

Collaborative practice: A grounded theory of connecting in community rehabilitation

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Attestation of authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge, it contains no material previously published or written by any other person, nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

A handwritten signature in black ink, appearing to read 'Pauline Penney', with a long horizontal stroke and a large, stylized 'P'.

Pauline Penney

Dated: 16th October 2013

Formatting

This thesis was formatted using the American Psychological Association (APA) style, 6th Edition (2010). To aid clarity, in the findings and discussion chapters (Chapters 5-9), the concepts and theoretical categories are identified using different font styles, as in Table 1 below. Common abbreviations used within the thesis are identified in Table 2.

Table 1: Fonts delineating conceptual ideas

Theoretical element	Font style	Example
The theory and central challenge	Times New Roman, 12 point, bold	Connecting Complexity management
Major theoretical category	Times New Roman, 12 point, underline	<u>Liaising</u>
Sub category	Times New Roman, 12 point, italic, underline	<i><u>Interacting</u></i>
Substantive code	Times New Roman, 11 point, italic	<i>Formal relating</i>

Table 2: List of abbreviations

Term	Abbreviation
Accident Compensation Corporation	ACC
Constructivist grounded theory	CGT
Healthcare worker	HCW
Interprofessional collaboration	IPC
Interprofessional education	IPE
Interprofessional learning	IPL
Ministry of Health	MoH
Symbolic interactionism	SI
World Health Organization	WHO

Glossary

Abductive reasoning

Abductive reasoning is a methodological tool used in grounded theory. It provides a means of moving away from the data to consider all theoretical explanations for a group of behaviours. The researcher starts with the data, considers all possible explanations, makes hypotheses for these explanations then rechecks them against the data. From that point the most plausible explanation is followed (Bryant & Charmaz, 2007a)

Coding

Coding provides a means of managing data, breaking it down by defining portions of data, capturing patterns and clustering them under suggestive titles (Charmaz, 2006; Lempert, 2007). Coding defines what is happening in the data. Two main types of coding are used in constructivist grounded theory: initial coding to label the data, followed by focused coding to sort and develop categories when comparing data. Theoretical coding is also used by some authors as a third stage of coding during the final analysis stage (Charmaz, 2006).

Collaborative practice (CP)

The WHO's definition of collaborative practice in healthcare is the same as that of IPC. Throughout this study the terms are used interchangeably, however preference is given to the term 'collaborative practice' as the label that participants used and responded to most readily.

IPC occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings. (World Health Organization, 2010d, p. 9)

Constant comparative analysis

Constant comparative analysis is the main analytical tool used in grounded theory and distinguishes grounded theory from other methods. In constant comparative analysis, data collection and analysis occur concurrently. This form of analysis uses inductive processes to move between data and emerging analytical ideas, comparing data with data; data with categories, categories with other categories and categories with concepts (Charmaz, 2006). The constant movement between data and analysis assists in

developing categories which are both abstract theoretical notions that are also grounded in participants' data.

Constructivism

Constructivism is a term with multiple meanings. In this thesis, it is considered as an epistemological position whereby 'truth, or meaning, comes into existence out of our engagement with the realities in our world' (Crotty, 1998, p. 8). That is, constructivism assumes that people construct the realities in which they participate. Hence, constructivist research explores how people construct their experiences. To do this, researchers enter the phenomenon, gain multiple views of it, and locate it in its varied contexts. Because researchers are considered a part of that process, constructivists acknowledge that their interpretation of the phenomenon is a co-construction made with participants and represents one possible interpretation, rather than an absolute truth (Charmaz, 2006).

Disability

The construct of disability is multifaceted. In this study, the term reflects a common clinical interpretation of the word, based on the classification within the International Classification of Functioning, Disability and Health (ICF): 'Disability is an umbrella term for impairments, activity limitations or participation restrictions' (World Health Organization, 2001, p. 3).

Epistemology

Epistemology is the study of knowledge. Specifically, it relates to one's beliefs about the nature of knowledge and how it is possible to know what we know (Crotty, 1998; Setup, 2012).

Healthcare worker (HCW)

In this study, the term HCW is based on the WHO's understanding: 'A health [care] worker is a wholly inclusive term, which refers to all people engaged in actions whose primary intent, is to enhance health. Included in this definition are those who promote and preserve health, those who diagnose and treat disease, health management and support workers, professionals with discrete/unique areas of competence, whether regulated or non-regulated, conventional or complementary' (World Health Organization, 2010d, p. 13).

Interprofessional Collaboration (IPC)

This term has multiple definitions in the literature. The definition used in this study is based on the consensus reached by the WHO: 'IPC occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings' (World Health Organization, 2010d, p. 9).

Interprofessional education (IPE) and interprofessional learning (IPL)

Interprofessional education is defined as: 'Occurrences when two or more professions learn from, with and about each other to enable effective collaboration and improve health outcomes' (Interprofessional Curriculum Renewal Consortium, 2013, p. 13; World Health Organization, 2010d). This can happen at both under-graduate and post-graduate levels, although the literature predominately focuses on under-graduate IPE. Recently, the term IPE has also been used interchangeably with 'interprofessional learning' (IPL), although there are differences between the labels.

IPL is defined as 'learning arising from interaction between members (or students) of two professions. This may be a product of interprofessional education or happen spontaneously in the workplace or in education settings' (Interprofessional Curriculum Renewal Consortium, 2013, p. 5).

Memo writing

Memo writing is considered a crucial step in grounded theory, providing the link between data collection and theory development (Birks & Mills, 2011; Bryant & Charmaz, 2007b). Memos are 'uniquely complex research tools' (Lempert, 2007, p. 245) used in a variety of ways throughout research from free jotting of ideas, through to conceptual linking and theory development. Utilised throughout the research process, memoing keeps the researcher engaging and questioning their analyses, which increases the abstraction and depth of their ideas (Bryant & Charmaz, 2007b).

Ontology

Ontology is the study of being and existence. Ontology relates to how one perceives the nature of reality, and in social science, the nature and structure of social reality (Crotty, 2003).

Rehabilitation

The definition of rehabilitation in this study is based around the parameters of the WHO International Classification of Functioning, Disability, and Health (ICF) (World Health Organization, 2001). Within the ICF model, rehabilitation is considered as a person-centred process that enables people with disabilities to reach their maximal physical, sensory, cognitive, and social functional levels, through measures which support optimisation of bodily function, activities, and participation (World Health Organization, 2001). My views of rehabilitation also draw on McKenzie's comments that rehabilitation is 'a problem-solving, educative and collaborative process, aimed at restoring well-being and independence' (McKenzie, 2002, p. 2). Rehabilitation is understood as more than a clinical method, but rather a holistic process that enables individuals with impairments to reach their optimum functional levels.

Theoretical Sampling

Theoretical sampling is a data collection tool undertaken in the mid and later stages of research when initial categories have been developed. In this process, the researcher actively seeks data and participants that may add depth or variation to their emerging categories, rather than randomly sampling or looking for representative populations (Birks & Mills, 2011; Glaser & Strauss, 1967).

Theoretical Sensitivity

Theoretical sensitivity refers to the researcher's ability to recognise and extract from the data elements that have relevance for the developing concepts (Birks & Mills, 2011, p. 59). Glaser and Strauss (1967) considered theoretical sensitivity an important aspect of grounded theory that was contingent on the researcher's ability to have theoretical insight into his area of research, combined with an ability to make something of his insights (p.46). It includes two components: baseline theoretical sensitivity and theoretical sensitivity developed through the course of the research. Baseline theoretical sensitivity consists of the a priori personal and professional experiences of the researcher, combined with the theoretical knowledge they bring to the area under study. This baseline sensitivity is enhanced by various tools and strategies that researchers use throughout the research to recognise and follow conceptual leads in data collection and analysis.

Teamwork

The definition for teamwork used in this study reflects ideals of collaboration and a shared purpose between HCWs. Xyrichis and Ream's (2008) description provides a useful understanding of teamwork within this context:

Teamworking is a dynamic process involving two or more healthcare professionals with complementary backgrounds and skills, sharing common health goals and exercising concerted physical and mental effort in assessing, planning, or evaluating patient care. This is accomplished through inter-dependent collaboration, open communication and shared decision-making, and generates value-added patient, organisational and staff outcomes (Xyrichis & Ream, 2008, p. 232).

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I was fortunate to be awarded a Vice-Chancellor's Scholarship through AUT University. The funding this provided enabled me to reduce my clinical work-load and focus on the research. AUT University also supported me to travel and present my study findings at the NZ Rehabilitation Conference in Nelson, 2013. I am very appreciative of their backing.

I am also grateful to the UK based Centre for the Advancement of Interprofessional Education (CAIPE) that sponsored my attendance at the World Congress on IPC in Sydney, 2010. This experience came at the beginning of my research, and provided a wonderful opportunity to learn from experts in the field.

Next, I would like to acknowledge the participants in this study. These people gave so generously of their time and trusted me with their experiences. I am especially appreciative of the two teams who agreed to my observing interactions in their settings. I truly hope that the findings from this thesis can in turn give something back to this dedicated group of workers.

The support offered by the grounded theory group I attend has been a wonderful source of encouragement, ideas, and challenge. Thanks go in particular to Maria and Jo, friends and colleagues who provided support and were open in sharing their academic journey and knowledge. Thanks also to the other clinical and academic colleagues who have encouraged me along the way, asking useful questions and generously giving of their time and knowledge.

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My three sons have not really known a time when I was not studying in some form, but I know that over the last three years there have been sacrifices. Thanks Corey, David, and Dylan for putting up with the times when I missed a sporting event, couldn't go on a school trip, or was a distracted mother. Thanks too for dragging me away from the computer and helping me retain a sense of fun when I got too bogged down in work.

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Abstract

Worldwide, healthcare provision is under pressure. Increasing demand for services combined with a shortage of healthcare workers (HCWs) and resources means innovative ways of working are needed. Interprofessional collaborative practice provides one way of managing this need, with research indicating benefits for clients, teamwork, and resource management. Despite this, errors in interprofessional working continue to occur in practice. The consequences of this are not only resource inefficiency, but also adverse client events, with many examples of failures in interprofessional working highlighted in reports from the New Zealand Health and Disability Commission and other international patient safety reports. Therefore, developing understanding of collaborative practice is an important area of research. While previous studies have explored collaborative practice in the areas of hospital care, in-patient rehabilitation, mental health, and palliative care, less is known about collaboration in the community setting. To rectify this knowledge gap, this constructivist grounded theory provides a theoretical explanation of collaborative practice in community settings, which can be used to inform clinical practice, education, and further research.

Data was gathered from 39 interviews of HCWs, and from 22 hours of field observations with two rehabilitation teams. This was then analysed using constant comparative analysis. From the analysis a substantive theory of connecting was constructed, its three main theoretical categories being liaising, forming-reforming, and guarding behaviours.

Three key findings emerged that contribute new knowledge to the field. Firstly, the central challenge HCWs faced in interprofessional community work was found to be complexity management. This involved managing the interlinked areas of client complexity, relational complexity, and situational complexity. Secondly, connecting was established as an essential process HCWs used in order to enhance collaboration and manage the different aspects of complexity in community work. Thirdly, it was clear in the research that interprofessional work in the community necessarily encompasses interagency work. The latter was poorly coordinated however, producing barriers to collaborative practice that resulted in clients and their families often needing to coordinate their own care across agencies.

The research findings lead to some important conclusions for future health workforce development. Enabling interprofessional work in the community health environment requires clear processes and structures that enhance collaborative practice. However, these processes and structures were understood and operationalised differently by workers and team leaders. The processes also differed from the approach reflected in policy documents. The theory of connecting developed in this research assists in clarifying these differences, and contributes to knowledge by explaining the context, strategies and perspectives HCWs use that result in improved collaborative practice.

Chapter 1 Introduction

In the long history of humankind those who learned to collaborate and improvise most effectively have prevailed (Charles Darwin).

The rhetoric of collaboration has been around for many years (World Health Organization, 1978), with varied understandings and definitions. In this study, collaborative practice is understood as two or more healthcare workers (HCWs) working together with each other, with clients, families, and other services in order to improve health outcomes. This opening chapter introduces the topic of collaborative practice, clarifies key terms, and identifies the aims, purpose, and rationale for the study. This is followed with a background section establishing the context in which the research was situated and an outline of the thesis structure.

Over the last two decades, collaborative practice has received widespread acceptance as a means of optimising healthcare provision (Croker, Trede, & Higgs, 2012; Gilbert, 2010; Sinclair, Lingard, & Mohabeer, 2009; Zwarenstein et al., 2009). However, whereas collaborative practice is lauded as a solution for workforce shortages, more effective teamwork (World Health Organization, 2010d) and modernising the health service (Day, 2006), on a practical level problems exist. Errors in interprofessional working continue to occur, with a lack of collaboration contributing to compromised client safety (Jackson, 2011; Lingard et al., 2012a; West, Guthrie, Dawson, Borrill, & Carter, 2006). The results of this are not just resource inefficiency, but also adverse client events and outcomes (Canadian Medical Protective Association, 2006; Suter et al., 2009).

In order to address problems with collaborative practice, it is important to understand how HCWs practice interprofessionally and the issues that influence their interactions and behaviours. This is important because changes in the social, political, and economic context mean that HCWs and teams need to work differently (Copnell, 2010; Gittell, Godfrey, & Thistlethwaite, 2013). In common with many Western nations, New Zealand faces a challenge in needing to manage burgeoning health needs in a context where there is a shortage of skilled HCWs and limited resources (Health Workforce New Zealand, 2011). The New Zealand Ministry of Health has responded to the increasing pressure on resources in several ways. While initially slow to embrace collaborative practices, shifts in policy now endorse interprofessional collaboration as a

resource efficiency solution (Ministry of Health, 2008). Additionally, efficiencies are sought through encouraging healthcare provision in the community, rather than hospital settings (Ministry of Health, 2008, 2011a). This has led to healthcare being undertaken in new ways and in a variety of settings (Health Workforce New Zealand, 2009).

The context of this study is HCWs providing rehabilitation services to clients through interprofessional work in community-based teams. This is significant from both a gap in knowledge and a methodological perspective (refer to Chapter 3). Rehabilitation is a process aimed at enabling people with disabilities to reach their optimum level of function, activity, and participation in society (World Health Organization, 2001; McKenzie, 2002; Wade, 2003), whilst curtailing healthcare costs and dependency (Kilbourne et al., 2008; Kuipers, Wirz, & Hartley, 2008). In the community setting, rehabilitation occurs as part of a sequence of healthcare, involving differing levels of health provision from primary to tertiary care. While rehabilitation is an established component of healthcare (Bachmann et al., 2010; Health Workforce New Zealand, 2011; Wade, 2005), the context of the community environment is less well understood, in terms of how rehabilitation HCWs collaborate in community teams and across agencies (Lukersmith et al., 2013). This is partly due to the difficulty of researching an area with so many variables and few standardised procedures for monitoring and evaluating rehabilitation practice (Finkenflugel, Wolffers, & Huijsman, 2005; Kuiper et al., 2008). Community rehabilitation is also underpinned by a complex working environment, in which differing healthcare professions and lay workers are required to work together in teams, but are frequently not co-located. The implications of this are discussed in subsequent chapters as they form the focus of this research.

1.1 Clarifying key terms

Words can have a variety of meanings in differing contexts. While a brief glossary is provided at the end of the thesis, the key terms used in this study are presented here to introduce the topics.

1.1.1 Interprofessional collaboration (IPC)

Interprofessional collaboration (IPC) is an umbrella term, developed over a period of forty years. While the term is sometimes considered in other contexts, such as business and political fields, the focus within this study is on IPC between HCWs in community settings. The current IPC definition from the World Health Organization (WHO) (2010d) represents a consensus of understanding within healthcare, and is the baseline definition used in this study.

Interprofessional collaboration occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers, and communities to deliver the highest quality of care across settings (World Health Organization, 2010d, p. 9).

The structures, processes, and outcomes of IPC are discussed in detail in Chapter 2.

1.1.2 Collaborative practice

The WHO definition of collaborative practice in healthcare is the same as that of IPC. As will be seen in Chapter 2, this overlap in terminology has made knowledge synthesis within the area difficult (Goldman, Zwarenstein, Bhattacharyya, & Reeves, 2009; Zwarenstein et al., 2009). At the start of the study, I followed the WHO lead in using the terms interchangeably, for example in the initial research questions. However, as the study progressed I noted participants favoured the term 'collaborative practice', and the label IPC was rarely used outside academic circles. The label of 'collaborative practice' seemed to better reflect participants' work with multiple individuals, rather than just other professionals, and aligned better with rehabilitation's person-centred approach. Consistent with the grounded theory approach of using participants' definitions of situations, I decided to preferentially use the term 'collaborative practice' when talking with participants and within the research findings. Therefore after Chapter 2, the term IPC is replaced with collaborative practice.

1.1.3 Rehabilitation

There are multiple meanings of the term 'rehabilitation' (Norrefalk, 2003). My understanding is based around the parameters of the WHO International Classification of Functioning, Disability and Health (ICF) (World Health Organization, 2001). Within the ICF model rehabilitation is considered as a person-centred process, which enables people with disabilities to reach their maximal physical, sensory, cognitive, and social functional levels, through measures which support optimisation of bodily function, activities, and participation (World Health Organization, 2001, p. 290). Essentially, the individual is viewed as a holistic being with their social, emotional, and contextual needs considered as part of their rehabilitation. This contributes to the complexity of community rehabilitative work, as will be seen later in the thesis.

The definition of rehabilitation also draws on McKenzie's views of rehabilitation as 'a problem-solving, educative and collaborative process aimed at restoring well-being and independence' (McKenzie, 2002, p. 2). McKenzie's definition is useful, as it ties in with the research focus by considering rehabilitation as a collaborative, problem-solving process, whereby flexibility and adaptability are needed, rather than a recipe-book approach to rehabilitation.

1.1.4 Community rehabilitation

Rehabilitation in the community context is a broad concept, incorporating the areas of health access, promotion, rehabilitation, education, livelihood, and social and disability empowerment (World Health Organization, 2010a, 2010b, 2010c). Community rehabilitation is executed through teamwork and collaboration. It includes 'the combined efforts of people with disabilities, their families, organisations and communities, relevant government and non-government health, education, vocational, social and other services' (World Health Organization, 2010b, p. 24).

Community rehabilitation often involves working across multiple environments, such as client homes, clinic settings, community gyms, or workplaces. This sets it apart from hospital or acute settings, where clients are seen in one consistent location. Clients undertaking community rehabilitation can be anywhere from days to many years post-injury or original health concern. Accordingly, community rehabilitation HCWs work under varying conditions with clients who are at different stages of rehabilitation (post-acute) than hospital-based HCWs.

1.1.5 Healthcare worker (HCW)

In the New Zealand health context, trained workers are usually referred to as health professionals. In this study, the broader term 'healthcare worker' (HCW) was used, allowing scope for non-professionally trained workers, who are often involved in community rehabilitation provision, to be included. The WHO description of a health worker aptly describes this term.

A health [care] worker is a wholly inclusive term, which refers to all people engaged in actions whose primary intent is to enhance health. Included in this definition are those who promote and preserve health, those who diagnose and treat disease, health management and support workers, professionals with discrete/unique areas of competence, whether regulated or non-regulated, conventional or complementary (World Health Organization, 2010d, p. 13).

1.1.6 Teamwork

There are many definitions of teamwork with varying meanings (Olupeliyawa, Hughes, & Balasooriya, 2009; Opie, 2000; Poulton, 2003; Reeves, Lewin, Espin, & Zwarenstein, 2010). As will be shown in Chapter 7, the concept of teamwork in this study is broad, as teams are considered to form and reform in a fluid manner around client need. Xyrichis and Ream (2008) consideration of teamwork as a dynamic process involving HCWs sharing common health goals and exercising concerted efforts in assessing and implementing patient care, resonates with the teamwork observed in this research. Similarly, the manner in which teamwork is accomplished 'through inter-dependent collaboration, open communication and shared decision-making' (Xyrichis & Ream, 2008, p. 232) fits with the focus of this study. The Xyrichis and Ream definition positions collaboration as a process that makes teamwork more effective. This is consistent with the core competencies for effective IPC (Canadian Interprofessional Health Collaborative [CIHC], 2010), suggesting the terms 'teamwork' and 'collaboration' are interdependent. In this study, the two terms are considered as independent notions that relate closely to one another.

1.2 Research aim

The aim of this research was to generate a theoretical explanation of collaborative practice in community rehabilitation. Grounded theory (Charmaz, 2000, 2006; Glaser & Strauss, 1967) was the methodological approach chosen for this study. This provided an inductive methodology that was useful in exploring social processes. The research questions used to guide the direction of this study were:

- How do healthcare workers view IPC in the community-based teams where they work?
- How do healthcare workers explain/construct their collaborative actions in community-based teams?
- In what circumstances do their actions change and why?

1.3 Purpose of the research

The variant of grounded theory used in this research was constructivist grounded theory (Charmaz, 2000, 2003, 2006, 2008, 2009). Constructivist grounded theory is contextual and recognises multiple different realities, rather than one definitive explanation for an issue. Following these principles, the purpose of this research was to construct a substantive theory that would provide an interpretive understanding of the ways in which HCWs practice interprofessionally in the community setting.

The research findings may inform future resource management and clinical practice both locally and internationally. Groups that may benefit from this study include community health teams, health funders, workforce and policy planners (e.g. Health Workforce New Zealand), and organisations that educate health professionals.

Contributing to the literature and developing knowledge in this area has the potential to ultimately improve the quality of interprofessional collaborative working, which may in turn benefit clients and impact health outcomes.

From a personal perspective, the purpose of undertaking this study arose from both personal interest and professional concerns. Initially, my interest in collaborative practice was shaped by my background of twenty years as a clinical physiotherapist. A decade ago, I experienced further exposure to collaborative concepts when I entered post-graduate study. My rehabilitation studies were undertaken in an environment where interprofessional learning was standard practice. Gaining new knowledge and

perspectives from differing health professionals cemented my preference for the interprofessional style of working. As I continued clinical work, and moved into leadership roles, I began to look more closely at how and why people collaborated, and observed what happened when collaboration worked well and equally when it did not. I saw issues with collaboration both within teams and across agencies, which drove my interest in studying the area further. As I shifted into community practice, my awareness that this area appeared to function in different ways from hospital-based healthcare grew, yet there was limited literature exploring these differences. Wanting to increase my understanding of IPC, I embarked on this research.

As a doctoral researcher, there was an element of personal exploration and growth through this research project. In the spirit of transparency, and as an audit trail, the research processes and decisions I made are discussed and critiqued throughout the thesis. In keeping with research convention, the study is predominately written in the third person narrative. However, as I consider myself a co-constructor in the research process (see Chapter 4), the personal pronoun is used when discussing the specific decisions I made.

1.4 Rationale for the study

As noted earlier, the literature around collaborative practice has grown substantially in recent decades. Despite this increasing knowledge base, at a clinical level errors and misunderstandings continue to occur with often serious consequences (Baldwin & Daugherty, 2008; Institute of Medicine, 2000; Leape & Berwick, 2005; Richardson & Storr, 2010). Examples of this include the deaths of 35 children at Bristol Royal Infirmary following errors in teamwork and interprofessional relationships (Bristol Royal Infirmary Inquiry, 2001) and the death of Baby P after communication breakdowns between services (Lord Laming, 2009). Reports from the New Zealand Health and Disability Commissioner (2009) reinforce international findings that failure of healthcare teams to use IPC effectively can result in client safety and quality of care issues. Conversely, improving understanding of collaborative processes has the potential to develop the effectiveness of service delivery and improve health outcomes for clients by minimising mistakes and improving communication (Suter & Deutschlander, 2010; World Health Organization, 2010d).

Increasing the efficiency and effectiveness of healthcare provision has recently developed heightened importance. The identified shortage of HCWs comes at a time when there is an ageing population with greater healthcare requirements, and technical advances mean people are surviving more serious health incidents (World Health Organization, 2010d). Increasingly, these healthcare needs will be met in the community setting, with policies in New Zealand and elsewhere favouring rehabilitation in primary care (McColl et al., 2009; Ministry of Health, 2011a; Taylor, Dalal, Jolly, Moxham, & Zawada, 2010).

As a result, there is a need to find innovative solutions to maximise the available resources and to work in ways that are more efficient. IPC is presented as a promising way of providing these sorely needed efficiencies, while ensuring that clients receive optimal care (Goldman et al., 2009). This study is important as it explores IPC in a context that has received limited attention. Previous literature has documented aspects of IPC competencies, capabilities, frameworks, procedures and outcomes (Canadian Interprofessional Health Collaborative, 2010; Interprofessional Education Collaborative [IPEC], 2011; Reeves et al., 2010; Suter et al., 2012; Walsh, Gordon, Marshall, Wilson, & Hunt, 2005; Willumsen, Ahgren, & Ødegård, 2012; Zwarenstein et al., 2009). The context of these studies has predominately focused on developing nations, hospital, in-patient rehabilitation, general practice, mental health, and palliative care. Less is known about collaborative practices in community rehabilitation settings, and there have been calls for further work in the field (Andersson, Ahgren, Axelsson, Eriksson, & Axelsson, 2011; Kendall et al., 2011; Malone, 2007; Ødegard & Strype, 2009; World Health Organization, 2010a, 2010d).

Additionally, there are limited theoretical models that provide a basis for developing collaboration in clinical practice (Lingard et al., 2012; Reeves, 2010; Reeves & Hean, 2013). Those theories that are in use tend to be drawn from other fields, with authors beginning to question whether such models accurately reflect and incorporate the complexity of healthcare teamwork (Lingard et al., 2012; Suter et al., 2009). In addition, New Zealand has been relatively slow to implement IPC policies (Workforce Taskforce, 2008). As a result, there is limited understanding of how the local workforce practises interprofessionally.

It is anticipated that this study will increase understanding of the collaborative processes HCWs use when working in the community. This knowledge may be used to inform clinical practice and healthcare education, support policy direction, and provide a platform for future research.

1.5 Background context

This section of the chapter provides background detailing the context of the research. Context is a strong thread in this study that is central to establishing the theory setting (Bryant & Charmaz, 2007b; Charmaz, 2006). Locating research in its setting is an important tenet of constructivist positioning, where meaning is understood as relative and conditional to a particular time and place (Bryant, 2002; Charmaz, 2003, 2006).

Community rehabilitation is influenced by a variety of contextual factors. At a macro level these consist of the New Zealand political context of healthcare systems, policies and direction, as well as the local cultural context. Contextual influences more directly focused on community rehabilitation include the development of rehabilitation services and the context of community rehabilitation funding and provision in New Zealand. These factors are explored in the following sections.

1.5.1 Political context

The political context of the New Zealand healthcare system has a strong influence on the development of collaboration in community healthcare. New Zealand's health and disability system is underpinned by a statutory framework comprising over twenty pieces of legislation, the most significant of which are the New Zealand Public Health and Disability Act 2000, the Health Act 1956, and the Crown Entities Act 2004. This framework establishes the structure underlying public health funding and the organisation of health services. At a macro level this entails the Ministry of Health (MoH) funding the twenty District Health Boards (DHBs) that are the vehicle for regional provision of health and disability services.

The majority of healthcare in New Zealand is funded through government expenditure (World Health Organization, n.d.), with payments by individuals and private insurers also playing a significant role in elective treatments. Hospital and specialist care is free for New Zealand citizens; while injury resulting from accidents is covered by the government funded Accident Compensation Corporation (ACC).

In New Zealand publicly funded community rehabilitation is a right for all, managed under the auspices of the MoH. The MoH sets strategic direction for community health and rehabilitative care through funding and policy. Arguably the two most influential policies affecting overall healthcare direction are the NZ Health Strategy (Ministry of Health, 2000) and the NZ Disability Strategy (Ministry of Health, 2001a). The NZ Health Strategy identifies seven core principles that should inform all health policies and developments, including community rehabilitation. The principles are:

ÉAcknowledging the special relationship between M ōri and the Crown under the Treaty of Waitangi.

ÉGood health and wellbeing for all New Zealanders throughout their lives.

ÉAn improvement in health status of those currently disadvantaged.

ÉCollaborative health promotion and disease and injury prevention by all sectors.

ÉTimely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay.

ÉA high-performing system in which people have confidence.

ÉActive involvement of consumers and communities at all levels (Ministry of Health, 2000, p. 7).

It is worth highlighting that the NZ Health Strategy includes collaborative health promotion as one of the key principles. This is not simply a suggestion, but a directive for collaborative practice arising from the highest level of policy. While the document does not define collaboration it does provide some indicators for action. For example one indicator aims to achieve ōa non-commercial, collaborative, and accountable environment that encourages cooperation on common goalsö (Ministry of Health, 2000, p. 3). Another directive aimed at mental health services emphasises the importance of collaboration between organisations, stating that ōhospital-based and community-based services must collaborate with each other and with non-governmental providersö (p. 22). Healthcare organisations are left in no doubt that collaborative practice is fundamental to community healthcare and rehabilitation in New Zealand.

The NZ Health Strategy is implemented through MoH directed priority areas, one of which currently includes the policy called ōBringing services closer to homeö (Ministry

of Health, 2001a, 2011b). This political directive supports making healthcare more accessible for clients in their local communities rather than hospital settings. This fits well with literature supporting community rehabilitation as effective practice (Dow, Black, Bremner, & Fearn, 2007; Ministry of Health, 2011a; Small, Green, Spink, & Young, 2009; Wottrich, Von Koch, & Tham, 2007).

Sitting alongside the NZ Health Strategy, the New Zealand Disability Strategy (Ministry of Health, 2001a) is another key driver of healthcare direction. Although launched over a decade ago, the NZ Disability Strategy provides the basis for major health reforms, which are still in operation today. The Disability Strategy comprises fifteen objectives with the overarching aim of working towards a fully inclusive society, where people with impairments can say they òlive in a society that highly values our lives and continually enhances our full participationö (Ministry of Health, 2001a, p. 1). Government departments are expected to consider the principles of the NZ Disability Strategy when developing any new healthcare policy in New Zealand. As will be seen later in this thesis, the Disability Strategy has relevance for this research, as it emphasises the notion of interagency collaboration within its objectives.

