagues' roles in the health system. They can do this by:

- discussing roles and responsibilities associated with their education, skills and knowledge; and
- promoting respectful, egalitarian relationships.

Type of Evidence = IIb, IV

Discussion of Evidence:

Professional and regulatory bodies have a responsibility to ensure similarities and differences in scope are unambiguous and clearly communicated intra-professionally, inter-professionally and to the public in general.

In a 2008 weakly rated mixed method study, Oelke, White and Besner asked nurses to what extent they were able to work to full scope and to identify perceived barriers and facilitators in optimizing their roles. They found a lack of understanding of roles was contributing to poor inter-professional and intra-professional relationships.

A 2010 moderate participatory action study by Burgess, J., & Purkis, M. E. (2010), of nurse practitioners reported that those involved in a successful collaborative practice possessed the commitment to value each team member's unique and significant contribution.



Research Gaps and Future Implications

The RNAO expert panel, in reviewing the evidence for this Guideline, identified the priority areas for research set out in Table 1. This section has 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	Establishing a standardized assessment and documentation tool for use by intra-professional teams in clinical practice
	Working relationships between RNs, RPNs, and nurse practitioners
	Impact of communication technologies and ease of access to information on intra-professional teams
	More studies mixing qualitative and quantitative tools could enhance the quality of practice research
	Relationship between intra professional team work within the context of primary nursing care model and continuity of care provider and care
OUTCOMES RESEARCH	The value of integrating patients and family with the intra-professional team
	Impact of intra-professional-based care on in-patient length of stay
	Influence of intra-professional teams on staff engagement
	Impact of intra-professional education on professional practice and specific clinical outcomes
	Additional studies are required on the impact of intra-professional collaboration on: patient care outcomes, nursing-sensitive outcomes, increased collegiality on the patient-care team and work-life satisfaction.
HEALTH SYSTEM RESEARCH	Health economic evaluations of intra-professional care strategies

These research suggestions are an attempt (by no means exhaustive) to identify and prioritize where we need more research on intra-professional collaboration. Many of the recommendations in this best-practice guideline are based on quantitative and qualitative research evidence, while others are based on consensus or expert opinion. We need more substantive research to validate the expert opinion. Increasing the research evidence can create the knowledge that will lead to improved practice and outcomes in intra-professional collaborative care.

Implementation Strategies

Implementing guidelines at the point-of-care is a multifaceted and challenging exercise; it takes more than awareness and distribution to get people to change how they practice. To be effective, guidelines must be adapted for each practice setting. It should be a participatory activity for stakeholders, and done in a systematic way to ensure the 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 (see **Appendix D**).

The Implementation *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 implantation.

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

The Registered Nurses’ Association of Ontario is committed to widespread deployment and use 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, 2012, 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 health@rnao.org.

Evaluating and Monitoring this Guideline

Organizations implementing the recommendations in *Intra-professional Collaborative Practice among Nurses* are encouraged to consider how to monitor and evaluate the implementation and its impact. Table 2 is based on a framework outlined in the *Toolkit: Implementation of Best Practice Guidelines (2nd ed.)*, (RNAO, 2012) and illustrates some specific indicators for monitoring and evaluation of this guideline.

Once these guidelines are successfully implemented, organizations will have a healthy workplace environment that supports all staff, from the front line to leadership. All units will have strong governance models that support the manager, charge nurse, front-line staff and students. All staff and students will feel they have equal input into discussions, and all will feel respected while working collaboratively with each other.

Table 2. Example of Indicators for Evaluating and Monitoring this Guideline

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
Objective	These indicators refer to the supports and resources required for a health system or health service organization to enable the successful implementation of the Guideline, <i>Intra-professional Collaborative Practice among Nurses</i> .	These indicators evaluate whether best practices directed at the education, training, and practice of health-care professionals to improve intra-professional collaborative practice have been implemented.	These indicators evaluate the impact of implementing the Guideline recommendations on health-care organizations, health care professionals, and client outcomes.

