Interprofessional Collaboration:

An Interpretive Descriptive Study into the Experiences of Entry Level Nurses

by

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Abstract

In Nova Scotia (NS), within their first year of professional practice newly graduated registered nurses are considered Entry Level Nurses (ELN) (NSCN, 2013, 2020). Until now, little was known about how ELNs experience interprofessional collaboration (IPC) in interprofessional (IP) teams in Nova Scotia. This Interpretive Descriptive (ID) study sought to advance nursing knowledge and greater understanding of ELN experiences. The overarching research question guiding this study was: what are the experiences of ELNs in relation to IPC in IP teams in Nova Scotia? Subsumed under this overarching question was a set of subsidiary questions that reflected the inquiry and analysis required to develop a more comprehensive understanding of IPC across ELN and aggregate perspectives.

Fifteen participants were interviewed and thematic analysis (Braun & Clarke, 2006) was conducted. Four main themes surfaced from the interview data. They are described as: (1) *emotions linked to IPC,* (2) *team characteristics,* (3) *development of IPC competency,* and (4) *contextual influences on IPC*. Several sub-themes were noticed and are discussed in this paper. As Nova Scotia continues to overcome the COVID 19 pandemic, the experiences shared by the participants highlight the importance of further discovery and research. More studies are needed to explore the extent to which these themes are prevalent in healthcare teams.

Today's healthcare milieu of multiple care providers and complex treatment regimens demand the active participation from nurses and all members of the interprofessional (IP) team including the patient and family (Accreditation Canada, 2019). Interprofessional collaboration (IPC) is an essential component in the delivery of nursing care. The *State of the World's Nursing 2020* report (WHO, 2020) proclaims the healthcare system needs RNs working to the full extent of their education and the maximization of their roles within IP teams (WHO, 2020). Similarly,

the Nova Scotia College of Nursing (NSCN, 2020) defines the RN as a collaborator required for optimal IPC.

New trends and issues are documented in nursing (ICN, 2020; WHO, 2020). The World Health Organization (2020) suggests that newly graduated registered nurses play a key role in resolving nurse burnout, current workload issues, and recruitment and retention challenges. The COVID 19 pandemic has highlighted the urgent need to address these issues in nursing, especially from the viewpoint of ELNs in unpredictable team circumstances while attempting to achieve IPC.

Preface

This thesis is an original work by Cynthia Lee MacQuarrie. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Interprofessional Collaboration: An Inquiry into Entry Level Nurse Experiences Using Interpretive Description, Study ID. Pro00101598, July 8, 2020. Later, research ethics was received from the Nova Scotia Health Research Ethics Board, Interprofessional Collaboration: An Inquiry into Entry Level Nurse Experiences Using Interpretive Description, Study ID. 1026148, January 28, 2021.

Dedication

This dissertation is dedicated to my brother, Callum Ian MacQuarrie. On July 10, 1995, Callum physically changed, but an inner fire and passion was born that day. Living life to the fullest is a choice and he chose to make the most of each day. Sailing, skydiving, skidooing, four wheeling, mouth-painting, making inspirational talks, and inspiring community change can be a challenge for the able-bodied person. Callum mastered all of these (and more), despite his physical limitations. He saw obstacles as part of his journey and his winning attitude made all things possible. I miss him every day. Your health challenges are imprinted in my thoughts and soul and are my motivator for change. Thank you for blessing me with your presence for the last 47 years and always loving me most for my imperfections.

Callum "Cal" Ian MacQuarrie

April 14, 1973 - March 31, 2021

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List of Abbreviations

AIPHE	Accreditation of Interprofessional Health Education
ALS	Amyotrophic lateral sclerosis
CAIPE	Centre for the Advancement of Interprofessional Education
CCRNR	Canadian Council of Registered Nurse Regulators
CEO	Chief Executive Officer
CIHC	Canadian Interprofessional Health Collaborative
CIHI	Canadian Institute for Health Information
CNA	Canadian Nurses Association
COVID-19	Coronavirus disease
CPCC	Collaborative Patient Centred Care
ELC	Entry Level Competencies
ELN	Entry Level Nurse
HCP	Health Care Providers
ID	Interpretive Description
IECPCP	Interprofessional Education for Collaborative Patient-centred Practice
IHI	Institute for Healthcare Improvement
IOM	Institute of Medicine
IP	Interprofessional
IPC	Interprofessional Collaboration
IPE	Interprofessional Education
IPEC	Interprofessional Education Collaborative
NEXUS	National Centre for Interprofessional Practice and Education

NNCP	National Nursing Competency Project
NS	Nova Scotia
NSCN	Nova Scotia College of Nursing
NSHA	Nova Scotia Health Authority
RN	Registered Nurse
PCORI	Patient Centered Outcomes Research Institute
WHO	World Health Organization

Key Definitions

Collaborative Patient Centred Care: A partnership between a team of health care providers and a patient where the patient retains control over his/her care and is provided access to the knowledge and skills of team members to arrive at a realistic team-shared plan of care and access to the resources to achieve the plan (CIHC, 2010).

Competency: A complex 'know act' that encompasses the ongoing development of an integrated set of knowledge, skills, attitudes, and judgments enabling one to effectively perform the activities required in each profession or function to the standards expected in knowing how to be in various and complex environments and situations (CIHC, 2010).

Dual Identity: The development of a robust sense of belonging to both own profession (In-Profession Favoritism) and to the interprofessional community (Interprofessional Favoritism) in which individuals view themselves simultaneously as a member of their own profession and the interprofessional team (Khalili et al., 2019).

Entry Level Competencies: The knowledge, skill, and attitudes required of newly graduated Registered nurses to provide safe, competent, compassionate, and ethical care (NSCN, 2020).

Entry Level Nurse: A newly graduated registered nurses within their first year of professional practice (NSCN, 2020).

Health Care Providers: A health occupation, vocation or career requiring special training and/or professional designation. This includes but not limited to nurses, physicians, nurse practitioners, pharmacists, social workers, dieticians, midwives, physiotherapists, occupational therapists, paramedics, designated caregivers, and alternative and complementary medicine practitioners.

Interprofessional Collaboration: A practice orientation that involves the interaction of two or more professionals or disciplines organized into a common effort, to solve or explore common issues with the best possible participation of the patient/family (Barr, 1998).

Interprofessional Competencies: Describe the complex integration of knowledge, skills, attitudes, values, and judgments that allow a health provider to apply these components into all collaborative situations. Competencies should guide growth and development throughout one's life and enable one to effectively perform the activities required in a given occupation or function and in various contexts (CIHC, 2010).

Interprofessional Education: Two or more professions learn with, from, and about each other to improve collaboration and the quality of care (CAIPE, 2002).

Interprofessional Socialization: A process in which individuals develop a dual professional and interprofessional identity (dual identity) through acquisition of both professional and interprofessional beliefs, values, behaviors, and commitments to become 'collaborative practice-ready' (Khalili et al., 2019).

Professional Socialization: An essential process of learning skills, attitudes, and behaviours necessary to fulfill the nursing professional role. This typically occurs during formal education and transition to practice (Price, 2009).

Professional Tribalism: The development of a robust sense of belonging to one's profession (In-Profession Favoritism) and creates a competition between professional groups (Khalili et al., 2020; Weller, 2012).

Role Clarification: Interprofessional competency focused on understanding of own role and the roles of others in an interprofessional context.

Teamwork: Describes an interdependent relationship that exists between members of a team. It is an application of collaboration (D'Amour, Ferrada-Videla & San Martin Rodriguez, 2005).

Chapter One: Introduction

Today's healthcare milieu of multiple care providers and complex treatment regimens demands the active participation from nurses and all members of the interprofessional (IP) team including the patient and family (Accreditation Canada, 2019). It is increasingly common to associate high quality healthcare with care that is delivered in this way (Accreditation Canada, 2019; CIHC, 2010). In fact, it has been noted that healthcare professionals working in an interprofessional (IP) team can best communicate and address the complex and challenging needs of Canadians (Accreditation Canada, 2019; CIHC, 2010; Health Canada, 2007; Kirby, 2003; Romanow, 2002). Interprofessional collaboration (IPC) also provides opportunities to have patients and their families engage in health and healthcare (CIHC, 2010).

Interprofessional collaboration (IPC) is an essential component in the delivery of nursing care. The Canadian Interprofessional Health Collaborative (Orchard et al., 2010) describes IPC as a central tenet to collaborative patient-centred care. Barr (1998) defines IPC as a practice orientation that involves the interaction of two or more professionals or disciplines organized into a common effort, to solve or explore common issues with the best possible participation of the patient/family. IPC is designed to promote the active participation of each discipline in patient care. IPC enhances patient- and family-oriented goals and values (Accreditation Canada, 2019), provides mechanisms for continuous communication among caregivers (CIHC, 2010; WHO, 2021), optimizes staff participation in decision making within and across disciplines, and fosters respect for disciplinary contributions of all health professionals (D'Amour & Oandasan, 2005; Deneckere et al., 2011; NSCN, 2020).

The Institute of Medicine (IOM, 2010) report *The Future of Nursing: Leading Change, Advancing Health* recommends the role of the registered nurse (RN) in leading and in managing

collaborative efforts with physicians and other members of the IP team. The report calls for new experiences in education and practice that will enable RNs to take the lead in developing and adopting innovative, collaborative models of care (IOM, 2010). Similarly, in Canada the Canadian Nurses Association (CNA, 2012) published *A Nursing Call to Action* recommending that RNs act in collaboration with other health care providers (HCP) and system leaders to ensure better health outcomes, better care, and better value for all Canadians.

The CNA call for action happened upon the backdrop of healthcare transformation impacting education and practice. There is no question that RNs need to lead the way in IP teams, but to what extent do RNs champion excellent IP care? The *State of the World's Nursing 2020* report (WHO, 2020) came as the world was being tested by the COVID 19 pandemic. Now, more than ever, the healthcare system needs RNs working to the full extent of their education and maximizing their roles within interprofessional health teams (WHO, 2020). As nurses graduate and enter the profession, a question is: What are the experiences of RNs within their first year of professional practice when working in interprofessional teams?

The Nova Scotia College of Nursing (NSCN, 2013, 2020) defines an RN within their first year of professional practice as an Entry Level Nurse (ELN). Entry Level Nurses are healthcare team members who accept the responsibility and demonstrate accountability for their practice and recognize their limitations, ask questions, exercise professional judgment, and determine when consultation is required (NSCN, 2013, 2020). Research demonstrates that during the first year of professional practice RNs experience a complex array of emotional, intellectual, sociocultural, and developmental issues that form part of their professional evolution (Benner, 1984; Duchscher, 2012; Best et al., 2019). Time is required for professional role acquisition (Best et al., 2019; Price et al, 2020) and an opportunity exists to better understand the contextual

nature of ELN experiences when working within interprofessional teams. Little is known about how ELNs experience IPC.

Statement of Research Questions

This study focuses attention on the current challenge associated with conceptualizing the nature of IPC from the point of view of ELNs in Nova Scotia and constructing a coherent approach to addressing it. To advance nursing knowledge and a greater understanding of ELN experiences, the overarching research question guiding this study is:

What are the experiences of ELNs in relation to IPC in IP teams in Nova Scotia? Subsumed under this overarching question is a set of subsidiary questions that reflect the inquiry and analysis required to develop a more comprehensive understanding of IPC across ELN and aggregate perspectives.

1. How do ELNs describe and explain IPC experiences in NS?
2. How do ELNs understand factors that influence experiences of IPC?
3. How do ELNs describe the facilitators and barriers to IPC?
4. What approaches do ELNs recommend to promote IPC in IP teams in NS?

Contextual Influences in Nova Scotia Health Ecosystem

Interprofessional collaboration (IPC) in healthcare can be diversely manifested in different situations, settings, and teams. Understanding experiences of ELNs requires consideration into the context in which they arise. Contextual influences within NS health ecosystem that may influence ELN experiences include: (1) healthcare context, (2) nursing context, and (3) interprofessional context. In this study, each context was explored to foster an understanding of the healthcare milieu during the time leading up to and during the study.

Healthcare Context

The population of NS is approximately 992,005 (Nova Scotia Department of Finance, 2021). One half of the province's population is living in rural communities. The NS perspective mirrors the Canadian context with respect to a high burden of chronic disease management, advancing citizen age, and the complexity and acuity of patients requiring acute care services. Specifically, there is a high burden of chronic diseases, such as diabetes, asthma, heart disease, and cancer, with an estimated $80 billion price tag in associated healthcare costs (CIHI, 2021). The percentage of our provincial population that is over the age of 65 is 20.8% (CIHI, 2021). Currently, this age cohort uses more than 50% of hospital-based care (CIHI, 2021).

Given the identification of care needs from a provincial perceptive, it has been asserted that an interprofessional team-based approach to care is a requirement (NSHA, 2021). Registered nurses can play a vital role in care coordination and have an opportunity to influence strategies that potentiate IPC. Additionally, IPC is noted as a strategy to alleviate human resource challenges in the provincial health authority (NSHA, 2021).

The Nova Scotia Department of Health and Wellness (DHW) has an overarching responsibility for healthcare in the province. Formed in 2015, the NSHA provides province-wide primary, community, and acute healthcare services by way of hospitals, health centres, and community-based programs, with some outreach for Atlantic Provinces. The NSHA is the largest healthcare employer in NS. The mission of the NSHA (2021) is to achieve excellence in health, healing, and learning through working together.

In November 2019, the NSHA appointed an interim CEO and removed three of its senior vice-presidents in a restructuring effort (Gorman, M., 2019, November 22) intended to improve local decision making and address concerns that the organization was overly bureaucratic and

complex. Further executive changes continued to address the structure that did not allow the NSHA to easily address challenges that may have been unique to individual zones, teams, or hospitals (Gorman, M., 2019, November 22).

Restructuring efforts were complicated by the arrival of the COVID 19 pandemic. In early March 2020, the first news release was distributed from Nova Scotia Public Health informing Nova Scotians that preparations to address the pandemic impact were underway across the health system as cases in Canada were on the rise (Government of Nova Scotia, 2020a). On March 15th, 2020, Nova Scotia Public Health announced the province's first three presumptive cases (Government of Nova Scotia, 2020b). At that time, it was not known that this was the beginning of our first wave and many healthcare related changes.

On that same day additional prevention measure became effective immediately such as facilities closing to visitors; individuals who had traveled outside of Canada were required to immediately self-isolate, even if symptom-free; and social distancing was now being enforced (Government of Nova Scotia, 2020b). It would only be another 7 days before the Chief Medical Officer, Dr. Strang, would be required to declare a state of emergency (Government of Nova Scotia, 2020c).

As the pandemic rapidly unfolded, the healthcare system was required to focus on containing the spread of COVID 19. Pressure to maintain the healthcare systems was then in competition with the urgency of controlling the spread of the virus and the need to provide new services to support the pandemic. Some system changes that occurred during the first wave were creation of testing facilities (Government of Nova Scotia, 2020d) and the prioritization of learner placement activities, and visitor and volunteer services. With increased testing and the requirement for increased lab capacity, enhanced infection control measures such as mandatory

masking and expanding virtual care were instituted to keep all Nova Scotians safe (Government of Nova Scotia, 2020e).

Entering May 2020, re-opening plans started to unfold and a review of learnings began as case numbers were declining (Government of Nova Scotia, 2020f). A formal review of the COVID 19 outbreak at Northwood's Halifax campus was announced by the Health and Wellness Minister Randy Delorey as many provincial case numbers were related to this population (Government of Nova Scotia, 2020g). Mandatory non-medical mask usage continued to be in effect in most public places (Government of Nova Scotia, 2020h) with plans developed for a provincial learner testing strategy at local colleges and universities.

As parts of Canada were beginning to experience a second wave, Nova Scotia continued to increase capacity for testing by creating an online COVID 19 self-assessment tool and the online ability to book a test (Government of Nova Scotia, 2020j). International students returned to NS as testing strategies were in place. The second wave of the pandemic began in November 2020 and the arrival of 1,950 doses of the Pfizer COVID 19 vaccine (Government of Nova Scotia, 2020l) was welcome news.

In December of 2020, an immunization program for COVID 19 began, mainly for healthcare employees working in areas of high risk for exposure. The new year (2021) started with Nova Scotia Public Health developing strategies that took into consideration immunization supply and demand while considering the current epidemiology and best practice guidance. COVID 19 variants influenced our third wave in April of 2021. Fast and furious was a description used at the time when describing the virus's impact on people and the healthcare system in NS. The chaos and fury brought about by COVID 19 variants of concern continued until June 2021, when case numbers diminished and the aftermath set in.

Over the remainder of the summer, the provincial health authority reviewed the third wave impacts, most notably, the fallout of the COVID 19 pandemic and strain on nurses. With a backdrop of the third wave, further health care transformation was announced. In September 2021, the NSHA's CEO and board were dismissed (Halifax Examiner, September 1, 2021) sending shock waves across the healthcare system. Premier Tim Houston sought to further streamline governance at the NSHA (Halifax Examiner, September 1, 2021).

Nurses in Nova Scotia rallied at Government House 2 weeks later. Narratives shared at the rally described an increase in movement of nurses, mental and emotional strain, and a lack of human resources to meet the ongoing healthcare demands of the pandemic (Global News, September 17, 2021). For some nurses, the pandemic resulted in an increase in absenteeism, change in job/position, or departure from the nursing profession (Global News, September 17, 2021). The new Progressive Conservative government and Premier Tim Houston made fixing the health-care problem in Nova Scotia its top priority and campaigned on the promise to invest a record amount of taxpayer dollars to do it (Global News, September 17, 2021).

Nova Scotia Nursing Context

To understand the development and status of nursing within Nova Scotia during the time of the pandemic, it is important to explore nursing's historical roots and influences. Several influential factors have both facilitated and hindered the development of the profession in the province. For more than 2 decades, Nova Scotia has had a Nova Scotia Nursing Strategy (DHW, 2014). Nova Scotia's Provincial Nursing Strategy was first developed in 2001 to develop and sustain a stable nursing workforce in the province. The most recent update to the strategy was undertaken in 2015 (Government of Nova Scotia, 2016).

Since its inception, more than $85 million was invested in the strategy (to date) to address nursing's three priority areas of recruitment, retention, and renewal. During that time, significant growth in these areas has been achieved (Government of Nova Scotia, 2016). More practicing Registered Nurses (RNs) are being retained in the nursing workforce. More students are entering and graduating from the province's RN education institutions, and more of them are remaining in Nova Scotia to practice after they graduate. As a result, the number of RNs has increased steadily after years of decline in the early 2000s.

Provincially standardized scopes of practice for RNs have been developed as well as new information systems available to monitor numbers of RNs. The policies implemented as part of the Nova Scotia Nursing Strategy are guided by evidence and by consultation with appropriate provincial nursing stakeholders regarding the different contexts and needs experienced by nurses at different stages in their careers working in different geographic regions and specialties.

The Provincial Nursing Network (PNN) acts as a resource and advisory body for the Department of Health and Wellness (DHW, 2014). Members of the network include practicing nurses, employers, educators, professional regulatory colleges, and unions. This diverse membership gives the network its strength and credibility to carry out its important function. The continued success of the Nova Scotia Nursing Strategy and its initiatives is a direct result of the ongoing collaboration amongst the members of PNN and relationships with key stakeholders in Nova Scotia and across Canada (DHW, 2015).

Given the inherent challenges in predicting the future, particularly as it pertains to the health of the population and other factors outside the immediate influence of the Nursing Strategy, investing in maintaining and improving the progress made to date is critical to ensuring a stable and adequate provincial nursing workforce in the future. The PNN continues to

strategize in relation to all matters related to the nursing workforce in the province.

A few examples of its achievements include: advocating for increasing the number of undergraduate nursing seats at Nova Scotia's universities (from 306 first-year seats in 2006 to 401 in 2014 to 471 in 2021) and aggressively hiring and retaining graduates of RN programs (90% of RN graduates were hired in 2014 compared to 53% in 2001) (Cruikshank & Ellis, 2015). In October 2021, Premier Tim Houston announced a promise to nurses who graduate from a school in the province over the next 5 years. This promise was "a standing offer to work in Nova Scotia" (Ray, C., October 28, 2021). These gains are impressive and they will help to inform a path forward to meet new nursing challenges.

Interprofessional Context

In 2010, the Model of Care Initiatives in Nova Scotia (MOCINS) was introduced as a solution to facilitate interprofessional practice and learning. It was built upon the premise of collaborative practice and the need to have the "right professional doing the right job at the right place and time" (Tomblin Murphy et al., 2012). Despite several attempts to implement MOCINS in NS has not succeeded in shifting a culture of healthcare silos toward a common vision in healthcare. The final evaluation report for MOCINS identified and recommended that care for patients was not adequate and required focused attention (Tomblin Murphy et al., 2012). This resulted in a thrust toward interprofessional education and collaborative practice to continue to change models of care in Nova Scotia.

Several recommendations have been offered by Tomblin Murphy and colleagues (2012) to ensure healthcare sustainability and enhanced HCP practice. The evaluation found that a health care model focused on CPCC resulted in better patient care and improved job satisfaction (considerable time was spent by MOCINS project leads to engage people, optimize nursing

roles, and introduce new members to the healthcare team) as well as reduce health human resource shortages. This gave rise to many questions around IPE and IPC in the province and sparked questions in relation to the nursing curriculum.

In the autumn of 2012, Nova Scotia launched a review to identify changes required to modernize and strengthen the quality, effectiveness, sustainability, and accountability of registered nurse undergraduate education (DHW, 2014). A steering committee representing the Department of Health and Wellness, the Department of Labour and Advanced Education (LAE), Cape Breton University (CBU), Dalhousie University (Dal), and St. Francis Xavier University (StFX) collaborated to review current programs and delivery models and make recommendations on a new, collaborative model of undergraduate nursing education to better meet current and future population health and care delivery needs (Cruikshank & Ellis, 2015). The concept-based curriculum was implemented in all three universities across the province with more evidence of IPE.

Given that the major influencing paradigm of healthcare was moving from a medical model towards collaborative practice, several questions arose in the NS healthcare community, specifically, questions in relation to the new provincial health authority's ability to support collaborative work. As well, it was found that it would be imperative that the RN's role and scope of work was clearly optimized and understood by all, as well as, most importantly, by registered nurses leading IPC.

In 2015, executive within the Nova Scotia Health Authority responded to these matters by announcing its first Chief Nursing Officer. One year later, the Interprofessional Practice and Learning (IPPL) portfolio was created by the NSHA executive with the intention of facilitating and advancing collaborative patient-centred care in the provincial health authority. IPPL's role

as a change agent for advancing collaborative patient-centred care (NSHA, 2019) became a necessity. Additionally, the team's leadership role with the Chief Nursing Officer, DHW, LAE, NSCN, and academic institutions on education, transition to practice, and professional practice matters quickly became evident.

A recent example of such leadership was the design and proclamation of a new Nursing Act in NS. In 2019, the Nova Scotia government proclaimed a new Nursing Act that brought about one regulatory body for the profession of nursing in the province (Government of Nova Scotia, 2019, June 5). It was positioned as facilitating an optimal scope of practice to demonstrate the kind of collaboration among health professionals necessary for Nova Scotians and for future healthcare in the province.

With the implementation of the new Nursing Act, the Nova Scotia College of Nursing (NSCN) had the ability to expand the scopes of practice for individual nurses with additional education within the overall scope of nursing (NSCN, 2020). The change in this Act had a direct impact on nurses' work for the more than 15,000 nurses working with the province (NSCN, 2020). The role of nurses as collaborators within healthcare team had been strengthened.

Disciplinary Perspective

In the context of the interprofessional multidisciplinary healthcare system, it is important to remember disciplinary origins and intellectual objectives (Thorne, 2016). Over the course of time, a range of healthcare experiences have influenced my disciplinary perspective—most notably, a personal experience that changed the course of my life. In sharing my story with you, I hope to shine a light upon some of the greatest educational tools available to me as a registered nurse.