Objective 13.1: Ensure all agencies that support children, youth and families work collaboratively to ensure that their services are accessible, appropriate, and welcoming to disabled children, youth and their families (Ministry of Health, 2001a, p. 27)

Beneath the auspices of these two main directives, other significant government policies also influence community rehabilitation and provide context for understanding political influences on HCWs and organisations in this study. Relevant examples of this include the Primary Healthcare Strategy (Ministry of Health, 2001b), the Health of Older People Strategy (Ministry of Health, 2002b), the NZ Clinical Guidelines for Stroke Management (Stroke Foundation of New Zealand & New Zealand Guidelines Group., 2010), the Rehabilitation Workforce Service Forecast (Health Workforce New Zealand, 2011), and the Traumatic Brain Injury Guidelines (NZ Guidelines Group, 2007). These policies vary in their emphasis on collaborative practice. Overall though, policy direction can be viewed as advocating coordinated teamwork, communication, and collaboration between HCWs and organisations in rehabilitative practice.

Working beside, but independent of the MoH, the Health and Disability Commission also provides best practice guidelines for HCWs. Of relevance to this study, the NZ

Code of Health and Disability Services Consumer Rights (Health and Disability Commissioner, 2009) advocates for HCWs to work together to support service quality. Right 4(5) of this Code states: “Every consumer has the right to cooperation among providers to ensure quality and continuity of services” (Health and Disability Commissioner, 2009, p. 1). While cooperation is not the same as collaboration, the Act establishes an expectation of openness between HCWs, which can be used to foster collaborative practice. Consistent with the overarching NZ Health Strategy, the Consumer Rights Code applies to all Health and Disability services in New Zealand, regardless of funding streams.

While the major health strategies have been in place for over a decade, it is only recently that government focus has shifted to acknowledge that the desired collaboration between healthcare providers, especially between community and hospital settings, was lacking (Ministry of Health, 2011a). Policy reflecting the shift towards collaborative practice in the community is seen with the “Better, Sooner, More Convenient” primary care initiative, announced in 2009 (Ministry of Health, 2009). This framework supports changes enabling community healthcare provision to become more collaborative in areas such as information sharing between hospital and community services, and developing opportunities to work together across services. The aim of the initiative is to reduce barriers between services and create a continuous health service (Ministry of Health, 2011a).

As noted earlier, the shifting emphasis towards community healthcare is further highlighted with the MoH’s current identified focus area of “Bringing Services Closer to Home” (Ministry of Health, 2011b). Through these initiatives, the MoH is sending strong signals to providers that collaboration in local contexts is the way of the future. However, there is currently minimal training available for organisations to implement these directives. The MoH is instead encouraging health organisations to develop collaborative community schemes themselves (Ministry of Health, 2009, 2011a). As the results from these schemes emerge, training and discussion around best practice will need to be developed further. Meanwhile, the ministry-level interest in collaboration indicates that the findings of this thesis could have relevance at macro as well as micro levels.

Additionally, while this study is situated in a local context, the political focus on encouraging collaborative practice and rehabilitation within community settings is by no means unique to New Zealand. Worldwide, directives from international organisations such as the World Health Organization (World Health Organization, 2010a, 2010d, 2011, 2013; World Health Assembly, 2013) indicate an increasing drive to foster these practices across all nations. Policy documents from other Western nations indicate that collaborative issues in community care have been a focus for some time. For instance, a decade ago in Australia, health policy advocated for a 'regionally planned, coordinated and prioritized approach to all community health and rehabilitation issues' (Productivity Commission, 2003, p.8). Similarly, policy in the United Kingdom emphasised the drive for coordinated and collaborative rehabilitation in the community setting (National Health Service Scotland, 2007). Hence this research should have relevance across both local and international contexts.

1.5.2 Cultural context

The development of collaborative practice in community rehabilitation is also influenced by the cultural context. The very first principle of NZ's Health Strategy (Ministry of Health, 2000) is to acknowledge that a special relationship exists between Māori (the indigenous race of New Zealand) and the British Crown (the government of NZ). This relationship is one of partnership, with healthcare being enacted in a bicultural relationship unique to New Zealand. Biculturalism refers to the recognition of two official founding cultures within New Zealand - Māori and Pākehā (New Zealanders of European descent) (Callister, 2011; Durie, 2005). Partnership with Māori is embedded through New Zealand's founding document, the Treaty of Waitangi. Signed in 1840, the Treaty is an exchange of promises between the British Crown and Māori, which formed the basis on which New Zealand became a British colony. Although differing understandings of the Treaty exist, at the heart of the Treaty are three commonly agreed upon principles. These refer to the perpetual rights of Māori to full partnership and participation with, and protection by the British Crown (New Zealand Ministry for Culture and Heritage, n.d.). Partnership and participation ideals are enacted at government level through the principle of reasonable cooperation, where the intention is for consultation between Māori and Pākehā on all issues of common interest (Callister, 2011). Health researchers and practitioners have been rightly challenged to more explicitly consider their work beyond the legislative requirements of the Treaty, in order

to reduce long standing disparities in health outcomes for M ōri (Smith, 1999). This is important, as issues of partnership working have particular relevance to collaborative practice.

In this study, partnership issues are important not only because of NZ's specific cultural context, but also in the manner in which they link with broader collaborative principles. Government policy in both America and the United Kingdom for example, emphasises partnership as a guiding principle in collaboration between health organisations (Johnson, Wistow, Schulz, & Hardy, 2003). Similarly, D'Amour, Ferrada-Videla, San Martin-Rodriguez, and Beaulieu (2005), note partnership as a central concept within the collaboration literature, defining it as 'two or more actors joining in a collaborative undertaking' characterised by an authentic and constructive collegial relationship (p.118). This seems similar to the idea of reasonable cooperation within the Treaty of Waitangi principles, highlighting that although this research is situated in a specific cultural context, partnership issues have international relevance.

Within New Zealand, commitment to the Treaty of Waitangi is enshrined within modern health legislation, such as the NZ Health Strategy, which impacts on healthcare direction, provision, and training. More specifically, the NZ M ōri Health Strategy ō He Korowai Oranga (Ministry of Health, 2002a) builds on the NZ Health Strategy by providing detailed strategies on how M ōri health can be optimised through Treaty principles (Nikora, Karapu, Hickey, & Te Awakotuku, 2004). Utilising the Treaty notions of partnership to optimise healthcare aligns with and complements the international drive for collaborative practice (World Health Organization, 2008, 2010d).

While there are a multitude of ways in which M ōri perceive health and well-being, two important cultural considerations provide context for understanding community rehabilitation. Firstly, the family (*whānau*) holds a central place when considering M ōri health and is seen as an essential part of a person's recovery (Mead, 2003). This is acknowledged within health models such as the MoH funded *Whānau ora* (family health) initiative (Ministry of Health, 2011c), which aims to empower communities to support families within the community context, rather than individuals within an institutional context (Durie, 2013). The second consideration is that M ōri understanding of well-being is holistic and takes into consideration much more than the injury or disease process (Nikora et al., 2004). This is exemplified with the M ōri

notion of Whare Tapa Wha (Durie, 1998), a model equating good health with the four walls of a house, where the taha wairua (a person's spiritual side); taha hinengaro (thoughts and feelings); taha tinana (physical); and taha whānau (family) are of equal importance. Holistic ideas that consider all aspects of a person's health and well-being fit well with IPC competencies that encourage person-centred care, and working with a wide range of people to support clients (see Chapter 2).

The cultural context of healthcare is important for workers engaging with clients, and HCWs in New Zealand are expected to understand the different ways Māori view health and well-being. Cultural training is a component of undergraduate health programmes, which are also offered to HCWs by MoH-funded District Health Boards. However, despite training and policy directives promoting collaboration and partnership with Māori, it appears that transferring this understanding into clinical practice is not easily achieved. Māori continue to feel marginalised by health services (Harwood, 2010; Nikora et al., 2004; World Health Organization, 2008) and have poorer health outcomes (Harwood, 2010). It appears that further work needs to be undertaken to better understand how collaborative practices can be made more effective for Māori.

While legislation enshrines the unique bicultural partnership of New Zealand, another aspect of the cultural context is the growing cultural diversity, particularly in large cities. Auckland, where the study is located, has more Pasifika people (Pacific Islanders) than any other city in the world (Ministry of Pacific Island Affairs, 2009), and an increasing proportion of Asian people, all in a city of approximately one and a half million people. Over the next ten years, New Zealand is expected to become more ethnically diverse in terms of the numbers of people identifying as non-European (Statistics New Zealand, 2006). The changes are predicted to occur through people of European descent decreasing from 76.8 to 69.4%; Māori increasing from 14.9% to 16.6%; Pasifika increasing from 7.2% to 9.8% and Asian people increasing from 9.7% to 16.0% of the population (Statistics New Zealand, 2008). People of Middle Eastern/Latin American and African ethnicities will make up the remaining 1% of the population. This increase in diversity is relevant, as ethnic minorities are disproportionately represented across poor health indicators in New Zealand (Ministry of Health, 2007; World Health Organization, 2008). This is consequently reflected in the increased proportion of clients from ethnic minority groups engaging with healthcare (Human Rights Commission, 2012).

The growing population diversity also affects the cultural context of HCWs, with increasing numbers of workers trained outside New Zealand. Within the public health system for example, nearly half of NZ-based doctors currently come from overseas, while there is a proportional under-representation of Māori and Pasifika health workers (Health Workforce New Zealand, 2009). This is noteworthy as HCWs need to understand the cultural context in which they work. Without this knowledge, misunderstandings and barriers to collaborative practice can arise (Pullon, 2008; Quinlan & Robertson, 2010). Indeed a recent report by the Human Rights Commission goes so far as to state that racism and poor cultural understanding contributes to health inequality across ethnic groups (Human Rights Commission, 2012).

1.5.3 Rehabilitation and the service context

The links between rehabilitation and collaborative practice have not been fully explored. This is partly due to shifting understandings of rehabilitative practice as the field has developed. While rehabilitation is perceived as a relatively new field within healthcare, the term has been in use internationally since at least the late 1930s (Opitz, Folz, Gelfman, & Peters, 1997). In the local health context, rehabilitation initially struggled to establish itself as a specialty, tending to be viewed as the poor cousin of traditional medicine (Moore, 1995). Up until the 1990s, the lack of a common rehabilitative language and guiding principles meant proponents frequently struggled to have a cohesive voice, resulting in less influence over funding decisions (Wade, 1992). The rather broad definition of rehabilitation espoused by the WHO (2001) demonstrates this ambiguity, with its statement that rehabilitation “includes a wide range of measures and activities from more basic and general rehabilitation to goal-oriented activities” (World Health Organization, 2001, p. 290). Importantly, collaboration was not mentioned at all in this definition.

Over the last decade, the profile of rehabilitation has improved, with the joint position statement from the Australasian Faculty of Rehabilitation Medicine, and NZ Rehabilitation Association (2011) demonstrating a clearer vision, and highlighting that coordinated and collaborative teamwork processes are an important component within the rehabilitation service context. This position is reflected in the expanding literature base exploring links between collaborative practice and rehabilitation (Crocker et al., 2012; Dean & Ballinger, 2012; Körner, 2010; Sinclair et al., 2009).

Locally, the importance of rehabilitation within the health service context has also been strengthened by a rising awareness of disability issues within legislation (Ministry of Health, 2012; Ministry of Health, 2001a, 2008). There is mounting evidence that rehabilitation improves quality of life and reduces long term dependency and care costs (Bachmann et al., 2010; Brasure et al., 2013; Cicerone et al., 2011; Lacasse, Martin, Lasserson, & Goldstein, 2007; Rosewilliam, Roskell, & Pandyan, 2011).

Despite the increasing prominence of rehabilitation, currently there is no comprehensive rehabilitation system in place in New Zealand (Health Workforce New Zealand, 2011). The rehabilitation service context is one of varying funding, practice, and collaborative models across regions, meaning clients do not receive equity of service nationwide. In a move to address this, the Australasian Federation of Rehabilitation Medicine and the NZ Rehabilitation Association recently banded together to plan the development of a national rehabilitation strategy (Health Workforce New Zealand, 2011). The aim of this work is to have a focal point for developing cohesive rehabilitation standards by the year 2020. The work on this continues with feedback being sought from a variety of professional and client groups.

While strategic debate continues, at the workforce level, rehabilitation practice continues to evolve as the service context changes. As noted earlier, current government health policy is aimed at increasing health provision in the community (Ministry of Health, 2011b). Rehabilitation models were already heading in this direction, with spiralling hospital costs, combined with research advocating the benefits of rehabilitation in natural settings (Kilbourne et al., 2008; Kuipers et al., 2008; Ministry of Health, 2008), encouraging community-based rehabilitation where possible.

Rehabilitation services are underpinned by the notion of holistic practice (McKenzie, 2002; World Health Organization, 2010a). This perspective is supported by the WHO's endorsement of a holistic model of health and disability, the International Classification of Functioning, Disability and Health [ICF] (World Health Organization, 2001). Within this model, the individual is viewed holistically with their health and rehabilitative needs fitting into the context of their personal life and environment. Hence, HCWs in a rehabilitative service context need to consider broader concerns than the client and their impairment. Central also to holistic rehabilitative perspectives is the notion of locus of control (Pyle, Arthur, & Hurlock, 2009), with the client needing to own their

rehabilitative goals and work collaboratively with their healthcare team to achieve them (Dwamena et al., 2012; Levack, 2008; Levack & Dean, 2012; Rosewilliam, Roskell, & Pandyan, 2011). For this to occur, rehabilitation services typically utilise person-centred models of practice that aim to engage with the client and fully involve them in decision making (McPherson & Siegert, 2007; Pryor & Dean, 2012; Van Dam, Ellis, & Sherwin, 2008). However, applying these principles in everyday practice is not simple. Scobbie, Wyke, and Dixon (2009) noted the challenges to implementing person-centred practice in rehabilitation when clients had unrealistically high expectations, or were not ready to accept the consequences of their health condition. Research continues into ways to develop person-centred practices and operationalise them through rehabilitation services that are inclusive and meaningful for clients (Bright, Boland, Rutherford, Kayes, & McPherson, 2012; Cheeseman, Madden, & Bundy, 2013; Dean & Ballinger, 2012; Dean, Siegert, & Taylor, 2012).

Some authors suggest that rehabilitation services should combine person-centred practice, evidence-based practice, and collaborative teamworking (Hall, 2005; Howarth, Warne, & Haigh, 2012; Sidani, Epstein, & Miranda, 2006; Suter et al., 2009). Though, integrating these models into the service context is problematic (Gittell et al., 2013). Rather than blending similar notions from each model, the concepts are typically described as discrete processes, for instance when person-centred practice and collaborative teamwork are considered as two separate competencies within IPC (Canadian Health Science Research Foundation, 2006; San Martin-Rodriguez, Beaulieu, & Ferrada-Videla, 2005). Poultonø (2003) definition exemplifies this, describing rehabilitative teamwork as 'the interactions or relationship of two or more health professionals who use interdependent, collaborative working to optimise person-centred care' (p. 187).

This delineation of concepts appears incongruous, with researchers on the one hand holding the person at the centre of the team, and yet separating them from the collaborative effort when discussing how HCWs collaborate to provide this person-centred practice. Whilst research indicates that for teamwork to be effective, the client must arguably be a member of that team (a collaborating partner) (McPherson & Siegert, 2007; Opie, 2000), others have highlighted the unresolved tension between person-centred practice and IPC in rehabilitation (Dean & Ballinger, 2012; Frosch, Elwyn, May, Gittell, & Trujillo, 2012).

1.5.4 The community rehabilitation context

In the field of community based rehabilitation there have been few systematic reviews to help consolidate the knowledge base. Mitchell's research (Mitchell, 1999a, 1999b), which covered the historical background to community rehabilitation and reviewed the available literature worldwide, disturbingly concluded that there appeared to be a reluctance to either undertake or permit research into the community rehabilitation context at that time. A few years on Finkenflugel et al. (2005) found that the international evidence base for community rehabilitation was fragmented and incoherent. In attempting to address this gap, Kuipers et al. (2008) considered the community rehabilitation context in developing countries. Their findings were primarily based at the implementation level, concluding that community rehabilitation frameworks and strategies should focus on issues of management and strategic leadership.

The WHO report (World Health Organization, 2010a) into community rehabilitation indicated an increased focus on this area, and presented a matrix for assessing the community context and developing community rehabilitation services. However, the report was primarily aimed towards increasing rehabilitation structures and processes in developing countries with non-professionally trained workers. Less is known about how HCWs view collaboration in established rehabilitation systems, or indeed, whether IPC regularly occurs in community rehabilitation settings (Crocker et al., 2012; Johansson, Eklund, & Gosman-Hedström, 2010; Körner, 2010).

Recent reviews (Grandisson, Hébert, & Thibeault, 2013; Lukersmith et al., 2013) indicate that despite the introduction of the WHO matrix (World Health Organization, 2010c) there are still significant gaps in understanding the community rehabilitation context. This understanding is hindered by a lack of standardised procedures and evaluative frameworks. Additionally, while research supports the effectiveness of community-based compared with hospital-based rehabilitation (Dow et al., 2007; Finkenflugel et al., 2005; Lukersmith et al., 2013; Velema, Ebenso, & Fuzikawa, 2008; Yin-han chung, Packer, & Yau, 2011), it is not known if the factors influencing collaborative practice are the same across different community rehabilitation contexts, such as home visits compared to outpatient clinic settings.

Working within a variety of rehabilitation contexts is common in the New Zealand community setting, influenced by funding streams and environmental factors (e.g. urban versus rural settings). As noted earlier, services around the country are not uniform and often reflect historic funding anomalies. Currently, there is a push for a review of rehabilitation provision (Australasian Faculty of Rehabilitation Medicine & NZ Rehabilitation Association, 2011) aimed at increasing national service consistency. Developing service consistency would support the implementation of collaborative practices across rehabilitation teams and contexts.

Developing consistency across community rehabilitation services is reliant on collaboration between the funding agencies. There are several sources of community rehabilitation funding in New Zealand, with the main funders being the MoH, the Accident Compensation Corporation (ACC), and to a lesser extent, the Ministry of Social Development. MoH funding enables local District Health Boards to provide post-acute rehabilitation, as inpatient care, or clinic-based outpatient care. District Health Boards also fund community teams of HCWs who assist people to engage with rehabilitation in the home setting. Additionally, the Ministry of Social Development funds services which support return to work and increased participation after serious medical incidents. This multitude of funders with blurred service lines makes collaboration across service agencies difficult. This is particularly evident in the divide between MoH and ACC community rehabilitation provision.

Unique to New Zealand, rehabilitation following accident or injury is publicly funded under a 'no blame' system by the ACC, who contract out community rehabilitation to both public and private healthcare organisations. ACC has a strong influence on how rehabilitation is provided in New Zealand, with ACC contracted HCWs being required to follow ACC reporting guidelines and rehabilitation protocols (Accident Compensation Corporation, 2001). These protocols promote collaboration between the individual client and HCW (Accident Compensation Corporation, 2006), but interestingly do not focus on IPC within healthcare teams, or across agencies. Another salient feature of ACC services is the use of a case management model. People with serious injury are assigned a support coordinator who acts as the main coordinator of services, rather than the rehabilitation team. The ACC model differs from usual case management, as the nominated case manager acts as both the service coordinator and

the fund-holder. They hold a powerful role in the client's life as they control access to all provision of funded equipment, rehabilitation services, and personal assistance.

While the community rehabilitation context is deeply influenced by funding mechanisms, at the level of the team and individual HCW, rehabilitation practices are also impacted by contextual influences which are not fully understood (Axelsson & Axelsson, 2009; Croker et al., 2012). Some of these influences are explicit, while others are embedded in local or professional understandings and perspectives. Examples of factors influencing community rehabilitation include: organisational frameworks; health professionals' scopes of practice (Ministry of Health, 2003); time and resource constraints; and interprofessional relationships and teamworking processes (Bélanger & Rodríguez, 2008; Brown et al., 2010; Grace, Coventry, & Batterham, 2012; Hansson, Segesten, Gedda, & Mattsson, 2008; McDonald, Powell-Davies, Jayasuriya, & Fort, 2011). How these factors influence HCWs collaborative actions has had minimal focus in the community rehabilitation literature and hence posited a potential initial line of inquiry for the study (Baxter & Brumfitt, 2008; Bell & Allain, 2011).

1.6 Structure of the thesis

The introduction has provided an overview of the aims and rationale of the study, and presented my personal reasons for undertaking this research. The background context has been established with a discussion about the political and cultural context, the development of rehabilitation, and an explanation of current service provision in New Zealand.

Chapter 2 is divided into two sections. Initially I present a pre-research review of the literature surrounding teamwork and IPC. This review, undertaken before data collection began, covers broad topic areas underpinning the work. The second part of the chapter was written post data collection, and reviews literature related to recent developments in areas arising from the study.

In Chapter 3 the methodological positioning of the study is detailed, with a discussion on the tenets of constructivist epistemology, symbolic interactionism, and grounded theory. Constructivist grounded theory is identified as the specific grounded theory variant used in this research, and the seminal works in this field are examined.

In Chapter 4 I specify the research methods undertaken in this study. Ethical considerations are articulated, the data collection methods of interviews and field observations explained, and the participants introduced. Following on from this, I explicate the grounded theory analytical processes used, providing examples from data collection and analysis to aid transparency. The chapter closes with consideration of ways to evaluate grounded theory studies.

Chapter 5 marks the beginning of the findings section, one of four chapters in which the research findings are explicated. In the first section I discuss complexity management, the central challenge faced by HCWs in community work, and present the three interlinked aspects of client, relational, and situational complexity. In the second half of the chapter I introduce the theory of connecting, outlining the components of the theory, along with the conditions, and perspectives that caused variations within the theoretical processes.

In Chapters 6- 8 the research findings are presented. In each chapter I explain one of the three theoretical categories underlying the theory of connecting. In Chapter 6, liaising is introduced, its purpose explicated, and the sub-categories discussed. In Chapter 7

forming-reforming is presented, while guarding, the third theoretical category of connecting, is discussed in Chapter 8.

In Chapter 9, I consider the original findings from the research, identifying their significance and place within current literature. The implications of these findings are deliberated with reference to clinical practice, education, and further research possibilities. Comment is made on the strengths and limitations of the study. The thesis finishes with a short section of concluding thoughts summing the research.

Fundamentally, as will be shown through the thesis, I propose that:

Interprofessional community work occurs in contexts that involve interlinked layers of client, relational, and situational complexity. To manage this complexity, HCWs use connecting processes involving liaising and forming-reforming actions that facilitate collaborative practice, and guarding behaviours that constrain connecting and protect the status quo, with the ultimate aim of providing efficient and effective healthcare.

Chapter 2 Literature review

2.1 Introduction

This chapter is divided into two main sections. Initially, the role of the literature review in grounded theory research is discussed. This is followed by a review of teamwork and IPC. Undertaken in 2010 before data collection began, this section reviews the extant works at the commencement of the study and establishes the sensitising ideas with which I approached the field. The second section of the chapter examines literature relevant to the research topic, which has been published since the beginning of 2010. This section focuses on the salient areas of collaborative practice, interprofessional education, and theoretical developments, thereby situating the theory of connecting within current literature.

2.2 Literature reviews in grounded theory

Grounded theory (Charmaz, 2000, 2003, 2006, 2009; Glaser & Strauss, 1967) is unusual as a research methodology in that it customarily places exploration of related literature after the initial data collection (Glaser, 1992; Glaser & Straus, 1967). The place of the literature review is frequently debated in the grounded theory literature (Birks & Mills, 2011; Dey, 1999; Glaser, 1992, 1998; Holton, 2007). The intention of this methodological principle is to avoid importing preconceived ideas and imposing them on the research, thus perpetuating the received view of the world (Glaser, 1998; Glaser & Strauss, 1967). Critics however, argue that researchers enter any study with assumptions and some knowledge of related literature (Strauss & Corbin, 1990). Rather than avoiding pre-extant literature altogether, it is how this knowledge is managed within a study that is important (Charmaz, 2006). Additionally, ethical and moral considerations add strength to the argument for reviewing literature early, to establish that the research is worth doing and will fill a gap in knowledge (National Ethics Advisory Committee, 2012).

This research is based on Kathy Charmaz's constructivist version of grounded theory (Charmaz, 2000, 2001, 2003, 2006, 2008c, 2008d, 2009, 2011; Charmaz & Bryant, 2011). Charmaz takes a practical approach to literature usage in theses, acknowledging that proposal requirements usually include a thorough knowledge of related literature. She advocates 'outlining the path to reviewers' (Charmaz, 2006, p. 166), and thereafter

letting the material rest until the researcher has developed theoretical categories, before returning to locate the work within the relevant literature. The researcher starts the study with an understanding of current thinking and some ideas and sensitising concepts to initiate inquiry (Charmaz, 2006), but does not take a position about the research to follow. Using grounded theory terminology, this means that the researcher begins with a baseline theoretical sensitivity (Glaser & Strauss, 1967; Strauss & Corbin, 1990) about the topic, based on their personal, professional and experiential history (Birks and Mills, 2011, p. 59), but remains open to what participants what to talk about.

Once the substantive theory has been generated, the literature is revisited, providing a place in which to locate, evaluate, and defend the emergent theory (Bryant & Charmaz, 2007a). In this PhD study, an early literature review was useful to provide a sound rationale for the study and demonstrate my academic potential as a student (Urquhart, 2007). I chose to review the general areas of IPC and teamwork to provide a baseline understanding, without delving too closely into research about community rehabilitation practice (see Chapter 1 for an overview of the community rehabilitation context). After the data analysis was complete I returned to the literature to explore recent developments in the interprofessional field. The review is therefore presented in two parts: a) literature reviewed prior to commencing data collection halfway through 2010; and b) a review of interprofessional developments since 2010. Literature I was prompted to review as a result of my findings is then considered in the discussion section of the thesis (Chapter 9).

2.3 Literature review: Pre-data collection

2.3.1 Interprofessional collaboration (IPC)

The notion of IPC is well established, with the Declaration of Alma Ata (World Health Organization, 1978) frequently cited as the first internationally coordinated approach to IPC. The Declaration focused on promoting coordinated, collective team approaches to improve primary healthcare. A decade later the WHO report on Learning Together to Work Together for Health (World Health Organization, 1988) highlighted the importance of educating trainee HCWs to collaborate and work as a team. The two successive decades saw knowledge about the benefits of collaborative interventions and their positive impact on client outcomes growing (Xyrichis & Lowton, 2008). However, synthesising this literature was challenging, as IPC is now used as an umbrella term

with multiple definitions, frameworks and processes emerging across a wide range of professional fields (Goldman et al., 2009; Zwarenstein et al., 2009). To assist in clarifying the diverse literature, this review of IPC was divided into sub-categories based on a Donabedian (1988) framework. Firstly, the evolution of IPC models and frameworks was mapped, followed by a review of collaborative processes. The section ends with a critique of IPC outcome measures.

2.3.1.1 IPC: Models and frameworks

The changing focus of collaborative frameworks reflects the evolving nature of the field over the last few decades (Goldman et al., 2009). While reference to interprofessional working can be found in literature of the 1960s (Barrett, Sellman, & Thomas, 2005), IPC frameworks began to emerge in earnest only in the late 1970s. Early IPC models were framed around the WHO targets of 'improving health for all' (Barrett, et al., 2005; World Health Organization, 1978). As IPC was a new field, frameworks were not fully established and authors drew on other areas such as organisational theory (D'Amour, et al., 2005) and organisational sociology (Wackerhausen, 2009) to form their models.

As the concept of IPC developed through the late 1980s and 1990s, the emphasis moved from the objective, medical perspective of 1970s healthcare, as researchers considered social and relational influences (Crotty, 2003) that affected implementation of collaborative concepts and frameworks. Collaborative frameworks were no longer referenced from other areas, but had evolved from practically implementing earlier ideas within team settings. Hence, the focus had moved from higher level policy development to a practical centering on team structure and settings. Interprofessional concepts of this era described the finer detail of collaborative processes, as they were enacted through teamworking (Corser, 1998; Gitlin, Lyons, & Kolodner, 1994; Hayward, DeMarco, & Lynch, 2000; Leathard, 2003; Opie, 2000). Collaborative concepts frequently explored in the seminal writings through that period include notions of sharing, partnership, power, and interdependency issues (Baggs & Schmitt, 1988; D'Amour et al., 2005; Henneman, Lee, & Cohen, 1995; Liedtka & Whitten, 1998; Opie, 2000).

More recently, a critical lens has been used by authors examining collaborative models in terms of power and autonomy issues (Ahlgren, Axelsson, & Axelsson, 2009; Axelsson & Axelsson, 2009; Canadian Medical Protective Association, 2006; Hall,

2005). Power sharing and non-hierarchical models are established concepts within modern collaborative and rehabilitative frameworks, reflecting a shift away from the dominant bio-medical model of healthcare (Barrett et al., 2005; Pyle et al., 2009; Reeves et al., 2010). Some authors had suggested that a side-effect of these shifts may be an increase in occupational power of the semi-professions and a resistance to change by the more dominant professions (Meads & Barr, 2005; Kesby, 2002). It was unclear how power sharing worked practically in community rehabilitation and what effect the variety of semi-professional and non-trained workers had on collaborative working. This provided an interesting sensitising point to consider in the field, where a range of both professional and lay HCWs interact.