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
<p>Organization/ Unit</p>	<p>System-wide integration of policies consistent with best practices related in intra-professional collaborative practice.</p>	<p>Specific organizational initiatives to establish and implement the following educational programs to nursing staff:</p> <ul style="list-style-type: none"> ■ Conflict management ■ Team building ■ Mentorship ■ Preceptorship 	<p>Nurses report satisfaction with education and training received related to intra-professional practice.</p> <p>Nurses are able to articulate the principles and components of effective intra-professional collaborative practice.</p> <p>Nurses' report increased participation in intra-professional collaboration.</p> <p>Percentage of nurses who attend continuing education/training session related to conflict management; mentorship; team building and preceptorship.</p>
	<p>The organization adopts and implements policies and procedures that support and are consistent with Guideline recommendations.</p>	<p>Pre and post guideline implementation of staff and patient satisfaction are measured.</p>	<p>Outcomes such as high quality care, demonstration of intra-professional competencies are evident and measureable through patient and staff satisfaction surveys.</p>
	<p>Organizations integrate technology to facilitate access to information, and the exchange of information across organizations.</p>	<p>Ongoing monitoring of effects of intra-professional collaboration processes, resources.</p>	<p>Percentage of clients who are satisfied with the care provided by their intra-professional team.</p>

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
	Organizations support Professionals working to full scope of practice.	Organizations establish Shared governance committees. Workload measurement tools are in place and utilized appropriately	Absenteeism rates in nursing staff. Sick time in nursing staff. Turnover rates in nursing staff.
	Availability of education and supports for the six domains of interprofessional competencies: 1. Care expertise 2. Shared power 3. Collaborative leadership 4. Optimizing professional/role/ scope 5. Shared decision making 6. Effective group functioning	Each of the 6 domains are measured by individuals and assessed at performance appraisals, through the use of an inventory of quantitative tools measuring collaborative practice outcomes.	Individual in all roles demonstrate competencies in communication and quality of care as measured through patient and staff surveys.
	Organizations utilize a <u>Nursing Work Index Scale</u> , to measure role ambiguity/clarity and control over practice.	Results re role ambiguity/clarity and control over practice is measured and shared with staff.	A plan is developed to address outcomes of nursing work index scale.

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
Patient/ Client	High quality care plans are in place, shared and monitored by and with the intra-professional collaborative team member responsible for the patient/client.	Ongoing monitoring of care processes directed by the care plan. Patient/client is provided with and educated on feedback process for care provided.	Process is in place for patients and staff to provide feedback on intra-professional collaborative practice. Percentage of clients who are satisfied with the care provided by their intra-professional practitioner.
Financial	Availability of adequate financial resources to support and implement Guideline recommendations.		Demonstrated cost-efficiency and effectiveness through: <ul style="list-style-type: none"> ■ Recruitment and retention cost savings ■ Sick time cost savings ■ Overtime cost savings



Process for Review and Update of the Guideline

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

- Guidelines will be reviewed and updated in a new edition, by a team of specialists in the topic area, with each new edition completed within five years of the publication of the previous edition.
- RNAO International Affairs and Best Practice Guidelines (IABPG) Centre staff regularly monitor the literature for new systematic reviews, randomized controlled trials and other relevant research.
- Based on the results of the monitoring, IABPG staff may recommend an earlier review for a particular guideline. If that happens, members of the original expert panel and other specialists and experts are consulted to help decide whether to review and revise the guidelines earlier than planned.
- Three months before the publication anniversary, IABPG Centre staff begin organizing the review by:
 - Inviting specialists in the field to be on the expert panel, which will comprise members of the original panel and other recommended specialists and experts.
 - Compiling feedback and questions received during dissemination of the guideline and comments and experiences from sites that implemented it.
 - Compiling relevant literature in the field and conducting a systematic review of the evidence.
 - Developing a detailed work plan with target dates and deliverables.
- New editions of guidelines will be disseminated according to our established structures and processes.