Personal Experience from 1995

I recall an experience when my brother Callum was in the hospital following a spinal cord injury. One year out of nursing school, I had very little exposure to spinal cord shock, injury, and the life-long complications Callum would face in his journey. While in intensive care, many well-intentioned health care providers (HCP) did their hourly checks, assessments, and tasks to ensure he was physically stable. My family and I were asked questions and would have to explain the details of the accident on multiple occasions; often details we did not want to have to repeat or rush through when describing them.

Health care providers made every effort to treat my brother, but fragmented care did result in poor outcomes. After leaving intensive care, Callum was on a ventilator for more than 2 months. He was placed under close observation within a busy medical teaching unit. Every week the medical staff and their team rotated in and out of the unit. It was several weeks before Christmas and the team met to inform us that Callum would never be able to breathe independently again. They asked Callum to consent to getting a permanent tracheostomy so that long-term ventilation would be possible.

Our family, including Callum, spent the weekend talking about the fact that he would not breathe independently again. It was a lot for us to comprehend on top of a long list of medical problems associated with his condition. The following Monday, a new team arrived at his bedside to meet him for the first time. They informed Callum that he would have his permanent tracheostomy inserted during the week and that they would have him breathing on his own "in no time". My brother was unable to talk at the time, but I remember the look in his eyes when he was informed of that. Confusion, mistrust, fear, and hope were all mixed into one expression as he tried to comprehend the unfathomable reality that two teams imagined such different

outcomes. In that moment Callum was clearly not part of the team. Over a 3-month period, he was re-trained to breathe on his own and for 26 years he continued to do so. When reflecting on his experience, Callum often talked about this as a low point in his journey.

I left this experience with a thirst to do things differently for the patients and families I cared for, both then and now, in my role as a healthcare leader. I had the privilege and pleasure of helping HCPs learn about, from, and with one another (Barr, 1998) on their journey to becoming interprofessional and collaborative. I have heard stories from patients, families, and HCPs that denote the reality of, and opportunities for, enhanced IPC in healthcare today.

Underscoring my work is my 26-year journey with my brother living with multiple conditions, including being quadriplegic. Callum's healthcare experiences were mine as we weathered the ups and downs of his condition together. I gained much knowledge through lived experiences, providing me with an in-depth understanding of IPC and its relevance to patients, their families, and the healthcare community. Yet, I also recognize the theoretical importance of being able to understand the parts of this phenomenon (in this case, IPC) so that I can generate an interpretive description to inform clinical understanding and inform IP practice and learning.

Personal Experience from 2021

I am turning now to my experiences amidst the data collection of my research. Callum died in 2021 and experiencing his death was very difficult for me. I reflected on the experiences of ELNs and it felt difficult because of my recent loss. I felt a great deal of emotion, most likely because I had been in their shoes and recognized the impact the pandemic had on all of us. As a healthcare leader, I had a role to play in forming their experiences, but I became clouded by the role I played in caring for my brother over many years. My reflection is guided and influenced by this, coupled with the unique opportunities I had over 26 years with him.

As a receiver of healthcare in NS for 26 years, my brother met many HCPs. He worked with ELNs as recently as late 2020/early 2021. Callum had a knack for welcoming newcomers. He was the CEO of his own health and built a business with his healthcare team. Callum took much pride in doing so.

Callum's employees cared for him, but he cared for them—it was reciprocal in nature as they learned a lot from each other. He respected his nurses and he taught them about caring without judgement—helpful for practice but also in life. He took special interest in new nurses, most likely because he related to their curiosity and youthfulness. Despite growing older, he had a young mind and was full of fun. Callum spent hours with them, describing the details of his body from how the hair on his chest could stand up on end like a magic trick or the many medications he took daily to create a degree of homeostasis for him. The time he spent with his nurses was private, intimate, and was Callum's way of continuing to contribute to their knowledge and experience. Leaving this as part of his legacy remains powerful.

I believe that each new nurse had their own unique experience with Callum. Their fear became his motive to help, their curiosity became his moment to teach, and his life experience became a place for them to connect. He was as invested in their growth as they were in his. He knew investing in them was like a secret key to a fountain of youth, keeping his body and mind strong for the day ahead. Through this, many friendships were formed and professional boundaries pushed to the limit. Callum helped me see ELNs in new ways.

The ELN experiences denote the central role nurses play in achieving connections with the patient and family. Nurses are critical to delivering on the promise of "leaving no one behind". They contribute to a range of health priorities as well as the delivery of interprofessional care. I believe my brother created very special nurses. He shaped them to

believe in their personal values. He advocated strongly for his values to be recognized as a part of his care and asked each nurse to have an open mind and learn about him as a person first, patient second. He valued their opinions and challenged them to open their minds to advocacy by patients and families. He often told staff that he would not make any major health decisions without his family involved. Over time, the team became more comfortable with this.

Callum valued education and constantly encouraged new staff to continue to learn, to be brave and when they were feeling afraid, to reach out. Callum taught people that if they were informed before they spoke, with the right information and approach people would listen. Some of the most opinionated nurses became some of his closest allies. He knew when someone's point of view came with the right intention. Callum also recognized those that did not attend with the right intention.

Callum created an inviting environment where knowledge could thrive, and as a result he became a resource for others. He inspired people to be better and cared deeply about their success. When the patient is the CEO of their health, care changes. I wish that the ELNs I interviewed could have met Callum. I am certain that each one of them would have left the experience having learned something. I know he would have told them to just "listen" and he would teach them.

Callum would have turned their fears to excitement; he would use his experiences to create a connection. He would have welcomed them to a hospital room or home with his sparkling eyes and smile. His feedback would become lines to live by in their transition to practice—gentle words spoken that would leave an impact.

In my research, I heard his voice. Maybe it was because he helped to shape me to be the nurse and healthcare leader I am today. It is because of him that I see and feel this experience so

intimately for the ELNs in NS. I was an ELN in NS during the time of his injury, 26 years ago. I worked on the unit he was later admitted to as a 22-year-old quadriplegic; I was 23. I believed he would live a better life, he just had to make that choice. He made the choice to live every day to the fullest and inspired me to be the best version of myself, as a mom, sister, daughter, nurse, and best friend. My vulnerability was necessary for my growth. My life experience with him cannot be dampened to make other people more comfortable. He used this experience to connect with people, be honest and real, and it was then up to others in how they wanted to respond.

The ELN experience during COVID stands out strongly. The care for my brother changed dramatically through this time. We started to limit the number of caregivers coming into the home as a portion of them could do only limited tasks because of COVID 19 guidelines around Aerosol Generating Medical Procedures. This postponed his care. Additionally, for an individual who relied on his connections with people, he became isolated from parts of his support system which had an impact on his health.

My brother's suffering became more visible to everyone, including himself. His calls for help became more frequent and I started to fall short on having the right answers. I reflect on this more now and wonder how he felt, more specifically, his fear when I would say "I do not know". Many health concerns we worked on together and found solutions, but we started to not have all the answers anymore. Things that worked in the past were no longer successful. He was changing, I was changing. We were learning together that we had no answers as our reality began to unravel.

Like the waves of the pandemic, I felt each peak and valley. The constant unpredictability was nagging on my soul, I was constantly in turmoil, focused on doing the right thing. I felt torn by my responsibilities at home and at work while caring for him at a distance,

wishing for a glimpse in time when we could be siblings again. When reflecting on the data of ELN experiences with patients and families that I was analyzing, it struck me how they felt the pandemic provided new opportunities with patient and families—some positive, others not so much.

I, too, saw this. The distance created a space for Callum to work with his care team in hospital in a different way. He relied on them and as a family member I trusted he was in safe hands. He met new people, my priorities shifted, and I felt uncomfortable by this. I made a choice to give him the space to be with others that could help him more than I could. My dedicated time was phone calls, short visits when permitted, and ambulance rides to the city. The ambulance rides became our best times together. They gave us 10 hours together; 4 hours up, 4 hours back and appointments in between. I am happy I had those drives. We shared our hopes and dreams for our futures during those ambulance rides.

On one drive he spent 4 hours counselling a member of the healthcare team around living with a disability in rural NS. She was becoming a family caregiver for her sister-in-law with ALS. Callum spent hours sharing personal details of his experience for the purpose of helping her. Her vulnerability and honesty with him pushed him to share more. They did not know each other before that day, but they became connected on a deeply personal level. He drew out of her exactly what she needed to ask and needed to hear.

She asked us not to tell her superiors as she felt that she may have crossed the boundaries of professional practice. Silently, I did not agree with her. I recall saying to myself that this was what professional practice is about! It took Callum 2 seconds to say how some boundaries are meant to be pushed and that he did not feel that she had acted unprofessionally. She breathed a sigh of relief.

I said very little during this ambulance ride. It was our last trip to Halifax together. He remained in the hospital and passed several weeks later. He helped her that day by giving her knowledge and hope during an unpredictable and scary time. It was a gift wrapped with a bow to be eventually unwrapped by this nurse with her sister-in-law.

From my viewpoint, this was what the pandemic did for HCP with their patients and families. Professional practice boundaries from yesterday have become blurred and grey and new rules are being written. Knowledge, informed by the past, has limited relevancy; yet people become united in a healthcare experience and something flourishes in the uncertainty. I want to be part of informing this new knowledge, a resolve that took root through years of legacy-building by my brother.

Chapter Two: Literature Review on Interprofessional Collaboration

Collaboration affects all aspects of a person's life (Schot, Tummers & Noordegraaf, 2020). It is important to create the conditions for people to receive interprofessional healthcare (Fox et al., 2019; Schot et al., 2020). Interprofessional collaboration (IPC) serves as a foundation required to enhance interprofessional care (Fox et al., 2019) and according to the WHO (2021) it is composed of working within integrated, team-based health and care settings. These features facilitate IPC and the acceptance of professional differences during interactions (Cook & Brunton, 2017; WHO, 2021) for the provision of care.

Increasingly, the interprofessional team cares for people from multiple backgrounds (discipline, cultures, faith traditions, gender). They are asked to enter partnerships that are sensitive to fundamental and personal needs expressed (Accreditation Canada, 2019; CIHC, 2010) by patients and their families. Multiple studies conducted within the Canadian healthcare system suggest an intolerance or insensitivity for diverse traditions and perspectives (Asanin & Wilson, 2008; Higginbottom & Safipour, 2015). Concern has been expressed that the Canadian healthcare model fails to be sensitive to or meet the diverse needs of people due to lack of IPC (Fox et al., 2019; Schot et al., 2020; WHO, 2021).

Despite the emergence of HCP competencies and interprofessional models of care, the biomedical model continues to be the dominant influence in modern healthcare (Feo & Kitson, 2015) and few have linked this to the invisibility of the necessary partnerships in care (McCormack & McCance, 2010; D'Armour et al., 2005) and IPC (CIHC, 2010). However, the Canadian healthcare system continues to predicate the goal of cure with an increasing emphasis placed on interprofessional care. Fundamentally, the goal to cure overpowers the goal to be collaborative and interprofessional rendering both to be invisible and devalued (D' Armour et al.,

2008; Feo & Kitson, 2015). Furthermore, the findings from my study include the importance of ELN preferences and experiences when building IPC in practice.

Canada's *National IP Competency Framework* developed by CIHC (2010) provides an integrative approach to describing the competencies required for effective IPC. Six competency domains highlight the knowledge, skills, and attitudes that shape IP collaborative practice (CIHC, 2010). Although it has been several years since its development, components of the framework are being used and tested by various stakeholders from government, regulation, education, and practice. The framework has been helpful to define professional competence, set consistent standards of practice across settings, and identify performance indicators for HCPs (Hepp et al., 2015; Reeves et al., 2009) irrespective of their individual differences.

While recognizing the need for a national framework, operationalizing, and measuring the progress has proven difficult (Interprofessional Global, 2021; Reeves et al., 2009; Tomblin Murphy et al., 2012). Current literature on this topic demonstrates success in interprofessional learning (Best & Williams, 2019; Reeves et al., 2013) but challenges exist in the approach to IP collaborative practice (Best et al., 2019; Stadick, 2020; Zwarensetin et al., 2009). A single theory or framework to guide IPC is lacking and may be an unrealistic goal given the precarious nature of professional and interprofessional practice and complexities in care.

The literature discussed in this chapter sets the groundwork and understanding of IPC in Canada. The aim of this section is to: (1) revisit the historical roots of IPC, (2) describe the rise of the *National IP Competency Framework* (CIHC, 2010), (3) define IPE for IPC, and (4) discuss questions that exist in relation to the *National IP Competency Framework* (CIHC, 2010) in practice today. The *National IP Competency Framework* (CIHC, 2010) provides guidance for the examination of my research questions and is the key framework used in Nova Scotia. For the

purposes of my research study, the only competencies under consideration are those related to the delivery of IPC and noted in the *National IP Competency Framework* (CIHC, 2010*)*.

History Revisited

The ideological origins of interprofessionalism in Canada were strengthened from 1960 to 1968 because of discussions in relation to team-based care and healthcare sustainability (Herbert, 2005). Two themes began to emerge in relation to interprofessional education and practice: the assumption that it can be taught through formal education and the notion that practice readiness is the by-product (McCreary, 1962; Szasz, 1969). From the 1970s onward, numerous changes took place in Canadian healthcare. Developments in regulation, education, and discipline-specific roles and responsibilities forced health professionals to practice differently. The evolution of professional roles has been described as creating strain, competition, and separateness (LaSor & Elloit, 1977; Nelson & Gordon, 2004; Reeves et al., 2010) within the healthcare team. Historically, discipline-specific knowledge created a silo-like approach to care that was rarely cohesive or collaborative (D'Amour & Oandasan, 2005).

Two landmark studies done in Canada (Kirby, 2003; Romanow, 2002) emphasized the critical need for healthcare reform and resulted in two influential reports: *To Err is Human* in the United States (IOM, 2000) and *An Organization with a Memory* from the United Kingdom (Department of Health, 2000). These two reports were the impetus for a global movement toward safer health care. The Canadian and International reports demanded a more accountable system addressing how well HCPs work together as an area of deep concern.

In 2002 Commissioner Roy Romanow's Report on the *Future of Health Care in Canada* stated the direction of the healthcare system must change to better meet the needs of patients, families, and communities. Changing the way HCPs are educated and practice were two key

activities to be addressed in achieving enhanced care. In 2003 the Canadian federal budget funded health initiatives to support reform in healthcare delivery (Health Canada, 2004). The budget committed $80 million over a 5-year period to target the education and practice changes required to foster IPC (Health Canada, 2004). This allowed Health Canada, in partnership with provincial and territorial governments, professional associations, academic, and practice partners, to play a strategic role in the advancement of education and practice for the benefit of collaborative patient-centred care (CPCC).

Health Canada and its stakeholders worked collaboratively in two priority areas including a *Pan-Canadian Health Human Resource Plan* (2005) and the *Interprofessional Education for Collaborative Patient Centered Practice (IECPCP)* initiative (2007). Ultimately, the IECPCP initiative was designed to enhance IPC by (1) demonstrating benefits of interprofessional education (IPE) for IPC, (2) increasing the number of educators prepared to teach IPE, (3) increasing the number of health professionals trained for IPC before and after entry-to-practice, (4) networking and sharing of best educational approaches, and (5) facilitating interprofessional collaborative patient centered care in education and practice settings (Health Canada, 2007). This initiative laid important groundwork allowing Health Canada and its stakeholders the ability to determine what Canada must do to advance IECPCP in the healthcare system. This gave rise to the development of the Canadian Interprofessional Health Collaborative (CIHC) that later spearheaded the design of a national competency framework and the body of knowledge used to support research, education, and practice in this field.

The Rise of a Competency Framework in Canada

The move toward competence was conceived in 1911 when F. W. Taylor claimed that efficiency and productivity could be heightened using an approach that described the ideal

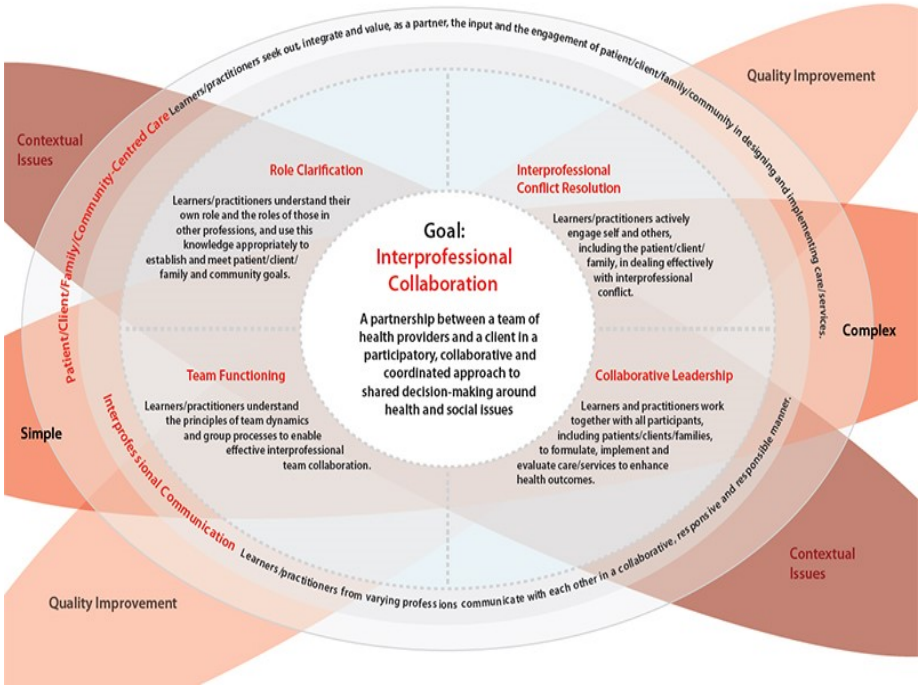
combination of knowledge, skills, and attitudes necessary to perform a specific task (Garavan & McGuire, 2001), a trend also seen in the development of competency-based education (Ford, 2014). In the years leading up to the design of the CIHC (2010) *National IP Competency Framework* (Figure 1), several health-related professions, regulatory bodies, and government organizations specific to healthcare advocated for the use of competencies to describe outcomes related to performance and provide provisional predictors of performance and delineate standards of practice (Reeves et al., 2009). The wide appeal of a competency-based approach was because of the adoption of consistent definitions, standards of practice, and observable indicators to help measure professional performance across multiple settings.

The CIHC (2010) *National IP Competency Framework* was developed based on a review of the literature, competency-based education, and existing competency frameworks related to IPE and IPC (CIHC, 2010). Roegiers (2003) and Tardif (1999) are two major competency proponents whose ideas guided the framework development (CIHC, 2010) and helped shape the overarching set of competencies within the framework. More specifically, Roegiers' (2003) perspective is evident by the integration of knowledge, skills, attitudes, and values needed to make judgments (Bainbridge et al., 2010) and Tardif's (1999) perspective is evident by the addressing of the complexity of IP learning and practice (Bainbridge et al., 2010).

The *National IP Competency Framework* was developed to advance Canada-wide competency in IPC (CIHC, 2010). It has six inter-related domains, each of which is operationalized through several competency statements. The six inter-related domains include interprofessional communication, patient/client/family/community-centered care, role clarification, team functioning, collaborative leadership, and interprofessional conflict resolution.

Figure 1

CIHC (2010) National Interprofessional Competency Framework



The framework has seven underlying assumptions:

(1) competency descriptors identify knowledge, skills, attitudes, values, and judgments that are dynamic, developmental, and evolutionary; (2) interprofessional learning is additive and reflects a continuum of learning; (3) interprofessional collaborative practice is essential for improvement in patient/client/family and community health outcomes; (4) the level of interprofessional competence demonstrated is dependent on the depth and breadth of opportunities for education and practice experience with, from, and about other HCPs; (5) adoption of interprofessional competencies into health professional programs occurs at different rates depending upon the level of learner and the complexity of learning tasks; (6) adoption of interprofessional competencies may require a shift in how learners, practitioners, educators, and practice environments conceptualize collaboration; and (7) interprofessional collaborative practice requires a consistent culture between learning and practice that supports IPC. (CIHC, 2010, p. 9)

The framework's competency domains and underlying assumptions extend across HCPs and practice contexts irrespective of their individual differences. Health care providers convey the framework in care and is supported through IPE to verify individual competencies and further refine talents. Competence is recognized when there is evidence that the knowledge, skills, and attitudes required to deliver care are consistently demonstrated in practice (Brasher et al., 2020; Tomblin Murphy et al., 2021). Recent perspectives request a theoretical framework that place factors, including relational (Almost et al., 2015; Brasher et al, 2020; Wei et al., 2020), social (Khalili et al., 2020; Price et al., 2020) and workforce planning and development (Tomblin Murphy et al., 2021) more visibly among interprofessional competency domains and underlying assumptions.

There is mixed evidence on how effective (or not) the *National IP Competency Framework* (CIHC, 2010) is in fostering new and collaborative practice patterns, especially considering the transformation that occurs within practice today (Brasher et al., 2020; Dahlke et al., 2020; Hepp et al., 2015; IPEC, 2016). The science of evaluating the effectiveness of IPC continues to evolve. Further work is underway to develop robust interventions that will complement the framework and enable reliable verification of the HCP's readiness and IPC competence in practice (Brasher et al., 2020; Dahlke et al., 2020; Fox et al., 2021; Johnson et al., 2021; Tomblin Murphy et al., 2021). Anchoring education, for example IPE for IPC, in more robust theories of how the professions come together in practice will most certainly improve the empirical success of Canada's *National IP Competency Framework* (CIHC, 2010).

Interprofessional Education for Interprofessional Collaboration

The Centre for the Advancement of Interprofessional Education (CAIPE) is credited with developing the accepted definition of IPE. IPE occurs when two or more professions learn with,

from, and about each other to improve collaboration and the quality of care (CAIPE, 2002). The *National IP Competency Framework* (CIHC, 2010) describes the starting point for curriculum content and goes as far as suggesting ways of embedding IPE in pre-licensure education including the academic accreditation processes to ensure systematic integration of IPE in health professions education (AIPHE, 2007).

Many reviews of the IPE literature have been completed (Adams, 2020; Azzam et al., 2021; Best et al., 2019; Hammick et al., 2007; Reeves et al., 2013; Paradis & Whitehead, 2018; Thistlethwaite & Moran, 2010; Zwarenstein et al., 2009) over the last decade. Within the literature, there is much debate about when to introduce IPE into educational programs of HCPs. One recommendation is for introduction to occur during pre-licensure education to avoid the development of negative stereotypes (Reeves et al., 2010; Khalili et al., 2013; Price et al., 2021) and guide how learners come to know other learners and relate to them through the development of positive attitudes and behaviors (Price et al., 2021).

Counter arguments have been made that IPE is better placed later in the learner's education (Reeves et al., 2013). Proponents of this approach feel that the learner must first have an appreciation of their own discipline before they can engage in effective IPE (Thistlethwaite & Moran, 2010; Whyte et al., 2017). The notion of a continuum of learning, with the introduction of different types of IPE experiences, is what is endorsed by CIHC (2010). There is a range of educational initiatives that can be used in post-licensure IPE, but many healthcare systems are fragmented and struggle to manage unmet health needs (CASN, 2022; WHO, 2010, 2020). Workforce shortages coupled with increased patient acuity compound the complexity associated with the planning and delivery of IPE in practice. Furthermore, today's healthcare milieu creates a certain level of unwillingness to endorse IPE because of associated costs, competing priorities,

lack of professional readiness, pedagogical challenges, and inertia in clinical education (Almost, 2021; Paradis & Whitehead, 2018; Whyte et al., 2017). In fact, there are opinions in the literature that note a need for new IPE approaches to reflect changing trends noted in healthcare today (Bainbridge & Regehr, 2015; Hepp et al., 2015; IPEC, 2016; Khalili et al., 2019; Paradis et al., 2018; Price et al., 2021; Reeves et al., 2013).