The emphasis on power sharing and the shift away from hierarchical issues perhaps reflects the rise of post-modernist thinking that takes a critical stance towards positivist models of the doctor as the sole health expert (Webb & Wright, 2000). Rather multiple perspectives of health are possible, and the client is invested in their own healing (Fox, 1991). In addition, the critical perspective has led to socio-political literature that considered IPC frameworks in terms of local and cultural concepts. This suggests a shift was taking place, from the focus on broad policy generalisation to a consideration of more specific factors affecting IPC (Gilbert, 2010; McKinley & Pullon, 2004; Mickan, Hoffman, & Nasmith, 2010). The WHO 'Framework for Action on Interprofessional Education and Collaborative Practice' (2010d) for example, demonstrated the importance of the local, contextual element, by emphasising the need for IPC models that provide local solutions to international problems.

The evolution of diverse collaborative frameworks shows how knowledge is situated and constructed by people's experiences and local perspectives. This provides an example of the multiple realities within which social constructivist grounded theory thrives (Charmaz, 2006). Articulating such conceptualisations of IPC has the potential to increase understanding and provide a way for organisations to identify areas for improvement in collaborative practices (Wackerhausen, 2009).

Despite IPC models evolving over time, the links between collaborative frameworks, processes, and clinical outcomes are still not widely understood (Zwarenstein et al., 2009). Hence, operationalising IPC models in health and rehabilitative practice has not been easy, nor was evaluating progress simple, since research to date focused on

descriptive studies (Reeves, 2010). Additionally, frequent restructuring of healthcare systems over recent decades has contributed to challenges in implementing collaborative models. New Zealand for example, has moved from having a centralised welfare-type health service delivery model in the post-war years, through to regionalised services in the 1980s, back to a semi-market model in the 1990s, before eventually returning to regional governance (Ashton, Mays, & Devlin, 2005; French, Old, & Healy, 2001). These reforms have had a flow on effect on initiatives such as IPC, as the rapid turnover of frameworks left little time to evaluate the effects of collaborative working at the process and outcome level (Leathard, 2003). The next two sections address these areas, by clarifying current perspectives on collaborative processes and outcomes.

2.3.1.2 IPC: Collaborative processes

It was evident from my first review of the literature that collaborative processes are complex and understood in multiple ways. This section highlights several perspectives about collaboration focusing on levels, areas, and mechanisms, as these represented common ways to consider collaborative processes. *Levels* of collaboration referenced simple frameworks. Hornby and Atkins (2000) for example, described three levels of collaboration: routine, simple, and complex. Routine levels of collaboration occurred as part of established job roles and could occur within a team, such as during team meetings, or between teams. For example, when a person transferred from an inpatient rehabilitation setting to the community, the inpatient staff would routinely contact the community rehabilitation team to refer the person for on-going support. Simple levels of collaboration occurred when collaborative interactions were straightforward, such as between two people with established roles and responsibilities. In contrast, the complex level of collaboration involved many relationships and unclear processes. While this approach is easy to understand, I considered the *levels* explanation of collaboration too compartmentalised for the multifaceted context of community rehabilitation. Models such as that provided by Hornby and Atkins (2000) appeared too simplistic to capture the realities of healthcare practice. Rather, before entering the field, I supported D'Amour and colleagues' (2005) position that multiple levels of collaboration can occur simultaneously, with many routine and simple collaborative processes taking place that together can create a web of complexity. This understanding provided a sensitising idea to take into the study and explore further.

A more in-depth scrutiny of collaborative processes was provided when collaboration was described in terms of *areas* of practice. For example, Ovretveit, Mathias, and Thompson (1997) discussed four main areas of collaboration related to team functioning. The first area refers to the degree of integration, or collaborative working between workers. Next are the degrees of membership in a work team, with differences identified between 'core' and 'associate' team members. This area was of potential relevance to community rehabilitation, where there appeared to be regular team members and associated others who were on the periphery of teams. The third area referred to the collaborative processes that occur when a client moves through the healthcare process, while the last area acknowledged the importance of team management to IPC. However, while these *areas* models described where collaboration occurred, what they lacked was a descriptor of *how* collaboration happened in these areas.

Payne (2000) also cautioned against having too great a focus on the areas model of collaboration within teams, warning that they can paradoxically result in difficulties in collaboration. For example, a team that concentrates on building internal collaborative practices may miss building interagency networks. Likewise, increasing collaboration within a team can focus the attention on interprofessional relationships, resulting in exclusion of clients, at a time when healthcare policy is advocating person-centred care models that focus on clients' needs (Davis, Byers, & Walsh, 2008; Slater, 2006). As my research began, I held the view that while the collaborative *areas* model provided in-depth insight into collaborative team processes, it lacked emphasis on the client's place in rehabilitation, and overlooked the place of interagency collaboration. As identified in Chapter 1, there remained issues with integrating person-centred care and IPC in the literature.

The third way collaborative processes were commonly addressed was in terms of the *mechanisms* that affect IPC. The WHO's report on IPC (2010d) summarised these mechanisms into three themes: Institutional support (governance models, protocols, shared resources, supportive management practices); working culture (communication strategies, conflict resolution policies, teamwork processes); and environmental issues (facilities, space, design). While information about these notions was growing, the interplay between these mechanisms was poorly understood (Ahgren et al., 2009; Axelsson & Axelsson, 2009; Kvarnstrom, 2008). Specifically, there was little

knowledge about the effects of collaborative mechanisms in the context of community rehabilitation (Ministry of Health, 2009; Ødegard & Strype, 2009). Additionally, because debate focused on issues impacting health teams, it may have led to an emphasis that was internal rather than multidirectional. This focus risked missing an important area of interprofessional work – that is, the collaborative work that occurs between agencies and sectors.

Interagency collaborations may be driven by a variety of influences, including government or regional healthcare policies. Interestingly, it is only in the last few years that the New Zealand MoH has followed international prompts to promote interagency collaboration at a policy level (Health Workforce New Zealand, 2009; Ministry of Health, 2009). Earlier recommendations for healthcare agencies to work collaboratively seem to have been problematic to instigate (Health Workforce Advisory Committee, 2006; Ministry of Health, 2002b). Similar to findings from other Western nations, collaborative implementation has been complicated by repeated health policy changes (Meads, Ashcroft, Barr, Scott, & Wild, 2005). Additionally, in New Zealand regional differences between the needs of the main centres, small towns, and rural areas meant high level interagency policies required modifying for local requirements. However, government reports released as this research began seemed to acknowledge these challenges, recognising that an increased focus on improving implementation of collaborative processes across agencies and sectors was required (Ministry of Health, 2009). It remained to be seen how this would be achieved in practice.

Clearly, operationalising collaborative policies requires the rehabilitation workforce to both understand and be practice-ready to implement changes. Internationally, educators of HCWs recognised this fact early, establishing undergraduate interprofessional education programmes in the 1990s (Gilbert, 2010; Leathard, 2003; Wilhelmsson et al., 2009). New Zealand began following this trend in the early 2000s (Horsburgh et al., 2006; McKimm et al., 2010), culminating in the 2009 opening of the National Centre for Interprofessional Education and Collaborative Practice at AUT University. Research outputs from the new National Centre suggest it could have a significant influence on future IPE development (Forman & Jones, 2010; McCallin & McCallin, 2009; McDonald & McCallin, 2010; Shaw, Tyacke, Sherrard, Hikuroa & Corbett, 2009).

The purpose of interprofessional education is to produce HCWs that understand collaborative processes and are practice-ready to collaborate in the healthcare setting (World Health Organization, 2010d). To achieve this, HCWs need to have developed the key competencies required for IPC. While these competencies continue to be refined and debated, when this research began the Canadian Interprofessional Health Collaborative (CIHC) had just published a framework describing six key competency areas for developing IPC: role clarification, team functioning, patient/ community-centred care, collaborative leadership, interprofessional communication and interprofessional conflict resolution (Canadian Interprofessional Health Collaborative, 2010). While this framework may provide a focus for interprofessional education, less clear was how the integration of these interprofessionally trained HCWs impacts on collaborative processes out in the established workforce (Pullon & Fry, 2005; Thistlethwaite & Moran, 2010). HCWs who are practice-ready to collaborate have only been graduating from New Zealand programmes over the last few years and at the start of this research there was little knowledge about how they are integrated into established rehabilitation teams (Horsburgh, Merry, & Seddon, 2005).

Nonetheless, the introduction of interprofessional education and learning has since seen a corresponding promotion of collaborative aims in organisations (Hammick, Freeth, Koppel, Reeves, & Barr, 2007). However, it is still not known whether these goals are consistently operationalised as collaborative processes. Meads et al. (2005) suggested the implementation of collaborative processes is affected by individuals' professional identity. Collaboration may be perceived as a means of enabling HCWs to gain knowledge of each other's professions, or as an attempt to restrict and hold onto role boundaries, depending on individual perspectives. Leathard (2003) saw the positive side, noting that the re-assertion of each profession can actually be useful for interprofessional collaborative processes. HCWs can learn about the roles and strengths of professions other than their own, an outcome which supports more effective collaboration. Conversely, Hall (2005) argued that increased specialisation has strengthened professional sub-cultures and acted as a barrier to collaborative processes. The impact of professional identity on IPC implementation continued to receive attention in the literature. This was partly led by policy directions that pushed for role blurring as a means of resource saving (Baxter & Brumfitt, 2008; Copnell, 2010), thereby keeping professional identity as a point of debate.

Operationalising collaboration is about more than overcoming professional identity issues however. DøAmour et al. (2005) for instance, contended that the implementation of collaborative processes needed to be understood as a human process, rather than a professional endeavour. They argued that HCWs are unlikely to use collaborative processes if they see the only purpose as 'being good for clients' (p. 128). This viewpoint was similar to earlier work by Hugman (2003). Hugman had questioned why HCWs would want to move beyond their 'tribal circle' (2003, p. 56) to implement collaborative processes, when each HCW perceived the benefits of IPC differently. This query remained unanswered at the time of entering the study (Baxter & Brumfitt, 2008). Hence, it provided a sensitising notion for the research, where the questions focused on how HCWs viewed collaborative practice in their community rehabilitation teams, and how they constructed their collaborative actions.

2.3.1.3 IPC: Measuring outcome

At the beginning of this research, it was clear that in order to defend the cost of implementing collaborative policies and processes, the outcomes needed to be effectively measured (Meads et al., 2005; Zwarenstein et al., 2009; Zwarenstein & Reeves, 2006). The seminal WHO report (World Health Organization, 2010d) summarised research at the time, by considering collaborative outcome measures across two levels: technical and interpersonal. Technical outcomes encompassed the physical and functional outcomes of IPC, such as improved client outcomes, reduced errors in communication, and cost factors. Interpersonal outcomes meanwhile encompassed less concrete measures, for example client or worker satisfaction, and client quality of life issues (World Health Organization, 2010d). While these two headers perhaps oversimplified what is a broad range of outcome measures, they provided a recognised means of categorising a complicated area.

Worldwide, there was sufficient evidence in 2010 to state that IPC had a positive effect on technical outcome measures (World Health Organization, 2010d). This had been demonstrated in terms of increased client safety (Brewer, 2006; Lowe, 2008) and decreased mortality (West, Tjosvold, & Smith, 2005). Collaborative interventions were also shown to reduce the cost of caring for clients, through more efficient utilisation of the limited staffing resource (Baxter & Brumfitt, 2008; World Health Organization, 2010d). Conversely, when IPC was not effectively practiced, negative outcomes have resulted, such as increased client injury rates, reduced access to services, and decreased

health outcomes (Fewster-Thuente & Velsor-Friedrich, 2008; Suter et al., 2009; Xyrichis & Lowton, 2008). It remained a challenge for all HCWs and policy makers that, despite mounting evidence of IPC benefits, failures in collaborative practice continued to occur, which resulted in adverse client outcomes (Baldwin & Daugherty, 2008; Richardson & Storr, 2010; Stelfox, Palmisani, Scurlock, Orav, & Bates, 2006).

Meanwhile, at the time of this first review (2010), researchers had begun to explore the less concrete area of interpersonal IPC outcomes from both client and HCW perspectives. Interestingly, despite positive client outcomes being promoted as a justification for IPC, in 2010 there were few studies which explored the clients' perspective of IPC (D'Amour et al., 2005; Shaw, 2008). The literature that was available indicated that clients expressed higher levels of satisfaction when healthcare was delivered by interprofessional teams, rather than a single profession (Meads et al., 2008; Opie, 1998). Equally, studies highlighted clients' desire for the collaboration between health teams and the client to be effective (Curran, 2007; Pyle et al., 2009). However, less well understood was the clients' perspective of their role within team collaborative processes, especially when multiple agencies were involved, such as occurs in community rehabilitation. This study does not attempt to address this area, but it posits a line for future research.

From the HCW perspective, results from smaller scale studies indicated that IPC could improve outcomes for workers. This arose through HCWs developing positive work cultures and increasing communication, which led to better staff retention (Lemieux-Charles & McGuire, 2006; LePine, Piccoloo, Jackson, Mathieu, & Sual, 2008; Suter & Deutschlander, 2010). Collaborative processes were also thought to increase job satisfaction and increase understanding of other workers' roles (Körner, 2010; Suter et al., 2009). However, because these findings were predominately based on small-scale, or lower-quality studies, further work was needed to definitely state how IPC impacted HCW outcomes.

Despite some indications that IPC resulted in positive outcomes for workers and clients, and government backing for IPC policies, barriers to collaborative practice were still reported. Some of these barriers included: power imbalance between professions (Delva, Jamieson, & Lemieux, 2008); lack of role understanding (Arksey, Snape, & Watt, 2007; King & Ross, 2004); ineffective communication (Baldwin & Daugherty,

2008; Zwarenstein & Bryant, 2009); poor leadership support (Reeves, Macmillan, & Van Soeren, 2010); differing work spaces; organisational processes that limited opportunities to collaborate, and a lack of interprofessional postgraduate education (Mickan et al., 2010; Quinlan & Robertson, 2010). It appeared that there was a tension between government and organisational structures advocating IPC and the collaborative practices actually occurring at the interprofessional and interpersonal level.

This section has reviewed IPC models, processes and outcomes. From this review I gathered ideas that were then developed into sensitising concepts, which were considered as I began data collection. Charmaz (2006) attributes the notion of sensitising concepts to Blumer's (1969) work, stating they provide 'initial ideas to pursue, and sensitize you to ask particular kinds of questions about your topic' (p. 16). Sensitising concepts can come from personal knowledge, professional positioning, or literature. My sensitising concepts for this topic arose from personal knowledge and experience (Appendix A), combined with ideas garnered from this literature review.

The review of IPC led me to understand that models of IPC were continually shifting, with frameworks not well understood by HCWs. I also perceived that the literature base around operationalising IPC models was still developing, and that little was known about IPC in community contexts. Meanwhile, at the training level, IPE had been established as a positive tool that supported undergraduates to become ready for interprofessional work. Less clear however, was the effect that IPE-trained workers had on collaborative processes in established teams.

Within clinical practice, IPC was established as a process that could have favourable outcomes for both teamwork and clients. Although HCWs generally perceived IPC favourably, they did not consistently understand how to implement collaborative processes. Perhaps because of this, errors in interprofessional working continued, resulting in adverse client outcomes. It appeared barriers to IPC remained, with failures to collaborate having ramifications for workers, clients, and organisations.

The summary of ideas from the literature review was considered alongside my own experiences, assumptions, and prior knowledge (Appendix A). From this, I developed several sensitising concepts that I considered pertinent in relation to my research questions. These concepts were established both as potential points of inquiry (Charmaz, 2006), and also as an audit to remind me of which ideas were pre-extant, and which came directly from participants in the research. The sensitising concepts I developed related to IPC were:

- Interprofessional knowledge and terminology was evolving.
- The impact of IPE was unclear at a practice level.
- IPC could positively impact team functioning and client outcomes.
- There was little information about IPC in community rehabilitation contexts.
- Funding parameters, profession-specific concerns and cultural aspects might influence HCWs' responses to IPC.
- HCWs perceived IPC as beneficial in principle, but there were barriers to implementation, and failures in interprofessional working continued.

2.3.2 Teamworking

The following section provides an overview of teamworking in healthcare, discussing pertinent literature before the data collection phase of the study that began in 2010. At the time of review, teamworking was closely aligned to IPC, indeed was frequently referred to as the main way in which IPC was enacted (Heldal, 2010; Lowe, 2008). Following the format of the previous section, this critique examines the main teamwork models, and reviews the structures and outcomes of teamworking.

2.3.2.1 Teamwork models

Within healthcare literature, many models of teamworking exist. One of the most commonly used frameworks identified three levels of teamwork: multiprofessional, interprofessional, and transprofessional teamworking (Lemieux-Charles & McGuire, 2006). These models cover a range of interprofessional teamworking from individuals working alongside each other, through to workers collaborating across professional boundaries. While the terms 'multidisciplinary', 'interdisciplinary' and 'transdisciplinary' were often used interchangeably, differences do exist between the concepts (Mu & Royeen, 2004). 'Discipline' referred to a field of study, whereas concepts of profession related to 'an occupation whose core element is work based upon the mastery of a complex body of knowledge and skills' (Cruess, Johnston, & Cruess, 2004, p. 74). In this review, the term 'professional' provided a more accurate depiction of workers within healthcare teams, and was therefore used in discussing teamwork here.

Teamwork models may be placed on a continuum with the multiprofessional model describing less collaborative ways of teamworking, while transprofessional models align with collaborative practices (Hall & Weaver, 2001). While the multiprofessional model was referred to in differing ways, conventional usage referred to a team of HCWs who individually worked with a client and where the focus was on professional tasks, rather than collaborative working (Baxter & Brumfitt, 2008; Thylefors, Persson, & Hellstro, 2005). Each HCW worked parallel to the others and the coordination of tasks was normally done through a hierarchical system with the doctor traditionally taking the leading role (McCray, 2009). The challenge with using this model of teamwork was that the emphasis on doctor as leader did not necessarily account for the variance of teams and autonomy of practice in the community context (Ahgren et al., 2009).

Interprofessional teamworking on the other hand was typically linked with collaborative effort, with positive client outcomes dependent on HCWs showing a high level of communication, mutual planning, sharing of responsibilities, and making joint decisions (Kvarnstrom, 2008). Finally, the transprofessional team was commonly portrayed as displaying the highest degree of IPC through integrated work practices and blurring of role boundaries (Frenk et al., 2010). Additionally, transprofessional working was said to promote new knowledge in areas where team members intersect and engage with each other (McPherson, Headrick, & Moss, 2001). Workers using this approach demonstrated aspects of role extension (increased professional knowledge), role enrichment (knowledge of other professions), role expansion (sharing expertise with other team members), role release (blurring of professional boundaries), and role support, such as training other professionals (D'Amour et al., 2005; Reilly, 2001). Transprofessional workers also showed reflexivity, being consciously aware of their work practices and interprofessional relations (Olupeliyawa, et al., 2009; Opie, 2000).

While these models of teamworking provided descriptors of behaviours teams aspired to, in practice team functioning was unlikely to be so cut and dried. Variable time and resource pressures, combined with differing understanding and motivations, could mean teams demonstrated aspects of each of the teamwork models at different times (Körner, 2010). It appeared that the nature of human interacting resisted type-casting into one model of practice. Overall though, the literature reviewed up till 2010 suggested healthcare teams were moving away from multiprofessional, hierarchical team models, instead promoting transprofessional, collaborative teamworking (Pullon, 2008; Zwarenstein et al., 2009). Xyrichis and Ream (2008) highlighted this shift in rhetoric, asserting that teamworking was a dynamic process accomplished through IPC and shared decision making. With this shift in thinking, transprofessional teamworking was perceived as a model which fostered collaborative practices within teams and was increasingly promoted as best practice in healthcare (Olupeliyawa et al., 2009; Xyrichis & Lowton, 2008). However, it was also evident that teamwork models did not operate in isolation, with consideration of the structures which supported and influenced team practice needed.

2.3.2.2 Teamwork structures

As teamwork and IPC concepts were closely linked, the structures supporting teamwork mirrored those influencing IPC. In reviewing the literature, these structures were able to be broadly grouped into: environmental structures, institutional support, and working culture (Kuipers et al., 2008; Nijhuis, Reinders-Messelink, de Blécourt, Olijve, Groothoff, & Nakken, 2007; World Health Organization, 2010d). *Environmental structures* that enhanced teamworking included co-location of staff, adequate facilities, and sufficient resources (Lemieux-Charles & McGuire, 2006). While resource sufficiency was a structural concern common to all settings, staff co-location and accessing adequate facilities were points of particular interest for this study. I knew from my clinical background that community rehabilitation workers often travelled individually to the client, rather than being permanently located in a clinic setting, and also that facilities were often less than optimal. The effect co-location and operational facilities had on collaborative processes was unclear however, and the potential impact of environmental structures provided a sensitising concept for the study.

Knowledge at that time indicated *institutional support* for teamworking occurred through protocols that addressed effective leadership, role clarity, smaller sized teams, clear goals, and occupational diversity (Bosch et al., 2009; Körner, 2010; Lemieux-Charles & McGuire, 2006). While most of these ideals were widely supported, diversity in teamwork composition was a contested point (Horwitz & Horwitz, 2007), with some authors suggesting power issues and occupational status impeded effective teamworking in multi-professional teams (Delva et al., 2008; Rutherford & McArthur, 2004). This was particularly relevant in hospital based teamwork, where historic notions of doctor as leader were common, but it was less clear whether this was relevant in community team settings, where workers typically had more autonomy (Ahgren et al., 2009). Autonomy was problematic however, as it could result in a lack of clear leadership that reduced team effectiveness (Bosch et al., 2009; Cashman, Reidy, Cody, & Lemay, 2004). It appeared that more research was needed to explore which aspects of institutional protocols best supported teamworking in differing settings.

The *working culture* was the third identified structure supporting teamworking, with positive working cultures linked to improved teamwork practices (Lemieux-Charles & McGuire, 2006). Belanger and Rodriguez (2008) identified that teamworking cultures which rewarded optimal performance and encouraged innovation could improve the

quality of their teamworking and IPC. Innovation in teamwork was an interesting concept, with its suggestion of autonomy and freedom to try new ideas seeming at odds with working cultures, which more typically aimed for team cohesion and standardisation of services. The New Zealand health setting with HCWs acting under profession specific 'Scopes of Practice' and legislation such as the NZ Health Practitioners Competence Assurance Act (Ministry of Health, 2003) appeared to limit HCWs ability to be innovative. Yet alongside this, researchers were advocating originality, stating that the quality of teamworking was related to working cultures that supported innovation (Cashman et al., 2004; West et al., 2005). There appeared to be tension between literature advocating innovative working cultures and organisational and legislative parameters of professional practice.

Leadership, which fostered a positive working culture and encouraged team success, provided a means of managing these tensions (Burke et al., 2006). Clear, effective leadership underpinned by institutional support was linked to successful teamworking (Bosch et al., 2009; Joseph & Winston, 2005). This was enhanced when organisations supported the role of leaders through leadership training and promoting positive working cultures (Kuipers et al., 2008).

Team meetings, another aspect of working culture, were reported to encourage innovation and IPC, by breaking down professional boundaries and improving communication (Opie, 2000; Rutherford & McArthur, 2004). However, this did not necessarily reflect practice in the community setting, with Belanger and Rodriguez (2008) finding community-based HCWs tended to meet only if they had problems to discuss.

One consequence of having less frequent team meetings appeared to be a decrease in effective communication, with resulting misunderstandings about professional roles and responsibilities being a common finding in interprofessional teams (Nijhuis et al., 2007; Xyrichis & Lowton, 2008). Jha, Prasopa-Plaizier, Larizgoitia, and Bates (2010), emphasised the risks of team structures breaking down when regular meetings and communication did not occur, contending that team conflict had the potential to influence client safety. Equally, when regular meetings occurred and effective communication was targeted as a task, constructive working relationships followed (Olupeliyawa et al., 2009; Quinlan & Robertson, 2010), resulting in improved

teamwork and greater collaboration (Sargeant, Loney, & Murphy, 2008). This was aided by clear communication of team goals and objectives, and clarification within the meetings of individual team members' roles (Bélanger & Rodríguez, 2008; Hassall, 2009).

Given that community teams appeared to meet less frequently than hospital or clinic-based teams (Belanger & Rodriguez, 2008), the communication strategies they used became a sensitising point to explore in this study. At the time of the review, it was unclear from the literature whether community workers replaced team meetings with other collaborative strategies, and if so whether these were formalised processes, or needs-driven reactions to events.

2.3.2.3 Teamwork outcomes

Teamwork outcome measures were difficult to quantify in healthcare due to multiple variables. Within the quality improvement literature, there was a notable focus on improving teamwork outcomes, emphasising the importance of teamwork to healthcare outcomes. Areas focused on in the literature included both technical and interpersonal measures such as client outcomes and safety, team efficiency, cost effectiveness, and staff retention/job satisfaction (Olupeliyawa et al., 2009). Interpersonal outcomes were often measured via surveys, questionnaires, and by monitoring staff retention rates (De Dreu & Weingart, 2003; Salas, Diaz Granados, Weaver, & King, 2008). Technical outcomes were more quantifiable, with auditing used as a tool to evaluate outcomes such as team efficiency, client outcomes, and cost effectiveness (Harris, Daniel, Wan, Zwar, & Powell-Davies, 2010). Auditing was used not only for identifying ways to improve performance, but also as an incentive to advance teamwork by acknowledging team successes (McSherry, 2008). Yet, despite auditing tools having a useful purpose in outcome measurement, they rarely captured the relational and collaborative aspects of teamwork. Audit measures that considered aspects of collaborative practice in teamwork were beginning to appear in the literature (Cashman et al., 2004). However, as New Zealand had only recently committed to policies endorsing IPC (HWAC, 2006, Ministry of Health, 2008, 2010), audit and evaluation of collaborative teamwork lagged behind international settings (Xyrichis & Lowton, 2008). On a local level, the impact of collaborative practices on teamworking efficiencies remained unclear.

When considering teamwork outcomes, client outcomes and patient safety perhaps deserved greater scrutiny than team efficiency and cost effectiveness. Since the seminal report *‘To Err is Human’* (Institute of Medicine, 2000) identified teamwork communication failures as the most common cause of adverse client events, teamwork practices have become a focus of system-based interventions to improve patient safety (Manser, 2009; O’Daniel & Rosenstein, 2008). Despite this, the evidence in 2010 indicated teamworking failures continued to result in negative client outcomes (Heldal, 2010; Kvarnstrom, 2008). For this reason, further study into teamworking and collaborative practices was necessary. Internationally, the models, processes, and structures underpinning teamwork and collaboration were becoming understood. Nonetheless, an understanding of how HCWs actually perceived collaborative practice and what changes their actions on a daily basis was still lacking. This study addresses this important gap in knowledge.

This section of the review has discussed teamworking in terms of models, structures and outcomes. It has also identified the gaps in knowledge relating to community teamworking in 2010. Background has been provided through an explanation of teamwork models, supporting structures, and a definition linking teamwork to IPC. Discussion on team composition, leadership, innovation, and the value of team meetings, effective communication, goal setting, and audit have been charted.

As with the section on IPC earlier, I drew ideas from the teamwork review that were combined with my personal knowledge and experience to form sensitising concepts related to the research questions. The ideas I garnered from the review of teamworking included the notion that transprofessional teamworking had congruence with collaborative principles. Also, teamwork was affected by conditions such as environmental and operational structures. Communication failures were a continuing problem in teamworking that impacted client and team outcomes. Additionally, issues of professional hierarchies affected team composition, particularly in hospital teams. It was unknown if hierarchies impacted on community teams to the same degree. In the review I also found that effective leadership enhanced teamwork processes and outcomes. Meanwhile, teamwork processes promoted regular meetings as a way of enhancing IPC, yet it was unclear whether this would apply in community contexts. Teamwork outcome measures were beginning to consider IPC, but at a local level the impact of collaborative practices on teamworking processes was unclear.

In considering this summary of teamworking ideas along with my own notions (Appendix A), the sensitising concepts that I would take forward into data collection included:

- Transprofessional teamwork and collaborative practice models were compatible.
- Teamwork was impacted by leadership performance, and professional hierarchies.
- Professional scopes of practice might influence teamwork processes.
- Teamwork communication failures were the most common cause of adverse client events, with communication seen as a task, rather than a process.
- Team meetings appeared to play an important role in teamworking.
- The environmental context could affect teamwork, with less known about the impact of the community context on teamworking.

2.4. Developments in the interprofessional field: Post-data collection

The final section of the chapter considers the literature examined after data collection was complete and analysis of the theory of connecting was well developed. Although not available at the time of undertaking my research, this information is considered pertinent to contextualise the field of interprofessional study as it stands in 2013. Recent developments in interprofessional education, competencies, and relationships are discussed, followed by an exploration of theoretical developments within the interprofessional field. Where relevant, comparisons with the theory of connecting are woven into the review, with links to the corresponding area in the thesis. Additional literature that is pertinent to the findings is then considered within Chapters 5 and 9. This follows the grounded theory tenet of positioning the emerging theory within relevant literature in order to compare the theory with established work (Charmaz, 2006; Glaser, 1998; Urquhart, 2001).

2.4.1 Interprofessional education (IPE) and learning (IPL)

If collaborative practice is to develop, there is an assumption that it will begin with interprofessional education (Nicol, 2013; Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013). Interprofessional education is commonly defined as: ‘occasions when two or more professions learn from, with and about each other to enable effective collaboration and improve health outcomes’ (World Health Organization, 2010d, p. 13). IPE can occur either pre- or post- qualification, and within educational programmes, or in workplace settings. This approach assumes that if people are learning together they will build relationships that will have a positive influence on how they work together and collaborate with each other. This assumption is a useful beginning for understanding IPE.