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Appendix A: Glossary of Terms

Analytical studies: Analytical studies test hypotheses about exposure-outcome relationships. The investigators do not assign an intervention, exposure, or treatment but do measure the association between exposure and outcome over time, using a comparison group (Centers for Disease Control, 2013). Analytical study designs include case-control studies and cohort studies. Case-control study: A study that compares people with a specific disease or outcome of interest (cases) to people from the same population without that disease or outcome (controls) (The Cochrane Collaboration, 2005). Cohort study: An observational study in which a defined group of people (the cohort) is followed over time either prospectively or retrospectively (The Cochrane Collaboration, 2005).

Collaboration: Working together with one or more members of the health-care team, each of whom makes a unique contribution toward achieving a common goal. Collaboration is an ongoing process that requires effective communication among members of the health-care team and a clear understanding of the roles of the individuals involved in the collaboration process. Nurses collaborate with clients, other nurses and other members of the health care team in the interest of client care.

(College of Nurses of Ontario Practice Guideline: RN and RPN practice: The Client, the Nurse and the Environment 2014) Retrieved on Feb. 18, 2015 from <http://www.cno.org/Global/docs/prac/41062.pdf>

Communities of practice: A community of practice is a group of people who share a concern or a passion for something they do, and learn how to do it better as they interact regularly.

(Wenger-Trayner: What is a community of practice?, December 2011) Retrieved on Dec 8 2015 from: <http://wenger-trayner.com/resources/what-is-a-community-of-practice/>

Consensus: A collective opinion arrived at by a group of individuals working together under conditions that permit open and supportive communication, such that everyone in the group believes she or he had a fair chance to influence the decision and can support it to others. (RNAO, Collaborative Practice Among Nursing Teams, 2006).

Continuity of care: A seamless, continuous implementation of a plan of care that is reviewed and revised to meet the changing needs of the client. The care may be given by various care providers, at various times and in various settings.

Controlled study: A clinical trial in which the investigator assigns an intervention, exposure, or treatment to participants who are not randomly allocated to the experimental and comparison or control group (The Cochrane Collaboration, 2005).

Descriptive studies: Descriptive studies generate hypotheses and describe characteristics of a sample of individuals at one point in time. The investigators do not assign an intervention, exposure, or treatment to test a hypothesis, but merely describe the, who, where, or when in relation to an outcome (Centers for Disease Control, 2013; The Cochrane Collaboration, 2005). Descriptive study designs include cross-sectional studies. Cross-sectional study: A study measuring the distribution of some characteristic(s) in a population at a particular point in time (also called survey) (The Cochrane Collaboration, 2005).

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

Health care team: An inter-professional group of individuals who are either directly or indirectly involved in a client's care. Depending on the practice environment, the composition of the team will vary. The team includes the client and the family.

(College of Nurses of Ontario Practice Guideline: RN and RPN practice: The Client, the Nurse and the Environment 2014) Retrieved on Feb. 18, 2015 from <http://www.cno.org/Global/docs/prac/41062.pdf>

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

Healthy Work Environments 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. (Field, M., & Lohr, K. (1990) Guidelines for clinical practice: Directions for a new program. Washington, D.C: Institute of Medicine, National Academy Press).

Holistic: Relating to or concerned with complete systems rather than with individual components. A system of comprehensive or total patient care that considers the physical, emotional, social, economic, and spiritual needs of the person ; his or her response to illness; and the effect of the illness on the ability to meet self-care needs. (holistic health care. (n.d.) Mosby's Medical Dictionary, 8th edition. (2009). Retrieved December 8, 2015 from <http://medical-dictionary.thefreedictionary.com/holistic+health+care>)

Integrative review: The integrative review is the methodology (1) problem formulation, (2) data collection or literature search, (3) evaluation of data, (4) data analysis, and (5) interpretation and presentation of results, that provides synthesis of knowledge and applicability of results of significant studies to practice. (Russell, C.L. 2005)

Inter-professional: 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 inter-professional 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).