There continues to be an urgency to address how HCPs learn within a system that is shifting in multiple directions (Bainbridge & Regehr, 2015; Best et al., 2019; Hepp et al., 2015). Most IPE programs assume that HCPs accept that they have an accountability, but this assumption, at times, remains at the level of theory, not practice (Barr et al., 2005; Hepp et al., 2015; Homeyer et al., 2018; IPEC, 2016; WHO, 2021). Interprofessional education for IPC with a robust practice orientation has become heightened because of the COVID 19 pandemic. Blending of IPE and practice, for example, in-situ simulation activities, facilitated clinical debriefs, or infection prevention and control team huddles, are powerful learning tools. These strategies provide a safe, engaging experience while fostering IPC. Future models of IPE for IPC should provide developmentally appropriate, workplace-based team training to enhance learning potential and alignment with the characteristics and demands of professional roles (Adams, 2020; Paradis et al., 2018) as well as practice realities.

Debate within the healthcare community continues, especially in relation to IPE more readily embracing a practice reality (NEXUS, 2021). Time and research will tell whether IPE fosters IPC, but a focus on only pre-licensure level education or post-licensure education is flawed. Future evidence should focus on the continuum of collaborative learning from pre- to post-licensure IPE that occurs for HCPs while moving in and out of complex practice environments (Interprofessional Global, 2021; IPEC, 2016) over time. Lastly, electing evidence-

based interventions that focus on the explicit teaching of IPC, like the interventions discussed above, might prove to be more effective and more easily adopted. Much knowledge has been gained in the field nationally and internationally, yet unanswered questions still exist.

Interprofessional Collaboration in Practice

CIHC (2010) describes IPC as a central tenet to CPCC. Barr (1998) defines IPC as a practice orientation that involves the interaction of two or more professionals or disciplines, organized into a common effort, to solve or explore common issues with the best possible participation of the patient/family. It is designed to promote the active participation of each discipline in patient care. It enhances patient and family-oriented goals and values (Accreditation Canada, 2019), provides mechanisms for continuous communication among care givers (CIHC, 2010), optimizes staff participation in decision making within and across disciplines, and fosters respect for disciplinary contributions of all HCPs (D'Amour & Oandasan, 2005; Deneckere et al., 2011; Khalili et al., 2019).

Nationally, many organizations use the *National IP Competency Framework* (CIHC, 2010) as a starting point for understanding and integrating IPC. Accreditation Canada (2019) strengthens IPC through the accreditation of health service delivery. It uses the CIHC framework in ensuring that organizational issues that impact IPC, quality of care, and patient safety are assessed within set standards and processes (Accreditation Canada, 2019; CIHC, 2010). This is a step in the right direction since IPC exists not only within a team, but also in the philosophy of the organization, the practice environment, and across organizations that influence each other (Gray et al., 2021; Hepp et al., 2015; Johnson et al., 2021; WHO, 2010). Each healthcare facility or unit is unique and therefore strategies used to establish IPC must consider local context, including requirements and challenges (Accreditation Canada, 2019; CIHC, 2010;

WHO, 2010) and the influential role of local leaders (Orchard et al., 2017; Reeves et al., 2010). A systematic review conducted by Lambrou and Merkouris (2014) found an important aspect of the practice environment was influential local leadership that supports collective IP competence and a team environment and practices collaborative decision making. Furthermore, local leaders that support practice decisions based on team-based expertise in the provision of IPC are critical (Almost et al., 2015; Flodgren et al., 2019; Lambrou et al., 2014; Price et al., 2019). Without this, the ability of a competency framework to accurately capture the level of competence of IPC practiced by a collective group of HCPs is limited (Allvin et al., 2020; Johnson et al., 2021; Price et al., 2019; Reeves, 2012; Reeves et al., 2009).

Practice models of IPC are themselves evolving considering current and ongoing research (Brasher et al., 2020; Hepp et al., 2012; Kitson et al., 2013; Kreps, 2016; Tomblin Murphy et al., 2012; Tomblin Murphy et al., 2021) resulting in a new understanding of IPC moving beyond what the *National IP Competency Framework* (CIHC, 2010) may describe (Hepp et al., 2015). At the same time, there is ample evidence from which recommendations can now be derived, even though continuous refinement will also take place. A strong foundation exists for a more practice-relevant frame of reference that is inclusive of collective competence in practice environments where structures and processes allow HCPs to practice safely and engage in IPC resulting in quality outcomes (Brasher et al., 2020; Hepp et al., 2015; Khalili et al., 2019; NEXUS, 2021; Orchard et al., 2017; WHO, 2021).

The COVID 19 pandemic has exaggerated the precariousness of IPC in practice. New practice challenges exist, most notably, the inability to optimally prepare HCP for professional and interprofessional practice (Tomblin Murphy et al, 2021). In addition, rapid and perpetual changes informed by evolving knowledge are the new norm (Duchscher et al., 2021).

Partnerships and enhanced mechanisms for sharing new knowledge amongst IP teams need to be developed to inform changing practices throughout the healthcare system.

In conclusion, it is important to create the conditions for people to receive interprofessional healthcare (Fox et al., 2019; Schot et al., 2020). The *National IP Competency Framework* (CIHC, 2010) has been adopted across Canada to foster IPC. The literature reviewed in this chapter sets the groundwork and understanding of IPC in NS and in Canada and provides a way to understand and translate findings and advance knowledge, noted in my research. The *National IP Competency Framework* (CIHC, 2010) shapes the phenomena of IPC in NS, is insightful, and applicable to practice.

While recognizing the need for a national competency framework, operationalizing, and measuring the progress has proven difficult (Brasher et al., 2020; Dahlke et al., 2020; Hepp et al., 2015; Interprofessional Global, 2021; IPEC, 2016; Reeves et al., 2009; Tomblin Murphy et al., 2012). Current literature on this topic demonstrates success in interprofessional learning (Best et al., 2019; Reeves et al., 2013) but challenges exist in the approach to IP collaborative practice (Best et al., 2019; Stadick, 2020; Tomblin Murphy et al., 2021; Zwarensetin et al., 2009). A single theory or framework to guide IPC is lacking and may be an unrealistic goal given the precarious nature of professional and interprofessional practice and current complexities in care.

Further work is underway to develop robust interventions that will complement the framework and enable reliable verification of IPC competence in practice (Brasher et al., 2020; Dahlke et al., 2020; Fox et al., 2021; Johnson et al., 2021; Tomblin Murphy et al., 2021). Anchoring education, for example, IPE for IPC, in more robust theories of how the professions come together in practice will most certainly improve the empirical success of Canada's *National IP Competency Framework* (CIHC, 2010). Electing evidence-based interventions that

focus on the explicit teaching of IPC might prove to be more effective and more easily adopted. Much knowledge has been gained in the field nationally and internationally, yet unanswered questions still exist.

Chapter Three:

Interprofessional Collaboration, Nursing Knowledge, and the Entry Level Nurse

Nurses play a key role in the healthcare team. With a unique combination of knowledge, skills, and attitudes, nurses help to address health inequalities and improve the wellbeing of many (National Academies of Sciences, Engineering, & Medicine, 2021). *The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity* report calls on nurses to play a leadership role in partnering with patients, families, and communities (National Academies of Sciences, Engineering, & Medicine, 2021). Nurses are uniquely positioned to bring expertise to working in partnerships with others to leverage contemporary IPC (National Academies of Sciences, Engineering, & Medicine, 2021; WHO, 2021). All nurses have a duty and responsibility to collaborate with other HCPs and sectors (WHO, 2021).

The recruitment and retention of nurses is a serious issue (WHO, 2021). To support nursing workforce challenges, a focused approach to recruit new nurses is underway. Newly graduated registered nurses significantly contribute to the workforce and their recruitment and retention is receiving considerable attention. Interprofessional collaboration (IPC) is proposed as a solution for enhancing newly graduated nurse retention (WHO, 2010, 2021), however very little is known about the factors that influence IPC among new nurses. To date, researchers have not sought to learn how newly graduated registered nurses engage in IPC, despite the need to do so.

Entry-level competencies describe the knowledge, skill, and attitudes required of newly graduated registered nurses to provide safe, competent, compassionate, and ethical care (NSCN, 2020). This chapter will explore key findings about IPC and the newly graduated nurse. The newly graduated nurse is labelled as an entry level nurse (ELN). The definition of the ELN will

be explored in the chapter, as well as what is known about the role in relation to: (1) IPC; (2) collaborative leadership, including collaborative decision making, partnerships, and transformational leadership; (3) IPE, IP socialization and IPC.

Professional Role in IPC

The rapid emergence of collaborative models of care in Canada has been remarkable. Alongside the emergence of new models of care, a significant debate about knowledge generation and nursing competencies exists. The knowledge debate has largely been an either/or discussion about who generates and who applies knowledge (Dahnke & Dreher, 2011). The tendency to compartmentalize knowledge in either one category or the other has created challenges for the discipline of nursing, in actualizing its professional role in practice.

From a philosophical point of view, the debate is interesting because it provokes a broad spectrum of questions about the identity and unity of nursing knowledge. Risjord (2010) offers a perspective that opposing views about nursing knowledge are historically rooted. The separation of knowledge development and application reflects the longstanding ideologies stemming from nursing's quest for scholarly status (Dahnke & Dreher, 2011). Nursing scholarship is traditionally a defender of knowledge discovery while being criticized as being removed from the realities encountered in everyday practice (Dahnke & Dreher, 2011; Risjord, 2010). On the other hand, nurses in everyday practice are being criticized for a lack of interest in the development and implementation of new knowledge to support best nursing praxis (Malloch & Porter-O'Grady, 2006).

As the debate about knowledge development continues to unfold, articulating what nursing knowledge is and what competencies are needed to attend to IPC is imperative. Risjord (2010) stresses nursing knowledge must address the epistemological and the ontological, ethical,

and experiential features pertaining to nursing in today's practice environment. Knowledge from this standpoint refers to knowledge that is warranted as useful to nurses when enacting professional roles in practice (Risjord, 2010).

In Canada, the registered nurse (RN) scope of practice is set out in provincial/territorial legislation and regulations complemented by standards, professional guidelines, employer policies, individual competencies, and patient and family needs (CNA, 2020; NSCN, 2020). While such controls determine the overall scope and boundaries of practice for RNs as a professional group, the practice competencies serve the purpose of describing what is required for practice. The term role has been defined as the enactment of the competencies within a particular context or setting (Besner et al., 2005; NSCN, 2020; Squires, 2004), while role clarity is understood as the awareness and embodiment of one's professional role and the roles of those in the IP team (CIHC, 2010; NSCN, 2020).

CIHC (2010) suggests that all members of the IP team must clearly articulate roles and competencies within the context of IPC. Each member must have the ability to listen to other professionals to identify where unique knowledge and skills are held and where shared knowledge and skills occur (CIHC, 2010; IPEC, 2016). In addition to this, in practice, health professionals must use role clarity to work within the boundaries of their discipline and determine who has the competencies to address the unmet needs of patients and families (NSCN, 2020).

An ELN is defined as a newly graduated nurse with up to 1 year of professional practice experience (NSCN, 2020). When entry-level nurses graduate from school and enter the profession, they are required to have foundational competencies (NSCN, 2020). This foundation is based on a set of entry-level competencies required to provide safe care at any stage in their

career. The competencies of the ELN reflect the centrality of the patient/family/community/populations, as they are crucial to all nursing practices (NSCN, 2013, 2020). However, the ELN competency statements that lend to role clarity are organized around five competency categories (Figure 2) including professional responsibility and accountability, knowledge-based practice, ethical practice, service to the public, and self-regulation.

Figure 2

NSCN (2013) Conceptual Framework for ELN Competencies in NS

The ELN must be able to integrate and perform the competencies at the same time to ensure safe, effective, and ethical practice (CNA, 2007; 2011). The competency statements highlight multiple sources of knowledge required to attend to IPC. Five excerpts from the NSCN (2013) *Entry-Level Competencies* document explain this further, for example the ELN:

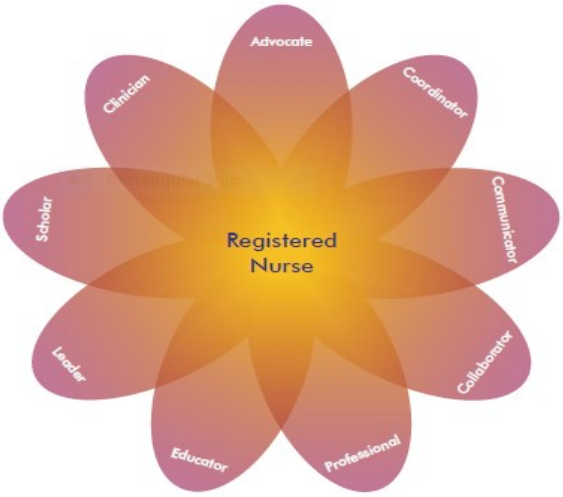
> articulates the role and responsibilities of a registered nurse as a member of the nursing and health care team; displays initiative, a beginning confidence, self-awareness and encourages collaborative interactions within the health care team; has a knowledge base about the contribution of registered nurse practice to the achievement of positive client health outcomes; and collaborates with the health care team to develop health care plans

that promote continuity for clients as they receive conventional, complementary and alternative health care. (pp. 20–24)

In 2017 the Canadian Council of Registered Nurse Regulators (CCRNR) initiated revisions of the previous Entry-Level Competencies (ELC) of Registered Nurses in Canada (NSCN, 2020). The five competency categories transitioned to nine key roles (Figure 3). Role clarity is necessary for IPC (CIHC, 2010; CNA, 2011) to enable the provision of safe, ethical, compassionate, and evidence-informed nursing care in any practice setting (NSCN, 2020). Furthermore, revisions also clarified that all groups involved in the provision of health care have a shared responsibility to create and maintain practice environments that support ELNs in providing safe, ethical, and quality healthcare as the practice environment influences the transition and consolidation of ELN practice and the development of further competence (NSCN, 2020).

Figure 3

NSCN (2020) Nine Roles of the Registered Nurse



More specifically, ELNs are collaborators who play an integral role in the health care

team partnership. NSCN (2020) asks the ELN to:

> Demonstrate collaborative professional relationships; Initiate collaboration to support care planning and safe, continuous transitions from one health care facility to another, or to residential, community or home and self-care; determine their own professional and interprofessional role within the team by considering the roles, responsibilities, and the scope of practice of others; apply knowledge about the scopes of practice of each regulated nursing designation to strengthen intraprofessional collaboration that enhances contributions to client health and well-being; and contribute to health care team functioning by applying group communication theory, principles, and group process skills. (p. 14)

Collaborative Leadership

Nursing leadership plays a pivotal role in the immediate lives of nurses and it has an impact on the entire healthcare system (CNA, 2020; NSCN, 2020; Orchard & Bainbridge, 2016; Pfaff et al., 2014; WHO, 2020). The CNA (2020) defines leadership as a shared responsibility. With the collective energy of shared leadership, nurses form strong networks and relationships that ultimately result in excellence in nursing practice (CNA, 2020). New collaborative models of care have radically changed leadership structures, particularly in nursing (NSCN, 2020; Orchard & Bainbridge, 2016; WHO, 2020). These changes provide opportunities for nurse leaders to demonstrate their leadership skills and play a greater role in decision making within the IP team (CNA, 2020; NSCN, 2020; Pfaff et al., 2014; WHO, 2020). The NSCN (2020) asks the ELN to influence and inspire others toward a common goal in the coordination of health care and the promotion of healthy and safe practice environments.

Collaborative (shared) leadership is viewed as a team-based collective phenomenon with

most of the research on this topic is at the team level of analysis (Ong et al., 2020). CIHC (2010) defines collaborative (shared) leadership as leadership within a team where HCPs, patients, and families have shared responsibility and mutual influence, whereby they lead each other to enhance health outcomes. Within IP teams, there are two components to the leadership role: task-orientation and relationship-orientation (CIHC, 2010). In the former, the leader helps other members keep on task in achieving a commonly agreed upon goal, while in the latter, the leader assists members to work more effectively together (CIHC, 2010).

Certain principles are mentioned in the literature in relation to leading effective teamwork (CIHC, 2010; CNA, 2020; Reeves et al., 2010; WHO, 2021). Principles commonly linked to collaborative leadership are positive impact of supportive leaders (Pfaff et al., 2014), collaborative decision making (Best et al., 2019; Embree et al., 2018; Health Canada, 2007; Krebs, 2016; NSCN, 2020; Politi & Streets, 2011; Reeves et al., 2010), building partnerships (Accreditation Canada, 2019; IPEC, 2016; McCormack & McCance, 2010; NSCN, 2012; Ong et al., 2020), and transformational leadership (Best et al., 2019; CIHC, 2010; NSCN, 2020; Orchard et al., 2017). This suggests that enacting collaborative decision making, building partnerships, and fostering transformational leadership may play a role in the development of collaborative leadership in ELNs.

Collaborative Decision Making

CIHC (2010) promotes that collaborative decision making is part of effective team functioning, where mutual respect is embodied, power is equalized, and collective decision making can happen. Politi and Street (2011) define collective decision making as collaboration between the patient/family and HCPs in making health-related decisions. Similar to CIHC, Politi and Street (2011) describe a process of mutual participation and cooperation between multiple

professionals, patients, and family members. Furthermore, NSCN (2020) asks ELNs to support and empower patients and their families in making informed decisions about their healthcare while respecting their decisions.

Partnerships

According to the National Nursing Competency Project (NNCP) (1997), nurses require more knowledge in partnering with patients, families, and communities. Nurses invite the expertise from all disciplines in the provision of care (NNCP, 1997). The NNCP (1997) defined partnership when ELNs: (1) demonstrate the attitudes which contributes to effective partnerships with patients and (2) partner with patients to achieve mutually agreed upon health outcomes.

Over a decade later, CIHC (2010) endorses partnership as an interdependence of work among all participants. McCormack and McCance (2010) identify participants in partnership as those involved in a caring interaction and which encompasses patients, families, and all members of the interprofessional team. NSCN (2020) describes ELNs as collaborators who play an integral role in the healthcare team partnership in the provision of care. The partnership is described as a mutual dependence and relationship while participating in IPC (CIHC, 2010; Hopwood et al., 2015; NSCN, 2020; Ong et al., 2020).

Transformational Leadership

Transformational leadership is deemed essential for managing change effectively for the delivery of IPC (Daurvin & Lorant, 2015; Orchard et al., 2017). The *National IP Competency Framework* (CIHC, 2010) asks that leadership establish a collaborative climate and integrate solutions to improve collaborative practice outcomes. A literature review conducted by Flodgren and colleagues (2019) supports the view that transformational leaders help narrow the gap on performance of IPC. Furthermore, Orchard and colleagues (2017) suggest leadership attributes

(for example, collaborative leadership, shared decision making, role modeling, and mentorship), more commonly described in transformational leadership, have the most positive impact on collaborative practice outcomes.

Martin and colleagues (2011) challenge healthcare organizations to move away from transactional (managerial) leadership as it detracts from the innovative and collaborative vision required in today's healthcare system. Transformational leaders are influential in changing practice and implementing clinical education (Orchard et al., 2017). Orchard and colleagues (2017) report that clinical leaders need to fit with emerging times by emulating three forms of leadership. These forms include: transformative, collaborative, and relational leadership as it applies to IPC. ELNs are expected to be leaders who influence and inspire others to achieve optimal health outcomes (NSCN, 2020) in a continually transforming healthcare system. Nurses with effective leadership strategies such as setting clear expectations for collaboration, removing organizational barriers to scope of practice, and advocating for models of care based on IPC are required (Tomblin Murphy et al., 2021).

Interprofessional Education, IP Socialization and IPC

Navigation into professional nursing practice has been well studied (Benner, 1984; Duchscher, 2012). Benner's *Novice to Expert* (1984) is a well-recognized nursing model that postulates how nurses construct knowledge over time. Benner's model is based on the original work of Dreyfus and Dreyfus (1977) who developed a skills acquisition model which proposes that during the acquisition and development of knowledge, a learner passes through five levels of proficiency: novice (0–6 mos.), advanced beginner (6–18 mos.), competent (1–2 years), proficient (up to 5 years), and expert (after 5 years) (Benner, 1984).

Entry into practice for the nurse is often described as difficult. Duchscher (2012)

describes that within the first year of practice, the ELN experiences emotional, intellectual, physical, sociocultural, and developmental issues that, in turn, feed into a progressive pattern of evolution. There is an alarming realization about the roles, responsibilities, knowledge, and relationships required for nursing practice (Duchscher, 2012). As well, the ELN is grappling with academic versus practice-based expectations around professional practice and IPC.

The *National IP Competency Framework* (CIHC, 2010) provides a starting point for describing the curriculum content, learning strategies, and methods to determine if IPC competencies are an outcome. The endpoint of learning is that the ELN enacts IPC in addition to: (1) strengthen their capacity to do so over time (CIHC, 2010; IPEC, 2016), (2) provide care where the patient/family actively participates (Accreditation Canada, 2019; McCormack & McCance, 2010; NSCN, 2020), (3) enact collaborative leadership (CIHC, 2010; Grant et al, 2016; Khalili et al., 2020; NSCN, 2020; Orchard et al., 2017), and (4) help to socialize future practitioners to be interprofessional collaborators (CIHC, 2010; Health Canada, 2007; IPEC, 2016; Price et al., 2020; WHO, 2020).

The issue of preparing nurses for IPC is named in the literature (CIHC, 2010; Health Canada, 2007; Price et al., 2021; Reeves et al., 2010; Sargeant et al., 2008; WHO, 2010, 2020; Zwarenstein et al., 2009) suggesting that nurses can no longer rely on chance encounters with the IP team to acquire such learning. Nonetheless, the learning of IPC in nursing is still in early development in Canada (Grant et al., 2016). There are several undergraduate nursing programs that integrate IPE that are reasonably well established (Dalhousie University, 2015; University of Alberta, 2016; University of British Columbia, 2016; University of Toronto, 2016). Price and colleagues (2021) recommend that academia should consider IPE in the pre-entry messaging and recruitment strategies into undergraduate nursing programs. Further opportunities exist in

relation to learning strategies, given the specific competencies required for ELN practice (Best et al., 2019; Kreps, 2016; Price et al., 2020; Thistlethwaite & Moran, 2010) and the existing gaps in nursing literature in Canada (Grant et al., 2016).

Early opportunities for IPE are of value and stronger linkages between academia and practice can position IPE along a transitional practice pathway for newly graduated registered nurses (National Academies of Sciences, Engineering, & Medicine, 2021). There are currently no established pathways that allow us to predict the education and practice experiences that could optimize IPC in particular clinical contexts (Duchscher et al., 2021). Knowing that the *National IP Competency framework* (CIHC, 2010) describes what IPC looks like, a transitional practice pathway for IPC that strategically builds the knowledge and skills required to practice well in varying practice areas is a gap. It is worth reiterating that there is an expected gap in the performance level of ELN when compared to the performance level of experienced RNs. It is therefore legitimate to continue to support and develop ELN competencies after graduation in ways that reinforce and build upon IPE initiatives through the development of a transition to practice program.

Recently, the Canadian Association of Schools of Nursing launched its first residency program for newly graduated registered nurses. The program is designed for healthcare institutions (CASN, January 27, 2022) to support the successful transition of ELNs into practice. Upon review, much of the curriculum is focused on nursing professional development and very little pays attention to IPE or IPC. This is alarming given the multiple calls to bridge IPE across pre and post licensure programming. Canadian nursing literature contains little depth and critical discussion surrounding IPE and IPC. The nursing profession must deliberately engage in a critical discussion of IPE to advance nursing knowledge and the nurse's role (Grant et al., 2016)

in IPC.

Professional and interprofessional development must be central tenets of any transition to practice program. Acuity and complexity of nursing care has increased exponentially and was compounded by COVID 19 pandemic. Traditional learning activities, such as clinical placements, that are critical in preparing to become a nurse have been disrupted. Effective nursing care requires teamwork; nursing workforce shortages are numerous and an issue of concern. Poorly transitioned nurses (lack of practice support), dysfunctional teams (negative socialization experiences and lack of teamwork) and indoctrination practices (evidence of professional biases and judgments) can have negative consequences for patients, staff, and organizations (Currie at al., 2012; Price, 2009; Price et al., 2019).