Nonetheless, the WHO (2010d) focus on professionally-trained HCWs is somewhat limiting, as it does not allow for the learning that occurs between professionals, lay workers, and clients when engaged in the wider aspects of healthcare. These aspects are beginning to receive more attention in the literature, particularly in the areas of primary healthcare and person-centred care (Frosch et al., 2012; Gittel et al., 2013; Tucker, 2012). This widening of the interprofessional lens is reflected by shifts in terminology, which encompass all individuals that learn from, with, and about each other in

healthcare. In particular, the term *interprofessional learning* (IPL) is increasingly used in place of IPE (Evans, Henderson, & Johnson, 2012; Interprofessional Curriculum Renewal Consortium [ICRC], 2013; Wagter, Van de Bunt, Honing, Eckenhausen, & Scherpbier, 2012). The ICRC (2013) highlights the differences between the terms, using the WHO (2010d) definition of IPE noted above, while referring to IPL as 'learning arising from interaction between members (or students) of two professions. This may be a product of interprofessional education or happen spontaneously in the workplace or in education settings' (p. 5). This change is important, as it encapsulates the workplace learning that occurs informally with a wide range of people, not just professionals.

Looking beyond definitions, in the pre-data collection review I introduced IPE as a means of preparing the health workforce to be ready and able to collaborate. I also noted there was limited knowledge of whether IPE impacted on collaborative practices in the workplace. Since that time, new initiatives and research projects have provided greater understanding and a more focused research agenda for IPE and collaborative practice.

An example of the increased focus was shown at the interprofessional symposium 'All Together Better Health 5 (ATBH5)' held in Australia, in 2010. This conference was particularly significant, as it provided opportunities for formal and informal collaboration between those involved with developing IPE/IPC around the world. The international connections were such that attendees were able to approve a resolution aimed at advancing the cause of IPE and collaborative practice internationally (Sydney Interprofessional Declaration, 2010). The five articles within the resolution upheld the right of all health users to integrated collaborative health services. The report suggested these collaborations could be achieved through services which create opportunities for interprofessional learning, with IPE becoming a core element in both undergraduate and continuing professional development.

In the same year, the Lancet Commission (Frenk et al., 2010) also examined ways IPE could be used to impact on healthcare outcomes. The authors recommended the promotion of IPE as a means of fostering interprofessional learning, thereby breaking down professional silos and enhancing collaboration in teams. Both the Lancet Commission report and the Sydney Interprofessional Declaration (2010) provided international examples of the connecting needed for IPC development, and

demonstrated the growing focus on exploring interprofessional education and learning in the workplace.

Another observable trend in IPE and IPL is the drive to develop international research and practice cohesion through standardisation of terms, sharing of knowledge, and acknowledged research foci (Sydney Interprofessional Declaration, 2010; World Health Organization, 2010d). A common language is crucial if interprofessional education and learning are to develop. In support of this, the US Institute of Medicine has recently instigated a global forum on IPE (US Institute of Medicine, 2012). The aim of the forum is to encourage on-going dialogue regarding innovations in IPE. Through this initiative four countries (Canada, India, South Africa, and Uganda) have developed research connections, and are currently involved in collaborative research projects. Other plans are also being explored to broaden collaborative IPE projects across other nations. Similarly, the newly launched Global Research Interprofessional Network (GRIN) initiative (Thistlethwaite, 2013) aims to support new researchers and promote the interprofessional agenda internationally. These developments are significant, as they provide clear structures that have the potential to promote global messages about IPE and IPL.

Along the same lines, the World Health Professions Alliance (WHPA) recently released a joint position statement advocating collaborative practice in healthcare (World Health Professions Alliance, 2013). This alliance represents 26 million HCWs in 130 countries worldwide. The WHPA statement emphasises five principles for effective IPC. These comprise the areas of: governance and policy structures supporting collaborative practice, health system infrastructures enabling collaboration, education programmes, collaborative policies based on sound evidence, and professional practice centred on individual needs. This WHPA Report encourages IPC by stating these practices will be promoted through advocacy, example, and by promoting educational, legislative, and system changes that strengthen collaborative partnerships, while responding to the local healthcare context. As the report is so new, it is unknown what effect the message will have on policy decisions in New Zealand. Certainly there can be no doubt that collaborative education, learning, and practice is high on the international health agenda.

The IPE and collaborative practice agenda is also a focus for southern hemisphere researchers. In Australia, as part of a nationwide initiative aimed at progressing IPE and practice (Dunston, Thistlethwaite, Forman, & Rogers, 2013), two extensive studies have recently been undertaken (ICRC, 2013; Nicol, 2013). The first of these marks the only known national audit of IPE, while the second examines IPE practices. Although focused on Australian practices, the reference group for the audit (ICRC, 2013) included New Zealand academics, indicating potential relevance for the local context. The audit was designed to enhance IPE and workforce development, with seven key recommendations arising from the research. These emphasise the need for: national coordination between government bodies, educators, and clinicians, development of national standards with a common language for IPE, adopting collaborative practice requirements into the accreditation standards of health professions, and developing a national approach to IPE knowledge, research, and information sharing.

The international focus for interprofessional research and practice is evident. While international connections are established, consolidation of terminology and competencies, together with 'constructive alignment' (Thistlethwaite, 2012, p. 61) of researchers, practitioners, professional bodies, and government departments is needed. These relationships are critical to promote and advance IPE, learning, and collaborative practice.

2.4.2 Interprofessional competencies

Consolidation of interprofessional competencies is an area that has received attention over the last few years. At the time of the first literature review, the CIHC group had just released a set of key competencies that HCWs needed to develop for effective collaborative practice (CIHC, 2010). Following this initiative, in 2011 an American panel comprising six professional groups (American Association of Colleges of Nursing, American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Dental Education Association, Association of American Medical Colleges, and Association of Schools of Public Health), further refined the core competencies by 'identifying individual-level inter professional competencies for future health professionals in training' (IPEC, 2011, p. 36). Of particular importance was the inclusion of the medical colleges within this group, demonstrating a will to widen the connecting needed for IPC and move beyond

historic professional hierarchies. Targeted at undergraduate student education, the resulting IPC competencies comprise four domains: Values/Ethics for Interprofessional Practice; Roles/Responsibilities; Interprofessional Communication; Teams and Teamwork. The development of these undergraduate collaborative competencies complements the broader competency frameworks undertaken by others (Buring et al., 2009; CIHC, 2010; Thistlethwaite & Moran, 2010).

Although the focus on interprofessional communication and teamwork in these competency frameworks provides a useful beginning, it does not go far enough. I contend that the current undergraduate IPE does not necessarily equip HCWs effectively for the complexities of the workplace (Lingard et al., 2012), where interprofessional relating challenges occur and connecting processes are needed. This has implications for practice that are discussed in Chapter 9.

Meanwhile, as refinement of collaborative competencies continues (Tashiro, Bryne, Kitchen, Vogel, & Bianco, 2011), other authors have begun to debate the way the competencies are being implemented and outcomes measured (Murray-Davis, Marshall, & Gordon, 2013; Thistlethwaite, 2012; Weinstein, Brandt, Gilbert, & Schmitt, 2013). The CIHC (2012) for example, recently reviewed the 128 quantitative tools being used to measure IPE and collaborative practice outcomes internationally. The review categorised the IPE/IPC tools according to six levels of interprofessional outcomes (Barr, Koppel, Reeves, Hammell, & Freeth, 2008), with some of the measures fitting more than one category. Interestingly, the largest category of tools measured attitudinal outcomes (64 tools identified), followed by behavioural outcomes (34), knowledge and skill development (20), provider (14) and patient satisfaction (8), and organisational level outcomes (6). This review was salient, as the results provide a catalogued resource available for researchers and clinicians to access, which might support greater cohesion across the research area. I find it problematic though, that there are so many outcome measures that attempt to quantify relational aspects of IPE/IPC, such as attitudes and behaviours. These crucial areas of practice are complex and resist simple explanation. A more effective approach might be to utilise findings from these quantitative tools to direct and inform qualitative inquiry that explores the underlying meaning behind HCWs collaborative behaviours.

Another notable move within the interprofessional field is the drive for collaborative competencies to become an auditable requirement at both pre- and post-licensure levels within professional standards (Interprofessional Curriculum Renewal Consortium, 2013). This broadening of the interprofessional lens beyond undergraduate level signals a push to formalise IPC competencies in practice. This is beginning to be seen internationally with some accreditation bodies moving to include interprofessional skills within their professional registration standards (Thistlethwaite, 2012). Examples of this are seen in the UK with the Nursing and Midwifery Council, in Australia for doctor registration, and in Canada for postgraduate training (Confederation of Postgraduate Medical Education Councils; Nursing and Midwifery Council, 2010; Royal College of Physicians and Surgeons of Canada, 2005). In New Zealand, collaborative practice is mandated in nursing competencies (Nursing Council of New Zealand, 2013), suggested as good practice for doctors (Medical Council of New Zealand, 2013), and alluded to in terms of communication and cooperation in allied health competencies (New Zealand Physiotherapy Board, 2013; Occupational Therapy Board of New Zealand, 2013). Clearly, IPC is being promoted at the regulatory level. The role of regulatory bodies and professional standards also arose within this research and is discussed in the findings and discussion chapters.

2.4.3 Interprofessional relating: Power, attitudes, and leadership

Interprofessional researchers have recently focused on aspects of interprofessional relating. One strand appearing in the literature considers the influence of power on collaborative relationships. Power dynamics have been called 'the elephant in the room' (Hart, 2011, p. 373) of interprofessional relating, with hidden tensions raising barriers to collaborative processes. Nugus, Greenfield, Travaglia, Westbrook, and Braithwaite (2010) argued there was a negotiated order in healthcare, with a balance between 'collaborative power' and 'competitive power' (p. 898) that varied depending on the setting. Competitive power situations where the doctor dominated were more prevalent in acute hospital settings, rather than community work. As will be seen, the theory of connecting supports the view of competitive power relationships being less prevalent in the community. Baker, Egan-Lee, Martimianakis, and Reeves (2011), also discussed power in relationships, noting that interprofessional interventions were limited by outlooks that reinforced traditional power hierarchies.

Not surprisingly, interprofessional relating appears to shift when professional autonomy is threatened by hierarchical issues. Machin and colleagues (2012, 2013) noted that professional autonomy was an important aspect of role identity and relating in community nursing that was underpinned by a sense of collaborative power sharing. When nurses perceived their autonomy was lessening, they felt disempowered and collaborative processes could suffer. In contrast, as will be shown in the theory of connecting, professional autonomy was mentioned as a positive contextual aspect of community work in this research (see Chapters 5 & 6).

Alongside power issues, HCWs' attitudes towards IPE and collaboration influence interprofessional relating (Makino et al., 2013; Nicol, 2013). As noted earlier, attitudinal change is increasingly used as an evaluative measure for IPE (CIHC, 2012; Gardner, Chamberlin, Heestand, & Stowe, 2002; Hyer, Fairchild, Abraham, Mezey, & Fulmer, 2000). HCWs' attitudes are viewed as an implicit factor in the success of IPE and collaborative interventions that, if disregarded, can have negative outcomes, such as the professional *ö*turf warsö portrayed by Chung et al. (2012).

Interestingly, the literature around IPE/IPL effecting attitude change that in turn supports interprofessional relating is inconclusive (Thistlethwaite, 2012). While IPE can increase understanding and knowledge of other professions, it does not necessarily impact favourably on individuals' attitudes towards collaboration (Ateah et al., 2011; Evans et al., 2012; Hanyok, Walton-Moss, Tanner, Stewart, & Becker, 2013). Neither can it be assumed that undergraduate IPE interventions have a lasting effect on attitudes post-licensure (Makino et al., 2013).

Indeed, IPE has been presented as an intervention that can either aid or hinder attitudinal change at the workforce level (Pollard, Miers, & Rickaby, 2012). Nicol (2013) for instance, found attitude a block to collaboration, with many HCWs not prepared to engage with IPE and collaborative principles. Barriers were caused by a fear of role substitution and an attitude that there was insufficient evidence to persuade HCWs to adopt collaborative practices. In contrast, Derbyshire and Machin (2011), reported positive attitudinal changes from IPE workplace interventions, facilitated by enhanced role knowledge, relationships that connected people, and communication networks. Perhaps the difference lay in this study only evaluating one profession (nursing), whereas other studies into interprofessional attitudes included a range of

professional groups. Nonetheless, Robben et al. (2012) also found positive attitudinal changes from implementing an IPE programme with established HCWs, linking the benefits to improved interprofessional relating and shared leadership, rather than the IPE intervention itself.

The inconsistent findings about the effect of IPE on HCWs' collaborative attitudes suggest other elements influence outcomes. Complicating factors such as gender, age, background, profession, and learning opportunities influence HCWs' attitudinal shifts and need to be considered when planning IPE/IPL interventions at both undergraduate and workplace levels (Curran, Sharpe, Flynn, & Button, 2010; Larkin, Hitch, Watchorn, Ang, & Stagnitti, 2013; Onishi, Komi, & Kanda, 2013; Wilhelmsson et al., 2009).

The role of leadership in interprofessional relating is another focus area within recent literature. The Lancet Commission Report (Frenk et al., 2010) signaled the importance of leadership to facilitate interprofessional learning and collaborative practices in the field. Andersson et al. (2011) reasoned that leaders themselves can be a barrier or facilitator of collaboration, within their team and across agencies. Leaders can enhance collaborative practice by allocating time and resources for HCWs to work interprofessionally, as well as considering the wider needs of clients and HCWs beyond their own team. However, leaders face challenges in implementing collaborative practices due to entrenched power and professional hierarchical assumptions (Lingard et al., 2012a; MacMillan, 2012). As will be discussed, leadership was an important factor within the theory of connecting, which is considered through the findings and discussion chapters.

2.4.4 Impact of IPE interventions

Alongside developments in interprofessional education, competencies, and relating, authors have also explored the impact of these interventions. Recent reviews of the area highlight there is still work to be done in clarifying the long term impact of IPE on clinical practice (Reeves et al., 2013; Thistlethwaite, 2012). Thistlethwaite's review of IPE interventions (2012) concluded that, while there was some evidence that IPE encourages positive interactions among differing professions, there was varying evidence as to its impact on professional attitudes towards collaboration. That is not to imply that IPE is necessarily ineffective, rather that the methods of evaluating its impact may need further consideration. As demonstrated by the CIHC (Law et al., 2009,

Canadian Interprofessional Health Collaborative, 2012) researchers are currently using a wide range of outcome measures within IPE and collaborative practice, of which assessing for effectiveness and impact forms only one aspect. Additionally, a lack of consensus over terminology means IPE and IPL are still used interchangeably by some authors, even though differences exist (as noted earlier in the chapter). Using a range of outcome measures, with imprecise use of terminology makes knowledge synthesis challenging, and definitive statements on the impact of IPE difficult.

One way to manage knowledge synthesis is to review only high quality research. The Reeves et al. (2013) review of IPE interventions demonstrated this with a focus on high quality studies examining IPE interventions in practice. This meant limiting the reviews to studies using randomised controlled trials, controlled before and after (CBA) studies or interrupted time series (ITS) designs. The Reeves et al. study was the third Cochrane review of IPE interventions since 1999, with a total of just fifteen studies included over that time. Synthesising the three reviews Reeves et al., (2013) reported that seven out of the fifteen studies indicated positive outcomes from IPE interventions. These occurred in the areas of patient satisfaction with care provision; reduced mistakes and improved working culture in emergency department teams; increased collaborative teamwork in operating rooms and emergency department teams; improved care management in domestic violence cases; and enhanced mental health practitioner competencies related to the delivery of patient care. However, four of the studies demonstrated mixed results and another four reported that IPE had no impact on collaborative practice or patient outcomes (Reeves et al., 2013, p. 2). The review concluded that although some positive outcomes were identified, it was not possible to generalise about the key elements of IPE or its effectiveness. It is notable that the majority of these higher quality studies occurred in hospital settings, meaning wider healthcare inferences need to be made with caution.

Alongside these high quality reviews, other authors suggest the impact of IPE interventions need to be measured at the clinical, rather than student level. Polard, Miers, and Rickaby (2012) contend that students are not aware of the true value of IPE until out in practice. Correspondingly, Nicol (2013) found little evidence that IPE had any direct effect on collaborative practices in those organisations that provided student placements. Additionally, there were varying opinions about whether graduates with IPE training would effect change in team practices when they entered the workplace.

The continuing lack of clarity about how IPE impacts on clinical practice or changes attitudes towards collaboration is an important issue, and raises pertinent questions. Does formalising IPE and collaborative compliance through professional accreditation or large scale international advocacy result in practice change? If individual attitude shifts are needed to implement change in collaborative practices, will the global focus on interprofessional competencies, along with regulatory changes mandating collaborative practice be effective? Or will HCWs simply be ticking boxes to achieve their annual certification? While focusing international attention on the issue is an important step forward, informed debate needs to continue as to the most effective means of advancing collaborative practice in the workforce.

2.4.5 The theoretical basis for IPE and collaborative practice

As part of this debate, there has recently been a focus within the literature on advancing the theoretical base of IPE and collaborative practice. From its origins as a largely a-theoretical field, the interprofessional arena now draws from numerous theories, mostly borrowed from psychosocial and educational contexts (Hean, O'Halloran, Craddock, Hammick, & Pitt, 2013a). Theoretical developments can be described in terms of 4 levels ó descriptive, explanatory, predictive, and prescriptive theory (Artinian, 1982; Brink & Wood, 2001), with the majority of interprofessional theory drawn from descriptive and explanatory frameworks.

The increased interest in theoretical understandings was highlighted in a 2010 *Journal of Interprofessional Care* editorial, when Reeves (2010) called for research that developed the theoretical base of IPC. More recently, an issue of the journal specifically addressed progress in this area (*Journal of Interprofessional Care*, 2013, Vol. 27, Issue 1). Within this special issue, Suter et al., (2013) reported on their scoping review of theories being used in the interprofessional field. They focused on the area of systems and organisational theories, as an area less well understood than the psychological and educational theories in operation. Findings from their review indicated there were nine theories currently in use in the interprofessional field. These included the organisational theories of: institutional theory, organisational learning theory, learning theory, and equilibrium theories. The systems theories were identified as: activity theory, chaos theory, complexity theory, presage-process-product theory, and systems theory. In looking to the future, Suter and colleagues identified another eight theories from the

systems and organisational areas, which may have potential for use in interprofessional work. However, I find the suggestion of drawing on yet more theory from other fields problematic. Grounded theory is not often included in these accounts, although it has much to offer in terms of explaining what is happening in practice (as will be shown in the theory of connecting). I believe we do not need more external models that present a received view of the world. Rather, what is needed is development of theory that integrates prior work, specifying it with data from within the interprofessional field to explain what is actually happening in this context.

Barr (2013) also reviewed the use of theoretical models, but specifically focused on those in IPE. In summarising the current trends, Barr confirmed that authors typically apply external theories when exploring IPE (e.g. activity, organisational and general systems theories), rather than developing original models. Barr found two main categories of theory use within IPE research – those using theory to inform IPE process improvements, along with theories that challenge current conventions beyond the process level. While the use of theoretical models is needed to increase understanding, I agree with Barr's caution that 'applying external theories can be counterproductive unless they are tested against the realities of practice' (p. 7). The subsequent chapters will demonstrate how I have addressed this concern, by developing an original theory of connecting, which is grounded in the realities of HCWs' everyday work.

Similarly, Hean and colleagues (2013a) also advocated the need to rigorously test external theories within the interprofessional field, drawing on social capital theory as an exemplar of how to achieve this. Bleakley (2013) adds to the cautionary voices, finding that new conceptual language arising from interprofessional theoretical developments can confuse HCWs. To avoid this, theory should be developed with practitioners, using language and concepts understood in practice. The use of grounded theory in this study provides an example of constructing theory with participants that has relevance and resonance.

In contrast, Hall, Weaver, and Grassau (2013), advocate the use of external theories as a means of increasing understanding of interprofessional processes. However, they adapt these theories to the context of interprofessional learning by weaving key components from several theories into a 'theoretical toolbox' that they use for IPE activities. It

remains to be seen whether this blended approach clarifies the field or muddies the waters.

Despite the predominant use of external theory within the interprofessional field, there are some original developments showing promise. For example, a new international network has recently been launched (In-2-Theory) which aims to build theoretical rigor in the interprofessional area (Hean et al., 2013). This community of scholars and practitioners has the potential to consolidate and mature the theoretical base for the interprofessional field, building on existing work and developing theory with particular relevance for this speciality area. It is anticipated that the contribution of the theory of connecting will add to the emerging theoretical base within collaborative practice.

2.5 Summary

This chapter has presented a literature review in two sections. Beginning with an explanation of the role of literature reviews within grounded theory, I then discussed literature available during pre-data collection (2010), focusing on the broad areas of IPC and teamworking. From this, gaps in existing knowledge and the sensitising ideas and concepts with which I entered the field were presented. In particular, I found a lack of knowledge around the impact of IPE in clinical practice, the barriers to IPC implementation, how HCWs actually practiced collaboration, and how the team leader influenced collaborative practice within a team.

The second section of the review was written post-data collection and involved a review of developments in the interprofessional field over the last few years, providing current context in which to situate the theory of connecting. From this review, it was seen that the need to clarify the longer-term impact of IPE with high-quality research remains a priority. Researchers are also focusing on standardising interprofessional terms, pushing for collaborative competencies in professional standards, and developing the theoretical basis for the area. Additionally, relating issues such as power, attitudes, and the role of leadership within ¹IPC are being developed.

The next part of the thesis moves into methodological issues. In Chapter 3 the research methodology is explicated, while in Chapter 4 I discuss the methods used throughout this study.

¹ From this section on, the term IPC is replaced by 'collaborative practice' (except for the original research questions) as this reflected the participants use of terminology ó refer to section 1.1.2

Chapter 3 Research methodology

3.1 Introduction

Articulating the theoretical assumptions upon which a study is based is an important principle in research. It aids rigour by clarifying the state of knowledge development at the time and explicating existing assumptions. Identifying the theoretical assumptions in turn supports the choice of research methodology (the rationale and philosophical assumptions underlying a study), and methods (the research processes) (Lincoln & Guba, 2000; Silverman, 2011; Wisker, 2008). This chapter fulfils this purpose, beginning with a discussion on the constructivist epistemology that informs this work.

After laying this foundation, grounded theory is introduced as the methodological process used in this research. Grounded theory is defined as a process of inductive theory building in which theory emerges from the data, rather than other sources (Crotty, 1998). In this section I present an outline of the origins of grounded theory and its development into differing variants, before introducing constructivist grounded theory (Charmaz, 2000, 2006, 2009) as the specific version used in this study. The chapter closes with discussion of the key components in grounded theory research.

3.2 Epistemological positioning: Constructivism

This research is underpinned by a constructivist epistemology, which maintains that knowledge is created by the individual and collective actions of people (Bryant & Charmaz, 2007b; Guba & Lincoln, 1994). Constructivism is very different to the positivist view of the world, where knowledge and truth are considered as objective notions (Crotty, 2003). Viewed from a constructivist perspective, the ontological notion of an external reality or truth is contentious, as the only reality a person can know is developed by thoughts, based on the meaning or knowledge the individual has constructed. Constructivism is therefore typically considered an ontologically relativist and subjective stance (Andrews, 2012; Guba & Lincoln, 2001).

Constructivism's relativist positioning has been critiqued by opponents contesting a view that holds there is no external objectivity (Andrews, 2012; Burr, 2003; Schwandt, 2003). I too have difficulty accepting the more extreme variants of constructivism, which hold that there is no absolute truth (von Glasersfeld, 1991). My understanding of

constructivism aligns with the more moderate ontological stance noted by Berger and Luckmann (1991), and the idea of subtle realism articulated by Hammersley (1992). I agree with the notion that reality can exist independent of human thought. Even so, the meaning one makes of this reality is always a construct, based on one's thoughts and experiences (Schwandt, 2000). A diamond for example is an actual object that exists, although people imbue it with differing meanings. For example, a diamond can be viewed as a source of income for a diamond worker, or a symbol of commitment in an engagement ring for a couple.

Constructivism is sometimes mistaken for 'social constructionism'. The terms have similar roots and are, at times, used interchangeably by various authors (Charreire-Petit & Huault, 2008; Lincoln & Guba, 2000). However, I join other authors in contending that there are differences between the terms. Bryant and Charmaz (2007a) for instance, discuss how constructivism focuses on individuals constructing their own version of reality. In contrast, their view on constructionism emphasises reality being defined by social interactions and collective actions. Schwandt (2000) and Young and Collin (2004), similarly agree with the emphasis on the social interactions of constructionism. In contrast, Guba and Lincoln's (1994) definition of constructivism stresses the methodological construction of knowledge, rather than social aspects. Andrews (2012) likewise, delineates constructivism as involving cognitive knowledge, while linking constructionism to social processes. Within grounded theory Charmaz (2009) refers to her work as constructivist rather than constructionist. Charmaz emphasises that social constructionists do not specifically include the researchers' actions as constructed, and do not account for researcher reflexivity. Accordingly, there is support for my stance of considering the terms as closely linked but separate.

While articulating epistemological understanding is an important constructivist principle, classic grounded theorists maintain that stating an epistemological position early in the research does not align with grounded theory methodology (Breckenridge, Jones, Elliott, & Nicol, 2012; Glaser, 2002; Holton, 2007). Glaser (2002, 2005) for instance, contends that grounded theory researchers should essentially remain neutral, waiting for a perspective to be identified by participants. If one takes a classic grounded theory stance, where the researcher is not considered an active part of the process, this may be possible. However, as a constructivist I see the researcher as a co-constructor of data and analysis and therefore I needed to articulate the position with which I began

this process. Accordingly, I have framed this research through constructivist epistemology, as this standpoint fits with the research aims, the methodology of constructivist grounded theory, and with my view of the world.

3.2.1 Constructivism and pragmatism

The constructivist movement was first described by Piaget (1967) who has been described as 'the great pioneer of the constructivist theory of knowing' (Von Glaserfeld, 1990, p. 4). The development of the perspective however, can be traced to earlier notions, particularly that of pragmatism. The rise of pragmatist ideals in the 1900s with authors such as Peirce (1935), James (1907), and Dewey (1938), challenged people to explore the notion of absolute truth. James (1907) for example, argued that truth is not a transcendent reality awaiting discovery; rather, that truth is created through the process of experiences. Similarly, other aspects of pragmatism can be seen as precursors of constructivist thought. The idea of primacy of practice, whereby theories arise from direct experiences and function as tools that assist people to understand their environment, sits well with constructivist ideas of making meaning from actions and experiences (Hookway, 2010). Likewise, the pragmatist notion of theory deconstruction, whereby philosophies are viewed as attempts to understand existence in specific contexts, rather than universal theories, informs constructivist principles of contextual knowledge. Modern pragmatic ideals continue to be linked to constructivism, with pragmatists such as Rorty (1989) questioning the value of searching for 'truth' in research, noting that there appears little relation between an individual's well-justified beliefs and reality. This view is not universal though, with other authors suggesting that differences exist between pursuing truth and pursuing beliefs, and therefore pragmatists are justified in inquiring after truth (Wrenn, 2005). Despite the on-going debate, pragmatic tenets remain at the foundation of constructivist thought (Charmaz, 2006).

Alongside the modern pragmatists, several authors have continued to develop the constructivist thinking begun by Piaget. Constructivist developments arise from four commonly articulated tenets (Dolittle & Camp, 1999; Garrison, 1997; Von Glasersfeld, 1998).

These constructivist tenets can be summarised as:

1. Individuals form knowledge through active cognitive processes, rather than passive accumulation.
2. People use cognition as an adaptive process to make their behaviour more acceptable in differing environments and contexts.
3. Through cognitive processes individuals organise and make sense of their experiences, rather than making an accurate representation of reality.
4. Knowledge emerges from both biological/neurological constructs, as well as from social and cultural interactions.

These four tenets are not unanimously accepted. They do though, form a basis to compare and contrast the differing approaches. Today there are three main forms of constructivism - cognitive, social, and radical, which share some aspects of the four tenets, but vary in focus and degree (Dolittle & Camp, 1999; Fosnot, 1996; Schwandt, 2000; Von Glasersfeld, 1991, 1998; Vygotsky, 1978). The main differences between these models are identified in Table 3, which is adapted from Dolittle and Camp (1999) and Von Glaserfield (1999).

Table 3: Constructivist models

Constructivist model	Defining principles	Adherence to central constructivist tenets	Knowledge assumptions
Cognitive constructivism	<ul style="list-style-type: none"> • Knowledge is situated externally. • Belief that an independent reality exists and is knowable to the individual. 	<ol style="list-style-type: none"> 1. Knowledge results from active cognition by the individual. 2. Knowledge acquisition is an adaptive process. 	<ul style="list-style-type: none"> • Knowledge results from accurate internalisation and (re)construction of an external reality. • Knowledge construction is a technical process of creating mental structures that represent the 'real' world. • Unlike the other 2 forms, it does not include the subjective nature of knowledge within the mind.
Social constructivism	<ul style="list-style-type: none"> • Knowledge is the result of social interaction and language usage. • Knowledge is a shared, rather than individual experience. • Reality is socially created. 	<ol style="list-style-type: none"> 1. Knowledge results from active cognition by the individual. 2. Knowledge acquisition is an adaptive process. 3. Knowledge arises through experiences, and does not necessarily reflect external reality. 4. Knowledge involves social/cultural and cognitive constructs. 	<ul style="list-style-type: none"> • Knowledge arises in the socio-cultural context. • Knowledge is contextual. • Knowledge is gained through co-construction of meaning in social settings. • Knowledge development is more concerned with meaning than cognitive structuring of knowledge.
Radical constructivism	<ul style="list-style-type: none"> • Knowledge arises internally. • Reality is unknowable. 	<ol style="list-style-type: none"> 1. Knowledge results from active cognition by the individual. 2. Knowledge acquisition is an adaptive process. 3. Knowledge arises through experiences, and does not reflect external reality. 	<ul style="list-style-type: none"> • Knowledge is internally constructed from experiences. • Knowledge is not objective truth. • External reality may exist, but is unknowable to the individual. • Knowledge construction is influenced by context.