Inter-professional collaboration: Inter-professional collaborative practice is centred on the needs of clients, enabling them to be partners in their care, with the most appropriate health professionals providing the services required to meet their health-care needs (Health Canada, 2010).

Inter-professional collaborative practice: is guided by shared values, a common purpose or care outcome, mutual respect, and effective communication; it optimizes participation in clinical decision-making within and across professions; evolves over time, requiring the flexibility to add or subtract health-team members based on the needs of individual clients; and must be supported through policy, protocols and procedures at all levels of decision making, including government, professional associations, regulatory bodies and healthcare organizations (The Multidisciplinary Collaborative Primary Maternity Care Project. Guidelines for development of a multidisciplinary collaborative primary maternity care model. 2006 May.; Orchard, C.A., Curran, V., & Kabene, S. (2005).; Sharp M: 2006:S4-8.)

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

Intra-professional collaborative practice team: Intra-professional collaborative practice involves multiple members of the same profession working together to deliver quality care (College of Nurses of Ontario, 2014).

Leadership: A relational process in which an individual seeks to influence others towards a mutually desirable goal (RNAO, 2013).

Meta-analysis: The use of statistical techniques in a systematic review to integrate the results of included studies. Sometimes misused as a synonym for systematic reviews, where the review includes a meta-analysis. (Glossary [<http://community.cochrane.org/glossary/5#letterm>]. Oxford, UK: The Cochrane Collaboration; c2004-2015 [Retrieved on January 12, 2016].) Available from: www.cochrane.org

Mixed methods: Mixed-methods research is a research design with philosophical assumptions as well as methods of inquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and analysis of data and the mixture of qualitative and quantitative data in a single study or series of studies. Its central premise is that the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone. (Creswell, J.W. and Plano Clark, V.L. (2007)

Nurses: Refers to registered nurses, licensed practical nurses (referred to as registered practical nurses in Ontario), and registered psychiatric nurses, nurses in advanced practice roles such as nurse practitioners and clinical Nurse specialists. (Registered Nurses' Association of Ontario (2013). Developing and Sustaining Inter-professional Health Care: Optimizing patients/clients, organizational, and system outcomes. Toronto, Canada: Registered Nurses' Association of Ontario.)

Nurse Practitioner: Nurse practitioners (NPs), or registered nurses in the extended class [RN (EC)s], are authorized to autonomously perform controlled acts and activities not available to registered nurses and registered practical nurses. (Retrieved from <http://www.cno.org/en/learn-about-standards-guidelines/educational-tools/nurse-practitioners/>)

Qualitative Research: 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. (Registered Nurses' Association of Ontario (2013). *Developing and Sustaining Inter-professional Health Care: Optimizing patients/clients, organizational, and system outcomes*. Toronto, Canada: Registered Nurses' Association of Ontario.)

Quasi-experimental study: A study that lacks randomization and a control group and therefore is not considered a “true” experimental design (e.g., a randomized controlled trial). The investigator controls the assignment to the intervention, exposure, or treatment by using some criterion other than random assignment (e.g., pre-post design) (Polit, Beck, & Hungler, 2001).

Randomized controlled trials: Clinical trials that involve at least one test treatment and one control treatment, concurrent enrollment and follow-up of the test- and control-treated groups, and in which the treatments to be administered are selected by a random process. (Registered Nurses' Association of Ontario (2013). *Assessment and Management of Foot Ulcers for People with Diabetes (2nd ed.)*. Toronto, ON: Registered Nurses' Association of Ontario.)