Although professional development and socialization in nursing is believed to occur largely prelicensure (Price et al., 2020), it continues into post licensure practice (Best et al., 2019). Khalili and colleagues (2020) note that profession specific programs may equip graduates but if the programs are only focused on nursing's professional identity, it creates a major barrier towards IPC. Emerging evidence suggests that the early socialization of ELNs to team-based care may positively impact IPC (Price et al, 2020). Early exposure to IPC within complex health organizations is a necessary experience. At first, the ELN may not understand the complexities of their role within the IP team but it is important for IP socialization to occur. It allows the ELN to see the impact of professional and IP efforts and reflect on the experience to help reinforce knowledge development over time (Khalili et al., 2013; Kreps, 2018; Price et al., 2020).

Khalili and Orchard (2020) describe the development of a dual identity (identifying with both nursing profession and that of the IP team) as the outcome of IPE and as necessary for IPC. This is required to develop the knowledge, skills and attitudes needed to be a competent

interprofessional team member (Khalili et al., 2020). To better support the next generation of nurses to integrate IPC into their ongoing professional development (Khalili et al., 2020; Best et al., 2019; Price et al., 2020). Evidence suggests that it leads to: a dual identity practitioner who contributes nursing's professional practice and expertise within team-based care (Khalili et al., 2020; Best et al., 2019); plays a role in developing a positive attitude toward the nursing profession and other professional groups (Price et al., 2021); and capitalize on this to advance IPC (Price et al., 2019).

In conclusion, nurses are uniquely positioned to bring expertise to working in partnerships with others to leverage contemporary IPC (National Academies of Sciences, Engineering, & Medicine, 2021; WHO, 2021). All nurses have a duty and responsibility to collaborate with other HCPs and sectors (WHO, 2021). *The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity* (National Academies of Sciences, Engineering, & Medicine, 2021) report and other research discussed in this chapter highlights the important leadership role nurses play in partnerships with patient, families, and communities. The Nova Scotia College of Nursing (2020) describes the role of the collaborator as an entry to practice competency.

In summary, nursing knowledge of IPC is growing and yet there is a paucity of evidence to inform entry level nursing practice. Several statements are noted and compiled to inform future Canadian nursing scholarship opportunities. Deliberate review of each statement may advance the nursing profession, which, in and of itself, is a welcome addition. The statements include:

1. The experiences of ELNs are a shared responsibility of governments, employers, professionals, regulatory bodies, professional organizations, and post-secondary educational institutions (Benner, 1984; CNA, 2020; IPEC, 2016; NSCN, 2020).
2. ELNs consolidate their competencies through experiences as a professional and a member of the interprofessional team (CIHC, 2010; CNA, 2020; Duchscher, 2012; IPEC, 2016; Price et al., 2020).
3. ELNs require resources to support the consolidation and development of their professional and interprofessional collaborative practice (CNA, 2020; Duchscher, 2012; NSCN, 2020; NSCN, 2013).
4. Experiences to strengthen collaborative leadership through formal education and practice support is necessary in today's nursing workforce (CNA, 2021; CIHC, 2010; Duchscher, 2012; IPEC, 2016; NSCN, 2013, 2020; WHO, 2010, 2021).
5. Interprofessional education begins in nursing education and continues through to the ELN's transition to practice (CIHC, 2010; Duchscher, 2012; IPEC, 2016; Grymonpre et al., 2021; NSCN, 2013; NSCN, 2020; WHO, 2021).
6. Professional and interprofessional socialization opportunities can assist with IPC (Khalili et al., 2020; Best et al., 2019; Price et al., 2019; Price et al., 2020).
7. Further research is required to better understand how ELNs engage in IPC, especially across teams, sectors, units, and geography (Best et al., 2019; CNA, 2021; Grant et al., 2016; Grymonpre et al., 2021; IPEC, 2016; Khalili et al., 2020; Kreps, 2018; Price et al., 2020; WHO, 2020).
8. Canadian nursing literature contains little depth and critical discussion surrounding the utility of IPE and IPC (Grant et al., 2016). Collaborative research between nurses in

academia and at the point of care is one way to foster a critical discussion needed for practice.

Newly graduated registered nurses significantly contribute to the workforce in the provision of safe, competent, compassionate, and ethical care (NSCN, 2020). Nurses are uniquely positioned to bring expertise to working in partnerships with others and help strengthen nursing to participate in health system transformation. The effects of the COVID 19 pandemic on nursing are significant. The pace of change necessitates strong collaboration across HCPs, domains practice and jurisdictions.

This chapter explored key findings about IPC and the ELN, specifically, the role in relation to: (1) IPC; (2) collaborative leadership, including collaborative decision making, partnerships, and transformational leadership; and (3) IPE, IP socialization and IPC. It is anticipated that the first three chapters have provided clarity in relation to key frameworks, definitions, IPC and ELN competencies, and future opportunities. My intention was to highlight components of each and present them in a way that linked them together so the reader could understand how I conceptualized my area of inquiry. Collectively, Chapters 1 through 3 work together to develop a more comprehensive understanding of why an inquiry into ELN perspectives is necessary.

Chapter Four: Methodological Framework

Interpretive inquiry is a complex and vital feature of clinical and research practice (Roulston, 2010). Interpretive inquiry helps us to understand and respond to the multiple social and physical facets of human lives (Cohen & Crabtree, 2008). It explores the complexity of human behavior beyond the scope of numbers and statistics and it elicits evidence from diverse individuals, population groups, and contexts (Thorne et al., 1997). Interpretive inquiry "enables us to learn about the world, extends our intellectual and emotional reach and by turn satisfies our curiosity" (Dahnke & Dreher, 2011, p. 230).

Much interpretive inquiry that examines health and human behavior has been conducted according to the social sciences and its methodologies. While this proved useful in the case of some clinical problems (Morse & Chung, 2003), nursing scholars often found inquires constrained by the dictates of the social sciences field (Thorne et al., 1997). Thorne and colleagues (1997) suggest that such practices resulted in a hollow allegiance to a particular philosophy and methodology. The desire to align to a particular social sciences tradition drew attention to the importance of rigor in qualitative research (Morse et al., 2002; Sandelowski, 1986). Over time, nursing scholars discussed the need for new approaches that better addressed clinical knowledge and practice (Thorne et al., 1997). An example of one such approach is the development of Interpretive Description (ID).

Interpretive description is a research strategy for illuminating, articulating, and disseminating knowledge that sits between what is already known and what is not known for the purpose of advancing knowledge in practice (Thorne, 2008). It provides a coherent logic, structure and orientation toward practice relevant findings, and attention to my disciplinary perspective and commitments. In this section, I highlight the historical evolution of ID, its key

philosophical assumptions, and some of the possibilities that can arise in the application of ID in designing and implementing my research study.

While a number of diverse qualitative methodologies exist that focus on understanding experiences, ID has a unique disciplinary goal that focuses on the implications of the research findings to the practice environment (Thorne, 2020). My goal from the outset of the study was to learn about the experiences of ELNs and situate these in light of broader structures and processes, as well as understand how we could improve practice. It was important to me that I use a methodology that allowed me to collect data that was directly related to practice and that acknowledged my knowledge in this area (Thorne, 2016). I was attentive to my social position in relation to this research: I was an insider based on my position as a healthcare leader in NS, but I was also positioned as a researcher that was unfamiliar with the current experiences of ELNs.

An ID study relies on constant comparative analytic processes to understand the phenomena under study, that according to Thorne (2016) originate from grounded theory. This analytic process was further shaped by the relationships I developed with participants during the interview process and a recognition that both the participants and I brought our beliefs, assumptions, and desires to this research (Clandinin & Connelly, 2000; Yanos & Hopper, 2008). This reflects the underpinnings of ID that there are multiple realities and that these are socially constructed (Thorne, 2016).

Emergence of Interpretive Description

The history of qualitative inquiry is comprised of many changes and developments. The groundwork for what has blossomed was laid as part of a large cultural movement called enlightenment (Dhanke & Dreher, 2011). Enlightenment became a catalyst for change, one that

continues to permeate the scientific community. The ideals of enlightenment supported the evolution of new ways of thinking and doing things and shaped scientific traditions and developments over time (Dhanke & Dreher, 2011).

The developments in nursing from the 1950s onward laid the foundation for the current level of research (Lincoln & Guba, 1985; Stolley et al., 2000). In the 1960s, nursing theory was used to guide learning, research, and practice (Stolley et al., 2000) and as a result, nursing schools at the graduate level became more common. The 1960s and 1970 saw the inception of nursing research journals and further supportive efforts for research in education and practice (Stolley et al., 2000). Nursing as a discipline began to take root with the ideas and practices of scientific traditions to advance nursing scholarship (Lincoln & Guba, 1985; Stolley et al., 2000).

The efforts in the 1980s were focused on refining and developing nursing research and the utilization of such research into clinical practice (Lincoln & Guba, 1985). At the time, developments and strides attained suggested that nursing was ready to rise to the professional demands being asked. A major focus of nurse research was the development of clinically based outcomes studies that provided the foundation for evidence-based practice (Morse & Chung, 2003) [evidence-based practice being the integration of the best possible research and evidence with a focus on clinical expertise and patient needs (Malloch & Porter-O'Grady, 2006)].

In a complex, health-oriented society research priorities began to shift. Nursing scholars saw this as an opportunity to link research efforts to develop the scientific knowledge base to guide nursing in education and practice (Estabrooks, 1998; Thorne et al., 1997). This then led to the extension of nursing knowledge and expertise in appraising, designing, and conducting research. Much of the evidence brought to clinical practice was derived from quantitative and qualitative research dominated by the social sciences (Estabrooks, 1998; Thorne et al., 1997).

An increasing focus on the need to research clinical phenomenon led to the reliance on social sciences. Social sciences such as anthropology, sociology, and psychology generated a range of methodologies recognized as ethnography, grounded theory, and phenomenology (Thorne, 2008). These methodologies dominated the field of qualitative inquiry at a time when nursing began to take serious interest in qualitative research. However, the research community was not particularly comfortable with this way of thinking about nursing science (Estabrooks, 1998; Thorne et al., 1997). This position often led to rejection of the theoretical motivation of the social sciences giving rise to significant debate in the research community.

The debate brought to light the importance of being able to articulate clear answers when asked about the nature of qualitative research (Estabrooks, 1998). Tensions heightened as particular rules and restrictions were positioned to enhance rigor and validity of the work. There was seemingly more concern about the alignment with a particular methodology than the applicability of the new knowledge (Thorne et al., 1997). In 1986 Margaret Sandelowski stated that multiple qualitative methodologies, the lack of clear boundaries between quantitative and qualitative methodologies and methods, and the tendency to evaluate qualitative rigor against scientific criteria was problematic.

Almost a decade later nurse scholars began to realize that having to "fit" with a methodology was detrimental to the one common purpose held by them collectively—to generate knowledge that has meaning (Estabrooks, 1998; Sandelowski, 1993; Thorne et al., 1997). The uptake of qualitative research for answering many of the compelling, complex, and contextual questions relevant to nursing science rapidly changed. Nursing scholars still drew on the theoretical traditions borrowed from the social sciences while others became more open to new ways of thinking (Thorne et al., 2004). ID has evolved as one way to approach research

with an interpretive flavor within the application context (Thorne, 2008).

Theoretical Traditions influencing Interpretive Description

In qualitative inquiry, theoretical, conceptual frameworks, and/or methods were borrowed from the social sciences to be used in applied health sciences such as nursing (Villarruel et al., 2001). Each theoretical framework comes from a particular social scientific tradition that has its own structure, purpose, and reason for being. Each of the social sciences exists to solve a particular intellectual problem (Dahnke & Dreher, 2011), not necessarily for the purpose of the applied disciplines, but that they exist with their own paradigm, evolving theoretical and/or methodological traditions (Villarruel et al., 2001). In nursing, these traditions were borrowed on and, to some extent, satisfied the desires of an evolving applied discipline initially.

Simplistically stated, the mandate of anthropology (human variations), sociology (social behavior), and psychology (workings of the human mind) was to document and interpret human variations grounded in theoretical and, at times, empirical problems (Thorne, 2016). These paradigms encompass an ontological, epistemological, and methodological lens regarding the nature and process of the inquiry (Lincoln & Guba, 1985). For Thorne (2008), applied to the study of health issues, the fundamental point of social science research is not to solve everyday problems of patients but rather to "capitalize on health phenomena to answer problems of a more elemental nature related to understanding how social groups behave or what constitutes the core nature of human experience" (p. 24).

While borrowing theoretical traditions proved useful in the context of some clinical questions, nursing researchers often found their inquiries constrained. Thorne (2016) describes this as a loss of disciplinary grip experienced by nursing researchers where language was manipulated to suit the theory and/or methodology instead of staying close to their applied roots.

The "fuzziness and irrelevance of the new knowledge forced nursing researchers to push the edges of methodological rulebooks" (Thorne et al., 1999, p. 125) recognizing that nursing "draws its lifeblood directly from the world of clinical realities" (Thorne, 2016, p. 38). As such, ID arose to build methods grounded in nursing epistemology and reasoning and yield legitimate knowledge for clinical practice (Thorne, 2016, p. 38).

Interpretive Description

The aim of ID is to generate knowledge relevant for the clinical context of applied health disciplines (Thorne, 2008). It aligns with an interpretive naturalistic orientation (Thorne et al., 2004) which includes the belief that multiple realities exist and can be studied holistically. As a result, there is a recognition that "reality is complex, contextual, constructed and ultimately subjective" (Morse, 2016, p. 83), the researcher and the researched interact to influence one another leaving knowledge inseparable (Thorne et al., 2004), and lastly, "no a priori theory could possibly encompass the multiple realities that are likely to be encountered" (Thorne et al., 2004, p. 3).

With this in mind, the goal of ID is not to generalize findings to a population of interest, but instead to explore, describe, and explicate possible human experience (Thorne et al., 2004). The epistemological foundation is the recognition that the human problem is viewed holistically (Thorne, 2008). There is always a recognition of commonalities and differences and a degree of openness for differences, no matter how rare. Moving back and forth between commonalities and difference with experience and ideas comprises the thinking with ID (Thorne et al., 2015). The knowledge is not static; "it is sophisticated, complex, flexible and infinitely adaptive" (Thorne, 2016, p. 33).

The intention of ID is to move beyond theorizing and describing to add application

(Thorne, 2016). The aim of this is to capture the human elements that are relevant to understanding, to expose patterns in complex experience, categorize commonalities and variations, and expand the critical reflection when understanding come to light (Thorne, 2016). Interpretive description gives researchers tools to be able to examine and better understand phenomena (Thorne et al., 1999) and create a deeper understanding of experience (Thorne et al., 1997). Following that description, researchers can gain further meaning, enhancing the action link to overall knowledge relevance (Thorne, 2016).

The assumptions and philosophical positions underpinning ID align well with those within my study's theoretical framework. These points of alignment include epistemological integrity, contextual awareness, analytic logic, pragmatic obligation, representative credibility, moral defensibility, disciplinary relevance, and probable truth.

Epistemological Integrity

The clinical epistemological position of the research guides the methodological strategies of the study. ID provides useful and accessible guidance in elaborating a research design, orients the research process toward the clinical context and the generation of practice-related findings, and draws attention to disciplinary biases and commitments (Hunt, 2009; Thorne, 2016). ID is intended to fill a need within nursing research for which other available methodologies are not well suited.

Contextual Awareness

Interpretive description is designed to account for the clinical context of research in nursing practice (Hunt, 2009; Thorne, 2016). Concerted effort is made to address the conceptual, methodological, and practical orientation associated with conducting contextually sensitive research (Thorne, 2008). Evidence is imperative and comes from a clinical epistemology that

does not fit into the conventional traditions of a hard "realism", but in a place somewhere between subjectivity and objectivity, with pattern recognition and pattern variations (Thorne, 2008). Therefore, expert clinical knowledge, though not formally studied, can be accessed to orient the study (Hunt, 2009; Thorne, 2016). Clinical knowledge is valued as a foundation for constructing nursing research.

Analytic Logic

Interpretative description methodology draws attention to biases that are held individually, professionally, and within disciplinary groups (Hunt, 2009; Thorne, 2016). Thorne (2016) recommends the use of a pathway to demonstrate logic behind the analysis of descriptive claims inherent to ID. The generation of an audit trail using reflexive memos allows the researcher to draw attention to biases and put steps in place to account for biases (Hunt, 2009). Additionally, the acknowledgement of biases and assumptions can be analyzed in relation to three important elements: (1) how they play out in the research, (2) to what perspective (individual, professional, or within disciplinary groups) may biases and assumptions influence the research, and (3) when the product of ID departs slightly from the original research question, the logic of that departure articulated as part of the research findings (Thorne, 2004). This can help the ID researcher determine how preconceptions influence the interpretation of the data (Thorne, 2004).

Pragmatic Obligation

Researchers are obliged to consider their findings from the perspective of how it can be helpful to practice incapable of rendering harm (Thorne, 2016). Research grounded in practice asks for a variation to researcher and participant roles, responsibilities, and relationships (PCORI, 2016). Partnerships can make innovative contributions to the field (PCORI, 2016) in

ways that have not been previously understood. Two examples noted in the literature include researcher and participant partnerships illuminating new questions from HCPs about their practice (Hunt, 2009; Thorne, 2016), as well as the product of the research having greater utility to HCPs in their practice (Hunt, 2009; Thorne, 2008).

Representative Credibility

The researcher positions the data in a way that allows for more time and no distinct endpoint; data saturation is not necessary. Study findings based on prolonged engagement with the phenomenon are more likely to afford credibility than those derived from a more superficial involvement (Glaser & Strauss, 1966). At the same time, it is important to recognize that if there is a prolonged time with the participants this may hinder the study credibility due to potential bias. As well, there is an increasingly ubiquitous discourse of data saturation (O'Reilly & Parker, 2013) where some believe that adopting saturation as a generic quality marker is inappropriate (O'Reilly & Parker, 2013; Thorne, 2016).

Moral Defensibility

The disciplinary lens asks for a more astute and critical view about ethics and morality: correlation and causation, coincidence and confidence, and living as a researcher and living with the researched (Vandermause et al., 2017). To live with the researched asks for less of a theoretical stance which may come with opportunities but also comes with risks (Thorne, 2008). The moral defensibility is supported by the researcher's disciplinary perspective, empathic alignment, and analytical strengths (Thorne, 2016). Research validity must be distinguished from the researcher's own sincerity and enthusiasm in presenting answers to clinical questions that have not been tackled in the past (Thorne et al., 2004).

Disciplinary Relevance

The disciplinary relevance is a credibility consideration. It is essential that the researcher have strong disciplinary knowledge as this may be required to explain the relationship between the new knowledge and their research before the profession (Thorne, 2016). In relation to disciplinary relevance, a gatekeeping can take many forms. Traditionally, this is understood as a person who stands between the researcher and the potential participants (Holloway & Wheeler, 2002).

Within healthcare, the organizational gatekeeper is understood as the research and development office and the professional gatekeepers as the leadership team including multiple disciplines (Holloway & Wheeler, 2002). The organizational gatekeepers have an awareness of research taking place, while the professional gatekeepers need to be convinced that the research is relevant. Gatekeeper support is crucial as they have the power to deny the research being undertaken. The best interpretive descriptions will pass what has been referred to as the clinician test when expert's knowledge illuminates new relationships and understandings (Thorne et al., 2004).

Probable Truth

The findings in an ID inquiry are filled with tentative truth claims (Thorne et al., 2004). Currently, there is not a set of standards against which the methodology and product can fully account for the notions of truth or even represent complete confidence that the findings are valid (Thorne, 2016). In ID, the researcher is not to seek truth but to construct fallible and tentative views of the world that can be altered, rejected, and made more secure (Thorne et al., 2004). In other words, the researcher can never confidently say that they know enough, and that no other version of the information can be sought.

Despite the potential shortcomings of ID, it is likely that many qualitative researchers spend time explaining, translating, and justifying research to the professional and/or scholarly community. Challenging questions around credibility are inevitable. Thorne (2016) describes ID as an invitation to imagine what is needed to answer some of the most pressing questions about clinical practice and the human experience. Paying attention to the opportunities and shortcomings identified by Thorne (2016) is vital. Nurses from practice and research communities need new approaches that better address the current and increasingly complex practice concerns that exist in healthcare today.

Research Design

An ID design with thematic analysis was well suited for my research. Thematic analysis is a flexible approach that can be used across a wide range of epistemologies and research questions (Braun & Clarke, 2006). Braun and Clarke (2006) argue that it provides a theoretically flexible approach to analyzing qualitative data. Thematic analysis was used to understand the ELN experiences.

Specific to this study, I brought my beliefs, values, and perspectives about the complexities associated with IPC in healthcare in NS. As a nurse, I brought 27 years of experience in clinical, education, leadership, and research roles which allowed me to participate in several initiatives involving diverse teams while shaping my perspectives on IPC. Three experiences stand out as relevant: 1) taking a leadership role in designing IPE for undergraduate learners at a Canadian university, 2) implementing IP models of care within acute and community-based settings in NS, and 3) appointment as a leader within a provincial health authority with a mandate to advance professional and IP practice and learning across the organization. Additionally, I brought the 26 years of experience associated with Callum's

condition and care within Nova Scotia's healthcare system.

Operational Definitions, Study Purpose and Research Questions

As was discussed in the literature review, IPC is challenging due to its complex nature. Often IPC is constructed using six CIHC competency domains that highlight the knowledge, skills, attitudes, and values that are essential for IPC. I believe it is crucial to consider ELNs' experiences when examining IPC competencies as defined by CIHC. Therefore, as discussed in Chapter 3, I have considered ELNs in my definitions as nurses within their first year of professional practice.

The purpose of my study was to inquire into the experiences of ELNs in relation to IP teams in the province of NS. The research questions that emerged from this line of thinking and that guided the study are:

1. How do ELNs describe and explain IPC experiences in NS?
2. How do ELNs understand factors that influence experiences of IPC?
3. How do ELNs describe the facilitators and barriers to IPC?
4. What approaches do ELNs recommend to promote IPC in IP teams in NS?

The Canadian National IP Competency Framework (CIHC, 2010) provides guidance for the examination of these research questions; the CIHC Framework comprises six domains and several competencies and is operationalized in the provision of care. For the purposes of this research study, the only competencies under consideration are those related to the delivery of IPC.

Design Principles and Key Decisions

Based on the study's purpose and research questions, I used a qualitative design that allowed me to answer my research questions in a comprehensive way. When reflecting on my

rationale for using ID, I realized that my reasons were multifaceted and reflected the rationale offered by Thorne (2008). This approach provided me with a contextual understanding of IPC.

A variety of data sources were used to explore ELN perspectives regarding IPC in IP teams in Nova Scotia. Thematic analysis shaped my understanding of ELN experiences. I engaged with the data and the analysis, seeking patterns and connections as different meanings were identified (Braun & Clarke, 2006). Lastly, my study was framed by my disciplinary epistemology.

Based on discussions with the Vice President of Research, Innovation and Discovery and Chief Nurse Executive from the NSHA, a decision was made to situate the study in all four of the zones in the health authority. Ethics approval to conduct the study was received from the University of Alberta REB, Ethics # Pro00101598 and the NSHA Research Ethics Boards, Ethics # 1026148. Ethics approval in the NSHA began in September 2020 and was received in January 2021. The approval took a significant amount of time because of the COVID 19 pandemic experience in the province.