Charmaz describes social constructivism as the variant underpinning her form of constructivist grounded theory (Charmaz, 2000, 2006). Extending the summary above, social constructivism is a perspective that draws on culture and context to understand what happens in society, and to construct knowledge based on that shared understanding (Derry, 1999; Kim, 2001). Social constructivists follow three main assumptions that are linked to general constructivism but focused on social interactions. These assumptions include: that *reality* is believed to be constructed through human activity, so that reality is not found, but socially invented (Kukla, 2000). *Knowledge* is also viewed as socially and culturally constructed, with meaning created through personal interaction with the environment and other people (Gredler, 2008). Additionally, *learning* is perceived as a social process, with meaningful learning said to occur most effectively when individuals are engaged in social activities. The emphasis on social processes within social constructivism fits well with the research questions in this study which ask: How do healthcare workers view IPC in the community-based teams where they work? How do healthcare workers explain/construct their collaborative actions in community-based teams? In what circumstances do their actions change and why?

3.3 Methodological positioning: Grounded theory

As I prepared my research proposal, I was aware that the choice of research methodology needed to be consistent with the research questions (Crotty, 2003; Denzin & Lincoln, 1994). In this case, it was evident early on that there was a fit between the emphasis in grounded theory on exploring social processes, and the research questions' focus on exploring how HCWs explain their collaborative actions in community rehabilitation teams. Still, to support credibility it was not enough to broadly state I was 'doing grounded theory'. Indeed, it is argued that generalist use of the grounded theory label weakens the trustworthiness of the method, opening grounded theory proponents to critique (Bryant & Charmaz, 2007a; Morse, 2009). Bryant and Charmaz (2007b) maintain that while grounded theory is a 'family of methods' (p. 12), rigour is supported by researchers clarifying which branch of the 'family' they adhere to. Yet choosing which variant of grounded theory to use is often difficult for novice researchers (McCallin, 2009). As part of developing my research skills, before beginning this research I explored the main variants of grounded theory that have developed over the last four decades. In reading the grounded theory literature, I became convinced that choosing a grounded theory variant that fitted with the aims of the study and my personal perspective was an important part of the process (McCallin, 2009; Morse et al., 2009). In the section below I describe my exploration and understandings of each variant. I begin with the original work of Glaser and Strauss (1967) and lead through the other variants as they chronologically developed. I finish the section with a brief explanation of why I chose Charmaz's version of constructivist grounded theory as the methodological process for this study. The last part of the chapter then explains constructivist grounded theory tenets in greater detail and outlines the key components of grounded theory according to Charmaz (2006).

3.3.1 Grounded theory development

The launch of Glaser and Strauss's seminal work, *The discovery of grounded theory* established grounded theory as a new qualitative research method (Glaser & Strauss, 1967). The original aim of grounded theory was to show how theory could be discovered from data that was systematically obtained and analysed in social research (Glaser & Strauss, 1967). At the time, the dominant research paradigm was quantitative, and the development of grounded theory was partially influenced by pressures to make qualitative work more objective, systematic, and logical (Walker & Myrick, 2006).

With a mix of quantitative and qualitative backgrounds, Glaser and Strauss collaborated together to mould an objective method that was innovative, melding the depth of interpretive methods with the logic from quantitative survey research (Charmaz, 2000; Glaser & Strauss, 1967). Grounded theory broke new ground with its premise that, rather than focusing on hypothesis-proving, researchers could inductively gather data first, and then systematically analyse it to discover theory grounded in the data (Dey, 1999; Walker & Myrick, 2006).

Following the initial development of grounded theory, Glaser and Strauss's careers moved in differing directions. Both authors continued to spread their work through articles, books, and mentoring students. Stern (1994) noted that it was evident to students early on that the two authors had quite differing approaches to grounded theory. This became apparent to the world when Strauss (1987) published his perspective on grounded theory, which emphasised descriptive analysis. This interpretation was expanded in partnership with Juliet Corbin (Strauss & Corbin, 1990, 1998). Strauss's work was strongly contested by Glaser (1992), who argued that the two versions of the methodology were so disparate that they should have different names – 'Grounded theory' for those following Glaser, and 'Conceptual description' for Strauss adherents. The authors continued to develop their individual views over the next few years.

Glaser, in particular, has been prolific in producing works articulating his position and critiquing the direction other researchers have taken with grounded theory (Glaser, 1978, 1992, 1998, 2001, 2002, 2003, 2005, 2011). In turn, other researchers have responded and furthered the debate surrounding the differing grounded theory variants (Birks & Mills, 2011; Breckenridge et al., 2012; Bryant, 2003; Bryant & Charmaz, 2007a; Corbin & Strauss, 1990; Dey, 1999; Henwood & Pigeon, 2003; Holton, 2009).

While retaining the main features of the original version, over time Glaser appears to have modified his stance in some areas. He has further developed theoretical coding, and refined the processes for coding and assessing rigour (Glaser, 1978, 1998, 2005). Glaser continues to mentor classic grounded theory students and a new generation of researchers continue the methodology, publishing through the classic grounded theory journal *Grounded Theory Review*. The classic version of grounded theory retains an objective perspective, where the researcher resists adding their own interpretations to

the data (Glaser, 2002). In reading Glaser's works from today's post-modern perspective, I found this position difficult to reconcile with my own views about how the researcher impacts on the process. For this reason, I did not consider utilising the classic methodology.

As Glaser continued his work, Strauss and Corbin (Strauss, 1987; Strauss & Corbin, 1990, 1998) further advanced their views on grounded theory, with an increased focus on coding and analysis frameworks using axial coding. Today, Corbin continues to refine their variant, honouring Strauss's memory by continuing the joint authorship (Corbin & Strauss, 2008). I was initially interested in the structure provided by axial coding, thinking it was a framework that may have provided a useful tool for my analysis. Yet, when I attempted axial coding at one stage of analysis, I found the framework too specific for my style of analysis. I felt it forced my analysis into pre-set directions that limited openness to other analytical possibilities.

The evolution of grounded theory did not stop with the disbanded partnership of Glaser and Strauss, but has continued through to the next generation as students of the originators brought their own perspective to the method (Morse, 2009). Schatzman's development of dimensional analysis was one of the earliest steps away from the original model. Initially developed while working with Strauss (Schatzman & Strauss, 1973), dimensional analysis is not considered as grounded theory per se, but a new method that gives tools for managing data analysis (Schatzman, 1991). Current proponents of dimensional analysis (Bowers, 1989; Bowers & Schatzman, 2009; Caron & Bower, 2000) continue the dialogue on ways this method is congruent with the tenets of grounded theory.

Another key proponent, Adele Clarke has added her version –situational analysis– to the grounded theory variants over the last decade (Clarke, 2003, 2005, 2009). Clarke, a student of Strauss, has extended his ideas on social worlds and arenas, adding the central component of situations and including her perspectives derived from feminism and post-structuralism (Clarke, 2009). Clarke depicts her method as a 'theory/methods package' (Clarke, 2009, p. 197) grounded in the epistemologies of symbolic interactionism, constructivist grounded theory, and situational analysis, and bound by Foucault's notions of discursive formations (Clarke, 2003). Clarke provides clear analytical tools to support her grounded theory methods, such as the use of situational,

social and positional maps (Clarke, 2009). These maps move analysis beyond participant actions to explore 'the key elements, discourses, and conditions of possibility that characterise the situation of inquiry' (Clarke, 2009, p. 211). Similar to my views of axial coding, in reading Clarke's work I felt situational mapping would shift my analysis into set frameworks. As this did not match my style of analysis, it was not pursued.

The other seminal development in grounded theory was driven by Kathy Charmaz, a student of both Glaser and Strauss. Drawing on ideas from the original authors, Charmaz developed a model of grounded theory based on constructivist tenets as articulated earlier (Charmaz, 2000, 2003, 2006, 2009). This method held immediate appeal and I found myself gaining insights as I read Charmaz's works. I chose constructivist grounded theory as the methodological process for this research because the constructivist perspective fitted with the research purpose and with my personal view of the world. In offering a flexible set of methodological tools, rather than a rigid framework, constructivist grounded theory methods also appealed as my preferred style of analysis.

3.3.2 Constructivist grounded theory (CGT)

Constructivist grounded theory has congruence with the epistemological and theoretical starting point of constructivism, thereby strengthening the theoretical position of this research (Crotty, 2003; Denzin & Lincoln, 2005). The moderate approach to social constructivism articulated by Charmaz (Charmaz, 2000, 2003, 2006, 2009; Charmaz & Bryant, 2011) fits the research questions which focus on how HCWs construct and understand their collaborative actions in teams. Recently, other authors have added depth to the CGT literature (Birks & Mills, 2011; Bryant, 2002, 2003; Bryant & Charmaz, 2007b; Clarke, 2005; Dey, 2007; Mills, Bonner, & Francis, 2006). While their work has also informed my thinking, for example Bryant's interesting rejoinder to Glaser where he critiqued classic GT's lack of response to 'the extensive critique of positivism over the last forty years' (Bryant, 2003, p. 2), this research remains underpinned by Charmaz's framework. Unlike positivist positioning, the influence of the researcher is a critical component in CGT, as they are situated inside the research as a co-constructor of data and analysis with the participants (Bryant, 2002; Charmaz, 2000, 2006). How I managed my role within this study is discussed in Chapter 4.

Within a constructivist grounded theory, the researcher's aim is to learn about social worlds (participants' lives and actions), and to understand both explicit and implicit perspectives. The finished product (the grounded theory) offers an interpretive understanding of a substantive area, which has wider applicability (Charmaz, 2008a). Salient features of constructivist grounded theory include notions that both data and analyses are emergent social constructions, are value related, and are situated in time, space, and culture (Bryant & Charmaz, 2007a). This is important for this study, as it allows the significance of the New Zealand community setting to be explored, and aims to produce an outcome that has resonance and usefulness for participants. It is also a potential limitation of the methodology, as wider applicability cannot be assumed. Rather, to enable theoretical usefulness across differing fields, constructivist authors should articulate how their research provides insight and understanding to more diverse populations. Considerations of the broader impact of my research are discussed in the data collection section of Chapter 4 and within the Discussion (Chapter 9).

Constructivist grounded theory places less emphasis on specific analytical methods than other variants, such as the axial coding model of Strauss & Corbin (1990). Hence, constructivist grounded theories tend to be 'plausible accounts' (Charmaz, 2006, p. 132), rather than objective theories. Charmaz makes a case that constructivist theory does not necessarily rely on a single basic process (Glaser & Strauss, 1967) or a core category (Corbin & Strauss, 2008). Instead, it 'recognises diverse local worlds and multiple realities, and addresses how people's actions affect their local and larger social worlds' (Charmaz, 2006, p. 132). While recognising Charmaz's argument that a core category is not essential, I wanted to remain open and, if possible, construct a theory using one core process to explain a complex area of practice.

3.3.3 Key components of constructivist grounded theory

Given the range of variants, it is not surprising that debate continues over which elements constitute the main components of grounded theory (Birks & Mills, 2011; Bowers & Schatzman, 2009; Bryant & Charmaz, 2007; Clarke, 2003; Glaser, 2003; Holton, 2008; Hood, 2007; Locke, 2007; Morse, 2007; Stern, 2007; Urquhart, 2007). The major components of the original version of grounded theory are constant comparative analysis, memoing, theoretical sampling, and data saturation (Glaser & Strauss, 1967). CGT meanwhile, considers the key processes to include: data collection,

coding, constant comparative analysis, memo writing, theoretical sampling, saturation, and theoretical sorting. In this section I outline these key components of grounded theory according to Charmaz (2000, 2003, 2006, 2009), and compare the CGT perspective to other variants position on these processes.

3.4.3.1 Data collection

Gathering rich data is an important consideration in all grounded theory research. While Glaser (2002) stated that in grounded theory 'all is data,' in practice some forms of data lend themselves to particular variants of grounded theory better than others. In CGT, data collection is more considered than the classic grounded theory variant. As Charmaz (2006) commented: 'Data vary in quality, relevance for your emerging interests, and usefulness for interpretation' (p. 16). Similarly, Morse (2007) noted that not all data are equal, and some will be of more use than others. Part of gathering rich data depends on the skill of the researcher, along with the method of data collection chosen. Intensive interviewing is considered an effective data collection method in CGT, as it allows in-depth exploration of participant areas of interest. Interviewing allows the researcher more control over the construction of data than other data collection methods (Charmaz, 2006). This influence is able to be tracked through analysis of tapes and transcripts, thereby highlighting the CGT principle of the researcher as a co-constructor of data with the participants.

Interviewing can be undertaken as a single method, but it is also complemented by the use of field observations. In CGT, observational data is collected that focuses on the studied phenomenon or process, rather than describing the setting (Charmaz, 2006). That is, observation is undertaken through considered selection of scenes that will add knowledge about processes and actions in an area, rather than describing structures and scenes. Researchers are not passive observers in the collection of this data, but rather 'probe beneath the surface and dig into the scene' (Charmaz, 2006, p. 23). Both interviews and observations were used as data collection methods in this research. These are considered in detail in Chapter 4.

3.4.3.2 Coding

Coding is the beginning step in data analysis. It is an interpretive process which involves labelling small sections of data with a name that summarises what is happening in the data. Coding works as a means of managing data, breaking it down by defining portions of data, capturing patterns, and clustering them under suggestive titles (Charmaz, 2006; Glaser & Strauss, 1967; Lempert, 2007). Grounded theory variants all hold coding as central to the method, but vary in the way coding is employed. For example, Glaser's coding families (Glaser, 1978), and Strauss's coding paradigms and axial coding (Strauss & Corbin, 1990) provide structured frameworks, whereas Charmaz (2006) avoids applying preconceived codes, aiming for emergent, open coding of data.

In constructivist grounded theory, coding has at least two main phases: initial and focused coding (Charmaz, 2006). In the initial phase, data is coded by labelling each line or small segment of data with words that reflect actions (gerunds), rather than topics. The aim of initial coding is to remain open to all possible theoretical ideas and to look for assumptions and implicit actions and meanings. In contrast, focused coding, which occurs later in the process, uses the most significant early codes to sort, organise, and define large amounts of data. The researcher makes decisions about which initial codes best fit the analytical direction indicated by the data, and uses these codes to compare and categorize data. It is a time of exploration and constant comparison, where codes are tested against the data to see if they adequately define the processes and can be used as labels for analytical categories.

A third type of coding, theoretical coding is additionally used towards the end of some CGT studies. Theoretical coding is a high level form of analysis that assists researchers to 'specify possible relationships between categories you have developed in your focused coding' (Charmaz, 2006, p. 63). Initially introduced by Glaser (1978), with his 18 theoretical coding families, theoretical coding can help lift an analysis, making it more coherent by integrating the analysis. Charmaz advocates using theoretical coding if the analysis indicates it fits, but cautions against imposing a theoretical code as a matter of course. Glaser (1978) similarly notes that theoretical codes must earn their way into an analysis.

3.4.3.3 Constant comparative analysis

As the researcher begins coding, constant comparative analysis, the main analytical tool in grounded theory, also commences. Constant comparative analysis, whereby data collection and analysis occur concurrently, is a hallmark of grounded theory (Glaser & Strauss, 1967). This form of analysis uses inductive processes to move between data and emerging analytical ideas and codes, comparing data with data, codes with categories, categories with other categories, and categories with concepts (Charmaz, 2006; Glaser & Strauss, 1967). The constant movement between data and analysis assists in developing categories, which are abstract theoretical notions that are also grounded in participants' data (Bryant & Charmaz, 2007b; Glaser, 1978; Glaser & Strauss, 1967).

3.4.3.4 Memo writing

Memo writing is considered a crucial step in grounded theory, providing the link between data collection and theory development (Birks & Mills, 2011; Bryant & Charmaz, 2007b; Glaser & Strauss, 1967). Memos are 'uniquely complex research tools' (Lempert, 2007, p. 245) used in a variety of ways during the process. Memoing ranges from free jotting of ideas, through to conceptual linking, and theory development. Memo writing is intended to keep the researcher engaged, reflective, and questioning their analyses, which increases the abstraction, richness, and depth of their ideas (Bryant & Charmaz, 2007b).

Some authors differentiate between procedural/ process memos and theoretical memos (Lempert, 2007). I consider all memos to be ways of creatively engaging with data, which assist a researcher to record analytical thoughts, undertake constant comparison of data, and develop their conceptual thinking. Stern (2007) considers memos as the mortar holding the developing theory together. Charmaz values memo writing as a tool that allows researchers to freely explore their ideas and increase the theoretical level of abstraction (Charmaz, 2006). As memo writing provides narrated records of analytical development, it serves the additional purpose of providing both an audit trail to track development of thinking, and becomes a storehouse for sorting and retrieving ideas (Strauss & Corbin, 1998).

3.4.3.5 Theoretical sampling and saturation

Theoretical sampling is a data collection strategy that promotes theoretical development. It is undertaken in the mid and later stages of research when initial categories have been developed. Glaser and Strauss (1967) originally described theoretical sampling as a process involving joint data collection, analysis, and decisions on what data to collect next in order to develop the emerging theory. Birks and Mills (2011) consider theoretical sampling a process of identifying and pursuing clues (that is, concepts that arise during analysis), which is central to making grounded theory emergent. Theoretical sampling is not about sampling for negative cases, unless this has arisen during initial data analysis. Rather it is a specific, systematic response to analytical memos that identifies lines of inquiry to pursue that will support category development, and assists in predicting where to find further data (Charmaz, 2006). From theoretical sampling, categories can be refined, analytical weaknesses resolved, and concepts developed to become more abstract.

Theoretical sampling is about following concepts and analytical directions that the researcher develops through increasing theoretical sensitivity (refer to page xii) as the data is analysed. As such, it is a strategy that can be individually tailored to the needs of the study. For instance it can be utilised to develop the properties of a category part way through a study, be used later in the process to explore links between categories, or move into different contexts to more fully develop the theoretical processes (Charmaz, 2006). This specific feature of grounded theory means that researchers may end up sampling in diverse areas and across fields they had not considered when commencing the research.

Knowing when to cease theoretical sampling and data collection can be problematic. Grounded theory authors often use the rationale of theoretical saturation to justify stopping data collection (Charmaz, 2006; Glaser & Strauss, 1967). Theoretical saturation refers to the point when fresh data no longer adds new theoretical insights (Birks & Mills, 2011; Bryant & Charmaz, 2007a, 2007b; Glaser & Strauss, 1967). However, critics argue that theoretical saturation is not truly possible in an emergent methodology, and that the term is too often used to justify small sample sizes (Dey, 2005), or to justify a study without actually proving saturation has been achieved (Morse & Field, 1995). Assumption of theoretical saturation is also noted as a common hazard affecting grounded theory rigour (Charmaz, 2006).

The constructivist perspective of grounded theory being conditional and contextual (as described earlier), aligns with the view that achieving theoretical saturation is challenging. Constructivists acknowledge that categories may continue to be modified after publication. In other words, the theory represents one explanation, rather than a discovered truth (Bryant & Charmaz, 2007a). The way I considered theoretical saturation and used theoretical sampling is discussed in Chapter 4 -Participant sampling.

3.4.3.6 Theoretical sorting and diagramming

Theoretical sorting and diagramming provide the practical means through which grounded theory analysis is organised, as theoretical links are formed between categories and concepts (Charmaz, 2006). Theoretical sorting involves compiling and comparing analytical memos to make logical sense of them, creating order and links that readers can follow. Sorting is individual, with each researcher finding a method that works for them. Charmaz (2006) and Glaser (1998) prefer hand sorting of memos, whereas other authors use computer software such as NVivo or MAXQDA (Corbin & Strauss, 2008). Either way, sorting and integrating of memos is a stage of analysis where sub-categories, categories, and concepts are compared, tentative links made, and possibly later discarded, and new links explored.

Sorting leads to arrangements of memos and categories, from which further memos are generated explaining the links. Diagramming is often used at this stage to provide visual representation of categories and their relationships (Charmaz, 2006, p. 117). Some grounded theory proponents treat diagramming as an essential part of grounded theory, and have developed specific diagramming methods which were not in the original version of grounded theory (Artinian, West, & Conger, 2011; Clarke, 2003, 2005; Strauss & Corbin, 1998). Charmaz (2006) supports diagramming as a tool to clarify analytical direction and integrate memos. However, she cautions against employing rigid diagramming frameworks which can force data into pre-set categories. As will be seen in Chapter 4, diagramming formed an important part of sorting in this study.

3.4.3.7 Evaluating grounded theory

The evaluation of a grounded theory study varies depending on the perspective and purpose of both the reader and researcher (Charmaz, 2006; Corbin & Strauss, 2008). While the substantive theory should have wider applicability and scope amongst differing populations, constructivist grounded theorists are particularly concerned with the findings having resonance and usefulness for those in the substantive (studied) area (Charmaz, 2006). Any evaluation therefore begins with knowledge of the intended audience and purpose of the research. The purpose of this research was to construct a substantive theory that contributed new insight into the ways in which community HCWs practice. It was anticipated the theory could be used to inform clinical practice, future resource management, and ultimately have an impact on the quality of interprofessional working. The intended audience includes community health teams, health funders, Health Workforce NZ², local and international researchers, and organisations that train and educate health professionals.

Each of the seminal grounded theory proponents has offered criteria for evaluating research. Glaser and Strauss (1967) originally suggested that grounded theories should demonstrate properties of *fit*, be *understandable*, be *general* enough to apply to differing situations within the substantive area, and allow the user *control* over the process as it changes over time. Glaser (1978) later modified these criteria to include: *fit, work, relevance, and modifiability* and then added *parsimony* and *scope* to his evaluative criteria (Glaser, 1992). Strauss and Corbin moved assessment in slightly differing directions with their notions of evaluating *data quality, research process* and *empirical grounding* (1990), adding *theory quality* in 1998 (Strauss & Corbin, 1998). Corbin has gone on to further refine these terms, now listing ten basic evaluative criteria and thirteen additional points for consideration (Corbin & Strauss, 2008). Charmaz (2006) meanwhile advocates for research evaluation that addresses the *credibility, originality, resonance, and usefulness* of the grounded theory to its proposed audience. In conjunction with these seminal authors, others have added to the discourse on appraising grounded theory research. Examples of these evaluative criteria include those proposed by Bryant (2002), Chivotti and Piran (2003), Crotty (2003), Holloway (2005), Bryant and Charmaz (2007a), and Cooney (2011).

² Health Workforce NZ is a government funded organization set up in 2009 to lead, coordinate and plan the development of New Zealand's health and disability workforce.

Alongside authors developing evaluative criteria, a more recent trend is the additional emphasis on assessing the narrative skill and style of the grounded theory research (Bryant & Charmaz, 2007a; Dey, 1999). Stern (2007, p. 121) for example, makes particular mention of 'skilful writing' which presents the theory using straightforward language rather than jargon. Glaser also writes about the challenges with using jargon (2009). Charmaz (2006) agrees with the use of straightforward language, but notes that grounded theory narrative may be rendered in differing ways for differing audiences. She comments on the importance of the narrative being compelling and having aesthetic merit in order to have an impact on a wide audience. This suggests a more nuanced view of evaluative criteria that goes beyond simple criteria checking. The manner in which I considered evaluative criteria during this research is discussed in Chapters 4 and 9.

3.4 Summary

In this chapter I have discussed my understanding of the epistemological, theoretical, and methodological underpinnings that informed this research. I established the constructivist /symbolic interactionist foundation upon which my research was built, outlined my exploration of grounded theory variants, and identified Charmaz's constructivist version of grounded theory as my methodological tool. Key components of grounded theory methods have been outlined, and the ways different authors use these tools has been discussed. The following chapter builds on this foundation by explaining how the research methods were utilised as the theory of connecting was developed.

Chapter 4 Research methods

4.1 Introduction

This chapter explains the research methods used in this study, and shows how I operationalised the methodological foundation described in the previous chapter. Research methods refer to the techniques and procedures used to gather and analyse data (Crotty, 2003). Specifically, in this study I refer to the constructivist grounded theory procedures used in data collection and analysis. The chapter opens with a consideration of the ethical aspects influencing the research. Next, my position as researcher within the study is explained. I then introduce the research participants, and discuss sampling and recruitment. In the second part of the chapter the methods used in this study are presented, supported with examples from the data analysis. Consistent with constructivist principles, I use the first person pronoun throughout this chapter, thereby identifying my active role as the researcher in the study.

4.2 Ethical considerations

Ethical approval for the research was gained from the Northern Region Ethics Committee on 11th May 2011 (Appendix B), and from AUT University Ethics Committee on 5th July 2011 (Appendix B2). Following ethics committee approvals, local District Health Board approval to access participants from their staff was obtained on 13th July 2011 (Appendix B3).

The ethics process followed the *Ethical guidelines for observational studies* (National Ethics Advisory Committee, 2012). The guidelines consider several important ethical principles. The foremost of these is respect of peoples' rights through consideration of autonomy and protection issues. The guidelines also state that research should allow for diversity amongst participants. As New Zealand is a bicultural nation, Māori ethical considerations under the Treaty of Waitangi need to be adhered to. The ethical principles of justice and beneficence are also important, in that inclusion/exclusion criteria are fair, and the risks of any study are reasonable in light of the expected benefits. Additionally, researchers must act with integrity, conducting honest inquiry and thoughtful analysis, and minimising potential sources of conflict of interest. The NZ ethics principles adhere to international guidelines such as the WHO ethics standards, and the Nuremburg and Helsinki codes (U.S. National Institute of Health;

World Health Organization Research Ethics Committee, 2011; World Medical Association, 2000). The guidelines also have features specific to the New Zealand context. For instance, as outlined in Chapter 1, Māori as the indigenous people of New Zealand have rights enshrined in legislation. These rights of partnership, participation, and protection mean consideration of Māori perspectives are an important part of ethical planning in any research proposal.

Within this study, I prioritised respect for participants throughout the process. This was shown in the manner I engaged with participants at their convenience, considered their emotional safety when asking questions, and addressed confidentiality issues. With regard to Māori concerns, in the planning stages of this study, I consulted with Māori through local networks, academic channels, and via the Māori Research Advisor at Waitemata District Health Board (Appendix C). Their advice that any Māori participants should seek guidance from whānau or kaumatua (family or elders) before being interviewed was passed on to the one Māori participant as part of the pre-interview process (see participant recruitment, section 4.4.2). Justice, diversity and beneficence were deliberated when considering exclusion criteria and the impact of participating in the study. Additionally, throughout the process I have reflected on my developing research skills with the aim of producing a product that has usefulness for the participant group (see Chapter 3).

As the research progressed it became apparent that a second phase of data collection with field observations would be useful. The Ethics Committees involved in granting the original ethical approval were contacted for guidance. An amendment to the original ethics document covering the observational phase of data collection was sent to the Northern Region of the New Zealand National Ethics Committee. The amendment addressed issues around minimising the impact of my observations on HCWs' workloads, and what to do if inappropriate behaviour was observed, or if sensitive issues arose. After receiving ethical approval on 7th Dec 2011 (Appendix B4), the AUT University Ethics Committee and local District Health Board were formally advised of the amendment as per their protocols. Following the completion of this research, a summary of the findings will be sent to the ethics committees, the District Health Board, and Māori advisors.

4.3 My position as researcher

Research undertaken from a constructivist perspective situates the researcher within the study as a co-constructor of data and analysis with the participants (Bryant, 2002, 2003; Charmaz, 2000, 2003, 2008d). Unlike the classic version of grounded theory (Glaser, 1978, 1992; Glaser & Strauss, 1967), the subjective leanings of constructivist grounded theory hold that I am not a neutral, passive observer, nor a blank slate without prior knowledge or assumptions influencing my research. Rather, my individual knowledge, assumptions, and research skills have an impact on the research. This can be seen through the interview questions I chose, the leads that I followed, the way I constructed my analysis, and how the final theory is articulated. For this reason, outlining my background influences and prior assumptions is an important component in establishing the credibility of the research and establishing the baseline theoretical sensitivity with which I entered the study (Charmaz, 2006). As a health professional working in the community, I held preconceived ideas and assumptions about working collaboratively. Some of these were conscious, while others were more embedded. These assumptions and experiences proved to be a mixed blessing for the study. While my professional contacts and standing gave me credibility and a starting point to engage with participants, it also made it more difficult for participants to view me as a researcher rather than a colleague. For example, participant comments such as 'you know how it is' had to be gently challenged, as I sought to uncover the participant perspective rather than my own assumptions.

I was also aware that how I managed my assumptions and perspective in the study needed to be purposefully and transparently worked through. Taking a constructivist position, I realised early on that my personal perspective with preconceived ideas and entrenched professional interests might influence decisions about study direction and theory construction. I wanted to find a means of identifying which ideas were influenced by my own assumptions, and which were initiated by participants. To support this aim, before interviewing began I brainstormed my assumptions and professional interests about collaborative practice, and wrote a memo listing sensitising concepts to be aware of during interviews. This also included the sensitising ideas and concepts drawn from my initial literature review (Appendix A). Following discussion with grounded theory colleagues and my supervisors, I decided that I needed to take this a step further and drew on their suggestions to undertake a sensitising self-interview,

with a colleague questioning me about my assumptions. In this way, I was able to identify some of my more explicit assumptions and then, when those ideas came up in data collection, to question whether they were initiated by participants, or forced by myself (Glaser, 1978). While I did not uncover many overt assumptions initially, as the research progressed I became aware of other more implicit assumptions that I held. For example, as leadership arose as a point of interest I became aware that my own experiences as a team leader were relevant. After the first interview with a team leader, I realised that I held assumptions about leadership that needed to be explored. For instance, I presumed that team leaders would be supportive of collaborative processes and encourage interprofessional work, yet this assumption was not upheld by all participants. As interviewing progressed, I used memoing to continue to question my own preconceptions, with the aim of following participant direction and not my own professional interests. This process assisted me to prepare for subsequent interviews, where I could ask questions directed by the analytical direction. For example: 'Others have mentioned team meetings as important. What purpose do they serve in your team?' (See data collection later in the chapter).