Registered Nurse: Self-regulated health-care professionals who work autonomously and in collaboration with others. RNs enable individuals, families, groups, communities and populations to achieve their optimal level of health. RNs coordinate health care, deliver direct services and support clients in their self-care decisions and actions in situations of health, illness, injury and disability in all stages of life. RNs contribute to the health-care system through their work in direct practice, education, administration, research and policy in a wide array of settings. (Feb 18 2015 <http://www.cna-aiic.ca/~media/cna/page-content/pdf-en/framework-for-the-practice-of-registered-nurses-in-canada.pdf?la=en>)

Registered Practical Nurse: In Ontario, RPNs are community college graduates. After graduation, they write a national certification examination. Once they successfully complete this exam, they are registered to practice as a nurse by the College of Nurses of Ontario. RPNs work anywhere health care is provided, in hospitals, homes for the aged, nursing homes, retirement homes, public health units, community nursing agencies, clinics, private practice, industry, schools, child care centres, children's camps. (Retrieved from RPNAO <http://www.rpnao.org/about>)

Relational leadership: Relational Leadership is defined as a relational process of people together attempting to accomplish change or make a difference to benefit the common good. (Komives, S, Lucas, N., & McMahon, T. (1998). *Exploring Leadership for College Students What Want to Make A Difference*. San Francisco: Jossey-Bass. (68-72).)

Scope of practice: Health care professionals optimizing the full range of roles, responsibilities and that they are educated, competent and authorized to perform. (Health Authorities Health Professions Act Regulations Review Committee, 2002)

Stakeholder: An individual, group, or organization with a vested interest in the decisions and actions of organizations that may attempt to influence decisions and actions (Baker et al., 1999). Stakeholders include all individuals or groups who will be directly or indirectly affected by the change or solution to the problem. (Registered Nurses' Association of Ontario (2014). Care Transitions. Toronto, ON: Registered Nurses' Association of Ontario.)

Systematic review: The Cochrane Collaboration (2011) says “a systematic review attempts to collate all empirical evidence that fits pre-specified eligibility criteria in order to answer a specific research question.” they use systematic, explicit and reproducible methods to identify, select, and critically appraise relevant research, and to collect and analyze data from the studies that are included in the review (The Cochrane Collaboration, 2011)

Teamwork: The combined action of a group of people, especially when effective and efficient. (Retrieved on January 12, 2016 from http://www.oxforddictionaries.com/definition/american_english/teamwork)

Transformational leadership: A leadership approach in which individuals and their leaders engage in an exchange process that broadens and motivates both parties to achieve greater levels of achievement, thereby transforming the work environment. Transformational leadership occurs where the leader takes a visionary position and inspires people to follow. (www.changingminds.org/disciplines/leadership/styles/transformationalleadership.htm)



Appendix B: Guideline Development Process

The Registered Nurses' Association of Ontario 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 *Intra-professional Collaborative Practice among Nurses, Second Edition* is the culmination of the work of an expert panel to integrate 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 systematic review of the evidence was based on the purpose and scope of the guideline and supported by three clinical questions. It captured relevant literature and guidelines published between 2002 and 2014. These were the research questions that guided the literature review:

What physical/structural/policy components at the individual, organizational, and system level affect collaborative practice in intra-professional nursing teams?

What cognitive/psycho/social/cultural components at the individual, organizational, and system level affect collaborative practice in intra-professional nursing teams?

What professional/occupational components at the individual, organizational, and system level affect collaborative practice in intra-professional nursing teams?



Appendix C: Process for Systematic Review and Search Strategy

Search Strategy:

A comprehensive search strategy was developed through an iterative process between a health sciences librarian and RNAO's research team. Three literature searches were conducted by the librarian in the following databases: Cumulative Index to Nursing and Allied Health (CINAHL), Cochrane Systematic Reviews (SR), Embase, MEDLINE, and MEDLINE In Progress. The searches were conducted from 2006-April 2014 and focused on the components that affect collaborative practice in intra-professional nursing teams.