Setting

My study occurred in the province of NS. The population of NS is approximately 992,005 (Nova Scotia Department of Finance, 2021) One half of the province's population lives in rural communities. The Department of Health and Wellness has an overarching responsibility for healthcare in the province. Formed in 2015, the Nova Scotia Health Authority (NSHA) provides province-wide primary, community, and acute healthcare services by way of hospitals, health centres, and community-based programs, with some outreach for Atlantic Provinces. The NSHA is the largest healthcare employer in Nova Scotia. It has over 23,400 employees, 7,000 volunteers, 5,500 learner placements, and 45 health services (NSHA, 2021). The mission of the

NSHA (2021) is to achieve excellence in health, healing, and learning through working together.

Participant Selection

RNs within their first year of professional practice were invited to participate in this study. The ELNs who participated were employed by the NSHA and worked with an IP team that was composed of two or more HCP. The HCP include but were not limited to physicians, nurse practitioners, public health providers, pharmacists, social workers, dieticians, family care givers, midwives, physiotherapists, occupational therapists, paramedics, and alternative and complementary medicine practitioners. It is important to note that each IP team within the province had a different IP team membership, dependent on patient/family/community needs and healthcare context, as well as geographic location. Even though all IP team members were vital to healthcare delivery in Nova Scotia, only ELNs were invited to participate in the current study.

Recruitment and Sample Size

Purposeful sampling methods were used to recruit 15 participants. An introductory email (Appendix A) was sent to Managers within the NSHA. Managers approached ELNs to determine their interest in participating. Interested ELNs contacted me by email or by phone. During the initial communication with the ELN, I provided a description of the study (Appendix B) and reviewed the informed consent (Appendix D) form. The participant was provided with a unique video link by email after our initial conversation.

Data Collection and Analysis

Data was collected by using in-depth, one-on-one semi-structured interviews which were recorded and transcribed verbatim. Consent was confirmed and interviews were conducted using virtual technology (Skype Business). Open-ended interview questions were used and observations were chronicled as field notes. The participant responses and my field notes were

used to generate an in-depth account of the experiences of ELNs. Data collected through recordings and/or transcriptions were stored and secured in accordance with the policies of the Ethics Review Board.

Thematic analysis was used for my data analysis. Braun and Clarke (2006) describe thematic analysis as a way for recognizing, analyzing, and writing patterns (themes) within data. Three interconnected and iterative phases occurred throughout the analysis. The first phase was a review of my personal experiences, disciplinary epistemology, and key frameworks that offered insight into the contextual and structural factors within IPC. This was discussed within the first three chapters of this thesis.

The second phase included ELN interviews (Appendix C) which continued to the conclusion of phase 3. My PhD supervisors and I independently reviewed the transcripts from the first two interviews. The interviews were hand coded for salient points or issues. During a 2-hour debrief, we designed the initial descriptive labels and coding tree. The descriptive labels framed several overarching themes and sub-themes. Rich quotations were selected to support each of the themes and sub-themes across the coding tree.

Phase three began near the end of ELN interviews when thematic analysis of the ELN interviews was sufficiently underway. I expanded the themes and sub-themes, sought data connections, and identified outliers. This created an opportunity for my disciplinary exploration. I asked myself four main questions "what is known? what is self-evident? what is interpreted? and what does this mean in terms of a research product?" (Thorne et al., 2004, p. 5). Throughout all phases of the data collection and analysis, I met with my PhD supervisors to discuss themes and my exploration. Additionally, I designed an audit trail making explicit the logic in how the data was fractured and re-built into my interpretive description (Thorne, 2016). Ongoing

researcher reflexivity was employed and documented (Braun & Clarke, 2006) and analytical decisions were justified in an audit trail and research journal to promote dependability (Lincoln & Guba, 1985).

Ethical Considerations

The use of virtual interviews made anonymity impossible to ensure for the participants. For this reason, every effort was made to ensure that identifiers remained confidential. Informed consent was obtained from all participants prior to the interviews. The consent form was reviewed by the participant and I, and understanding of the study, its implications, and possible effect on the participant was verified prior to the participant providing verbal informed consent. Verbal informed consent was documented as part of the recorded interview. Owing to the nature of this study, informed consent forms were developed based on the REB protocols for the NSHA (Appendix D) and the University of Alberta, Study ID. Pro00101598.

Limitations

Interpretative description pursues vital knowledge about subjective human experiences (Thorne, 2016). Thus, it is essential that we have access to criteria to assist with conducting this kind of research. As described early in Chapter 4, ID was designed to address what had been an epistemological confusion within qualitative research in clinical practice. As a health researcher in clinical practice, regardless of how careful I am, there is a risk that my findings will more readily be accessible. Therefore, the credibility of my research extends beyond adherence to methodological rules and to the meaning of the research findings in clinical practice.

While qualitative research includes guidance by which it may be judged as epistemologically, technically, or theoretically sound, Thorne (2016) has guiding principles that are accepted across the qualitative research spectrum. It is to these guiding principles that I

turned when considering the limitations of my research study. Four limitations are discussed below.

Contextual Awareness

Clinical knowledge accessed to orient the study (Hunt, 2009; Thorne, 2016) creates the foundation for constructing an ID. The COVID 19 pandemic posed substantive changes within the healthcare system during my study. Nurses in NS were a central component of the pandemic response, from executive leadership to professional roles with patients, families, and communities. Nursing involvement in the pandemic response may have impacted the sample size and transferability. Further contextual challenges, because of the COVID 19 pandemic, included evolving clinical knowledge and practice context, enhanced response bias due to a perceived need for collaboration, increased infection rates, and resulting quarantine that happened in the province during my interviews.

Analytical Logic

Thorne (2016) recommends the use of a pathway to demonstrate logic behind the analysis of descriptive claims inherent to ID. The interviews were conducted over a greater extended timeframe (some interviews were postponed) than intended. What happened to each ELN outside of the scope of the research had a direct impact on the eventual findings that developed. Some analytical relationships from one interview to the next may have been lost or gained. Additionally, there was a large amount of data collected that may have led to false interpretations and increased biases. To assist with this, I reflected upon my preconceptions to uncover and examine my assumptions, biases, beliefs, contradictions, and experiences with IPC.

My analysis was organized as follows: review of frameworks, thematic analysis, and disciplinary review followed by an overall interpretation. The stages of my analysis were related

to one another and no irreconcilable differences were noted with my PhD supervisors.

Pragmatic Obligation

Researchers are obliged to consider their findings from the perspective of how it can be helpful to practice incapable of rendering harm (Thorne, 2016). Research grounded in practice may result in a variation in researcher and participant roles, responsibilities, and relationships. Some ELNs described personal experiences with a series of emotions (i.e., fear and shame). Because of this, I became empathetic and supported the ELNs' handling of the emotions. While this may have contributed to my deeper understanding of the ELN experiences, it may have put the ELN outside of their comfort zone. My empathy was used to access the voice of ELNs who may have been marginalized within a healthcare system in turmoil. ELNs were told that if discussions during the interviews gave rise to issues or discomfort, they could terminate the interview. No participants requested termination of the interviews.

Moral Defensibility

Participants in research should reflect the diversity of our culture and conditions in NS, considering race, ethnicity, gender, and age. The lack of diversity among my research participants has ethical consequences. This includes impeding my ability to generalize results and it prevents some populations from experiencing the benefits of my research. Additionally, because my study occurred in one province in Atlantic Canada with a small sample size, the findings may not be helpful elsewhere.

In conclusion, I presented the application of ID in designing and implementing my research study. The particulars of my research design: research questions, setting, participants, recruitment and sample size, data collection and analysis, ethical considerations and limitations were discussed. Interpretive description and my research design collectively supported my

inquiry into the experiences of ELNs in relation to IP teams in the province of NS. My findings are presented in Chapter 5.

Chapter Five: Results

In the following chapter I present findings from the interpretive description (ID) study detailed in the previous chapters. Fifteen semi-structured one-on-one interviews were conducted to examine ELN experiences with IPC, situated within healthcare teams throughout the NSHA. An overview of participant demographics will be presented, followed by the emergent themes of the study. Braun and Clarke's (2006) thematic analysis was employed.

Four main themes emerged from the interview data. They are noted as: (1) *emotions linked to IPC,* (2) *team characteristics,* (3) *development of IPC competency,* and (4) *contextual influences on IPC*. Several sub-themes emerged within the main themes: (1) *emotions linked to IPC* (sub-themes of vulnerability in not knowing. satisfaction, and gratification), (2) *team characteristics* (sub-themes of members on the team, team relationships, and team commitment), (3) *development of competency* (sub-themes of leadership support, developing their own practice, and improved self-confidence), and (4) *contextual influences on IPC* (sub-themes of context of care and the COVID 19 pandemic). The themes and sub-themes are displayed in Table 3.

Participants

Fifteen participants were enrolled in the study. Ten participants were comfortable being contacted and re-interviewed if required. This was not required. Of the 15 participants, one was a male and 14 were female. All registered nurses were employed in full-time equivalent position. Table 1 illustrates participant characteristics.

Table 1

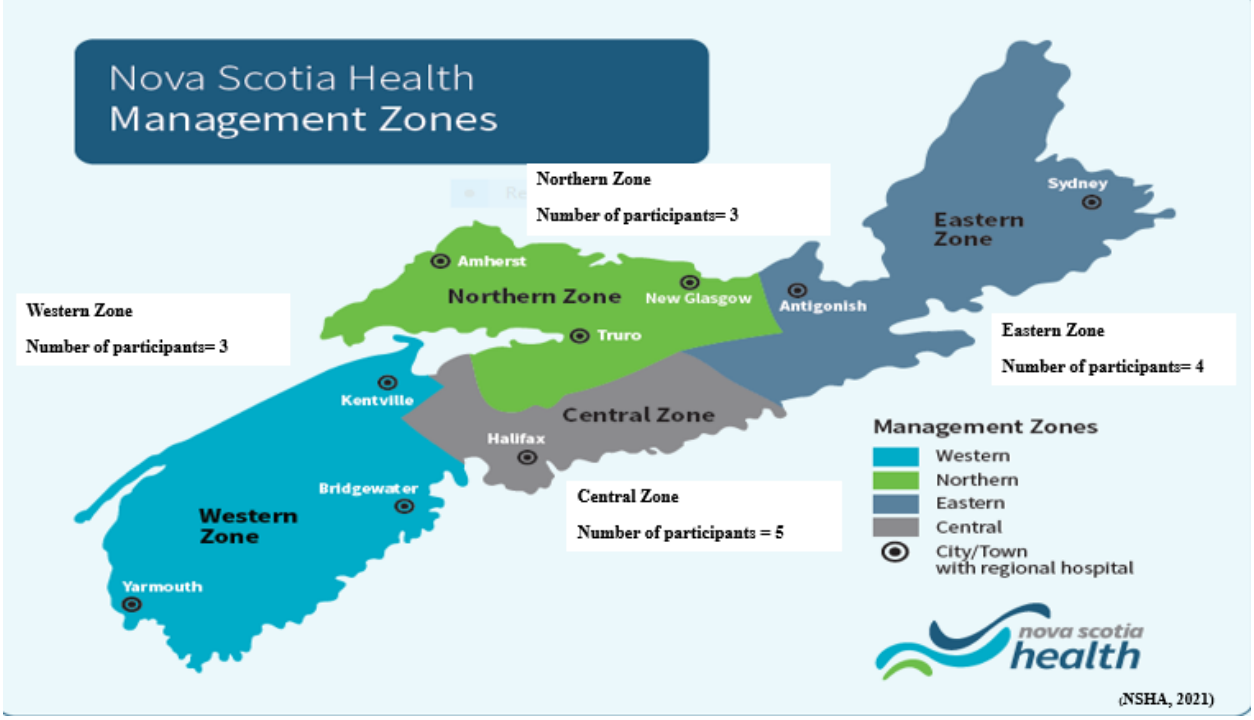
Participant Characteristics

Participant	Pseudonym	Interview Date	Gender	Age (Yr.)
P1	Sally	March 5, 2021	F	23
P2	Jennifer	March 11, 2021	F	22
P3	Nancy	March 12, 2021	F	24
P4	Geoff	April 19, 2021	M	25
P5	Noella	April 23, 2021	F	23
P6	Cathy	May 4, 2021	F	23
P7	Kate	May 5, 2021	F	32
P8	Carla	May 7, 2021	F	23
P9	Leah	May 7, 2021	F	22
P10	Treena	May 9, 2021	F	24
P11	Shannon	May 10, 2021	F	23
P12	Melanie	May 15, 2021	F	26
P13	Heather	May 17, 2021	F	24
P14	Megan	May 20, 2021	F	22
P15	Tracey	June 2, 2021	F	28

All 15 participants were in their first year of professional practice and in a variety of practice settings throughout the province. All participants started their employment with the NSHA during the COVID 19 pandemic. The first three participants were interviewed during March 2021. The remaining 12 of the 15 participants were interviewed between April and June 2021, when COVID 19 significantly impacted the NS healthcare system. A provincial map of the NSHA with participant numbers per management zone is noted in Figure 4. All the members had worked with their team for less than a year.

Figure 4

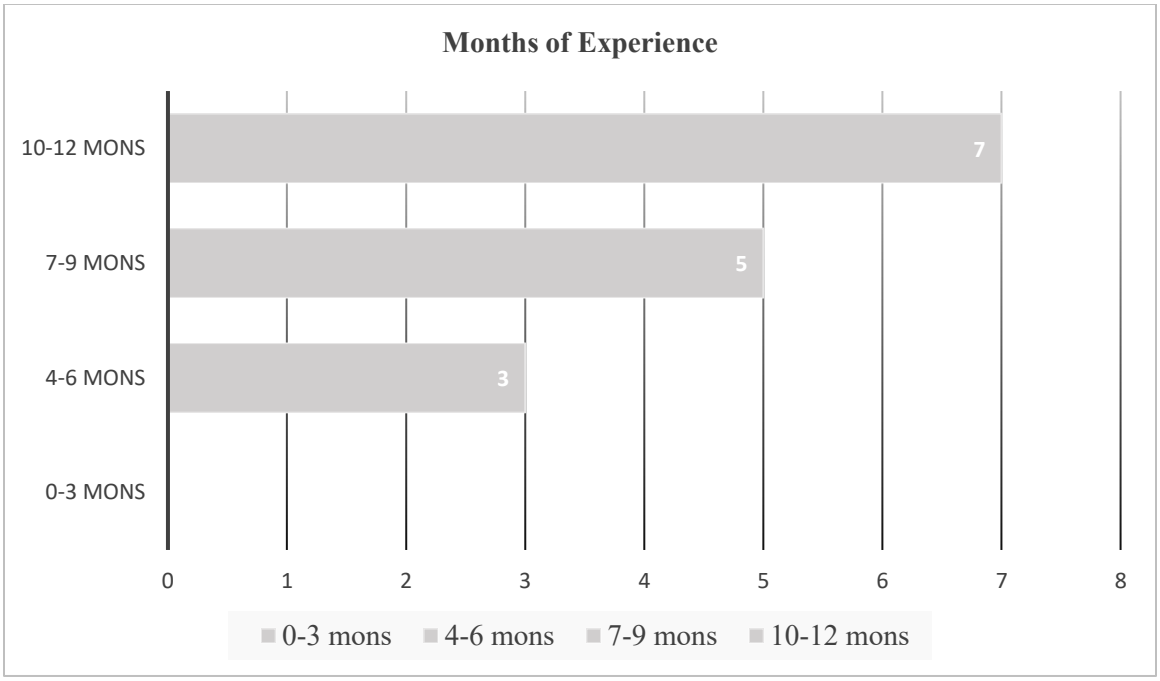
Participant Location with the NSHA



It is important to note that the participants embody a range of experiences, varied practice settings, and each had worked with numerous different HCPs, which is representative of the population of HCPs working in the NSHA. These attributes and conditions provide a robust and well-rounded picture that is suited to the investigation of ELN experiences with IPC. Among the participants 80% had more than 6 months of post-graduation nursing practice, where the remaining 20% had less than 6 months of experience.

Table 2

Months of Experience of Entry Level Nurses



Qualitative Findings

In keeping with recommendations made by Thorne (2016), all collected data (transcripts from interviews, field note observations, and researcher reflections) were analyzed sequentially. An inductive method was undertaken with the first two interviews. The initial coding with descriptive labels was designed and validated with my PhD co-supervisors. The initial coding tree was further built upon during the review of the subsequent 13 interviews. Four key steps were completed throughout the analysis process and they included coding for label, sorting of patterns in the label, outlier identification, and generalizations with constructs and finding connects with IPC.

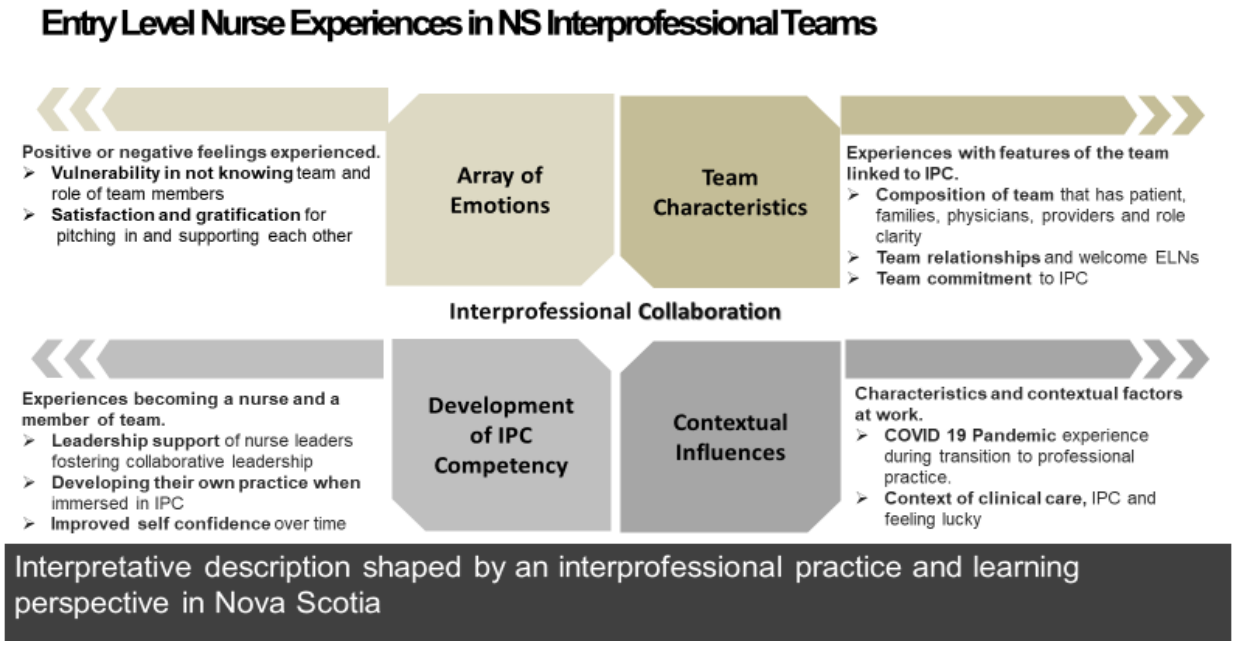
Transcripts were reviewed in detail on several occasions. In weekly meetings with my PhD co-supervisors, I had an opportunity to dwell in the data repeatedly and purposefully to develop relationships within it (Thorne, 2016). The analysis involved line by line coding to

identify basic concepts, followed by focused coding to develop interpretive categories (Thorne, 2016). Interpretation involved further refinement of these interpretive categories to reflect analytical insight about themes related to ELN experiences with IPC (Thorne, 2016). I wrote memos at each stage of data analysis to support interpretation (Thorne, 2016).

My disciplinary perspective as a nurse leader with a decade of work in interprofessional practice and learning, supports the interpretative authority and improves credibility of findings (Thorne et al., 2004). Other quality strategies included ongoing analytical debriefing, written and verbal, with PhD co-supervisors to ensure epistemological and methodological integrity. Additionally, personal experiences and perspectives were highlighted in a research journal and reflections. Figure 5 displays my interpretative description.

Figure 5

Interpretative Description



Emergent themes are displayed in Table 3. Owing to the sensitivity of the topic under discussion, coupled with the small number of participants, each participant will be referred to by a pseudonym to ensure anonymity when using any direct quotes. To help set the stage for a discussion about IPC, and prior to asking them questions, participants were asked to reflect upon times when they had worked as a member of the healthcare team—what the experience was like for them, what went well, and what had not gone well. The average length of the interviews was 50 minutes (range = 42 to 58 minutes).

The participants discussed IPC through four main themes: (1) *emotions linked to IPC,* (2) *team characteristics,* (3) *development of IPC competency,* and (4) *contextual influences on IPC*. The themes and sub-themes are summarized in Table 3. Before sharing more about the themes and sub-themes, it is important to describe how ELNs spoke about IPC after their reflection. The way they described experiences varied a great deal. Kate shared,

> *I coordinate the psychiatry clinic and triage mental health requests from the clients. To do my job effectively, I communicate with other team members to acquire collateral information I use for client care. As well, I communicate plans/decisions to the team. I work closely with the psychiatrist and we see all clients together. This practice supports continuity of care and allows for us to approach the clients together, communicate with them, and effectively assess outcomes.*

Whereas Cathy described a challenging experience where she was asked to work in a new practice area.

> *I did not realize how much my team helped me transition and learn until I worked in another area where I was out of my comfort zone. I did not have a long orientation on*

the new unit and to work as a new member of the team . . . . I asked many questions . . . . but it was hard on me.

Many ELNs shared positive experiences they had while working as a member of a healthcare team. On some occasions they were spectators of fragmented communication and ever-changing team composition and responsibilities. Experiences that were described as challenging made IPC difficult and had a negative impact on them (e.g., emotions, transition). The outcomes of the thematic analysis is discussed in more detail below.

Table 3

Main Themes and Subthemes

Main Theme	Description	Sub Theme
Emotions linked to IPC	Positive or negative feelings experienced	Vulnerability in not knowing Satisfaction and gratification
Team Characteristics	Features of the team linked to IPC	Members on the team Team relationships Team commitment
Development of IPC Competency	Becoming a nurse and a member of team	Leadership support Developing their own practice Improved self-confidence
Contextual Influences on IPC	Characteristics and contextual factors at work	Context of clinical care COVID 19 pandemic

Emotions linked to IPC

Participants identified various emotions they felt as they commenced their career and transitioned into new teams. They shared narratives of feeling *vulnerable in not knowing* where to turn in the team and *satisfaction and gratification* when experiencing IPC with other members of the team, including the patient and family.

In the sub-theme of *feeling vulnerable about not knowing* where to turn, participants shared their emotions, especially when engaging with HCPs. Jennifer described,

entering the profession for the first time it can be difficult. It is hard to know what is right for the patient and I have a difficult time knowing where to turn (on my team) for help. I try and provide patients with the resources and education necessary, but I want to do better.

Sally noted,

I was afraid during my first days on the unit, especially because I did not know the roles each team member played.

Furthermore, Noella pronounced that she often left work,

with an anxious feeling that I have missed something that I should have shared about my patient with a team member.

Emotions shared in this way affected how the participants collaborated and contributed to the IP team. One of the major concerns being that the participants struggled with not knowing where to turn for help and the vulnerability associated with this. Actions to robustly support the participants in their transition into teamwork is lacking based on the narratives. Melanie's experience stood out for me. She described how members of her team could "*make or break her day*".

I have good experiences now, but I had to get to know my team. I was nervous to communicate with certain people (HCPs). I have learned from others' negativity not to be that way.

Melanie continued and explained,

some HCPs still are difficult to work with, where [with] other HCPs I have no concerns—they respect me. I have learned to work around bad behaviors of certain team members. Some HCPs expect me to know everything and this is difficult . . . . I turned to

my support system to talk to, I am surrounded by a family of nurses and my mom is a nurse.

Melanie described vulnerability in a different way. For example, she identified vulnerability when not knowing HCP's personal traits. In knowing them personally (e.g., individual traits), she could anticipate the response of the HCP during IPC. Managing IPC based on personal traits is problematic. This view ignores the professional responsibility HCP have to enact IPC in practice and to role model such. Although, collaboration is part of the NS Health's mandate, HCP enactment is an obvious gap. A question may centre on reconciling and validating the HCP experience to better understand the fallout of the pandemic on their IPC competence.