Additionally, throughout the data collection process, discussions with my supervisors and fellow researchers assisted me to refine my interviewing skills and question my assumptions. Particularly useful were the times when a supervisor read over my transcripts and commented on areas where I was potentially leading the participant, or missed following up a comment due to assumed knowledge. For instance, in an early interview 'team dissension' was coded. I assumed that this arose because of professional role issues between individuals. Yet this was perhaps simplistic and did not uncover hidden patterns of behaviour. Reflecting with supervisors later, I saw how more nuanced questioning could have extended exploration of the issues, moving beyond professional interests to uncover implicit concerns. These sessions served as procedural safeguards and assisted my professional development as a researcher. Throughout the process I learned to become more reflexive.

Another source of procedural checking and monitoring of my assumptions came via a grounded theory group I attended. This group of grounded theory researchers met monthly to discuss grounded theory from a variety of perspectives. Peer critique and debate forms an integral part of grounded theory methods. I found this group provided a place for shared learning that extended my methodological understanding and enhanced

my development as a grounded theory researcher. Examples of ideas I discussed with this group were: the place of the literature review; Charmaz's notion of theoretical starting points; the use of computer analysis tools in grounded theory, and differing ways to code data. I also gave dress rehearsals of conference and university faculty presentations to this group, and found that feedback enhanced my final presentations.

4.4 Introducing the participants

This section has been included in the methods chapter, rather than later in the thesis, as I wanted readers to gain an impression of the participant group that will inform their reading of the findings. In total I undertook 39 interviews. Twenty-nine participants were interviewed, with 10 of these people re-interviewed later, as I sought to deepen conceptual development. In the observational stage of the study, 22 hours of observations were undertaken, following participants in two community rehabilitation teams. The following professions were represented: community agency (lay) workers, counselling, dietetics, health administration, nursing, occupational therapy, orthotics, physiotherapy, private healthcare practice owners, social work, speech language therapy, and team leaders.

The omission of doctors from the participant group was a potential limitation of the sample. However, this was consistent with the methodological reasoning of grounded theory that samples according to emerging concepts, rather than people. Initially, when developing my research proposal, I had noted a growing knowledge base around doctor/nurse collaborative interactions (Davies, 2000; Dougherty & Larson, 2005; Lockhart-Wood, 2000; Manjlovich, 2010; Zwarenstein & Bryant, 2009). In contrast, I sought a range of participants that would better reflect the variety of HCWs in community rehabilitative practice. While I did not exclude doctors, they did not volunteer to join the study. As interviewing progressed, participants were asked who they considered as members of their extended teams, and who they collaborated with. Doctors were rarely mentioned. It appeared that they were perceived as external specialists who were referred to, or who made referrals. They were not seen as active members of the team. From a hospital-based perspective where the doctor as leader concept commonly persists, this finding may seem surprising. However, as noted in the literature review, in the community setting HCWs have more autonomy and notions of leadership are less clear (Ahgren et al., 2009; Nugus et al., 2010). Participants did not

find it unusual that they worked in teams without regular involvement or leadership from doctors. Following participants' leads, I decided doctors would not add to my emerging concepts, and they were not sought during later theoretical sampling.

People were excluded from participating if they were unable to communicate in English during an in-depth interview. Using this exclusion criterion possibly limited the voice of HCWs with English as a second language. However, as HCWs are expected to converse comfortably with their clients in English in their daily practice, this appeared a reasonable ethical justification for exclusion from this study (National Ethics Advisory Committee, 2012).

Participant experience ranged from a new graduate with six months clinical experience through to participants who had more than 20 years' experience in their field. The majority of participants in the interviews were women (26/29), and most work-related interactions in the observational phase were also between female HCWs. Because this reflected a common gender imbalance in community rehabilitative work, and gender did not arise as a conceptual concern, men were not specifically sought during theoretical sampling. Participants came from a variety of cultural backgrounds. A substantial number had received their professional training overseas (See Table 4).

The two teams from the observation phase had an average of 10 members in each team. Team members came from a variety of allied health professions. The HCWs in these teams were predominately female. Both teams were well-established, with a low turnover of staff. Each had a mix of full and part-time staff. One of the teams worked out of a clinic setting in the community. The other had an office base, with HCWs using this venue for meetings, while working mostly in clients' homes. This provided a wide variety of observational opportunities, covering clinic settings, home visits, office interactions, as well as interagency meetings.

Table 4: Participant characteristics

Characteristics	Number of participants					
Gender	Female:	Male:				
	26	3				
Working hours (part/full-time)	P/T	F/T				
	14	15				
Years of Experience	0-2yr	2-5yr	5-10 yr	10yrs+		
	3	5	5	16		
Professional role	OT	PT	SLT	Other HCW*	Lay HCW*	Team leader*
	4	4	3	8	4	6
Area of original training	NZ	UK	North America	Asia	Australia	Europe
	18	6	2	1	1	1

* -Other HCW category included nurse (2), dietician (2), social worker (2), orthotist (1), counsellor (1).

* -Team leader category included health practice owners.

* -Lay HCW included administrator roles, assistants and untrained carers.

4.5 Participant sampling

4.5.1. Research location and sample pool

The research was undertaken in one of New Zealand's largest cities, with a population of just over one million people. Participants were HCWs engaged in community rehabilitative work within the greater boundaries of this city. This geographical spread enabled sampling of participants working in a range of community settings - urban, small town, and semi-rural.

As mentioned in Chapter 1, the term 'healthcare worker' (HCW) was used (World Health Organization, 2010d), rather than the more usual 'health professional', to enable sampling of lay workers and management personnel should the need arise. The context of community rehabilitation teams gave a wide scope for participant sampling, while intending to distinguish from those HCWs who only see people in in-patient settings, or worked in acute care, such as Accident & Emergency clinics. Rehabilitation HCWs tend

to assist people who have complex healthcare needs, both in their homes and in out-patient type clinics. These people typically require rehabilitative provision from a variety of HCWs over prolonged periods of time. In supporting these clients, rehabilitation HCWs therefore engage with many other HCWs, both professionally trained and lay workers, as part of their interprofessional work.

4.5.2 Grounded theory sampling rationale

The aim of sampling in constructivist grounded theory is to source participants who can provide breadth of data to explore a research problem (Birks & Mills, 2011). The focus is not on representing a population (Crotty, 2003; Denzin & Lincoln, 2005).

Additionally, because grounded theory research is emergent, the number of participants is not precisely known at the outset (Charmaz, 2000, 2001; Stern, 2007). Sampling is directed by leads arising from the data, with participants continuing to be sought until the theory is developed and categories fully explicated. However, in my case, to ensure the research was in fact achievable and to meet ethical requirements, an initial estimate of participant numbers was needed. I noted Charmaz's (2006) suggestion that approximately 25 participants often sufficed for medium sized studies. Stern (2007) suggested that 20-30 interviews or hours of observations were typically enough for her to reach saturation. Additionally, reading Sandelowski's work (1995, 2001) on sample size convinced me that sampling in grounded theory was ultimately a matter of judgment, based on the purpose and method of the study and the available resources. I did not have past grounded theory experience to draw on, so based my initial projections on the experience of Charmaz and Stern when I decided that I would interview approximately 25 participants. As noted above, eventually, 29 participants were interviewed, 10 of them twice (39 interviews in total). Twenty-two hours of field observations were undertaken.

The use of field observations as a secondary data collection tool was added later in the study (see data collection below), once it became apparent that observations would aid conceptual understanding. For example, as *liaising* arose as a theoretical concept, participants talked about it in differing ways, but it was unclear from interviews what these differences meant in practice. Through field observations I was able to observe that *liaising* occurred both formally and informally, such as during team meetings and informal corridor interactions. I also saw that *liaising* opportunities were prioritised

differently by HCWs and team leaders. These observations deepened my understanding of differing perspectives and showed how context (e.g. HCW co-location) was important for liaising opportunities.

4.5.3 Sampling strategies

Following constructivist grounded theory methods, differing sampling strategies were used during the data collection stages (Charmaz, 2006; Morse, 2007). For the interview stage, purposive sampling was initially used to recruit HCWs from a variety of community rehabilitative settings. Purposive sampling is a means of intentionally sourcing participants who may provide rich data (Cresswell, 2003; Denzin & Lincoln, 2003). For this research, although time and funding constraints limited me to one broad geographical area, I purposefully sampled across a range of community rehabilitation teams to try to recruit participants who worked under a range of funding, organisational and clinical parameters (see participant recruitment below). In this manner I aimed to garner a wide range of data that would enable me to explore the research questions.

Later in the interview stage when theoretical concepts were being developed, I moved to theoretical sampling (see Chapter 3) for specific participants who could help deepen my understanding of theoretical categories and the linkages or variations between them (Dey, 2005). Supervisory mentoring and further reading encouraged me to be bold about theoretically sampling for 'excellent participants' (Morse, 2007, p. 231), who would be articulate, knowledgeable, and reflective.

As theoretical sampling is driven by leads arising from previous data and analysis, it was used in several differing ways during the research. For example, as the notion of team leaders began to arise within the data, I sampled for team leaders from both private and publicly funded teams to explore the notions of organisational influences and leadership styles. Likewise, theoretical leads also suggested that HCWs in allied health (for example therapists), appeared to connect through shared working conditions such as joint client visits (see Chapter 6). I wondered if connecting would hold across professional groups who did not routinely undertake joint visits, and hence sampled for participants such as nurses, to follow these leads. Through this, I identified that those HCWs who did not undertake joint visits had to use other communication channels, such as email and client notebooks to connect. Because I needed to develop conceptual depth, I also re-interviewed certain participants who had spoken about an area of

theoretical interest. For example, one participant spoke about guarding behaviours being the main issue in her team. This person was re-interviewed for further detail and through this I began to understand how guarding restricted liaising processes, by limiting relationship building and increasing professional role protection (refer to Chapter 8).

In the observational phase, the sampling pool consisted of those HCWs who had indicated interest in being part of the second stage during their interviews (see participant recruitment below). The sample was constrained by the need to get whole team approval for the observations to occur in their workplace. In the end, the sample was drawn from two community rehabilitation teams whose members had agreed to the observations.

4.5.4 Participant recruitment: Interview stage

Interview participants worked in a variety of community rehabilitation teams. This included:

- Three different teams from one District Health Board. These teams were publicly funded via the MoH.
- One therapy team, funded by the Ministry of Education.
- Two community support agencies.
- Participants from four private agencies, funded either via ACC contracts, or by direct client funding.

Initial recruitment was organised by contacting the team leaders of the organisations and explaining the research. If leaders expressed interest, I sent them a study protocol document with more information (Appendix D), and asked them to email their team members my 'Invitation to participate' form (Appendix E). People who expressed interest in participating were asked to contact me for further discussion, at which stage I sent them the information sheet (Appendix F). At that stage, I advised the one participant who identified as Mori that she might wish to discuss the study with whānau and/or kaumatua (family and elders) before proceeding; however, she chose not to do this.

As data collection progressed, snowballing techniques (Bryant & Charmaz, 2007) were used to recruit more participants. I asked current participants to pass on details of the study to other colleagues who might be interested. This method proved useful, as many

people who were interviewed stated they had enjoyed the process and promoted the study positively to their colleagues.

While early sampling was inclusive and driven by responding to interested participants who contacted me directly, in the later interviews, as noted earlier I utilised theoretical sampling. To do this, I identified and recruited HCWs who had the potential to illuminate theoretical areas of interest. For instance, when 'clinical experience' arose as a strong theoretical lead, I wanted to explore whether there was a difference between extended clinical experience and recent training, so I theoretically sampled for participants who could add variation to this topic. To avoid coercion, recruitment of these participants involved an approach via an intermediary or via email request. For instance, I asked a participant who had mentioned having a recent graduate in her team if she would approach that HCW on my behalf.

When to stop recruitment became an issue, as I became immersed in the data and potential new leads and insights arose. The notion of being overwhelmed by data was all too real at one stage (Urquhart, Lehmann, & Myers, 2010). Yet, eventually, as predicted in the constructivist grounded theory literature (Birks & Mills, 2011; Bryant & Charmaz, 2007a; Charmaz, 2000) new leads became fewer in the data. I became more focused on recruiting those who could add depth to my conceptual thinking and returned to re-interview participants to clarify categories and consider variations. For example, as the category of 'liaising' developed, it initially seemed to be about increasing information sharing and efficiencies through debriefing. I was unsure whether the category would be more appropriately framed as 'linking' I returned to re-interview a participant who had commented on links between professionals, with the aim of identifying whether 'links' differed from the liaising processes that I was constructing. Through this questioning, I uncovered more about the importance of building relationships to support liaising, and established that links were formed as a result of liaising processes.

I also re-read a wide range of grounded theory texts and grounded theory studies, searching for ways other authors had justified ceasing data collection. As noted in Chapter 3, theoretical saturation is frequently used as a rationale for ending data collection. However, I questioned whether saturation was truly possible in a constructivist grounded theory, where theory is considered modifiable and contextual.

In this study therefore, it is not claimed that theoretical saturation was reached; rather that recruitment and data collection continued until the same ideas kept arising, and sufficient depth of data was obtained to inform the construction of the theory.

4.5.5 Participant recruitment: Observation stage

During the interviews, participants who described examples of collaborative practice within their community teams were asked if they would be interested in participating in a possible second observational phase of the research. Several people indicated interest. However, at the time of the initial interviews I was undecided whether observational data collection would proceed. I had not undertaken observational research before, and was initially unclear of the potential benefits for my research. Reading other studies, text books, and talking with grounded theory colleagues in the early stages of data collection, led me to a greater understanding of the value of observational data. I perceived it could be beneficial for deepening category development and observing implicit actions (see Chapter 3). By the time the decision was made and additional ethical consent gained (Appendix B4), several months had elapsed since some of the initial interviews. Due to the time lapse, other matters had become more pressing for several of the participants, and two HCWs had left their roles. I needed to re-engage with the teams, by sending out information sheets again, and talking to team leaders about supporting a second phase of data collection.

Because the observational phase involved observing HCWs' interactions with other team members, consent had to be gained not only from the individual participant (Appendix G), but from the whole team. This became problematic in one instance, as a team leader who had indicated her team would be agreeable to participate in observations had since left her role, and the new leader did not wish to participate. Nevertheless, recruitment for the observational phase was eventually obtained by approaching two other team leaders who had participated in prior interviews. They were asked to obtain consent from their team members (Appendix G2) for me to be present on site. I planned to shadow identified HCWs and observe their professional interactions, but not clinical treatments, as clients had not been included in the ethical considerations. The aim was to follow one individual HCW at a time, observing their collaborative interactions within a typical work day.

Once team approval was gained, I contacted the participants from the two teams who had previously been interviewed, to confirm they were still interested in participating, and sent them information sheets about the observation phase (Appendix F2). Six participants were eventually recruited from the two teams for individual observations totalling 22 hours.

4.6 Data collection

Within constructivist grounded theory methods, data collection and analysis occur simultaneously. Analysis began with the first interview, framed the direction for future data collection and continued throughout the process. It was not a linear process, but intertwined with data collection (Charmaz, 2000; Glaser & Strauss, 1967). Hence, while the data collection procedures are articulated separately in this section, they should be considered in conjunction with the data analysis segment.

4.6.1 Data collection: Interview phase

For the interview phase, data collection involved individual interviews with participants, lasting from 45min to 1hour 15min in duration. The interviews were conducted at the participant's convenience, in accordance with the ethical principle of beneficence (National Ethics Advisory Committee, 2012). I travelled to meet individuals in workplaces, homes, or cafes, as suited them. Participant consent was gained for interviews to be tape-recorded and transcribed, and for notes to be taken during the interviews (Appendix G3). Participants were also asked if they would be willing to participate in a follow-up interview and/or observation, if the analysis indicated it would be beneficial to the emerging theory. At the end of each interview, I wrote brief memos noting whether any key words, concepts, or phrases emerged, and jotting down comments about the interview such as distractions and contextual influences. I also noted whether the participant expressed variations in thinking related to my current stage of analysis and recorded immediate questions that came to me. Reviewing these memos at home often sparked a theoretical idea, which was then written up in a longer, separate memo. For example, when participants talked about guarding professional knowledge, but also related instances of fluidity of practice, I wrote a memo about the apparent tension between these two notions. From this I began to develop more focused questions exploring the conditions that shifted HCWs actions between guarding and flexible practice, such as being a new team member.

I transcribed the initial nine interviews, but due to time considerations, the rest of the transcription was carried out by a professional typist who signed a confidentiality agreement (Appendix H). I found the transcription process useful to develop my research skills, as the focused listening required for transcribing served to increase my understanding and conceptual thinking. It also showed flaws in my questioning and areas where I had assumed participant meaning. For instance, I noticed at one stage I forced one of my pre-conceptions into an interview when I asked a participant about professional scopes of practice. As it was not a concern for that individual, they did not pick up the conversational thread, and I learnt a valuable lesson about interviewing. Memoing and self-reflection during the transcription process assisted my analysis, as reading the transcripts and listening to the tapes sparked an analytical query, suggested a link with previous interviews, or provided an idea to follow up. As an example, an early analytical memo questioned the impact of differing funding structures on HCWs collaborative practices. This occurred both with my own transcription and later, when reading the professionally typed transcripts. The knowledge I gained from this process was then used to inform questioning in subsequent interviews.

One unexpected issue arose around the scheduling of interviews. One of the team leaders had consented to the study under the proviso that I conducted any interviews with her team members within a tight overall time-frame of one month. This presented a methodological challenge as noted in a memo at the time (refer to Appendix I). Having to undertake several interviews in a short space of time meant there was little time to reflect, and constantly compare incoming data with previous analysis between interviews. On reviewing these transcripts later I noted there was little growth in focused conceptual questioning during this time. My questions did not pick up on many leads from the previous interviews. From this I learnt that I worked best when I had time between interviews to analyse data and consider the next steps. Reading theoretical texts reassured me that learning one's own individual pacing style is a part of skill development within grounded theory (Bryant & Charmaz, 2007b; Holton, 2008).

The initial interviews were designed to be non-structured, starting with broad generative questions intended to allow the participant to discuss areas of interest to them. I also had prompting questions on hand, which were used to initiate discussion when it stalled. These were based on the sensitising ideas found through the early literature review. While this questioning was directive in some ways, I tried to be open in the way I

phrased questions and responded to participants, so that the person would respond to the general topic on their terms. For example: "Tell me about working with others in your team" or, "If I was to use the words: 'collaborative practice' what springs to mind?" Successive questions were based on previous responses so that I followed the participants' lines of interest. This form of questioning follows the grounded theory principle to remain open to what is actually happening and to allow the participants to discuss issues of relevance to them (Charmaz, 2000; Mills et al., 2006).

Remaining open, while simultaneously comparing data with previous analysis was challenging at times. Throughout the data collection, I kept returning to the previous data, rereading transcripts, memoing ideas, and gaining ideas for possible lines of enquiry, as per the constant comparative method. As tentative categories emerged from coding the initial interviews, potential lines of enquiry were raised. Subsequent interviews became semi-structured, using more focused open-ended questions to explore and define the emerging categories. For example, "Others have mentioned professional trust as a factor in their teams. Do you have any comment on that?" If participants responded to the question with interest, I would draw them out further by questioning about some of the potential category indicators (e.g. establishing professional competence as a pre-requisite for developing trust). This constant comparison of data with data is considered a key factor in conceptual development and ensures that the participant voice is clearly maintained (Charmaz, 2006; Hood, 2007).

As data collection progressed, interviews became more focused on developing conceptual ideas and depth within the emerging categories. I initially wrestled with how to introduce conceptual questioning without forcing the data, a tension that is apparent within the constructivist grounded theory literature (Birks & Mills, 2011; Charmaz, 2006; Mruck & Mey, 2007). Remaining mindful that purposeful questioning would increase the depth and effectiveness of data collection (Gubrium & Holstein, 2001), I debated with colleagues and supervisors over whether using conceptual phrases in questioning led, or forced responses from participants. Trying out a variety of questioning strategies, it became apparent that even if I used a conceptual phrase in questioning, if it did not have meaning for participants they would not talk about it (Charmaz, 2008; Glaser, 1978). Similarly, if an idea did resonate for them, participants would take the phrase and use it in ways I had not considered. Examples of this questioning method included: "If I mention negotiating, does that have any relevance to

your work? or When you talk about preciousness, is that the same as being guarded, or is it something else? Can you tell me more about it?

In addition, as the main categories were developed, I returned to some of the participants to check that the developing ideas had resonance and enough depth to explain the varying processes. For example, 'being flexible' was a theoretical category at one stage, but it didn't seem to fit all the nuances of the sub-categories. I showed a participant a cluster diagram (cluster diagrams are explained in Data Analysis) of my ideas at the time and explained my conceptual thinking to her. Through her responses, I gained insight that resulted in my considering 'forming' as a conceptual notion, leading to the eventual category of forming-reforming. In total, ten of the original participants were re-interviewed over a period of several months. While similar to the qualitative notion of member checking (Birks & Mills, 2011), I did not consider this stage as separate. Rather, it was part of the constant comparative method within grounded theory and linked with constructivist ideals of data co-construction between participant and researcher.

When the main theoretical categories had been established, I wanted to check the concepts for resonance with a broader audience (Lempert, 2007; Mills et al., 2006). While constructivist grounded theory is understood as contextual to the time and situation in which it was constructed, it is important for the theoretical concepts to be transferable and useful across other fields, as this adds to the quality of the research and strengthens the theory (Charmaz, 2006; Corbin & Strauss, 2008).

To test for transferability I approached a variety of groups, such as other HCWs, my grounded theory study group, work colleagues, and business people outside the health setting. These people were not considered part of the original 29 participants, but being outside the rehabilitation arena, they allowed consideration of the theoretical categories across substantive areas (Bryant & Charmaz, 2007a). Discussions included showing people a clustering diagram of the theoretical categories (Appendix J) and asking if any areas grabbed their attention, or had resonance for their work. This methodological checking tool proved surprisingly useful, with comments from those outside the health arena clarifying areas where the analysis was weak and suggesting different perspectives and labels used in other contexts. An example of this was when people in the business field used the term 'stakeholders' when referring to negotiating. This

caused me to reflect on the variety of stakeholders in my study (i.e. the client, HCW, team, and the organisation), and to consider how each fitted into negotiating. I brought the term 'stakeholder' back to check it with HCWs, but it did not have particular resonance for them so it did not earn its way into the finished theory. Other individuals commented on aspects of the theory they saw in their own workplaces, readily giving examples of the categories 'guarding' and 'liaising' across differing contexts. People generally required greater explanation of the category 'forming-reforming', which was predictable, as it is an abstract term. This category did not resonate with all, but I would not expect it to, as workplaces practice in differing ways, and forming-reforming may not occur in all work situations (see Chapter 7). The reduced responses to this category highlighted that aspects of collaborative practice in the community context differ from other work settings.

Through taking my theoretical concepts to a broader audience, I was able to deepen my analysis and consider aspects beyond the studied setting. While this research does not claim automatic generalisability, overall the theory appeared to demonstrate transferability and usefulness (Charmaz, 2006; Corbin & Strauss, 2008) outside the health field. This was reassuring, as it suggested that further study into differing areas could be useful to extend the research in the future.

4.6.2 Data collection: Observation phase

As noted earlier, participant observation was added to the study as a data collection tool part-way through the research. The aim was to augment conceptual development (see Chapter 3). From the interview phase, I had gained information on what participants perceived was occurring in their working environments. I believed that observing some of the processes in situ would aid depth of understanding. Utilising a combination of interviews and field observations is recommended in the literature (Denzin & Lincoln, 2005). Ovretveit (1998) notes observations strengthen a theory by triangulating data already collected through interviews. Similarly, Charmaz (2006) notes the value of observations as a means of considering people's actions in context.

In this study I particularly wanted to observe conceptual processes such as team forming, guarding, and interagency liaising in action, and see whether they were overt or embedded actions.

The observational phase involved following and observing individuals in their work settings over a period of several hours. The six participants were individuals who had previously been interviewed and were part of the two teams who consented to participate in the observation phase (see participant recruitment section above). These participants were not personally known to the interviewer, although some rapport had been developed through the earlier phase of the research. The aim was to observe a variety of HCW interactions and settings, such as interagency work, team meetings, informal discussions, office communication, and lunch room conversation. Specifically excluded were interactions during client treatment and I removed myself during these sessions. The rationale for excluding observations of client treatment sessions was that the focus of the research was on interactions between HCWs, rather than between HCW and client. While some client treatments involved joint visits, the majority of sessions were with individual HCWs and a client. In addition, team leaders had indicated they would not consent to observations occurring during client treatments as they were concerned about the impact on clients, and hence ethical consent was not sought to observe during these times. Observations were generally undertaken in an open fashion with the aim of observing and recording interprofessional interactions in the community work setting (Denzin & Lincoln, 2003). A general field note structure was followed (Appendix K) using headings adapted from Morse and Field (1995). This considered the general areas of environment, situational issues, participant behaviour, interactions, and researcher impressions/analysis. Each session of observations varied across settings, context, and the number of people involved, reflecting the real world practice setting, and emphasising the dynamic, complex nature of community work. As a constructivist researcher, I wanted to deepen my analysis and explore whether the implicit meanings I had perceived from the interviews were observable in practice (Charmaz, 2009). For instance, did HCWs move between perspectives (see Chapter 5) and if so, what actions could I observe that influenced these shifts?

An example of one day of observations included: Observing interprofessional interactions at a clinic base; travelling with the participant and a colleague to a client's home (work-based discussions in car); travelling to an interagency meeting about a client; going back to the clinic base; lunch with colleagues; and attending a full team meeting. Observing a HCW across a working day was enlightening, with insights such as the value HCWs placed on informal relating revealed at unexpected times (e.g. when

travelling in a car with colleagues). During the observations I mostly sat quietly, although at times, I would talk with participants asking what an interaction with a colleague had meant to them. My research role was as a moderate participator within the observation, rather than being a passive observer (Spradley, 1980). I took notes on collaborative issues such as observable interactions, potential barriers to collaborative practice, and documented links or questions related to my developing analysis. For example, the links between speech language therapists and dieticians noted during interviews was observed to have both positive and negative implications, with professional guarding as well as positive liaising noticed. Following each observation, I used the field notes to generate memos which were used as extra data for analysis.

4.7 Data analysis

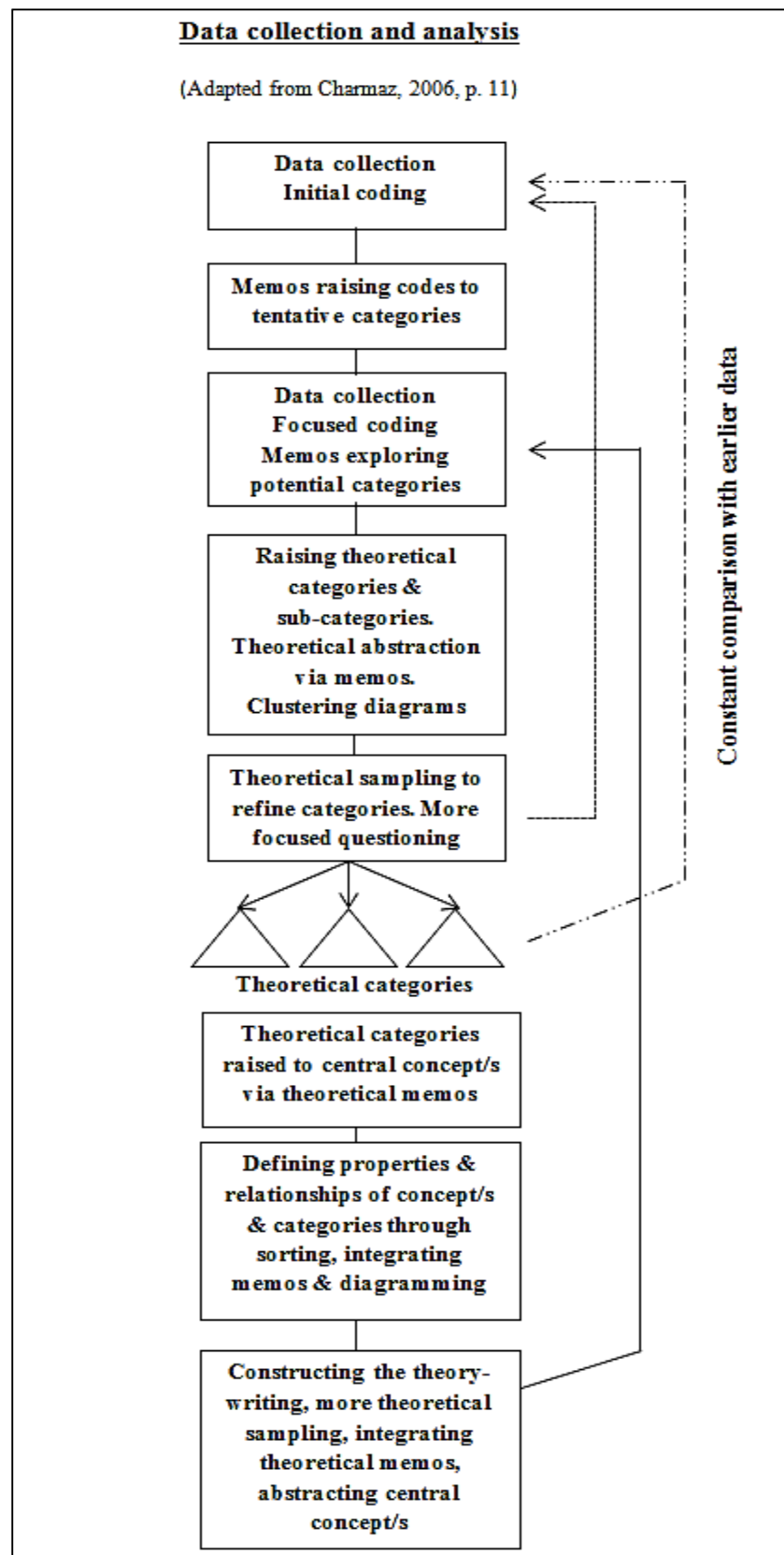


Figure 1: Data collection and analysis schematic

4.7.1 Data analysis: Overview

Figure 1 (adapted from Charmaz, 2006) demonstrates the cyclic, iterative nature of data collection and analysis in grounded theory. Analysis in this study broadly included the stages of: coding (initial and focused); constructing tentative categories; using constant comparative analysis, diagramming, and memoing to further develop categories into major theoretical categories (liaising, forming-reforming, guarding) and minor sub-categories (e.g. interacting, networking and referring); raising a major category to the main concept (connecting); and integrating the whole theory through forming explanatory links between theoretical categories and the main concept.