Appropriate keywords and subject headings relating to nursing collaborative practice were used in each database as determined by the librarian. Examples of search terms used singularly and in combination include: nurses, workload, conflict resolution, intra-professional relations, and collaborative practice. Panel members were asked to review their personal libraries to identify key articles not found through the search strategies. Results were exported into Reference Manager Software and merged; duplicate citations were removed.

Inclusion/Exclusion Criteria

General inclusion criteria included: (a) primary focus on collaborative practice between all nurses in all health care sectors, (b) nursing teams (intra-disciplinary teams), (c) published in English, (d) published in a peer reviewed journal, (e) any study types (systematic reviews, RCTs, meta-analysis, qualitative and descriptive/observational studies), (f) published between 2006-2014. Articles were excluded if they were (a) commentaries, dissertations, letters to the editor, and editorials, (b) ≤ 1 page, (c) protocols on study designs, (d) focus on interdisciplinary teams/multidisciplinary teams, and (e) included other health care professionals (e.g. physicians, social workers, physiotherapists, etc).

Relevance Review

Two nursing research associates independently screened titles and abstracts for inclusion/exclusion based on a priori criteria. Next, full-text articles of selected abstracts were retrieved and reviewed independently by the two associates for relevance. Disagreements were resolved by the nurse program manager.

Search Results:

Combining the three searches, 29,065 articles were identified. After removing duplicate studies, titles and abstracts of 26,619 citations were screened to determine relevance to inclusion criteria. Of the 415 articles pulled for full-text relevance review, 76 were identified for data abstraction and analysis. Quality appraisal resulted in 11 articles rating strong, 39 rating moderate, and 26 rating weak. The presentation of the results for this systematic review is structured around the research questions used to guide the study search.

A comprehensive guideline search was conducted and did not identify any guidelines relevant to the scope of this best practice guideline.

Figure 4. Instruments Used to Assess Methodological Quality

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

1. Qualitative Studies

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

2. Quantitative Studies

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

3. Systematic Reviews

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

Articles were categorized based on their relevance to the 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. 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 resulted in the following themes:

Themes for question 1:

- Retention & recruitment
- Organizational culture/climate
- Conflicts related to work structure
- Interventions to promote teamwork
- Models of care delivery

Themes for question 2:

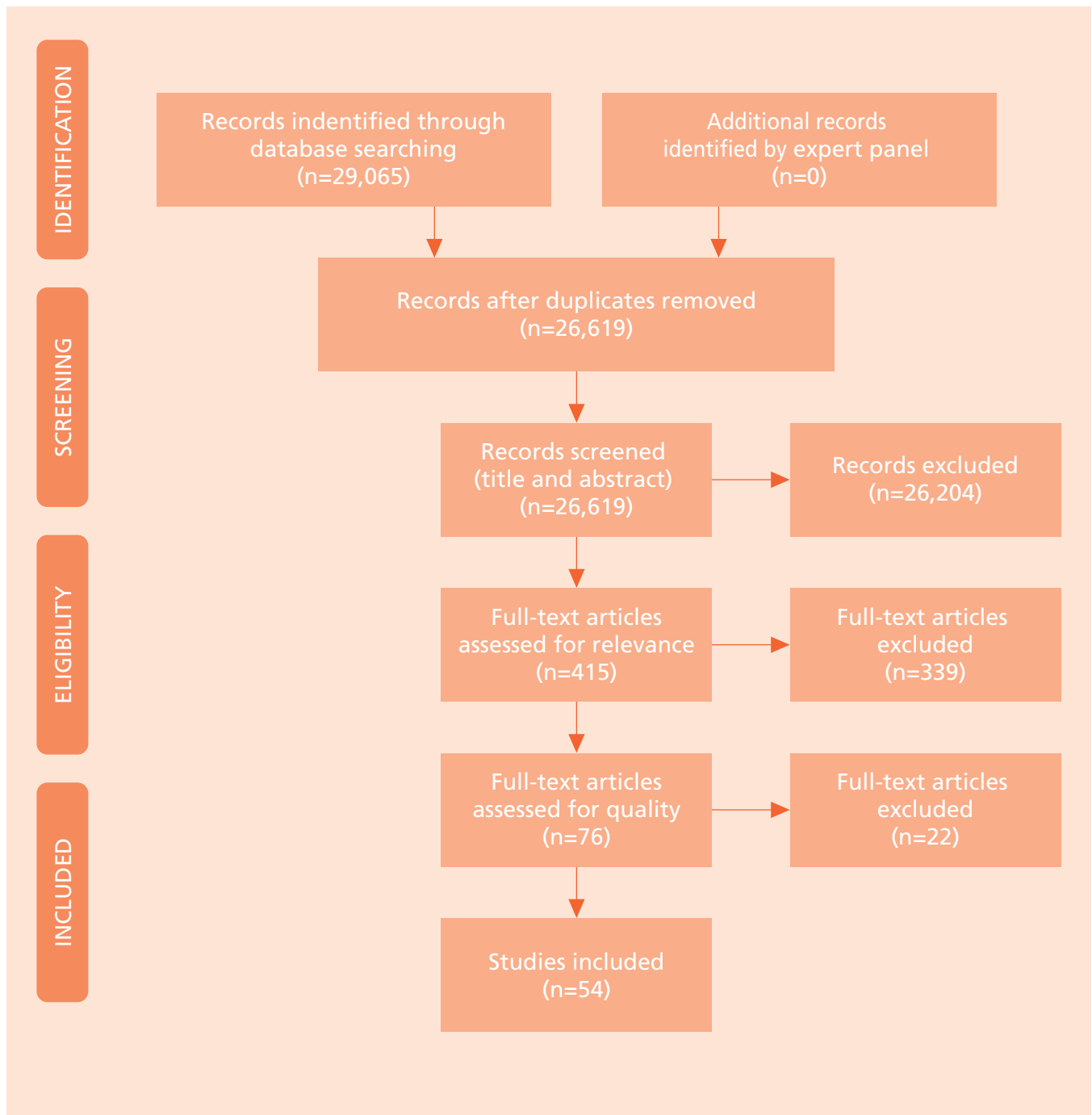
- Nurse-nurse collaboration
- Team nursing
- Job satisfaction
- Nurse managers

Themes for question 3:

- Collaboration between nurse practitioners
- Scope of practice
- Control over practice and teamwork