Other ELNs shared *satisfaction and gratification* when experiencing IPC with HCPs. Based on Heather's experiences with IPC in her team, she shared,

we have a close-knit team and our care is more personal. The members of our team work well together and collaborate . . . . challenges happen (e.g., transfers, limited staff) that may impact our team. But we find a common ground with team members and make decisions together.

When asked to elaborate on this, Heather explained,

because we work through our differences our care is more holistic.

Heather's experience varies significantly from Melanie's. The ebb and flow of IPC is being witnessed and experienced by participants when in practice. Leah's experience with IPC:

I have learning moments every day. I have so many positive experiences and some struggles. Working with residents in long-term care, I have a responsibility to educate the residents and their family . . . . environment can be stressful but our team stands by each other and supports each other. The team puts a plan in place, for example, I work

very well with the recreational therapist, to have a common goal . . . in relation to my resident's recreational plan.

When asked how she was making a difference in the lives of her residents and their families, Leah shared,

I work with all HCPs. We have a team that supports each other. I think of them as my family and right now the same applies to my residents.

All participants viewed positive interactions with HCPs as part of IPC, where the resident/patient/family is central to IPC competence. Participant views on collaboration with the resident/patient/family was noticed. Important information was shared about how care was performed and how the resident/patient/family view influenced IPC. Carla shared,

the past year hasn't been typical. When I started out, I experienced anxiety . . . because I am no longer a student. I adjusted well to being a member of the team. I formed professional relationships with dieticians, pharmacists, physiotherapists, physicians, and other nurses. By working together as a team, it accomplishes shared goals to achieve high quality care . . . From what I've seen, patient care is improved and good outcomes are the end result when the patient is part of our team.

Similarly, Noella expressed gratitude for IPC when she observed an improved patient outcome.

nothing beats feeling like you really helped someone. Recently, I had a sick patient. She experienced sepsis and it happened very quickly. Her vital signs changed and her condition just seemed overall a little poorer, so I called in the charge nurse and I called the physician. I was intimidated because I did not know the physician well. In the end, he was really nice and the other nurses helped me. Luckily, I caught the sepsis before anything bad would happen to my patient. After I was off, I got a text from my manager

letting me know that the physician and charge nurse stopped by the office to say what a great job I did managing my patient's condition. When I reflected on the situation, I felt proud that my patient received the correct care and testing in a timely manner before it changed her outcome. It was great to know that I truly helped her.

The prevailing emotional dichotomy suggests the ebb and flow of IPC. This view supports the fact that for years IPE and IPC have been encouraged in NS healthcare delivery. Interprofessional initiatives have focused on traditional solutions - ranging from increasing IPE in professional programs as an 'add on' or enhancing IPE in general hospital orientation - with mixed results. At times, blind to the practice reality of the HCP and IP team. The fact being that in the foreseeable future, the ebb and flow will have accelerated so much, the health workforce may not be able to keep up. How then should researchers, educators , and health system leaders approach this reality and respond?

Team Characteristics

Many participants highlighted team characteristics during their interview. ELNs observed or directly experienced events where team characteristics made an impact on IPC. The experiences were representative of three sub-themes including: *team composition; team relationships; and team commitment* having an impact on IPC.

Megan described how *team composition* influenced IPC.

My experiences have been influenced by the entire interdisciplinary team, my supportive manager, clinical nurse leader, and the patients that we care for.

Kate stated she works,

with an excellent team of nurses and health professionals.

Tracey shared,

Families are a member of our team and nurses intersect with them the most. Our unit clerk also deals with them a lot. I am still getting to know all the members on the IP team. Identifying who is on the team and their role will help improve IPC.

Team members in NS have a responsibility to foster IPC, especially during the first year of a registered nurse's professional practice. In particular, experiences that are supported by positive role models of IPC. Participants identified a mediator in the team to support them and act as a catalyst for IPC. They more commonly described this individual as a nurse in both a formal or informal leadership role. Their experiences suggested that some of their vulnerabilities were negated by the mediator role.

Kate described her mediator as,

supportive and embodies transformational leadership. Staff members feel respected and appreciated, resulting in greater morale and collaboration.

Nancy identified this role as someone to,

provide advice, bounce ideas off of with respect to effective collaboration.

Nancy explained how this individual facilitates IPC:

my team lead helps my understanding my RN role—working as a nurse (as compared to a student) there is so much more required. My patients really need all different team members to be involved for best possible patient outcomes.

Kate corroborated Nancy's perspective. Kate shared,

My nurse lead . . . has made my entry to practice a pleasure. . . . I wanted a better knowledge about the scope of practice of other team members, particularly social workers and occupational therapists. Knowing everyone's role, strengths, and

weaknesses and what each person on the team can do best for the patient situation is key. My nurse lead helped me with this.

Nancy and Kate recognized nurse leaders as a member of the team and the integral role nurse leaders play in advancing IPC in every day teamwork. Participants identified relationships with team members, with or without the nurse leaders who enacted the role of a meditator. When a meditator was present, they stimulated and supported participants in IPC. This included relationship building and role clarification with other HCPs. With the meditator, the participants expressed gratitude and appreciation, underscoring how this was enriching for them. Nurse leaders played a strong role in ensuring participants had a safe environment to learn and grow within their first year of professional and interprofessional practice.

When participants were asked how the healthcare team made a difference in patient/families lives in NS, team relationships emerged from the data. The sub-theme of *team relationships* was explored further in two interconnected places: ELN relationship with patients/families and relationships with other members of the IP team.

Jennifer offered her perspective on the importance of relationships with patients/families,

Patient/family-centred care is so important. Everyone [members of the team] plays a role in the care and has a good assessment [of patient and family needs] and finds out how best to advocate for our patients and families. Patient advocacy needs to be strongly demonstrated. I feel appreciated from the patient's perspective. . . . Nurses have taken on more of an emotional role.

Nancy stated,

the impact depends on the interactions we have with the patient/family. It may be a positive interaction or negative one, but building relationships is key.

Jennifer and Nancy identify the necessary role of interprofessional communication to develop and sustain quality team relationships. They recognize that strengthened collaboration would assist them with effective interprofessional communication especially when developing a common goal with patients and families. Participants described dynamic patient and family experiences brought on by the pandemic. Leah articulated,

> *I make a difference in the lives of Nova Scotians by treating them like my own family and at times, as nurses, we are their family*.

It was noticed that some ELNs expressed feeling unqualified to address patient and family concerns. When team relationships were not effectively managed, it resulted in negative implications. From their viewpoint, participants described this as having a negative impact on fruitful IPC. Sally expressed,

> *Family members feel bad and this is very upsetting for me. The family seems to take their frustration out on nurses and doctors [and] in my area and our communication has changed.*

Kate expanded,

> *Our patients are unable to have all their family members visit them, only able to connect virtually. Nurses must be the support person for them. I am getting lots of questions, many phone calls from families wondering about family members' conditions. I feel anxious about saying the wrong thing.*

Sally and Kate acknowledged the need to understand patient and family challenges brought on by pandemic. They believed effective interprofessional communication and relationships as being pivotal to high quality patient-centred care that involves the family. Visitor restrictions as a result of pandemic protocols and the addition of virtual visits, advanced in a matter of months

in most practice setting within NS Health. In many ways, virtual team-based care was stood up urgently. The acuity of this need brought on by the pandemic influenced participants ability to build a rapport and relationship with all members of the IP team, especially the role of the family. When asked to describe challenging experiences when working as a member of a healthcare team, Nancy responded,

> *Nurses need to communicate a lot of information to families. We are getting lots of questions, especially about resident wellbeing [including] many phone calls wondering about a family member's condition. These can be difficult conversations and it is important to work as a team.*

One of the outcomes of IPC is defined as enhanced patient/family-centred care. While the participants appeared to value family contribution, in certain situations they described being at odds with family desires, causing strain on relationships and collaborative experiences. Additionally, several participants shared practice scenarios to describe positive or challenging interactions with HCPs. For example, Cathy shared how HCPs combined their expertise to determine how best to meet the needs of patients and families.

> *I approach IPC as ensuring I am working alongside other professionals while providing care to my patients. For example, I am currently employed on a surgical unit; therefore, when patients are post-operative they require consults [with] many different healthcare professionals to ensure a full recovery. Examples are physiotherapist with early mobilization, dieticians with diet advancements, pharmacists with medication adjustments, and others.*

Sally stated,

> *I believe that collaboration is what most benefits the patients. For collaboration to occur, all team members need to be on the same page . . . need time to work together and be able to welcome each other's perspectives.*

Jennifer specified,

> *it is all about strong communication. Our team tries to do team huddles and if the day is busy, we schedule a few quick check-ins with each other, making sure we are on the same page and not missing anything.*

Sally and Jennifer suggest that there are a myriad of opportunities and challenges for HCP to consider. Negative interactions were a problem within IP teams. This may speak to the issue as why some of the participants expressed feeling vulnerable. In particular, some participants faced interactions with HCPs with different perspectives on issues, complicating communication and relationships. Interprofessional collaboration requires open lines of communication and participants believe complicated communication led to not feeling welcomed as part of the team. Members of the IP team in NS can make an impactful difference in the circumstances surrounding IPC. Additionally, in reducing unfavorable practice circumstance for newly graduated registered nurses. Megan described,

> *there are times when I had to stand alone and be committed to the process . . . a way of delivering care that is collaborative, even when it was not easy working through the issue.*

Sally shared a similar experience,

> *my first couple of months as part of my team were difficult as I did not feel welcome or heard.*

Treena described IPC with another HCP,

when learning about IPC as a student, it was thought that you would be working with HCPs. But that isn't necessarily the case once you actually are in the role of a nurse. You have to advocate and fight for your voice to be heard.

When asked to elaborate on her experiences, Treena continued,

the negative interactions that I have faced . . . using them as a learning opportunity, knowing not to treat others that way . . . I have learned to control what I can let go of what I cannot. Transitioning as a new grad and impacts from negative relationships/interactions—these are connected. My experience wasn't ideal, I focus on how I will make it better for other new nurses and learners.

Treena's experience stood out for me, particularly in relation to what she faced when working as a new member of a healthcare team. There are a number of reflections I had after the interview: (1) are HCPs receptive to ELN perspectives? (2) do ELNs have exposure to positive team relationships in pre and post licensure experiences? ? (3) are there examples where her experience had an impact on patient or family outcomes (positive/negative)? (4) how does this experience influence Treena's team relationships and IPC in the future? When Treena was asked, how do you think the healthcare team makes a difference in patient/family lives in NS, she answered,

the hospital is the place where people come to get better . . . patients are thankful for our care. Some patients/families only want to hear from the physician, but I think people are grateful for the care they receive.

Treena's commitment to IPC resonated throughout the interview. Other participants discussed their willingness and commitment to IPC. Geoff shared,

> *every morning we do a team huddle and our manager asks everyone to participate and collaborate . . . it can be a lot in one day and I think I am doing ok as I expected it to be hard. I put my feelings aside and recognize a sense of duty and I think this is a big part of my job.*

Sally described her commitment to IPC,

> *I had to push harder to keep up the values (when caring for patients during the pandemic) . . .. I had to care for people in a different way and my team had to work together to come up with ideas to better meet their needs.*

The dramatic shift from in-person to virtual care offers prospects for improving or challenging IPC overall. Without purposeful design, the virtual team-based care model could result in dire intensification of disconnects experienced by new IP team members. When participants worked with IP teams in ways that were familiar to them, they felt more competent in IPC. Yet, new ways of care provision for example, practicing virtual visits, exacerbated complications in relationships and feeling welcomed as a member of the IP team.

The sub-theme of *team commitment* was tested in Geoff's and Sally's experiences. Both narratives included that being part of a team was hard work and having a high level of commitment allowed the team to come up with new ideas to meet patient needs. The participants described facilitators and barriers to team commitment in a number of ways. Geoff and Sally expressed their personal/professional commitment as one example. Additionally, participants perceived HCP commitment as having an importance to IPC. Jennifer described,

> *team members want to participate in IPC . . . patients need all different aspects of care to be involved in order for best possible patient outcomes and [eventual] discharge from [the] floor. Our team is good at this.*

Additionally, Noella shared,

> *patient care can be fragmented at times. Everyone is all in because working with an individual with a stroke requires each HCP with large commitment. As a new grad, consulting about each of my patients with the team helps me get a better idea of the big picture rather than just the nursing perspective. I've had team members thank me for consulting with them because the patient definitely needs . . . x, y, or z. . . . it's a good feeling to have everyone rooting for the same cause you are. I think it lifts the patient up in bad times and I have learned a lot that I do not feel I would have learned elsewhere*.

Noella's example described the valuing of HCP expertise to ensure patient needs are met. Additionally, HCP commitment in valuing her perspective facilitated her development and contribution. Shannon summarized team commitment nicely,

> *we are hands on as a team, when our emotions are going up and down (pandemic related) our commitment has remained the same.*

While team commitment to IPC is espoused across NS Health, before determining what can be better, the organization needs to explore and answer if HCP have the interest to do so and what needs to be put in place to support this. An alignment of the *National IP Competency Framework* (CIHC, 2010) into IP practice has occurred. Participants shared experiences related to balancing the patient, family, and HCP perspectives and listening to all parties in shaping a common goal. Responsive and respectful communication played out inconsistently in practice complicating IPC and CPCC. Participants offer insights to researchers, educators and healthcare leaders to unpack systemic barriers and determine team commitment to IPC. Additionally, open and candid conversations with newly graduated registered nurses in relation to performance of

IPC is critical alongside of HCP and broader organizational performance. When this work is done, NS Health can move on action strategies to enhance IPC and CPCC.

Development of IPC Competency

The third theme relates to competency with IPC. Participants shared experiences about leadership, role development, and improved confidence. This has resulted in three sub-themes: *support of a leader, developing their own practice, and improved self-confidence* as influencing IPC.

In the sub-theme *support of a leader*, it was found that leader competency in IPC played a role in participants' experiences as a part of the healthcare team. The participants shared that a leader who was more competent in IPC encouraged them, offered varying viewpoints, and were supportive, especially when the participants felt like they needed help. When recounting how supportive a leader was, Tracey revealed,

> *there was one day I called my manager because [of] one of my patients. I had to talk through with her what happened and ask for guidance. She was very supportive and talked through the actions with me. One thing is that she sees my capabilities sometimes more than I see them in myself and she told me I was doing a good job and . . . [gave] me the validation I needed.*

Sally shared,

> *Our manager instituted rapid rounds with a small group of the IP team to accomplish shared goals with our patients and families. Having a nurse leader that is ready to help in this way helps me transitioning in my role.*

Kate stated,

excellent leadership makes all the difference in the world [by] role modelling IPC and giving helpful hints in my practice.

With reference to the development of IPC competency, the participants addressed the importance of seeing IPC in action to empower them to enact IPC. Collaborative working behaviors represented by role models enabled participants to develop new IP practice patterns. Geoff described,

having support of leaders is . . . someone there to ask questions [of]/bounce things off of and being able to identify the HCP . . . I should go to.

Melanie stated,

it is very important to have effective leaders that know when to push you and encourage you.

As evidenced by the multiple accounts, participants need collaborative leaders to lead IPC. Collaborative leadership competency being role modelled and taught in practice is key. Concerted collaborative leadership strategies were described by participants from varied domains of practice. As a result of a supportive and collaborative leader, Cathy learned,

to better demonstrate how nursing contributes to the team and the delivery of care. Working as a nurse, it requires me to work alongside many HCPs in ensuring patients' needs are met. I believe that my preceptor showed me effective IPC; I have seen this firsthand.

The participants discussed how the support of a leader facilitated IPC because ELNs were building their role in the team. This was achieved by influencing and leading participants in practicing collaborative leadership. Collaborative leaders focused on building capacity and assessing the participants comfort and competence in doing so. Together they co-led the care

transformation required with or on behalf of the patient and family and across silos and care sectors. Jennifer shared the impact of having the support of a leader during her transition,

> *I am more open-minded about working as a member of the team. I have learned to step into more of a leadership role rather than just doing what people tell me to do. I continue to learn to mix different personalities and conflict styles. It's all about strong communication and collaboration.*

While supportive and collaborative leaders have made good progress with the participants, a lack of leadership support will hinder this growth. Heather shared how a lack of support from a leader hindered IPC,

> *that a lack of leadership contributes to ineffective IPC on my team.*

Development of leadership competencies associated with IPC requires individual and collective advocacy and accountability to each other, especially the patient and family. Collaborative leadership when present assisted participants in *developing their own practice*. Treena described learning about the nursing role,

> *I thought that I would be working as [part of] a team, but that isn't necessarily the case once you are in the role of a nurse. You advocate for your patients when working with other team members and my clinical nurse leader mentored me in this role.*

Leah shared,

> *I have the responsibility of educating my patient on all the current information and sharing [that] information with my team. My preceptor was a good role model in relation to collaborating with my team.*

Continued professional development led to ongoing interprofessional refinement. Several participants shared how leaders coached them in IPC, beyond the time of a formal preceptor-

preceptee relationship. The significance of this contribution shows the support for transitioning baccalaureate-prepared registered nurse workforce. Acknowledging the challenges faced by leaders and participants alike, as a result of the pandemic, how do we learn from experiences to shape the new practice era. Geoff described,

> *I was fully supported by my manager and clinical nurse educator for any questions [that arose]. . .. It was a huge adjustment being an ELN and part of a team, but luckily I had a ton of leadership support to coach me along the way.*

Noella described how her clinical nurse lead coached her to enact IPC,

> *giving report[ing] to my CNL on day shifts helped me stay more organized by saying everything out loud. It is giving her the information about all my patients and opportunities for her to prepare me to collaborate with other team members*.

The unprecedented disruption caused by the pandemic, revealed the substantial support leaders are willing to give. Support that the participants found meaningful in ways described as: improved self-confidence as a registered nurse, developed professional identity and enhanced IPC competence. *Improved self- confidence* was shared on a number of occasions. Jennifer described,

> *Because of the team I work with, I do not believe I experienced transition shock as a new nurse working in an emergency department. The time I spent with this team, they got to know me and my ability to be a nurse and I think this had made a difference.*

Cathy stated,

> *I have had many positive experiences in the transition to practicing competently on my own. Some of these experiences were the length of my orientation, the staff on the unit, my manager, team lead, and other members of the team. My colleagues were a positive*

impact on my professional practice as they were excellent educational resources for my learning. My team members helped [me] in my transition . . . [to] become confident and feel like a nurse.

When asked to explore her experience in more detail, Cathy shared,

Nothing beats the feeling like you have helped someone. There's been a few times that patients and family members say nice things to me about my nursing care and it always feels nice to get positive reinforcement from the person who's on the other end of the care. I am becoming more confident as a nurse.

Positive participant experiences are critical to early professional development. The development of Cathy's professional identity is significant, particularly the creation of her professional identity and the correlation with her development of IPC competency. From my perspective, Cathy described connections between the sub-themes and how it influenced IPC and patient outcomes. This interview distinguished itself because of Cathy's smile when she stated, "*becoming more confident as a nurse*". I asked her what this felt like and Cathy responded, "*I feel proud*".

The narratives shared by the participants make visible both positive and negative experiences. When they had access and support from collaborative leaders, they shared more positive experiences. In the absence of support from collaborative leaders, they were more likely to view IPC as challenging. Without a climate of shared decision-making, leadership and accountability within the healthcare team, the participants were more likely to view destabilizing IPC as a personal failure. In the absence of leadership intervention, the daily uninterrupted negativity promoted the participants feeling of vulnerability and inadequacy. Mitigating this is critical.

Contextual Influences on IPC

Contextual factors played a role in participant experiences with IPC. Participants provided a number of examples in relation to two sub-themes: *context of care* (e.g., where they worked as a member of a healthcare team) and the *COVID 19 pandemic* (e.g**.,** how this influenced IPC). In April of 2021 Nova Scotia entered its third and most complex wave of the COVID 19 pandemic. This wave was complicated by variants of concern (Government of Nova Scotia, 2021, April 23). Twelve of the 15 participants were interviewed between April and June 2021, when COVID 19 had a significant impact on the NS healthcare system.

The participants shared experiences when *context of clinical care* such as policy changes, team process, and clinical environment influenced IPC. Sally shared,

> *at the beginning of the pandemic, we stopped our interprofessional rounds because of group size limitations. Our communication with patients, our families, and each other changed because of physical distancing rules and all the personal protective equipment we must wear*.

The dynamic of team process and practice changes, on-going efforts to revise and improve clinical care, and endeavors to develop IPC, are a critical part of ELN experiences. So too are the patient and family's response to such changes and interactions with them. The pandemic revealed new IPC, laying bare to inequities and division; but also galvanizing solidarity and collaboration.

Carla shared,

> *Person-centred care has been impacted by the pandemic. We are not just nurses right now. We are spending time with patients while family/visitors are limited. The pandemic has made us do things differently.*

Furthermore, Sally described an experience,

> *As team members, we had to push harder to keep up the values (e.g., collaboration, and how we used technology to follow people in their homes and/or outpatient visits). Because of the pandemic we had to care for people [in] different way[s] and we had to work together to come up with ideas to better meet their needs.*

Evidence related to the impact of COVID 19 pandemic on nursing and IPC is evolving. Very little is known about the impact the pandemic has had on ELN practice. Perceptions of navigating collaboration ranged from, Jennifer's, "*the pandemic has created a strain in how we interact as a team*" to Carla's, "*the pandemic has highlighted how care is more holistic and collaborative*." This diversity reflected how participants, in diverse care settings, navigated methods of working together differently. Confronted with the pandemic amid their transition into professional practice, researcher, educators, and healthcare leaders need to play close attention and explore ways to meet the participants where they are in practice. The participants are revealing serious gaps in IPC across our provincial health authority. This is forcing us to look at issues, previously recognized but likely swept 'underneath the rug', to be explored at a later date. Participants continue to work with inconsistencies described in practice, the rug needs to be unturned and challenges that prevent IPC in practice exposed and resolved.

Kate's experience highlighted the *context of clinical care* from a different view point. She linked work culture and the environment as a facilitator of IPC.

> *I have the pleasure of working with a team with a positive work culture. It makes everything we do easier and creates an environment that supports collaboration and excellence in care*.

Kate started her nursing career in January 2021 and was employed in mental health and addictions (MHA). Earlier in the analysis, I shared how Kate described how she enacts IPC in her work. Additionally, she noted,

> *I am very fortunate to have a supportive work environment in MHA. In my role, IPC is essential.*

Melanie started her career in November 2020 and was employed in a medical unit. She was reassigned to a COVID 19 assessment centre. Melanie described,

> *I was pulled to COVID unit which interrupted my orientation. I had to float and did not have much experience. I did not have a long orientation, therefore, I had to adapt to the environment and work as a team member. This has not been a happy transition but I have learned a lot of lessons about team work.*

The *context of clinical care* was explored in more detail by Sally. Sally stated,

> *Due to the COVID 19 pandemic, there was limited participation of team members. Some of the alternative methods that the team tried are round sheets and rapid rounds which were somewhat helpful. I think what we learned is that we need to have rapport to resolve the types of conflict we have experienced through the pandemic.*

Participants described the landscape of nursing in multiple practice contexts as unpredictable. Several key strategies to optimize IPC were noted. Many strategies speak to the degree of professional transformation underway while being placed in uncertain practice environments. As they strive for IPC, the description of a consistent practice environment stands out. Consistency is understood as being in a practice area where they are familiar with the patient population, practice context and know the team members. Participants perceived inconsistencies as negatively impacted their ability to enact IPC and this needs to be met with rigorous evaluation

to determine if this is the case. Tracey described her role with families during the pandemic when her practice area had an outbreak with COVID impacting patients and HCPs. Tracey noted,

> *families were calling more and hearing the news that nurses had COVID. I had to reassure them more and I had to think about if I was in their shoes, I would be doing the same thing. I had to give them the reassurance that their family member was ok. And with increasing cases there was just more fear. They did not know what was happening in the hospital and they [had] hear[d] a story in the news [that] there is an outbreak in nurses. I do not think I was prepared to communicate so much but I did the best I can to inform them and collaborate.*

Tracey's experience denotes the importance of increased communication with the family as predictability decreased in clinical context. It is obvious in this example that Tracey was sought out by the family and she valued them as a partner necessary for IPC.