Throughout the data collection and analysis, memoing was utilised as a key methodological tool. As noted in Chapter 3, memoing is a central strategy in grounded theory, providing the analyst with a means of engaging with and questioning their analyses, which increases the abstraction and depth of their ideas. In this study my memoing varied from one paragraph of jotted notes, to a diagram with lines and questions all over it, to a ten page analysis of a category. Memoing began from the first deliberation of the topic and was undertaken both as a considered regular practice and also whenever inspiration struck. Memos were dated and often extended at a later date, as I compared and developed my ideas. In the analysis stage, memoing served as a crucial tool, enabling me to abstract away from concrete data to consider theoretical possibilities for raising the level of my analysis. The memos were collated and summarised, as the thesis chapters began to be written and informed both the methodological and discussion chapters. Examples of memo writing are provided in Appendices I, Q and R.

4.7.2 Use of quotes

The extensive use of quotes in the findings chapters of this thesis reflects the constructivist principle of keeping the participant voice prominent (Bryant & Charmaz, 2007b). Quotes were chosen which best reflected the category, identified a conceptual word, or demonstrated a pertinent phrase (Mertens & Ginsberg, 2009). Quote selection was not a simple process as data was precious, and I had a tendency to want to include too many quotes. Refining my writing and considering the value of each phrase assisted in selection, with some quotes additionally being edited for length or intelligibility. Additionally, I have chosen to occasionally include my interview questions (in italics) in the quotes to give clarity to the participant response and show that the replies were not forced.

While it is common practice to add detail about the participant directly after the quote (Wiles et al., 2008), I have chosen not to do this. This decision was based on methodological principles, in that grounded theory abstracts away from individuals to explore group patterns of behaviour (Charmaz, 2006). I thought that individual role descriptors would distract from that purpose. Additionally, with some of the professional groups only having 1 or 2 participants, anonymity may have been compromised by adding particulars to the quotes (Corden & Sainsbury, 2006; Wiles et al., 2008). Instead, the participants have been allocated simple first name pseudonyms. This acted as a marker for me to be able to cross-reference back to the original data. By adding a name after the quote, I also intended to retain the sense of the participant voice being paramount. That is, these were real people talking, not merely nebulous data. More detailed participant information has been provided earlier in this chapter (see Table 4).

While the analysis and findings generally follow writing convention in commenting on data directly from participants, there are a few occasions where I have cross-referenced statements with published work. This was done to acknowledge established literature on certain minor points, not developed further in the discussion chapter.

4.7.3 Coding

As data were collected from interviews and observations, it was compared with previous data and coded using the constant comparative method of analysis (Charmaz, 2006; Charmaz & Bryant, 2011; Glaser & Strauss, 1967). This involved asking analytical questions such as: 'What process or action is happening here?' and 'What theoretical category are these data a study of?' (Charmaz, 2008b). By focusing on 'defining what is happening in the data' (Charmaz, 2006, p. 68), the risk of my own preconceptions, or extant codes entering the analysis was minimised.

As already noted, coding can involve a combination of line by line coding, and analysis of actions or processes (see Chapter 3). As part of the process of developing research skills, I began coding with handwritten line by line coding. Transcripts were set up with space for coding on one margin and room for short memos on the other (Appendix L). While I coded, I wrote brief analytical memos directly onto the transcript for later follow up. Initial coding began with the reflective questions: 'What does this action suggest? From whose point of view?' My first couple of coding attempts were largely descriptive, with line by line codes that were individually quite long. I then began to assign shorter codes using gerunds (verbs used as nouns) to focus on active processes (Birks & Mills, 2011; Glaser, 1978). Using line by line coding became problematic for me however, as I was becoming overwhelmed by data and it was blocking my thinking. I returned to the grounded theory texts to explore other ways of coding. Charmaz's (2006) method of moving quickly through the data, and assigning incident by incident codes for fit and relevance appeared to be appropriate for the type of data I was collecting and my style of working. I also tried keeping the language grounded in the participant voice using in vivo codes (coding using participant's own terms) where possible. Charmaz suggests in vivo codes are useful to capture both shorthand terms specific to a field, as well as participants' novel ways of describing experiences (Charmaz, 2006, p. 55). An example of this was the phrase 'the elephant in the room.' Several participants used this phrase to refer to unexpressed tension within their teams.

By interview seven, the increasing number of codes brought with it a need to capture and summarise the coding and memos which I had hand written onto the transcripts. While a computer package such as NVivo could have been used, I chose to manually condense and summarise the codes and memos from each interview in table form

(Appendix M). The use of computer software is accepted by some grounded theorists (Birks & Mills, 2011; Dey, 2005) and denounced by others (Glaser, 2005). I made the decision to use a more hands on approach in order to stay close to my data and think through each change. Using this approach, I was able to compare data across interviews and see where I had used differing wording for similar codes, such as 'debriefing' and 'checking in'. I was then able to make decisions on the most appropriate label and remove less important codes. These decisions were made based on the code that best represented the action or the code that appeared most frequently in the data. An example of a coding summary is provided in Appendix M, using the data from Appendix L.

Once I had done this summarising however, I noticed my codes seemed somewhat banal and lacking in originality, with commonplace ideas such as 'communication styles' arising. A critique from supervisors at the time suggested I develop analysis from being largely descriptive and focused on professional concerns (such as 'professional supervision' and 'client compliance'), and re-code my transcripts with a more conceptual focus. This advice lifted my thinking and I moved to using focused coding (Charmaz, 2006) to re-sift through the data. This involved taking frequently used earlier codes that had explanatory power, and using them to compare and recode earlier data. I did this through re-reading transcripts as well as performing word searches of transcripts and memos on the computer. Examples of this recoding included using the codes 'referring on' and 'professional protecting' (see Chapters 6 and 8).

4.7.4 Conceptual development

4.7.4.1 Constructing categories

Through summarising the codes from each interview, I began to see recurrent patterns of behaviour and areas of concern repeatedly mentioned by participants. From memoing these ideas, I began to raise tentative early categories based on the most substantial codes in my data. Charmaz (2006) defines categorising as raising significant codes and abstracting patterns of behaviour into an analytical concept. The category is then tested through constant comparative analysis, with the underlying properties and relationship to other categories explored. Early examples of categories that were later subsumed into other categories were -interagency working and -fluidity of practice. Categorising was not a simple or linear process, but involved much immersion in the data, re-reading and coding of earlier transcripts and analytical memoing of ideas. Testing the properties of categories occurred through subsequent interviews, observations and analytical memos, with theoretical sampling used to identify participants who could help clarify aspects of categories (see Data collection section earlier).

4.7.4.2 Clustering diagrams

As the early categories emerged, they were initially disparate with limited strands linking them. Using the diagramming technique of clustering (see Chapter 3) provided a means of exploring and organising the categories (Appendix N). While not all grounded theory authors support diagramming (Glaser, 1978), within constructivist grounded theory diagramming is a well-established method (Charmaz, 2006). It is advocated for supporting data analysis, relationship development between categories, and triangulation of data (Buckley & Waring, 2013; Lempert, 2007). As a type of diagramming, clustering provides a non-linear way of understanding and organising material that moves the researcher further into studying actions, their relationships, and significance (Charmaz, 2006). Clustering provides a visual way of tracking relationships that also has parallels with Clarke's (2005) conceptual mapping but is not limited by Clarke's frameworks of situational, social, and positional mapping. Because it suited my personal learning style, clustering was used frequently throughout the analytical process as a sorting tool to link codes and develop categories.

Clustering involved free drawing with pencil and paper, as well as physically sorting and moving around cards on which I had written codes, observational data, and

analytical memos. Having cut out cards was helpful as many changes and rearranging of the clustering diagrams occurred over several weeks. Each time I got a clustering that resonated with my emerging conceptualisation, I transposed it to computer and wrote memos about my analytical choices. The use of Inspiration computer software provided the means to keep the clustering process legible and track changes in my analysis. Examples of clustering are provided in Appendix J and N.

4.7.4.3 Exploring different analytical tools

During the analysis stage, I also explored various tools used by grounded theory proponents. As noted previously, several authors advocate analysis processes based around a framework, such as axial coding (Strauss & Corbin, 1998), situational mapping (Clarke, 2005) or Glaser's theoretical coding families (Glaser, 1978). While analytical frameworks provide structure and enhance the researcher's ability to compare relationships between categories, they are also problematic from a constructivist standpoint. Frameworks may force data into extant categories, thereby limiting the possibility of seeing new ideas and constructing new codes (Birks & Mills, 2011).

While heeding this caution, I was also interested in exploring how other grounded theory tools might increase my learning experience. Part-way through the analysis I trialed using Schatzman's dimensional analysis framework (Bowers & Schatzman, 2009; Schatzman, 1991) to explore the role of participant perspective in the analysis. Dimensional analysis uses symbolic interactionist principles to construct components of a social process by naming, or 'dimensionalizing' parts of data into properties, such as perspectives (Kools, McCarthy, Durham & Robercht, 1996, p. 316). The dimensional analysis framework provided some useful points to consider, which eventually resulted in my defining the three perspectives informing HCWs work (profession-dominant, teamworking, and holistic perspectives). These ideas are discussed in Chapter 5. Later on, to further challenge and develop my thinking I also tried to review my analysis using axial coding (Strauss & Corbin, 1998). In this case, I found Charmaz's caution relevant, as I struggled with trying to force my analysis into pre-defined areas and hence quickly stopped trialling this method. What eventually worked best for me during analysis was developing a series of questions that I used to interrogate my data (Appendix O). The questions included: What main processes/actions are occurring? What is the process about? What the properties, conditions, consequences and variations of the category? What perspectives might people be acting from? What is happening in

the wider context? This list was based on a combination of Charmaz's work (2006), and the causes, context, and conditions from Glaser's 'Six C's' theoretical coding categories (Glaser, 1978). This analytical process assisted in identifying gaps in analysis, and refining my categories, while not forcing the data into pre-set categories.

4.7.4.4 Theoretical categories and concepts

As the major categories became organised through memoing, clustering diagrams, and analysis, smaller categories either fell away or were subsumed by others. Many memos were written as I explored differing ways to re-construct the data, with categories and sub-categories shifting throughout the analysis. For example, earlier analysis had 'managing service complexity' as a theoretical category, where-as it eventually became the main challenge or concern of participants. Likewise, the main concept of connecting originally sat as a theoretical category, before I noticed its prominence and explanatory power and raised it to be the central concept. Appendix P gives an example of my conceptual development mid-way through the process. Decisions were based around which categories best reflected the data, and clarifying where data was strongest. Eventually, three major theoretical categories (liaising; forming-reforming, and guarding) were constructed, which worked to explain the central concept of connecting (see Chapters 5 and 9). Further analysis developed the sub-categories of the three main theoretical categories, and their variances and relationships to each other. This is discussed in subsequent chapters.

4.7.4.5 Theory integration

The product of this study is a grounded theory. Theory can be viewed as an 'explanatory scheme comprising a set of concepts related to each other through logical patterns of connectivity' (Birks & Mills, 2011, p. 113). Integrating a theory is about using analytical strategies to raise the theoretical explanation to the highest conceptual level and ensuring that relationships and links between each aspect of a theory are considered. Theoretical integration in this study was achieved through the constant comparative method of comparing categories, considering the relationships and variations between them via diagramming and memos, and eventually arriving at a central concept (connecting), which worked to integrate the three theoretical categories of liaising, forming-reforming, and guarding.

Towards the end of analysis, my supervisors encouraged me to consider whether using the grounded theory tool of theoretical coding would benefit theoretical integration. Theoretical codes arise from Glaser's work on coding families (Glaser, 1978, 1998, 2005). Over the years, Glaser has identified over 50 theoretical codes (e.g. the 'Levels' code) and coding families (e.g. 'Strategy' and 'Degree' families), that serve to explain the relationship between the central concept and its categories. Classic grounded theorists consider theoretical codes as the relational model through which all substantive codes are related to the core category (Hernandez, 2009). They provide a 'framework for enhancing the explanatory power of your storyline and its potential as theory' (Birks & Mills, 2011, p. 123), and serve to 'integrate the substantive theory' (Glaser, 2005, p. 11). Charmaz considers theoretical codes as a potentially useful way of 'moving your analytic story in a theoretical direction' (Charmaz, 2006, p. 63). I view theoretical codes as another analytical tool, useful for considering data from another lens and progressing analysis and write-up. I agree with Charmaz's view (2006) that grounded theories do not necessarily need to be written with an overt theoretical code, and in this case I have chosen not to do so. Perhaps if I had considered this earlier in my analysis, theoretical coding may have been a more useful tool to promote theoretical development. However, I felt that trying to impose a theoretical code at the end of theory development, would not have the stated aim of lifting and integrating my analysis, but rather may have confused my conceptual explanation.

In critiquing my approach, I considered Glaser's assertion (2005) that theoretical codes are always present, even if not articulated. From this standpoint, the implicit theoretical code underlying the theory of connecting would be from the 'Interactive' coding family (Glaser, 1978). This coding family includes the codes of: mutual effects, reciprocity, mutual trajectory, mutual dependency, interdependence, interaction of effects, and covariance. Throughout my findings chapters, suggestions of the interactive theoretical code are both implicitly and overtly (see Interacting in Chapter 6) viewed in the ways the three theoretical categories are linked to connecting and each other. I frequently refer the reader across chapters to show links and interactions between the categories. Nevertheless, because these chapters were largely drafted before consideration of theoretical coding, I make no assertions to purposefully using a code. Rather, this perhaps adds weight to Glaser's view that theoretical codes are present whether one acknowledges them or not.

4.8 Evaluating the quality of the research

As was commented on in Chapter 3, there are many different evaluative criteria used to assess grounded theory research. Readers will have their own perspective and approach to evaluation. For my part, as I was undertaking grounded theory following Charmaz's approach (2000, 2006, 2008a, 2009) I aimed to address her evaluative criteria of credibility, originality, resonance and usefulness.

Credibility considers the methods used to construct the theory. Particular emphasis is placed on considering whether the study achieves deep insight into the setting, whether there are strong links between categories and the data, and logical associations between data, argument, and analysis. To evaluate for credibility, transparency of methodological process is crucial. Reflexive memoing throughout the process is used to elucidate how the researcher constructs their theory. In keeping with this tenet, Chapter 4 has provided an open, reflective account of the methodological processes used. To clarify methodological explanations, examples from data analysis were provided within this chapter, rather than exclusively producing these within the findings chapters.

Originality refers to whether the grounded theory provides new insight into a topic, and how it may challenge or extend current ideas and practices in an area. It also addresses the significance of the work in practical and theoretical terms. The manner in which originality is addressed is presented in the findings (Chapters 5-8) and discussion (Chapter 9) sections of the thesis.

The purpose of *resonance* is to consider whether the theory has meaning for the participants, and whether it gives them deeper insight into their daily lives. Resonance is achieved through exploration of both exposed and implicit meanings, which provides for depth and breadth of categorisation. The theory should be understandable by participants and those working in the field, with people recognising the fit of the theory within their context. Resonance has been considered within the research process, by returning to participants (see section 4.5.1 earlier) to confirm meaning and fit with them. Resonance is also considered within the discussion on connecting and complexity management in Chapter 5 and in Chapter 9.

Usefulness is achieved if the grounded theory offers interpretations that people can take and use in their everyday lives. This was important to me as both a clinician and

researcher. As a clinician I had observed difficulties with collaboration in practice and this was a contributing factor in my decision to undertake this research. It was therefore imperative to me that the theory resulted in findings which had clinical application and usefulness. Additionally, a grounded theory is useful if it presents avenues for further research and contributes original knowledge to the field. The manner this has been achieved is discussed further in Chapter 9.

Charmaz (2006) notes that having strong originality and credibility will naturally increase the resonance and usefulness of the work. Combining this with compelling writing that has aesthetic merit and analytical impact, these criteria formed the framework for the way in which I developed this grounded theory. Further discussion about the quality of this research is found in Chapter 9.

4.9 Summary

This chapter has outlined the research methods and ethical considerations undertaken throughout this research. Following constructivist principles I have situated myself as researcher within the study, co-constructing data with the participants. As part of developing the credibility and trustworthiness of the work, the decisions and developments made through the data collection and analysis processes have been articulated with multiple examples provided. Additionally, the manner in which I addressed quality issues, based on Charmaz's evaluative criteria, has been presented. The following chapters move into the research findings, commencing in Chapter 5 with an overview of the theory of connecting. This involves presenting complexity as the central challenge in interprofessional work that is managed through connecting processes.

Chapter 5 The theory of connecting

5.1 Outlining the findings section of the thesis

The second section of the thesis explores the findings related to the theory of **connecting**³. There are four chapters within this section, summarised by the outline in Table 5. In Chapter 5, I begin the findings by returning to the aim of the study and the research questions. In answering those questions, I present **complexity management** as the central challenge faced by HCWs, and introduce **connecting** processes as the means by which HCWs managed that complexity.

Table 5: Outline of the findings chapters

Chapter	Topic
Chapter 5	The central challenge: complexity management . Overview of the theory of connecting : definition, categories, perspectives, and conditions.
Chapter 6	The theoretical category of <u>liaising</u> . Sub-categories: <i>interacting</i> , <i>networking</i> , <i>referring</i> .
Chapter 7	The theoretical category of <u>forming-reforming</u> . Sub-categories: <i>interprofessional practising</i> , <i>flexible practice</i> , <i>forming teams within teams</i> .
Chapter 8	The theoretical category of <u>guarding</u> . Sub-categories: <i>professional shielding</i> , <i>protecting</i> , <i>negotiating</i> .

³ In the findings and discussion sections of the thesis, different font styles are used for conceptual ideas. Refer to Table 1, p. vii.

5.2 Introduction

This aim of this thesis was to generate a theoretical explanation of collaborative practice in community rehabilitation. The research questions that directed the study were:

1. How do HCWs view IPC in the community-based teams where they work?
2. How do HCWs explain/construct their collaborative actions in community-based teams?
3. In what circumstances do their actions change and why?

In exploring these questions with participants, the first two questions were answered through the findings that showed HCWs viewed interprofessional work in the community as complex, and undertook **connecting** actions to manage this **complexity**. As will be shown later in the chapter, the third research question was addressed by considering the perspectives HCWs used, and the conditions that shifted **connecting** processes.

Because HCWs' collaborative actions changed relative to the **complexity** of community work, it is important to understand the notion of **complexity** before discussing **connecting** processes. Therefore, the first section of the chapter explains **complexity management**, with its interlinked components of client complexity, relational complexity, and situational complexity. The second section introduces **connecting**, outlines its three theoretical categories, and describes the perspectives and conditions that shift **connecting** processes.

5.3 The central challenge: Complexity management

As noted above, in this study it was evident that **complexity management** was the central challenge faced by HCWs in their interprofessional work. **Complexity management** was a dynamic, contextual notion, representing the interlinked and interactive client, relational, and situational challenges encountered by HCWs in their interprofessional work. When working together within this context, HCWs utilised **connecting** processes to manage the complexity.

Participants used **complexity management** as a label to encompass a myriad of issues where the concerns were often unclear. These issues involved three related components: client complexity; relational complexity, and situational complexity (see Figure 2). In

considering the components of **complexity management**, I encompass how HCWs view clients and their families; the relationships they need to maintain across client and professional groups; and the diversity of the situations in which collaborative community work occurs. The three components are interlinked and it was rare for HCWs to contend with one aspect of **complexity management** in isolation. For instance, working with a complex client would usually result in more relational complexity, as HCWs needed to engage with a wider range of people to support that client. Similarly, situations which were complex needed careful handling and were often linked with relational complexity. This multifaceted depiction presents a new way of viewing **complexity management**, which is discussed further in Chapter 9.

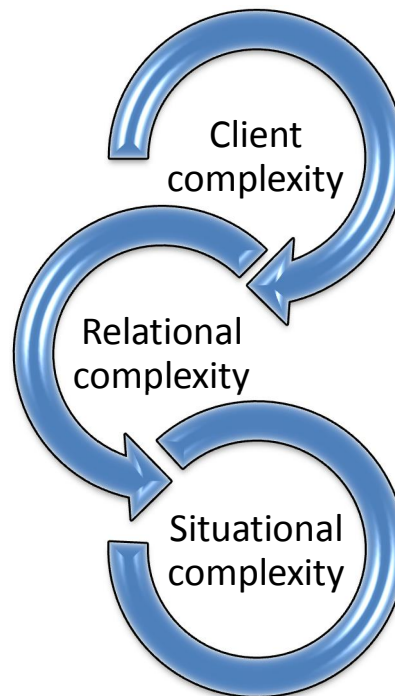


Figure 2: Components of complexity

5.3.1 Client complexity

Client complexity referred to the management of clients who had challenging health and psycho-social needs. In order to manage clients' complex needs, HCWs needed to **connect** with each other, adapting working practices, and adjusting their caseloads. Participants used the term **complexity** as an umbrella term when referring to clients' multiple needs that were evident in the community setting. The term 'complex client' was usually articulated without qualifiers, with an assumption that it was generally understood. John's comment below exemplifies this, along with his surprise when I asked for clarification of the term.

P: There's a nurse specialist role that is being rolled out at the moment and they are very much involved with complex clients' dealing with people who by their very nature are very complex in their needs.

I: *What does that mean exactly? "Very complex in their needs?"*

P: Well, I'm sure you know. It's around them having multiple health problems. It's around getting access to them, or maybe they aren't compliant with treatment. It's all that stuff. And the family dynamics comes into it too. You know - the ones you don't give to your new staff. (John)

Despite the assumption of mutual understanding, participants construed 'client complexity' in differing ways. The term was varyingly used to reference a client with multiple, challenging problems or needs; as professional shorthand for a client with challenging psycho-social issues; or to refer to a client requiring involvement from multiple HCWs.

If it's been a really complex client, or complex social issues, or lots of people involved, we'll kind of discuss managing those ones as a team. (Carol)

Assisting complex clients with multiple health needs was a routine part of community rehabilitative work. HCWs reported they held little control over the types of clients being seen in the community. Indeed, HCWs perceived that client complexity was, if anything, increasing over time. This was attributed to policy directives supporting rehabilitation and management of chronic health issues in the community (Ministry of Health, 2009). It also occurred because more people were surviving serious health incidents due to modern medical techniques. Participants reported that these

increasingly complex clients required varied support, which resulted in HCWs **connecting** with a range of people.

I: Is it usual for you to have more than two people involved with the client?

P: Not typically, but we do it for more complex patients. So for example, those with serious brain injury will often have physio, OT [occupational therapy], and speech involved. (Georgina)

Client complexity was made more challenging when it required family management. Complex clients did not exist in isolation, with associated psycho-social issues around family dynamics common. HCWs did not necessarily have the skills to manage this aspect of complexity. In one team, Barbara, a social worker, identified this difficulty and used **connecting** processes to support HCWs who were managing clients' psycho-social issues: 'I saw my role as a social worker to support the rest of the team in engagement with a complex family or situation if that was an issue.' Social workers were not present in all teams however. More typically, HCWs reported they managed client psycho-social issues as best they could, and referred onto others if the situation was beyond their ability, or impacted their work with clients.

Management of client complexity increased workloads. There was an assumption amongst participants that increased client complexity would necessitate more time and often involved **connecting** across service agencies.

We base the workload on the hours you work. You have about one client per hour that you work. So if you are full-time you might have about forty clients on your case load. [They have] mixed complexity, so they wouldn't all have the same high need so you couldn't take on forty complex at once. (Jamie)

The increased workload resulting from complex client management was not consistently addressed at an organisational planning level. It was evident in this study that healthcare teams typically responded to individual client need, rather than proactively planning for a wider agency approach to **complexity management**. When the differing needs of complex clients remained formally unacknowledged, it raised a dilemma for HCWs. Supporting these clients necessitated increased time and a wider interagency approach, yet managing clients' complex needs was often uncoordinated across agencies.

That's an example of where collaboration worked after things were so frustrating. But it was more complicated than it needed to be, because of how this other team operates. There needs to be more openness and coordination across the services, especially with these complex cases.
(Cathleen)

In summary, clients in community rehabilitation often presented with complex issues beyond the basic referral concern. HCWs used the term 'client complexity' as general professional shorthand, yet in practice held differing assumptions about what this meant. HCWs were not always trained, or prepared to manage clients' extra psychosocial needs, but managed the best they could. When clients had complex health and psychosocial issues, HCWs assumed they would require increased resources and greater **connecting** within a team and across agencies. This assumption may in itself have contributed to the issue of **complexity management**, with participants presuming difficulties before they arose. Likewise, HCWs perceived that when clients' complex needs were not formally coordinated at an organisational level, problems occurred. While HCWs believed they had minimal influence over the complexity of clients referred to their services, the interlinked aspects of relational and situational complexity are areas where **connecting** and collaborative practices could have a more noticeable impact.

5.3.2 Relational complexity

Relational complexity refers to the multiple relationships and interactions HCWs engaged in that were managed through **connecting** with others. The interactions were complex in that they were contextual; they varied from day to day; involved relating to a diverse range of personalities; and occurred both within a healthcare team and across agencies. The daily variations arose as each client had a differing mix of people involved in their care. Relational complexity began with comprehending who was interacting with each client, a situation that was all too often unclear, and acted as a barrier to **connecting**.

I know there's complex needs around working with children. There can be so many people involved; trying to figure out who is involved can be quite daunting to parents. It's hard enough for my staff to work out who's involved when lots of agencies are going in. (Nina)

Identifying the diverse range of people involved with a client was only the first of several challenges inherent in relational complexity. Another fundamental aspect was the need for HCWs to relate to a wide range of personalities across a range of settings. Participants commented that even within their own teams, **connecting** with differing personalities impacted on their work. "My personality is going to impact my work, as is yours, and the clients; it's all going to influence what we do in our life." (Amelia)

While the multiple relationships and interactions in community work were complicated by the need to relate to differing personalities, some participants observed that community work appeared to attract a certain type of worker.

I think it [community work] probably does attract a different type of worker. [It attracts] Those people who want autonomy and the freedom to think outside the square, to work holistically with clients. (Linda)

This is not to suggest that all those working in community rehabilitation have similar personalities, although Linda went on to state her belief that community work in general suited certain personalities.

P: I've heard so many people say 'I just love working in the community. I couldn't go back [to hospital work]. And vice-versa, there's plenty of hospital staff who wouldn't ever want to work in the community.

I: *What do you think that's about?*

P: I think it's to do with their personality. Some people just suit the routines and structure of hospital work. Maybe they feel secure with more defined roles. Whereas other people get out here and just blossom. Those are the ones who are flexible, adaptable. (Linda)

This perception adds another layer to the notion of relational complexity. Data indicated that community work polarised people and that HCWs did not stay in that context if they did not **connect** with the team culture, or the perceived lack of working structure. Julia expanded this view, suggesting that certain personalities may be attracted not only to particular team contexts, but more specifically to particular professions.

I believe that certain personalities choose certain fields in their life journey. I think that it's not hard and fast, but there is a certain type of person that wants to become a dentist, and a certain person wants to become an airline pilot, and a certain person wants to become an OT. (Julia)

Team leaders looked to manage relational complexity when recruiting. They talked of searching for personality traits that would support the building of multiple relationships and **connecting** within their operational model.

With recruitment, I think we prioritise recruiting for good relationships within a team, and for personalities that are going to build relationships across the agencies, and across the services. It's about character and attitude. (Jamie)

The proactive emphasis on personality fit and relationships within a team was less evident in private teams, such as ACC-funded contractors. In these contexts, HCWs were recruited more for experience and their ability to work autonomously. Because private contractors often did not share an office base and hence did not interact daily, team leaders placed less emphasis on team fit, preferring to employ HCWs based on professional skills. Yet, managing the relational complexity of diverse individuals working together in contract teams was problematic. For example, tension commonly arose in private teams when HCWs who hadn't formed a connection needed to collaborate around a client.

It was about two strong people having different opinions I guess. I mean I didn't really know this speechie [speech language therapist]. And because we were going in separately, we didn't get to talk things over, until it got blown out of proportion. And then we referred it onto the manager, and it had to be resolved that way. (Amelia)

The lack of **connecting** in contracted teams was attributed to time and funding mechanisms. When HCWs were predominately funded for hands-on clinical hours, there was little incentive, other than professional best practice, for HCWs to spend time building relationships. In spite of this, several participants reported investing time for **connecting** even when they were not paid for it. This demonstrates the importance HCWs placed on **connecting** as a means of managing relational **complexity**.

Relational challenges within teams went beyond individual personalities. Having a variety of professions within a team meant **connecting** across differing professional perspectives. At times, these fundamental differences in professional approaches caused relational tension. For instance, Stephanie talked of differences between the professional perspectives of speech language therapists (SLTs) and dieticians. She gave the example that SLT requirements for a person to be hungry when developing eating skills, may conflict with dietician priorities of maintaining clients overall caloric levels. Identifying and addressing these differing professional perspectives added a layer of **complexity** to relating within teams.

Adding to these challenges, role assumptions, issues of professional hierarchies and a lack of role understanding complicated team relating, and interagency **connecting**. While these notions have previously been widely linked to poor team functioning (Delva et al., 2008; Kvarnstrom, 2008; Suter et al., 2009; Zwarenstein et al., 2009), participants in this study extended the notion of role understanding further, noting that even *within* a healthcare profession, opinions differed over role parameters. Sometimes these views were impacted by the undergraduate training healthcare workers received.