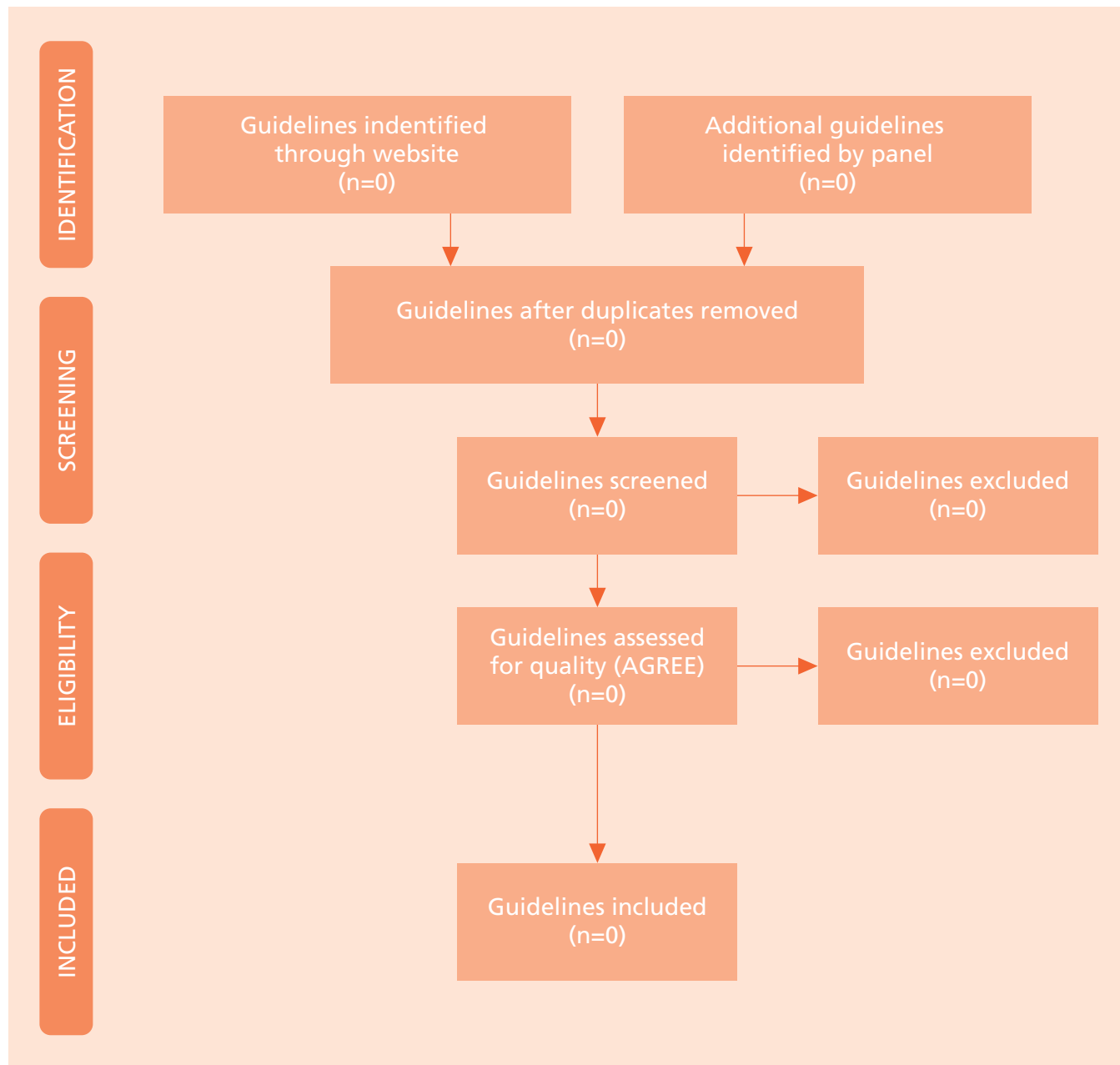


Article Review Process Flow Diagram



Flow diagram 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

Guideline Review Process Flow Diagram



Flow diagram 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

Appendix D: Description of the Toolkit

Best practice guidelines can only be successfully implemented if there is 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 the 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 a health-care organization.

The Implementation *Toolkit* provides step-by-step directions to individuals and groups involved in planning, coordinating and facilitating guideline implementation. These steps reflect a process that is dynamic and iterative, not linear – at each phase simultaneous preparation for the next phases and reflection on the previous phase are essential. Specifically, the *Toolkit* addresses the following key steps, illustrated in the “Knowledge to Action” framework (RNAO, 2012; Straus et al., 2009):

- Identify problem, then identify, review and select knowledge (a best practice guideline);
- Adapt knowledge (the BPG) to local context by:
 - Assessing barriers and facilitators to knowledge use; and
 - Identifying resources.
- Select, tailor and implement interventions;
- Monitor knowledge use;
- Evaluate outcomes;
- Sustain knowledge use.

Implementing guidelines that result in successful practice changes and have a positive clinical impact is a complex undertaking. The *Toolkit* can help. Download it at <http://rnao.ca/bpg>.

ia BPG

INTERNATIONAL
AFFAIRS & BEST PRACTICE
GUIDELINES

TRANSFORMING
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KNOWLEDGE

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