Several practice inconsistencies were expressed by participants and are worth mentioning. They were mostly attributed to the COVID 19 pandemic. The participants also related contextual factors to the success, failure, and unexpected consequences on IPC. The examples include: (1) fractured learning experiences, (2) increase in the internal movement of nurses, (3) increased workload, (4) impact on mental and physical wellbeing, and (5) increase in self-preservation resulting in a lack of IPC (e.g., getting through the day) to name a few. Melanie described her transition during the pandemic:

> *these are unprecedented times, it is hard, but I think we know that this will make us better nurses, making us more capable, stronger, and better to handle things in the future. And where I work and feel the support from the team of people we have, I feel lucky. Even when I think about the other month, I [was] floated to another floor and*

> *[saw] different teams and that "helping" piece does not happen everywhere. I am lucky to work where I work [and] have such an approachable and supportive manager who is willing to step in as needed and having colleagues in my team that I can talk to.*

Heather stated,

> *the COVID 19 pandemic had an influence on my preceptorship . . . it was fragmented at times because my preceptor would change frequently and be reassigned to another unit for COVID 19 care.*

Treena and Cathy shared that the consequence of an abrupt end to their final clinical practicum (because of the COVID 19 pandemic) disrupted progress and preparation for team work. Treena informed,

> *my final placement was not complete. In speaking with other grads, not having it made our transition . . . more difficult.*

Cathy's final practicum finished 2 weeks early due to increased COVID 19 cases in NS. She stated,

> *the abrupt ending to my program influenced my transition. Because of this, I felt unprepared to work in my team.*

Consistency in participant transition into professional and interprofessional practice was impacted due to interruptions in clinical placements and other traditional learning opportunities. Geoff described leadership opportunities. "*I have learned to step into more [of a] leadership [role] because of the number of ELNs on my unit,*" stated Jennifer. Geoff described being placed in a charge nurse position when he was also responsible for ELNs, as his charge nurse was reassigned.

Lastly, participants expressed high turnover of staff during the COVID 19 pandemic.

The participants described specific consequences on performance. Nancy pronounced,

> *there has been a high turnover and a lot of new nurses on the unit that are figuring things out together.*

Melanie's view aligned with those of Nancy, stating that there was a

> *the steep age gap of the nursing staff (2/3 of nursing staff have less than 3 years of experience) so we lead together.*

There are two critical issues that feed into this experience. Firstly, and as noted earlier, the participants described their maturing into registered nurses competent in IPC requires the support of collaborative nurse leaders. And secondly, their transition is being described as not just a professional experience, it is an emotional experience that is mediated by the support of others. While is it is understood that there is a transition period, in the most consistent of a reality, transition from the pandemic viewpoint is consistently inconsistent, from protocols to preceptors to practice. Nancy and Melanie described stress when transitioning from student nurse to registered nurse during the pandemic, specifically when role expectations were to rapidly function as a competent nurse. Noella added her concerns,

> *with my interprofessional team I realize there may not be trust because of my lack of experience. But my strategy to combat those tensions is to look toward a real strong collaborator and mentor, someone that I look up to and has more experience than me, who I can trust and have tough conversations with in terms of conflict resolution and that is very helpful for me.*

Tracey shared concern about her friends (other ELNs),

> *I talk a lot with other ELNs. All our transition has been during the pandemic. Talking to nurses I know that nursing is hard. But is it always going to be this hard? . . . If it is, I*

> *do not know if I can do it for the next 20 or 30 years. I haven't really known what nursing is like outside of the pandemic. And the additional workload (e.g., new health and safety requirements, social distancing measures) is beginning to take a toll on my emotional wellbeing.*

With their role as a nurse still under construction, questions arose around the long-term impact their experience would have on IPC. The analysis brought to light many unanswered questions around participant experiences of IPC during the COVID 19 pandemic. The intention of participants to work collaboratively was unmistakable, even when it was difficult. In closing, I share two perspectives. Geoff was an ELN who worked in a facility in a remote community in NS. Geoff stated,

> *to date I have been working as a nurse at my current place of employment for about a year. To say it's been challenging is an understatement, especially amongst a pandemic, but also the most valuable and rewarding year of my life. I formed valuable and irreplaceable friendships and strong team relationship[s].*

Carla worked in a different part of the province in a surgical care unit and shared,

> *Care is more holistic and interprofessional now. The pandemic hasn't made us do this; it just highlights what we should have always been doing.*

Participant intra-pandemic experiences pose a challenge to IPC. A deeper exploration into the number of concerns shared requires urgent action. An investment or re-investment in IPE is needed as a result of inconsistent or inadequate support during their transition into professional practice and integration into IP teams. While the pandemic is not an ideal catalyst for adoption of more 'new' ways of practicing, the lessons and experiences shared by the participants must not be lost in the ongoing pandemic. Furthermore, there is a risk that the experiences will be

unconsciously normalized or be silenced within larger recovery activities without critical reflection and appraisal.

In conclusion, this chapter denotes findings from this interpretive description (ID) study. Thematic analysis of 15 interviews gave a voice to ELNs working in healthcare teams in NS. Four main themes surfaced from the interviews. Several sub-themes were noticed and discussed. As Nova Scotia works to overcome the COVID 19 pandemic, the experiences shared by the participants highlight the importance of further discovery and research. The themes reflected here should inspire future research sparked by the knowledge gained in this study. More studies are needed to explore the extent to which these themes are prevalent in healthcare teams.

Chapter Six: Discussion and Conclusion

This ID study was developed to further my understanding of ELNs' experiences with IPC in healthcare teams in Nova Scotia. The study was conducted within the provincial health authority in NS. Study participants consisted of 15 RNs within their first year of professional practice. A thematic analysis (Braun & Clarke, 2006) of the data was conducted and four themes were identified. They were described as: (1) emotions linked to IPC, (2) team characteristics, (3) development of IPC competency, and (4) contextual influences on IPC. Several sub-themes were noticed and discussed.

Throughout this study, I reflected on and explored why I was interested in knowing more about ELN experiences with IPC. Why was this important to me personally and professionally? My interest was rooted in contributing to the knowledge about interprofessional collaboration in healthcare teams, but more so to better understand ELNs. This was important because of my personal experiences with my brother Callum coupled with my role as a nurse and healthcare leader in NS. My reflections provided clarity about preconceived notions I may have had in relation to IPC in healthcare teams in NS and was fundamental to my overall understanding.

Lastly, my discussion chapter is focused on the alignment of the research methodology with the research inquiry and the meaning of the themes as a backdrop for the discussion. Participants in my study were given the opportunity to reflect on IPC when working in teams in NS. By asking them to share their experiences of IPC, ELNs were compelled to think about and describe both positive and challenging experiences. This required a level of reflection and discernment in relation to IPC. The act of doing so confirmed, for most ELNs, that they were essential to their team, especially in partnering with the patient and family. Furthermore, their descriptions demonstrated coherence with CIHC's (2010) definition for IPC.

Investigating IPC with 15 participants who had been working in healthcare teams for less than a year was informative. The results demonstrated that being new to a team generated an array of emotions, opportunities, and challenges as ELNs commenced their career. The participants stressed the impact that emotions, IP team composition, leadership, and context had on the possibility for IPC. Each of the impacts will be discussed further in the remainder of the chapter.

An Array of Emotional Experiences

When participants described emotional experiences, several perspectives stood out. These included the great amount of stress they felt as they commenced their careers and the uneasiness that came to light during their transition into new teams. Participants described a range of emotions while working as new members of the healthcare teams. They shared narratives of feeling overwhelmed, disappointed, and worried about not knowing where to turn for support in the team. Transition into IP teams was emotionally challenging for participants.

When participants were asked what it was like to be an ELN in NS, descriptions often entailed terms such as stressful and uncomfortable. Some participants spoke of experiences with visible emotion (facial expressions and tears) and others described optimism and satisfaction. The emotional distance created by the pandemic may have influenced their experiences significantly. Participants described how their transitions were complicated because of the COVID 19 pandemic, leading to personal isolation and not knowing what nursing was like outside of the state of a provincial emergency.

Some participants described psychological stress and were concerned about their career going forward. They described aspects of transition program gaps between pre-licensure and practice realities. Strengthening the emotional support for ELNs is instrumental to achieving

IPC. Participants described finding competence and confidence increasing over time, especially with the bundling of concurrent strategies: (1) achieving IPC with patient, family, and IP team; (2) addressing emotional stress during transition; and (3) reducing turnover of preceptors and other team members. The COVID 19 pandemic impacted the personal and professional lives of participants motivating further changes to roles, responsibilities, relationships, and levels of knowledge in IP teams in NS.

There is a plethora of literature on the transition process (Benner, 1984) and transition shock (Duchscher, 2009). Other studies focus on the emotional support for new nurses in the clinical setting (Ebrahimi et al., 2016) and professional socialization (Price et al., 2019). Recent literature re-affirms that new graduate nurses experience stress during their transitions to practice (Ebrahimi et al., 2016; Duchscher et al., 2021; Huang et al., 2020). With worries and a sense of a lack of control over their environment comes a substantial need for emotional support.

Ebrahimi and colleagues (2016) indicate that new nurses require a diversity of techniques when transitioning into practice. The techniques include (1) providing emotional reassurance that is confidential, (2) monitoring verbal and non-verbal behavior, (3) cultivating seeds of hope, and (4) fostering emotional belonging. Duchscher and colleagues (2021) suggest that challenges imposed by the COVID 19 pandemic in undergraduate nursing education, nursing practice and the workplace has exacerbated transition shock in newly graduated registered nurses in Canada. Benner's (1984) model from *Novice to Expert* would suggest that ELNs may not have the competency or experience to adequately deal with care stressors brought on by the COVID 19 pandemic, therefore preventing IPC.

Urgent and sustainable action is required (Duchscher et al., 2021; Feeg et al. 2022). Leading up to the pandemic, studies have not clearly specified the meaning of emotional support

to ELNs as a facilitator or barrier to IPC or the team's responsibility and role in such (Benner, 1984; Duchscher, 2009; Duchscher et al., 2021 Ebrahimi et al., 2016). Also, in keeping with the study findings, emotional support (lack thereof) impacted IPC in the pandemic; particularly between wave one and two in NS. This may be magnified today with the additional stressors and fear in the workplace (Feeg et al., 2022). Research is needed to evolve nursing and interprofessional knowledge within the context of a global pandemic, which provides a unique context for ELNs. It would be particularly interesting to re-engage the 15 ELNs that participated in this study and learn more from them over time. Do later waves of the pandemic shape their IPC differently? Did team dynamics change as different pressures evolved, or as different supports or the lack thereof become a greater issue.

Experiences with Interprofessional Teams

Teams play an important role in the everyday work of ELNs. This was made visible when participants encountered situations when other HCPs would offer perspectives in care. Interprofessional collaboration (IPC) has merit in making sense of encounters experienced by ELNs. Participants emphasized the importance of IP teams where favorable experiences fostered IPC. They explained scenarios (i.e., rounds, huddles, teamwork) when each member of the team had a responsibility to "chip in". Not doing so could put their patient and team in jeopardy. Participants described themselves as collaborators who played an integral role in the health-care team, but at times a lack of team support described by ELNs got in the way of effective IPC.

It is obvious from participants that variations exist in relation to IPC in NS healthcare teams. Because of this, ELNs are impacted in their transitions into collaborator roles. Nova Scotia College of Nurses (2020) describe ELNs as collaborators who play an integral role in the health care team partnership. Treena provided several examples of how members of the team

were not supportive and how this impacted her experience and role as a collaborator. Treena described the behavior of some team members as *very unwelcoming*. She demonstrated optimism when sharing her ability to learn from the experience and mentor future ELNs or learners in a different way. My impression of this statement was that despite the challenges she faced, she was optimistic and hoped to empower others in the future.

The ELNs in the study want to enact the role as a collaborator and become part of IP teams by: (1) feeling welcomed and supported (sense of belonging in team), (2) having their knowledge valued (realistic expectations), and (3) their different perspectives welcomed (evidence of IPC in team). In their viewpoint, the ELNs in this study felt that IPC was about relationships and the need for sound communication, respect, trust, and appreciation of what ELNs bring to the team.

For ELNs, HCPs need to (1) demonstrate IPC competency descriptions as described by CIHC (2010), (2) break down the barriers of stigma that ELNs sometimes face, (3) anticipate that the ELNs' knowledge is not beyond their experience and (4) recognize that mastery of IPC is mythical and misguided for the entry level practitioner. When IP teams have realistic expectations and supports in place, the ELNs felt welcomed and safe to develop IPC competency through practice experiences. Treena shared, *a welcoming team is open to new members joining and being part of the team.*

From the ELN viewpoint, working in a welcoming team facilitated inquiry, dialogue, an understanding of the ELNs as well as their potential to grow as nurses. Welcoming is not formally recognized in the IP literature. Such a 'finding' suggests the need to both challenge current practice and actualize the underlying assumptions CIHC's *National IP Competency* Framework (2010) was built upon, especially how: (1) the adoption of interprofessional

competencies requires a shift in practitioners conceptualize collaboration; and (2) practice requires a collaborative context that supports IPC (CIHC, 2010).

The aim is not to dismiss the practical contribution of CIHC's *National IP Competency Framework* (2010), Benner's *Novice to Expert* (1984) or Duchscher's *Transition Shock Framework* (2009), but rather calls for an alignment of perspectives and more critical debate in research and practice. Few studies explore how, why, and in what circumstances, ELNs transition into IP teams for the purpose of IPC and what HCPs can do to enhance welcoming. Conducting a secondary analysis of qualitative data in the study to examine this issue around welcoming or unwelcoming IP teams is an opportunity. Furthermore, this secondary analysis may be strengthened by integrating theoretical frameworks emerging to support the concept of dual identity (Khalili et al., 2020) or professional socialization (Price et al., 2021) during the transition of newly graduated registered nurses within their first year of professional practice.

Collaborative Leadership Experiences

Leadership is important in every aspect of being a nurse, from entry level all the way through to nurse executive roles. In the role of collaborator, nurses are tasked with leading and diffusing collaborative efforts with all members of the IP team (NSCN, 2020). Newly graduated registered nurses must understand and apply leadership principles that support IPC (CIHC, 2010). While participants spoke about leadership experiences, few discussed their independent role. Participants commonly spoke about leaders (as mediators) and their influence on IPC. This was more commonly described as a mediated experience, for example preceptor or mentor led with the ELN.

Collaborative leadership is a critical element in creating and sustaining IPC (CIHC, 2010). Engaged leaders with collaborative attributes were more likely to support/mediate ELN

transition to teams and from the perspective of the ELNs, this fostered IPC. Participants described other nurses in this way versus other members of the healthcare team. Additionally, the nurse leader (engaged and collaborative) helped ELNs move from a mindset of having the right answers to the collective decision-making needed for collaborative leadership.

Some participants described not knowing when to step into collaborative leadership because of their lack of competence and confidence to do so. Leaders (when acting as mediator of IPC) had conversations with ELNs to help them grow. Additionally, with mixed emotions participants discussed not having the ability to see all the important parts of the puzzle, which may have perpetuated their lack of competence and confidence for IPC. In such experiences, leaders supported participants to move from feeling to thinking to executing leadership in teams.

Deteriorating collaborative leadership was identified as barriers to IPC by study participants and described as fractured communication impacting collective decisions and perpetuated siloed thinking. In some cases, participants experienced fear of approaching colleagues. Participants described team members perpetuating and replicating poor behaviors without leader intervention. Furthermore, ambiguity produced in day-to-day operations impacted participants, the IP team as well as leaders.

A study conducted by Trefethen (2021) noted that collaboration between leaders and the ELN is crucial. Newly graduated registered nurses are unfamiliar with how to engage in collaboration and often require partnerships with leaders (Trefethen, 2021). Partnerships between the leader and the ELN will support the nurse's feelings of safety and value (Trefethen, 2021). Participants echoed how structured support/partnerships with nurse leaders facilitated IPC.

The Nova Scotia College of Nursing (2020) challenges newly graduated registered nurses to recognize that no one scope of practice is totally unique, and with that understanding, collaborative leadership may become more evident. Understanding and managing fault lines in complex team structures will be critical for ELNs to realize the benefits of diverse leaders, not just nurses. Thinking about the participant's experiences in this light suggests a conceptual connection between professional tribalism, newly graduated registered nurses, nurse leaders, and IPC.

Professional tribalism is described as the tendency of various professions to act in isolation from, or even in competition with, each other (Bozorghadad et al., 2020) and can be a barrier to IPC (Bozorghadad et al., 2020; Orchard et al., 2016). Orchard and colleagues (2016) suggest that nurse leaders should re-examine their role within IP teams to prevent professional tribalism. Spending more time with the IP team may potentiate the values and way of thinking that fosters IPC (Bozorghadad et al., 2020; Leithead et al., 2019).

Recent literature suggests different ways of thinking about professional tribalism in health care and its impact on IPC (Bozorghadad et al., 2020; Leithead et al., 2019; Orchard et al., 2016; Weller, 2012). A deeper exploration may lead to an understanding of why IPC barriers develop, how they may be addressed, the value of our own and others' professional identities, and interprofessional socialization (Karnish et al., 2019; Khalili et al., 2020; Leithead et al., 2019; Price et al., 2020; Weller, 2012). Additionally, as IPE aims to prepare ELNs with collaborative leadership and other important interprofessional competencies (CIHC, 2010; IPEC, 2016; Ong et al., 2020), this may provide another mechanism to prepare ELNs for practice experiences and help them identify and work through the challenges that can accompany leadership within the practice context (Ong et al., 2020; Reeves et al., 2010). Discovery into

leader experiences, collaborative leadership, and professional tribalism, along with how these play a role in IPC is required to meet current and future ELN needs.

Contextual Influences on Interprofessional Collaboration

Contextual factors are broadly defined in three main categories, (1) healthcare context, (2) nursing context, and (3) IP context. Based on participant experiences, ELNs identified a complex set of influences on IPC. The contextual factors identified align well with some of the key contextual factors identified by Arrowsmith and colleagues (2016) in their review of collaboration in primary care teams: (1) professional, (2) organization, and (3) external factors. The present study makes a new contribution by highlighting the COVID 19 pandemic within the healthcare context in NS. It is important to note that contextual factors faced by participants both positively or negatively influenced IPC.

Many participants associated positive experiences as having good luck. It was often described in a way that was beyond their control and was reliant on other people within the team. Additionally, ELNs felt there were inner (emotional impact of becoming a nurse) and outer (team influence and healthcare context) circumstances that coaxed or potentiated luck but it was something they had less control over, but it still profoundly influenced them.

Luck was described by Tracey and other participants in a number of ways. Tracey and I spent a considerable amount of time discussing her experiences. Tracey's experiences stood out for a number of reasons. She described being reassigned to a COVID area during wave 3:

> *I went to work and was informed by my manager that I was going to be reassigned to the COVID unit. I was fully supported by my manager and clinical nurse educator for any questions I had. It was a huge adjustment period, but luckily, I had a ton of team support.*

During our conversation, Tracey looked worried and described another experience that was not favorable or "lucky". When asked, Tracey shared three influencing factors about the experience including, in-hospital COVID crisis, disconnects between what was taught in school and what was the practiced reality, and team conflict influencing patient care. When I asked the question, "what do healthcare leaders from in and outside of NS need to know about in relation to your experience with interprofessional collaboration and teamwork?" Tracey responded that healthcare leaders need to "*stop reassigning ELNs to areas with staff shortages and suboptimal IPC and teamwork.*"

Story and Kenner (2021) share a similar perspective in what has been described as "having luck" by ELNs in NS. Healthcare teams work in high stakes environments to provide team-based care (Story & Kenner, 2021). Story and Kenner (2021) postulate that IP teams can have intertwined intentions and activities and when this does not occur HCP should be hesitant to join IP teams. Not only did some participants of this study have concerns with their transition into the nursing profession, but they were also hesitant to join a team delivering suboptimal care and questionable IPC. In the first example shared by Tracey, members of the IP team were attentive to her. Alternatively, her challenge to healthcare leaders suggests the precarious position she was in, not being able to opt out of suboptimal IPC and teamwork and the distress this caused.

Complexity called forth by the COVID 19 pandemic further complicated experiences which resulted in unsavory IPC. Most participants discussed how the pandemic influenced their transition to becoming a nurse and a member of the healthcare team. It challenged their values, readiness for IPC, and perhaps their behavior (positive or negative) when opportunities arose because of the pandemic. Luck, from this perspective, speaks to participant readiness to justify,

challenge, or avoid unsavory IPC.

The foundational and intersecting elements that support ELNs experiences of entering an IP team, are visible in the CIHC (2010) *National IP Competency Framework* and/or Benner's (1984) *Novice to Expert* and Duchscher's (2009) *Transition* Shock Framework. Each framework contains assumptions and variables. Unfortunately, challenges imposed by the COVID 19 pandemic have made the control of these variables problematic (Duchscher et al., 2021). Rigorous evidence related to the impact of the COVID 19 pandemic on nursing practice, especially entry level practice is required.

Future Considerations

Canadian Journal for Nursing Leadership dedicated its last edition of 2021 to the dawning of a new era in nursing. The events over the last two years, challenged the profession in ways that are not fully understood. Prevailing silos in care, a dysfunctional system with ever-widening fracture lines among HCP are further undermining the capacity to collaborate and innovate (Naigle, 2021). Although many issues have been simmering, the importance and time to inform a new direction for nursing is now. This raises the question: What is the desired future for nursing in Canada, and how is that informed by an interprofessional practice and learning perspective?

Personal Reflection from 2022

The events over the last two years, have challenged me in ways that I do not fully understand. The best way to describe it is leading in and through ambiguity. As I think back to the conversations with participants, I am reminded of the emotional uncertainty and ambiguity they described. I wake up every morning feeling a knot in my stomach. I have made decisions when all options were not favorable and been pushed to the breaking point because of persistent

uncertainty. Yet, I continue to have the courage to lead, sometimes, terrified of what may come my way and I am left with questions: How will my own practice and position in relation to IPC help me lead at these times? Have my experiences of being part of teams helped me prepare for leading in a pandemic? What experiences in IP teams would have been beneficial in anticipation of a pandemic? What I do know now is that leading in ambiguity requires both personal and professional commitment.

Amidst the pandemic, I have experienced that there are fewer 'hard and fast' rules as many situations are unique. I am more often placed in scenarios with last-second changes, plans that keep shifting around, and unclear circumstances. Most items are time sensitive, and in most cases I am acting with imperfect information. It requires a more open and innovative leadership approach to navigate ambiguity. I wonder how ELNs socialization processes are changed because of the need to deal with greater ambiguity. A year after Callum's passing, I yearn for just another moment with him. He always could find a way forward despite the uncertainty. I have learned how his teachings instilled leadership attributes that more comfortably acclimate to the ambiguity.

The COVID 19 pandemic has shone a light on nursing. More often, I hear about nurses leaving or wanting to leave the profession. For years, nursing shortage and strain has been discussed (CNA, 2012; IOM, 2010; ICN, 2020; WHO, 2020). The pandemic has brought to light how vast the ignorance of this issue has been and has amplified the impact the pandemic has had on nursing. Nursing shortage and strain is a living realty in NS. The uncertainty in the workforce is palpable; this uncertainty was also palpable in my conversations with participants. The healthcare system is in crisis (Tomblin Murphy et al., 2021). Collaborative thinking and working is our only path forward (Tomblin Murphy et al, 2021). I wonder if our healthcare

system had responded to the multiple calls (CIHC, 2010; Health Canada, 2007; Kirby, 2003; Tomblin Murphy et al, 2012) to become more interprofessional, if the loss of nurses, now, from our workforce may not be so noticeable. I wonder if the decades of 'silo' thinking and professional tribalism have impacted the nursing profession and workforce? I see us creating more 'silos' as a result of self-preservation and this concerns me. I too can see this struggle echoed in the experiences of participants. There is a risk that voices from nursing will rely on strategies and perspectives from the past to design solutions for today. Collaboration and innovation are important in setting the path forward and shape new insights about IPE and IPC.

The experiences of study participants are instrumental in understanding future opportunities. A series of propositions are discussed. My belief is that the propositions will represent some of the most pressing concerns and will generate much needed conversations about the delivery of interprofessional care in the Nova Scotia healthcare system. The propositions outline ways in which researchers, educators, and healthcare leaders can challenge and better support education and practice equally for the benefit of ELNs. With nurses making up a significant portion of the HCP in the NSHA, a lack of action may have significant consequences on the health of all Nova Scotians.

Four propositions are designed to represent the viewpoint of participants when asked two final interview questions, (1) what do healthcare leaders from and in NS need to know about in relation to your experiences with IPC? and (2) if there is one thing you could change about your approach to IPC what would it be? The four propositions are noted below.

Proposition # 1: Enacting Nursing's Professional Role is Influenced by Emotions

Noella stated,

I wish I would have recognized earlier that you need to take on a professional identity as a nurse. There is a certain way to do things . . . a certain way to communicate and collaborate with others . . . I was nervous.

Like Noella, participants described a range of emotions while working as new members of the healthcare teams. These included great amounts of stress as they commenced their career and the uneasiness that came to light during their transition into new teams. Through experience, the ELNs will progress with increasing confidence and competence for full enactment of the RN role within the interprofessional teams (CIHC, 2010; NSCN, 2020). A lack of emotional support during their transition may influence their confidence and competence and contribution to the teams.

The ability of the newly graduated nurse to work with other HCPs to deliver care is a critical element for professional practice. Understanding and appreciating professional roles and responsibilities and communicating effectively emerge as the two core competencies for IPC (Stevenson et al., 2021; Suter et al., 2009). Role clarity and effective communication are inter-related and are linked to positive patient and provider outcomes (NEXUS, 2021; Reeves, 2012; Suter et al., 2009).

Based on participant experience, role clarity and effective communication were influenced by emotions. Study participants described an inability to access others' skills and knowledge appropriately through consultation (CIHC, 2010) within the context of their clinical work. Dadich and Olson (2017) describe this as a culture-clash that shows up when a new HCP transitions into teamwork. It is evident particularly when emotions matter to the new HCP and

their experience demonstrates an illegitimacy of emotions within practice (Dadich & Olson, 2017). A comparative study conducted by Huang and colleagues (2020) noted that the COVID 19 pandemic has placed immense pressure on nurses identifying that more emotional support and training opportunities are needed. Within interprofessional research, emotion is largely under-emphasised (Dadich & Olson, 2017).

In summary, studies have not provided a clearly specified meaning of emotional support for ELNs as either a facilitator or barrier of IPC (Duchscher et al., 2021; Feeg et al. 2022; Huang et al., 2020). Also, in keeping with my study findings, emotional support (and the lack thereof) had an influence in IPC. With that in mind, recommendations stand out: (1) research is needed to evolve nursing and interprofessional knowledge within the context of a global pandemic, which provides a unique context for ELNs; (2) exploration of the relationship between the IPC competencies and emotions, especially considering the additional stressors described in the workplace by ELNs, should be a specific area of focus for researchers, educators, and health system leaders; and (3) new knowledge on emotional support and team strategies is needed to consider contexts when fear and heightened emotions are experienced during IPC. If acknowledgement of emotions remains unspoken in IP research, new knowledge will not be derived and the unexamined effects will continue to undermine IP efforts.

Proposition # 2: Interprofessional Socialization Impacts Interprofessional Collaboration

Nancy stated that IPC was difficult to achieve because she "*did not know what team member to go to*". Other participants shared a desire to understand the scope of practice of other team members. Some participants shared experiences of feeling unwelcomed by the healthcare team. The participants challenged researchers, educators, and healthcare leaders to address interprofessional socialization as a component of IPE to facilitate IPC.

A recent study conducted by Karnish and colleagues (2019) demonstrated how interprofessional simulation activities, when designed to improve knowledge, attitudes, and behaviors that reflect positive IP socialization and fruitful IPC, can be beneficial. From this viewpoint, IP socialization helps the ELN to develop IP and uniprofessional identities simultaneously (Karnish, et al., 2019). Khalili and Orchard (2020) describe this as the development of a dual identity (identifying with both the nursing profession and the IP team) as the outcome of this socialization process and being necessary for IP teamwork (Karnish et al., 2019).

Interprofessional socialization is identified as an emerging practice to better support the next generation of HCPs to integrate IPC (Karnish et al., 2019; Khalili et al., 2013, Khalili et al., 2020; Price et al., 2014; Price et al., 2018; Price et al., 2021). Healthcare teams in NS should welcome and socialize future practitioners to be interprofessional collaborators in a positive way. Interprofessional education, particularly interprofessional simulations, maybe a mechanism of enhancing ongoing socialization and development of a dual identity.

Until interprofessional socialization is understood through further research, there are a few recommendations that seem in order based on my study findings. The recommendations include: (1) recognition of the concept of welcoming, and how welcoming is conceptually understood by ELNs which is currently not explored in the IP literature; (2) studies to explore how, why, and in what circumstances ELNs transition into IP teams for the purpose of IPC as well as what HCPs can do to enhance welcoming; and (3) study and inform the theoretical positioning and underlying assumptions of the *National Interprofessional Competency Framework* (CIHC, 2010) through the application of the framework in the practices of varying teams and practice environments that include transitioning ELNs.

Additionally, Khalili and Orchard (2020) suggest that the use of an interprofessional socialization framework holds merit. Now more than ever before, a transformation of nursing curricula is critical to the socialization of nursing's professional and interprofessional identity. Further research should focus on investigating interprofessional practice and learning interventions to influence IP socialization and IPC. Conducting a secondary analysis of qualitative data in this study to examine this issue around welcoming or unwelcoming IP teams is an opportunity.

Proposition # 3: Leading Collaboratively in Teams Requires Exploration

Cathy learned, with her nurse leader, to better demonstrate how nursing contributes to the team and the delivery of care. "*Working as a nurse it requires me to work alongside many HCP in ensuring patients' needs are met. I believe that my preceptor showed me effective IPC. I have seen this firsthand.*" Other participants shared experiences in their role as collaborators alongside other team members.

In the role of collaborator, nurses are tasked with leading and diffusing collaborative efforts with all members of the IP team (NSCN, 2020). Participants spoke about nurses as leaders and mediators and their influence on IPC. While participants spoke about leadership experiences, few discussed their independent role in spreading IPC among the team. This was more commonly described in a mentored or preceptorship experience, often under the guidance of a mediator. This perspective is validated by a recent qualitative study conducted by vanDuin and colleagues (2022). Without the role of a mediator, new HCPs struggle to bridge the gap between themselves and the interprofessional team, preventing IPC and were left wandering the landscape of practice feeling isolated (vanDuin et al., 2022). In my study, the role of the mediator was key in fostering IPC and participants more commonly described leading with

nurses versus with other members of the healthcare team.

Bozorghadad and colleagues (2020) describe this tendency as professional tribalism that may inhibit collaborative leadership. This was echoed in research conducted by Almost (2021), Orchard and colleagues (2016) and is also a perspective shared by Weller (2012). Given the interprofessional evidence to date and my study findings, several opportunities exist. I present three. First, to engage in an exploration into the tendency of professional tribalism with ELNs, inclusive of evidence on fault lines in complex team structures and the leadership attributes and competencies required and later, the potential impact on ELN experiences with IPC. Secondly, this new knowledge can inform re-thinking interprofessional practice and learning and collaborative leadership in relation with competencies as defined by CHIC (2010). Third, while it may not be reasonable to expect educational institutions to provide evidence of an impact on post qualifications organizations, opportunities for cross-sectoral collaborative leadership in research exists (McNaughton, 2018; Price et al., 2020). The task now is to challenge deeply-held beliefs and reconsider the way in which collaborative leadership is conceptualized and lived out in interprofessional practice, learning and research. The shift may explicate historical and deep-seated values that contribute to fault lines in IP teams influencing the quality of IPC and how ELNs are socialized professionally and interprofessionally in NS.

Proposition # 4: Inquiry into New Nurse Experiences during the COVID 19 Pandemic

When asked the final interview questions, participants noted several recommendations for researchers, educators, and healthcare leaders. Several contextual influences came into play, most notably the COVID 19 pandemic. Participants described the pandemic experience in ways that changed them as individuals, nurses, and team members. While the navigation of nurse transition has been well studied (Benner, 1984; Duchscher, 2012; Duchscher et al., 2021), an

opportunity exists to examine new nurse intra-pandemic experiences while transitioning to professional and interprofessional practice.

Specifically, participants described (1) fractured learning experiences (e.g., incomplete clinical placements); (2) an increase in the movement of nurses (e.g., short- and long-term and travel assignments); (3) increased workload (e.g., working short staffed); (4) impact on mental and physical wellbeing (e.g., descriptions of being stressed, anxious and physically harmed); (5) an increase in self-preservation behaviors, resulting in a lack of IPC (e.g., getting through the day); (6) lack of trust in leaders (e.g., absence of leadership); (7) feeling like they were *tossed in the deep end and expected to swim*; (8) enhanced IPE to facilitate IPC (e.g., in-situ simulation); and (9) revisiting nursing recruitment and retention (e.g., the missed nurse leader and aftermath). Many of these experiences require deeper exploration.

Participant experiences demonstrate significant moments of ambiguity and at times, describe less than ideal circumstances. Amidst the pandemic, I have experienced that there are fewer 'hard and fast' rules due to many unique situations. Entry Level Nurses, similarly, describe being placed in scenarios with unclear circumstances. Complexity called forth during the COVID 19 pandemic created a lack of stability for new and experienced nurses (Duchscher et al., 2021). Interestingly, in the midst of this new complexity, ELNs raised the notion of 'having luck' when stability and predictability was experienced. The Nova Scotia College of Nursing (2020) calls upon registered nurses to become more involved in team-based care at a time with less predictability or higher complexity. In a qualitative study, Sargent and colleagues (2008) describe that for effective IPC and team-based care to occur, simply having contact with other HCPs is not enough. When more experienced HCPs stressed the need for time to achieve IPC, newer HCP expressed some surprise at the amount of work that was required (Sargent et al.,

2008). Interprofessional teams have intertwined intentions and activities (Story et al., 2021). Ambiguity and lack of stability can bring an IP team closer to achieving IPC or pull them apart (Brennan et al., 2021; Ong et al., 2019). Relying on 'luck" or chance encounters with other HCPs to enact IPC is problematic (Sargent et al., 2008).

Below are some of the most pressing issues and recommendations in relation to luck, complexity, and ELN experiences with IPC. Urgently, research into instruction of undergraduate nurses in complex circumstances through a trajectory of time is needed, where structured conversations and debriefs become a critical opportunity to teach, learn, and follow up once they enter practice. Secondly, a review and revision of the foundational definitions of complexity as noted in theoretical and regulatory frameworks used in NS healthcare, for example the *National IP Competency Framework* (CIHC, 2010), Duchscher's (2009) *Transition Shock Framework* and NSCN (2020) *Entry Level Competencies for the practice of Registered Nurses*. Each framework contains assumptions, variables and notions around complexity. Rigorous evidence related to intra-pandemic complexity in nursing practice, especially entry level practice would greatly add evidence to inform practice.

Research has advanced our understanding of IPC from practice and learning perspectives (Best et al., 2019; Hepp et al., 2015; IPEC, 2016; Khalili et al., 2019; Reeves et al., 2013). In many ways, participant experiences have shone a light on several barriers to fruitful IPC. With that in mind, one further recommendation at the level of practice. The situation of having a lack of evidence-based strategies that focus on barriers, along with the short- and long-term impact of IPE on ELNs in IPC (McNaughton, 2018), continues. Disconnects between academia and practice are already identified in the literature (Best et al., 2019; Hepp et al., 2015; IPEC, 2016; Khalili et al., 2019; McNaughton, 2018; Reeves et al., 2013). Has an even greater divide been

created? If so, is it understood and could this contribute to ELN's description of 'having luck'?

The International Council of Nurses (2020) reported that approximately 90% of nurses are concerned with their workload, stress, and burnout related o the COVID 19 pandemic. Additionally, 20% of national nursing associations worldwide reported an increase in nurses leaving the profession in 2020 as well as an increase in intention to leave (ICN, 2020). To address the shortage anticipated by 2030 in all countries, the World Health Organization (2020) suggests the total number of nurse graduates would need to increase by 8% per year on average, alongside an improved capacity to recruit and retain these graduates. The COVID 19 pandemic has highlighted the urgency that is needed to address these alarming trends in nursing, especially from the viewpoint of ELNs in unpredictable practice circumstances while attempting to achieve IPC. Barriers to IPC emerged strongly from my research, suggesting that more quantitative, qualitative and mixed-methods studies may be needed to clarify long term impacts. Rigorous evidence related to the impact of the COVID 19 pandemic on nursing practice, especially entry level practice is required.

Conclusion

Today's healthcare milieu of multiple care providers and complex treatment regimens demands the active participation from nurses and all members of the interprofessional team including the patient and family (Accreditation Canada, 2019). Interprofessional collaboration is an essential component in the delivery of nursing care. The *State of the World's Nursing 2020* report (WHO, 2020) proclaims the healthcare system needs RNs working to their full extent of their education and the maximization of their roles within IP teams (WHO, 2020). The Nova Scotia College of Nursing 2020) defines an RN as a collaborator needed for optimal IPC.

Until now, little was known about how ELNs experience IPC in NS IP teams. This ID

study sought a greater understanding of ELN experiences. The overarching research question guiding this study was: what are the experiences of ELNs in relation to IPC in IP teams in Nova Scotia? Subsumed under this overarching question was a set of subsidiary questions that reflect the inquiry and analysis required to develop a more comprehensive understanding of IPC across ELN and aggregate perspectives.

Thematic analysis of 15 interviews gave voice to ELNs working in healthcare teams in NS. Four main themes surfaced from the interviews. They were described as: (1) *emotions linked to IPC,* (2) *team characteristics,* (3) *development of IPC competency,* and (4) *contextual influences on IPC*. Several sub-themes were noticed and discussed. Interpretation and refinement of these categories happened and reflect: (1) analytical insight about themes related to ELN experiences with IPC (Thorne, 2016) in NS IP teams and (2) my disciplinary perspective. A series of propositions were discussed and represent some of the most pressing concerns in nursing and interprofessional practice. The study highlighted the importance of how, for ELNs, (1) enacting nursing's professional role is influenced by emotions; (2) interprofessional socialization impacts interprofessional collaboration; (3) leading collaboratively in teams requires exploration; and (4) inquiry into ELN's experiences during the COVID 19 pandemic is critical. Future work that is grounded in practice is required to generate a new understanding of IPC (definitions and frameworks) that guide ELN practice.

Researchers, educators, and health system leaders need to break from historic ways of thinking (Grant et al., 2016) to inform practice and some of the challenges faced in nursing, IPC and other. The current approach to IPE and IPC, while necessary, is not sufficient to address existing needs of ELNs in this study. Multiple calls for nursing to become more interprofessional have happened and are partially answered (CNA,2012; ICN, 2020; NCSN,

2020). The slow progress made in nursing has resulted in a widening of a competency and complexity gap felt by newly graduated RNs in practice (Stevenson et al., 2021). This places exponential pressure on ELNs to perform with or without the support of leaders (Almost, 2021). Nursing leaders who enact collaborative leadership play a significant role in ensuring ELNs and IP teams have a place to grow, particularly within their first years of professional and interprofessional practice (Almost, 2021; Dushscher et al., 2021; Stevenson et al., 2021).

There is an urgent need for researchers, educators, and healthcare leaders to advocate for newly graduated registered nurses in the healthcare system in the continued response and recovery from the COVID 19 pandemic (Dushscher et al., 2021). New nursing knowledge and pedagogical approaches are required to advance the profession from silo thinking to enhanced IPC. Nurses can lead the path forward only when IPC is central to the approach. The COVID 19 pandemic has highlighted the urgency that is needed to address these alarming trends in practice, especially from the viewpoint of ELNs in unpredictable team circumstances while attempting to achieve IPC. This study opens the possibility for further dialogue about the impact of the pandemic on IPC and IPE on ELNs.

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Appendix A: Memo to Managers/ Directors

Study: Interprofessional Collaboration: An Inquiry in the Experiences of Entry Level Nurses using Interpretive Description.

What is this all about? This is a qualitative study designed to expand our understanding of ELN's experiences with IPC when working in healthcare teams in Nova Scotia. An insight into these experiences will be helpful in framing how best to support newly transitioning nurses working in healthcare teams within Nova Scotia.

Who is conducting the research and who are the potential participants? Under the supervisions of Dr. Vera Caine and Dr. Susan Sommerfeldt, Cindy MacQuarrie RN MN, a graduate student at the University of Alberta Faculty of Nursing, will be conducting this research as part of her graduation requirements and would appreciate our help in identify potential participants for the study. Potential participants must be over the age of 18, English speaking and cognitively capable of providing informed consent. The study involves a one on one face to face interviews that are approximately 60-90 minutes in length.

What am I asking you to do? Identify participants, provide them with a letter that outlines the research and ask their permission for me to contact them with more information about the study and seek their permission to participate.

How will this benefit me? I am planning to hold a focus group after all the data has been collected to get your feedback about the findings and their relevance to your practice. I will ask for your input about dissemination of the findings and recommendations for future research.

Any questions? Contact me! Phone: 902-258-5554 or email: cmacquar@ualberta.ca

Appendix B: Letter of Introduction for Participant

Study: Interprofessional Collaboration: An Inquiry in the Experiences of Entry Level Nurses using Interpretive Description.

A study to better understand the experiences of Entry Level Nurses (ELN) with interprofessional collaboration when working as a member of a health care team in Nova Scotia. It is hoped that the information that is collected in the study will be useful to improve interprofessional collaboration and support for ELNs working in teams for the first time.

The nurse researcher who is conducting this study is Cindy MacQuarrie. She is a nurse and is presently a student in the PhD program at the Faculty of Nursing at the University of Alberta. This study is part of her graduation requirements although she is determined to make sure that any data she collects is shared with you and with others in the community to ensure that you get the best support possible.

As an entry level practitioner in Nova Scotia, you are a potential participant for this study. If you are willing to give up 60-90 minutes of your time to participate in a confidential interview with Ms. MacQuarrie please let a member of the staff know and they will provide you with Ms. MacQuarrie contact information.

Please be assured that whatever your decision is about the study, it will not impact on your employment or transition into professional practice. You have the right to refuse to participate.

Thank you for giving this your consideration.

Appendix C: Entry Level Nurse Interview Questions

1. First let me tell you a little about myself and why I want to do this study.

2. Can you tell me a little about yourself – where are you from, what got you into this field of work, how long have you been doing it, what did you do before?

3. What is it like to be an Entry Level Nurse (ELN) in Nova Scotia? Tell me about your experiences working as a member of a healthcare team.

4. What positive experiences have you had? What factors influenced this experience?

5. Describe a challenging experience when working as a member of a healthcare team? What factors influenced this experience?

6. Based on the experiences (shared in 4 and 5), how do you approach IPC?

7. How do you think the healthcare team makes a difference in patient's/families lives in NS?

8. Does your education provide you with an adequate background to work as a member of the healthcare team? What else do you see as necessary?

9. What do healthcare leaders from in and outside of NS need to know about in relation to your experience with interprofessional collaboration and teamwork? (what is working and what may need to change?)

10. If there was one thing you could change about your approach to IPC and teamwork what would that be?

11. Is there anything you would like to ask me?

12. Once I have collected all the information, I plan to share my findings with ELNs. May I contact you to participate?

Appendix D: Informed Consent

Title of the study: Interprofessional Collaboration: An Inquiry into the Experiences of Entry Level Nurses using Interpretive Description.

Principal Investigator	**Co-Supervisor**	**Supervisor**
Cynthia MacQuarrie Faculty of Nursing ECHA 5-021 University of Alberta Edmonton, AB Phone: Email: cmacquar@ualberta.ca	Dr. Susan Sommerfeldt Assistant Professor Faculty of Nursing ECHA 5-258 University of Alberta Phone: 780.492.9509 Email: ss13@ualberta.ca	Dr. Vera Caine Professor Faculty of Nursing ECHA 5-021 University of Alberta Phone: 780.248.1974 Email: vcaine@ualberta.ca

Invitation to Participate: You have been invited to take part in a research study. A research study is a way of gathering information and to answer a question about something that is not well understood. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

Purpose of the Study: You are being invited to participate because you are an Entry Level Nurse (ELN) employed by one of the healthcare employers in Nova Scotia and you work with an interprofessional team that is composed of two or more health care providers. I am looking to gain a greater understanding of ELNs experience with interprofessional collaboration when working in healthcare teams in Nova Scotia. The findings may also be helpful in the province and outside because of a gap in current research in this area.

Participation: It is anticipated that at least 15 ELNs will participate in this study throughout Nova Scotia. The length of this study for participants is a single interview that will take about 60 to 90 minutes. The entire study is expected to take about 12-18 months to complete and the

results should be known in 2 years. The University of Alberta requires that I must fully explain to you the details of this inquiry, the terms of your involvement, and any expected risks and benefits before you sign the attached form and give your consent to participate. You are under no obligation to participate. If you choose to participate, your participation in the study is voluntary. You can refuse to participate or withdraw from the study at any time without any consequences.

Study procedures: The purpose of the interview is to best understand the experiences of ELNs with interprofessional collaboration when working in healthcare teams. This will be accomplished by the one on one interviews and one additional focus group scheduled after all interviews are complete. Virtual conversations (Skype Business) will happen if face to face meetings cannot be arranged. One on one face to face interviews will occur at a mutually agreed upon geographic location. The interviews will be audio taped. Audio taped materials will be stored in a secure location. You may contact me after the interview if follow up is needed.

Benefits: There are no personal benefits to participating in this study. Participating in this study will provide you with an opportunity to share your story and thus contribute towards a greater understanding.

Risks: There are no known risks or any anticipated discomforts to participating in this study. You may refuse to answer questions or stop the interview at any time if you experience any discomfort.

Confidentiality and Anonymity: Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. If the results of this study are presented to the public, nobody will be able to tell that you were in the study. However, complete privacy cannot be guaranteed. I will keep the information confidential, to the extent permitted by applicable laws. Even though the risk of identifying you from the study data is very small, it can never be eliminated.

Data Storage: All word documents – transcripts, journal notes will be kept in a locked filing cabinet. Electronic copies of conversation transcripts will be encrypted and stored on a password protected computer. All study documents will be kept for a minimum period of *5* years according to the University of Alberta policy.

Compensation (or Reimbursement): I will also provide coffee, tea, and small snacks if we meet in person.

Information about the Study Results: When the study is completed, I will provide a summary of the inquiry outcome. If you would like to receive a copy, please let me know by indicating your mail or email in the space below.

Address: _____

_____

Email Address: _____

Your completion and signing of this form indicate that you have understood the information regarding participation in this inquiry and your consent to participate.

Contact Information: If you have any questions or require more information about the study itself, you may contact the researcher at the numbers indicated above.

The plan for this study has been reviewed and approved by the Research Ethics Review Board at the University of Alberta. If you have any questions regarding your rights as a research participant or how the research is being conducted, you may contact the Research Ethics Office at 780-492-2615.

Consent:

I agree to participate in the study. YES NO

I give my permission for the research to be used beyond the dissertation project, in presentations, and in other forms such as academic journals. YES NO

Name: _____

Date: _____

Signature: _____

Please keep a copy of this form for your records.