I don't think the [occupational therapy] training is really comprehensive. I think therapists come out of university not really understanding what their role is. And if I don't know what I do, it's really hard for me to tell you what I do! And it's different now to when I trained too. They come out knowing different things. (Julia)

At other times relational complexity was influenced by international differences in role understanding. **Connecting** processes were complicated when HCWs who had trained in other countries, understood their roles differently to those trained in New Zealand.

Here in New Zealand speechies do all of that [feeding programme]. In the United States the OTs do all of that. Speechies don't have anything to do with feeding, at least in California. And in Canada speechies and OTs do it together. (Julia)

When role understanding varied across a profession, relational complexity arose, as HCWs used individual role assumptions to facilitate **connecting** with other professionals. This was arguably made more difficult in the community where, in response to the complexity of the setting, roles tended to be less defined than in the hospital environment.

Working in the community, you are exposed to sometimes unexpected things, or dealing with different people. It can be more complex than hospital. The roles are less defined. (Rowena)

Community work also involved the necessity of working across agencies, further complicating HCWs' interactions and relationships. Interagency working (see Chapter 7) involves both relational and situational complexity, forming a context specific to community healthcare.

5.3.3 Situational complexity

Situational complexity referred to contextual environments that were diverse, variable, and had control issues. The situations were complex in that they varied from day to day and client to client. The community environment was less controlled than hospital settings, requiring HCWs to adapt to complex, changing situations, with little or no warning.

It's about the system really, or the environment. Because in hospital, in the clinical setting, everything needs to be quite precise. But in community work, we are really dealing with a more complex, less controlled environment. (Cathy)

Differences in the situational complexity between hospital and community environments were poorly understood by those outside the area. HCWs entering community settings had limited understanding of the situational complexity, which led to **connecting** challenges.

I: *Is community work different than working in a hospital?*

P: Yes, it is and I think not everyone realises that until they get out here. Some people come looking for flexible work hours - new mothers, say. And others don't realise there's a difference until they start working. They decide pretty quickly whether it's for them or not. (Amy)

Situations were complex at both micro and macro levels. Micro-level considerations included those aspects affecting HCWs **connecting** within their daily work. Prominent within this were notions of HCWs' professional and personal safety in the community. Because the working environment was dynamic, **complexity management** was unpredictable, with HCWs often not knowing much about the situations they would face when visiting clients. Challenges ranged from language barriers, to access issues, accusations of misconduct, vicious dogs, or confrontational relatives. When given warning of safety issues, two HCWs would visit the client together to minimise risk. However, given the fluid nature of community work, predicting risk was not always possible. Situational complexity presented an on-going challenge.

There have been occasions where we've done joint visits if the situation has called for it. If it's been a really complex client, or complex social issues, or safety issues. (Carol)

Equally, the complex situations also strained professional detachment and impacted on professional safety and **connecting** processes in other ways. Rehabilitation frameworks that incorporated holistic consideration of the needs of the client, could lead to HCWs becoming emotionally involved in the situation. John commented on the need for professional boundaries when adopting a holistic perspective, perceiving that they worked as a safety net for both HCW and client.

[In the community] you can lose perspective and become emotionally caught up in it and you don't really see it from a detached point of view. Having someone else going, "Actually do you really need to be involved in that?" Things like that really bring you back to your role. I guess it's about safety, for you as a clinician, and safety for the person you are working with. (John)

Being reminded of role boundaries was about HCWs **connecting** at an appropriate level in complex situations. Professional safety was supported through peer supervision, debriefing, and avoiding professional isolation. However, this was complicated when organisations did not fund **connecting** opportunities.

When you go out for coffee to debrief with each other, you have to build it in, because we're all private and not on salary. But we do it, we have to. It's crucial. Crucial to not getting isolated and making sure you're not doing some lone ranger sort of thing. In terms of safe practice it's actually vital. (Lydia)

While situational complexity influenced professional safety, clinical experience acted as a moderating effect, influencing how complexity was managed. As will be seen later in this chapter, experience levels were considered one of the conditions that shifted HCWs' behaviour when **connecting**.

When you first graduate you've got very little experience and somehow the level of complexity of working out here, with all the family dynamics, makes it much harder. So new grads definitely need that hospital experience, that learning and support of others, before trying out the community. (Sara)

However, managing situational complexity through engaging experienced HCWs creates a barrier to entering community work. This poses concerns for future training and recruitment of community HCWs. If younger staff are not encouraged to enter this

context, and mentored by experienced staff, gaps in service provisions will eventually arise.

At the macro-level it was noticeable that situational complexity encompassed the need for interagency **connecting**. This differed from the hospital environment where HCWs regularly engaged with the same professional teams. Characteristic of complex situations, these interactions in the community were unpredictable, varying according to client and situation.

And I think for any new therapist coming along, it's really important to understand where we sit in the whole greater community. So the OT students we have at the moment, they have no idea how the other agencies in our area work, how it fits together. And it's very hard to explain it to them, because it's not black and white. It's very complicated. (Cathleen)

The situational complexity of interagency **connecting** increased when both professional and lay teams were involved. For instance, when lay carers, whānau (family), community support groups, and cultural advisors supported clients alongside professional healthcare teams. These differing agencies and individuals had their own processes, agendas and perspectives which intersected around the needs of the person requiring support. Team leaders needed to consider how their teams should be involved in **connecting**, in order to manage the relational and situational complexities which arose.

I think the team leader always has to reflect on what is happening and how things are happening, given that there are multiple teams involved, and many differing people, with many complexities to consider. (Nina)

The fluid nature of these team arrangements reflects complexity principles of working within boundaries of instability (Haynes, 2003). This notion is developed further in the discussion of forming-reforming in Chapter 7.

This section of the chapter has presented **complexity management** as the central challenge HCWs faced in interprofessional community work. The manner in which HCWs managed the complexity was through **connecting** processes, which are introduced in the next part of the chapter.

5.4 Connecting

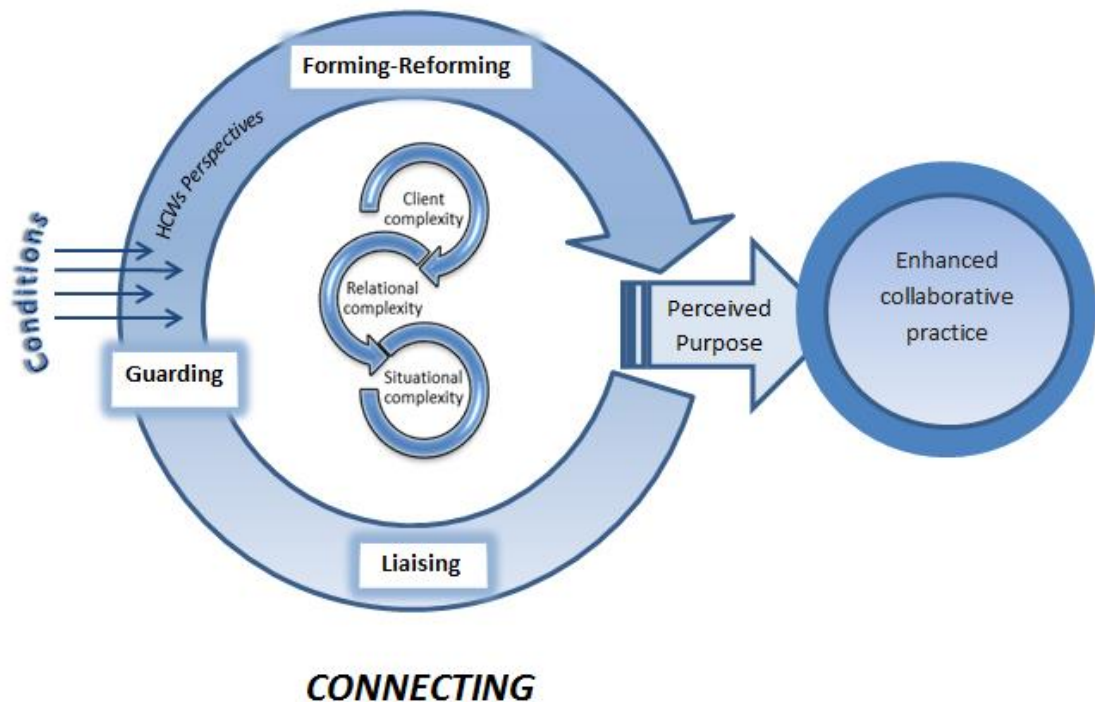


Figure 3: The theory of connecting

Connecting is the central concept that explains how HCWs **managed complexity** when working interprofessionally in community teams. The components of the theory are summarised in Figure 3 above.

In this diagram, the three interlinked aspects of client, relational, and situational **complexity** are shown in the middle of the figure, as they represent the central challenge faced by HCWs. The outer circle is a ring of action. It signifies the **connecting** processes (liaising, forming-reforming and guarding) that HCWs used to manage the **complexity**. The perspectives HCWs operated from are also within this circle, as these influenced **connecting** actions. The manner in which this occurs is described later in the chapter.

The conditions that shifted **connecting** processes are shown acting externally on the circle (see later in the chapter). Finally, the smaller circle on the right indicates the rationale for undertaking **connecting** to enhance, or improve collaborative practice.

Findings indicate that **connecting** was perceived as essential for interprofessional work, with some processes facilitating, and some moderating, collaboration.

It's very much about introducing some processes that are going to be useful to build more connectedness and interpersonal dynamics – it opens up the connections, the ability to then connect with each other outside of meetings. (Denise)

If I think of times when we might be liaising with other community teams, that throws up questions for us as a team, about how do we connect with these people? How do we make sure we're all on the same track? (Brenda)

Connecting involved liaising, which encompassed interacting, networking and referring; the forming-reforming processes of interprofessional practising, flexible practice, and forming teams within teams; and guarding processes of professional shielding, protecting, and negotiating. Within the theory of **connecting**, the theoretical categories of liaising and forming-reforming were facilitative collaborative practices **connecting** people and systems, while guarding behaviours were protective and moderated **connecting** and collaboration.

The three theoretical categories within **connecting** are briefly introduced here, with a full discussion of each provided in the subsequent chapters.

- Liaising. HCWs used liaising processes as a means of **connecting** that managed all aspects of **complexity**. Liaising involved interacting, networking, and referring that occurred both formally and informally, within a team and across agencies. Liaising aimed to build relationships and increase communication channels. It was also used as a means of managing resources and enhancing interagency working.

It's doing those extra things – making phone calls to the family, liaising with other people and agencies – coordinating services with other teams, liaising about who's doing what. (Julie)

- Forming-reforming was a process reflecting the fluidity of practice HCWs required as they collaborated in interprofessional work. Forming-reforming was considered a positive aspect of **connecting**, with its processes of flexible practice, interprofessional practising, and forming teams within teams supporting collaborative practice. The purpose of forming-reforming was to increase

responsiveness to complex needs and allow adaptation to complex relationships and situations.

You're doing that to be flexible and available. So that you're not so rigid in your practice so that you won't only do this or that. But you'll adapt to do what's needed. (Rowena)

- Guarding processes occurred around *professional shielding* of roles, *protecting* the client and profession, and *negotiating* resources when managing client and relational complexity. Guarding was a valuable process within **connecting** as it allowed HCWs room to defend, maintain, or change dynamics within their complex work situations. Rather than using processes aimed at increasing **connecting** across teams and agencies, guarding involved constraining actions that maintained the status quo and limited **connecting**.

We're actually very, very guarded and defensive and the reality is: well I actually don't want anybody else doing the things I believe I should be doing as an OT. (Amy)

While these three linked categories encapsulate the theory of **connecting**, it is important to stress they were not fixed, static notions. Rather, the processes were influenced by a range of factors and conditions, which answer the third research question of when and why HCWs' actions change. These variations arose from within individual HCWs as differing viewpoints or perspectives, and externally as conditions impacting on **connecting** processes. For clarity, I have chosen to explain the conditions and perspectives here, before they are integrated within the analysis findings in subsequent chapters. The more detailed analysis of the categories of **connecting** is presented in Chapters 6 to 8.

5.5 Perspectives utilised by healthcare workers

The third research question asked 'Under what circumstances do HCWs' actions change and why?' In approaching this question through a symbolic interactionist lens, I was aware that individuals act towards others according to the meanings they ascribe to them, based on their thoughts and perspectives (Blumer, 1969; Charmaz, 2006). An individual's shifting perspective therefore provides part of the answer as to why HCWs' actions change.

In this study, participants were observed to approach **connecting** in their interprofessional work from differing perspectives. Appendix Q provides a memo tracking my analytical development regarding perspectives. The perspectives have been grouped into three main areas: the professional, teamworking, and holistic perspectives. Working from a particular perspective was observed in action, but was rarely articulated by participants. This sometimes led to misunderstandings, as described in the examples below. While individual HCWs appeared to orientate themselves more strongly with one perspective than another, within the course of a working day, individuals were observed to move between these perspectives. These shifts were necessary for participants to manage **connecting** in a context that was fluid and complex.

5.5.1 The professional perspective

During **connecting**, when HCWs adopted a professional perspective they were focused on their role as an individual professional providing a specific service within a team. From this perspective, HCWs' **connecting** with clients focused on how they could use their own professional skills to assist the client. This was within the usual scope of their professional training and represented the typical lens with which HCWs approached their interprofessional interactions. For instance, when a physiotherapist discussed a client's walking progress with a colleague they were using their professional perspective.

HCWs could still be collaborative within this perspective, for example sharing profession-specific knowledge with the team, such as manual handling advice. However, when the professional perspective became too dominant, role and resource guarding were observed. This raised barriers to **connecting** and collaborative practice. For instance, this was observed when HCWs would only undertake tasks they perceived as being their role. Other examples involved HCWs who had high workloads

withdrawing into a professional perspective that focused on the task at hand, rather than **connecting** with other professions. During observational data collection, the professional perspective was viewed regularly, as participants went about their daily practice. **Connecting** was managed through liaising with other HCWs and lay workers, but centred on professional discussions rather than relationship building, or team development.

5.5.2 The teamworking perspective

From a teamwork perspective, **connecting** was apparent as HCWs prioritised the interprofessional team over their specific profession. While still carrying out their professional duties, HCWs emphasised team functioning, and their impact on others.

You're making clinical decisions that are affecting clients and the team you work with all the time. And you're mindful of that. So if you're stressed, or you've not quite got the balance right - say you're spending too much time liaising but not enough on your case stuff, then that's going to impact on your team relationships, and on the family you're working with. You have to consider your impact on others. (Violet)

Collaborative practices of knowledge sharing and supporting other members of the team were valued within this perspective, with liaising processes and **connecting** evident. Team leaders typically approached their work from this perspective, rather than a professional perspective. Team leaders needed to adopt a broad view of what supported the team, regardless of their professional affinity. Sometimes this led to tension when other team members were prioritising differing perspectives, or felt the team leader was moving away from their professional roots. For example, during one observation a team leader organised a professional development session for all staff. One HCW commented to me that the leader should know better, and should not be encouraging therapy skills to be shared amongst other professions. In this example the team leader was adopting a perspective that encouraged **connecting** through teamwork, while the HCW was prioritising the professional perspective in focusing on her professional role boundaries.

5.5.3 The holistic perspective

HCWs often perceived **connecting** was more effective and clients received better service when they approached their work from a holistic perspective. This involved HCWs viewing themselves as part of a wider circle, developing broad **connecting**, and collaborating with clients, family, and other HCWs. As Stephanie noted, 'I think in our team we try to work in a really family-centred way, getting others involved as well, because you're only a small part of that person's life.' Practising holistically meant considering perspectives beyond the current team focus. This perspective was linked with holistic models of person-centred care (McCormack, Karlsson, Jan-Dewing, & Lerdal, 2010; Slater, 2006; Van Dam, Ellis, & Sherwin, 2008), yet went further with an emphasis on **connecting** across healthcare and service agencies. In this study, having a holistic perspective appeared to be an important part of community work.

We see people head to toe, holistically. The whole person, and all those around them. It's vital in our work. You have to look out for things beyond your role.
(Elise)

However, time, resource, and organisational constraints meant HCWs were not always consistent in using this approach. For example, HCWs in private contexts (e.g. ACC - funded contractors) found this perspective difficult to implement, as they received no direct funding for the time taken to **connect** with a wider circle. Additionally, team leaders were not always dedicated to this perspective, with their mandate more focused on collaborative practice within their own team. HCWs reported occasions when team leaders would refuse HCWs **connecting** opportunities such as attending meetings with other agencies. At times, it appeared that adopting a holistic perspective was more of a vision than a practice reality.

5.6 Conditions impacting on connecting

Conditions refer to the underlying situations and circumstances that affect the perceptions and actions of people (Caron & Bowers, 2000; Charmaz, 2009). Changing conditions provide the second part of the answer to the third research question, as they address the circumstances under which HCWs actions change. In this study, several conditions impacted on how participants practised **connecting** and influenced their shifts between perspectives. While individual variations were common, analysis identified four salient conditions affecting participants' **connecting**: organisational structures, the working context, experience, and leadership styles.

5.6.1 Organisational structures

The means by which rehabilitation organisations were funded was a major condition influencing HCWs' **connecting** with others. As noted in Chapter 1, the two main providers of rehabilitation funding in New Zealand are the Ministry of Health (MoH) and the Accident Compensation Corporation (ACC). Both have separate policies and funding protocols for community rehabilitation. One important difference is that MoH workers are usually salaried members of a defined rehabilitation team with wider connections to other MoH -funded health teams in their area through their District Health Boards. This includes shared access to client note systems, similar organisational structures, and opportunities to network and have joint professional development sessions.

ACC provides similar services for in-patient rehabilitation; however, in the community context, its organisational structure is different. In this setting, ACC contracts private healthcare teams to provide services to individual clients on a needs basis and for a prescribed length of time. Each team is effectively in competition for the contracted services and therefore less likely to share resources. Individual HCWs on these teams are contracted to see clients for a specific purpose, and often work from their own homes rather than an office base, thereby limiting their options for collaborating and **connecting** with others.

As contractors, we're all working from home environments, so that kind of informal catching someone at work just doesn't happen. Collaboration is harder; you have to make the effort to email, to phone, to text, to touch base about things. (Diana)

Additionally the funding of ACC contract work is tied to client contact hours, meaning **connecting** opportunities are both unfunded and come at an opportunity cost of lost billable hours.

With the private work if you're not treating, you're not getting paid. So with all the collaborative stuff you do in the public teams, you're getting paid for that time. Whereas with ACC you don't get that. So you have to freely give up that time. You email, or you phone each other. Whichever way you do it, it's unpaid. (Fran)

This presented a significant barrier to collaborative practice and increased relational complexity, with participants funded under private contracts needing to make conscious efforts to prioritise **connecting**, at a potential cost to themselves.

5.6.2 Working context

HCWs' working context was a condition that provided both opportunities for and barriers to **connecting**. The working context shifted how HCWs acted, and impacted on their ability to collaborate with others. Organisational frameworks and policies largely set the working parameters, with HCWs having little control over the context. The larger organisations tended to have a central base HCWs travelled to each morning, checking in before going out to see clients in the community setting or **connecting** with clients as out-patients at that central office setting. This context provided opportunities for informal collaboration and **connecting**, as HCWs saw each other briefly each day.

The health teams they have an office all together, you know where they all come at the beginning and end of the day, so they can kind of grab each other to talk about this child, or that problem. [It's a place for] a quick debrief about something. (Lydia)

Not all HCWs perceived the benefits from a co-located work context, or took the opportunities for **connecting**. Those who were focused on a professional perspective just wanted to get out and treat clients, perceiving the trip into the office was wasted time.

I: Are there any benefits in coming into the office? Does it give you an opportunity to touch base with others for example?

P: I don't know that we do connect much at that time. Personally I find it easier to see clients on my way into work. It seems such a waste of time for me otherwise to drive all the way here. (Sara)

In contrast, smaller teams and contracted individuals often had different working contexts. This often meant a small central office, which HCWs visited infrequently; they mostly worked out of their own home offices and saw clients in their homes or community settings such as a gym or workplace. Working within the client's home or workplace gave HCWs opportunities for **connecting** with family and carers supporting the client, and moved their focus to a holistic perspective. However, when working on reports at home, it was all too easy for a HCW to become isolated and to shift into a professional perspective, as they were not **connecting** with other HCWs.

This isolation could be mitigated through the working context of joint visits, which fostered **connecting**. This condition occurred when HCWs travelled together to work with a client. Joint visits happened if the client was considered particularly complex, if the home environment was unsafe, or if an extra pair of hands was needed for treatment (see Chapter 6 - Interacting). **Connecting** opportunities arose within joint visits during the travel time, through joint working, and from learning about other HCWs' treatments. Yet, joint visits were not always favoured by HCWs, with perceptions about differing personalities and working styles limiting how, and when joint visits occurred. It appeared relational **complexity** became a barrier to collaborative practice at times.

Joint visits can be good, because you have time afterward to do all that collaborative stuff that you should do at the end of the session. Like "Did you see when you fixed his trunk, I was able to do this with his arm, what do you think?" But because we've all got personalities, and some people aren't too happy with each other, joint sessions don't always happen. So that's been an issue. (Stephanie)

The working context of HCWs' hours of employment provided another condition that impacted on perspectives and **connecting**. When HCWs were full-time employees with one team, there was both more time and opportunity to focus on collaborative practices. This did not mean **connecting** consistently occurred with full-time staff; rather that the opportunity was available. However, many HCWs in community work were part-time employees with limited time for anything other than clinical work with clients. Team

leaders needed to actively work to include part-timers by using techniques such as alternating staff meeting times, and using electronic communication and joint notes to give part-timers **connecting** and collaborating opportunities with the team. The influence of part-time working is discussed further in Chapter 6 - Networking.

5.6.3 Experience level

The experience level of HCWs was a condition that drew strong reaction from participants in this study. Greater levels of experience were perceived to enhance HCWs' ability in **connecting** and collaborating with others. The prevailing view was that clinical experience was required to work safely within the community setting.

If you've never worked in a hospital, if you've never worked alongside other health professionals, on a day to day basis, then if you go straight to working in the community I think it's inherently unsafe. I get concerned when I hear about new grads in the community. (Lydia)

Increased experience levels appeared to assist HCWs in managing the complexity of community work. Additionally, experienced HCWs were perceived as being more able to use a holistic perspective in **connecting** with a variety of others. Experience levels were valuable in terms of both clinical and life experiences. For instance, some team leaders preferred to employ HCWs with life experience, viewing maturity as a valuable trait for **connecting** and collaborative practice.

In terms of what I'd look for in terms of a clinician, I'd look for someone with life experience. I think that helps a lot in terms of having the maturity to deal with situations ó [it helps] with tricky situations and clients. That's really important. (Georgina)

Having greater experience levels was not always considered necessary, however. Some participants challenged the prevalent view on experience, commenting that younger HCWs with positive attitudes could also adapt to the **complexity** of community work.

People feel that you need to have a certain amount of experience to enter community work. But I think that actually contributes to one of the issues with recruitment really. And actually what we should be doing is supporting people to enter it. Because you don't just automatically have those skills having come from another context, like having transferred from hospital work -this setting is really different from that. (Jamie)

The condition of experience levels was not exclusively about clinical experience or maturity. When HCWs started a new job, this provided a catalyst for changing conditions regardless of their level of experience, as they created a need for forming new relationships and **connecting** with others. This occurred from the beginning of their induction process until they had established their place in the team.

We've got a really tight core of people who've worked here for a long time. And then just recently, we've had a whole lot of new people start. And so it's interesting to watch. As a team we're not as collaborative anymore. So you have to go back and build those new relationships together and find that place of professional safety within a new team. (Julie)

New staff challenged the status quo, causing shifts in patterns of behaviour within established teams. This was seen during one observation session, when a new staff member suggested a change to the team meeting procedure, based on experience from her previous job. Meanwhile, team leaders perceived inducting new staff both as a time of opportunity and a time of uncertainty, as they waited to see if the new person connected within their team culture.

5.6.4 Leadership styles

The condition of leadership styles had a noticeable effect on **connecting** processes. Participants perceived that **connecting** and collaborative practices were either facilitated or hindered by the operational style of their team leader. Open, transformational, or relations-oriented leadership styles that allowed for autonomy of practice, such as the models suggested by Antonakis, Avolio, and Sivasubramaniam (2003), or Bass and Bass (2008), were considered conducive to liaising and forming-reforming processes.

I: *Is there anything specifically that your manager does that facilitates working together?*

P: I think being open-minded. Like, if you've got any issue, you can go to her and likewise she can come to you if she's got any concerns. So it's a nice balance. It is very open and trusting. And you're treated as a professional. I guess it's nice to be given the professional accountability and the trust to make your own decisions. (Robert)

In contrast, more restrictive leadership practices, which were bureaucratic and task-orientated, led to guarded behaviours with HCWs more likely to remain in a professional perspective, focused on doing their assigned roles. Examples from the data

demonstrated this, with several members of one team referring to the micro-managing style of their team leader.

Just talking about it makes me feel angry about it, but she [team leader] keeps on putting her two cents in. She won't just let us get on with doing our job. It takes so much time and really for what? Aren't we all trained professionals? (Paula)

Restrictive leadership practices left HCWs with limited autonomy to manage the challenges of relational and situational **complexity** or enable **connecting** with other agencies.

Interestingly, participants attributed a leader's style to the individual's personality, rather than viewing it as the leader responding to specific organisational protocols, or actively working from a chosen style. This was important as it is well established in the leadership literature (Bass & Riggio, 2006; Hersey & Blanchard, 1977) that individuals should purposely utilise differing types of leadership in differing circumstances. Yet the participants in this study did not perceive leadership style as purposeful. When HCWs personalised leadership actions it affected the perspective they operated from, and shifted the emphasis they placed on **connecting** processes. The influence of leadership on **connecting** processes is discussed further in Chapter 9.

5.7 Summary

The first of four findings chapters, Chapter 5 introduced the theory of connecting and provided answers to the three research questions. The chapter began with a description of **complexity management** as the central challenge faced by HCWs in interprofessional work. **Complexity management** was presented as a contextual notion with three interlinked components: client, relational, and situational complexity. This explanation provides a new way of viewing complexity within the interprofessional literature, which will be discussed in Chapter 9. The second part of the chapter introduced **connecting**, with its three theoretical categories of liaising, forming-reforming and guarding, as the means by which **complexity** was managed. The HCW perspectives and salient conditions that act to shift **connecting** processes were then explained. The ensuing three chapters expand on the theory of **connecting**, and respectively address its three theoretical categories.

Chapter 6 Liaising

This chapter and the next two, individually present the three theoretical categories underlying the theory of **connecting**. This chapter begins by introducing and explaining the category of liaising and its sub-categories of interacting, networking, and referring. Variations and conditions causing shifts in the process of liaising are interwoven throughout the chapter, along with the influence the differing perspectives described in Chapter 5 have on the process. Examples from the interview and observational data are used throughout the chapter in order to ground the category in the data and ensure that the participant voices resonate.

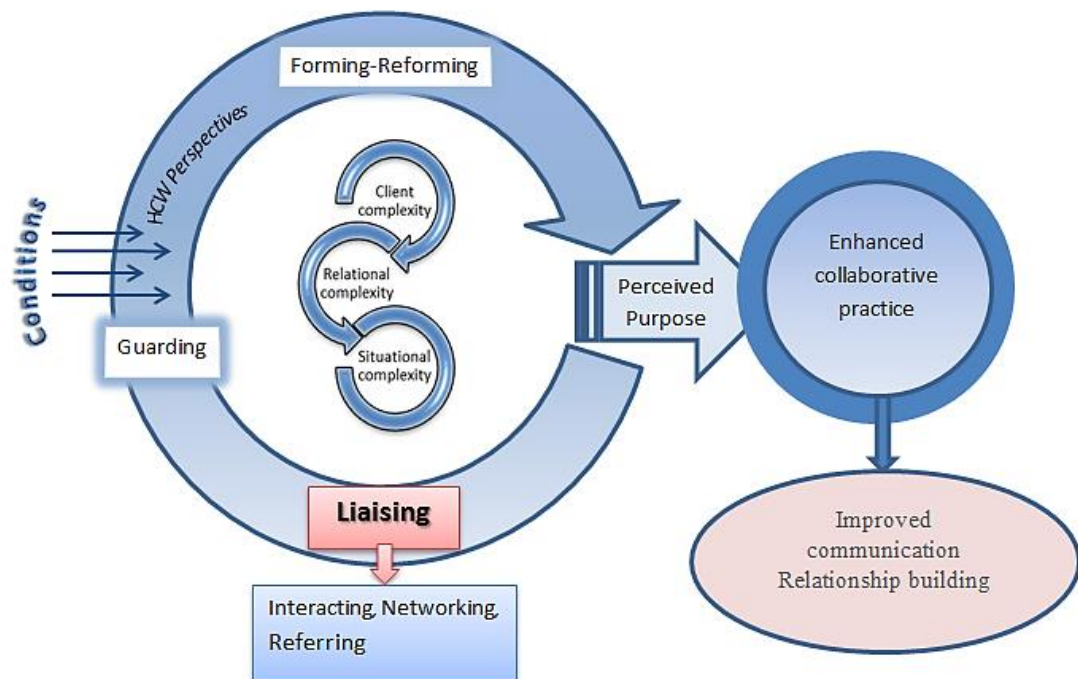


Figure 4: Liaising purpose and processes

6.1 Definition and purpose

Liaising refers to the ways in which HCWs were interacting with, networking with, and referring to each other as they managed the complexities of their collaborative work. Interacting was a form of collaborative practice which occurred through *formal* and *informal relating* and by *interagency relating*. Networking arose through *opportunities*, but was complicated by *part-time working*. Referring appeared to be an important process of liaising, as it facilitated both *interprofessional* and *interagency* referral.

The purpose of liaising was to improve communication, and facilitate relationship building. The ultimate aim was to enhance collaborative practice and minimise mistakes from miscommunication. Liaising occurred regardless of which perspective HCWs were operating from, but was more common when HCWs favoured the teamworking or holistic perspectives. Participants frequently commented on the importance of liaising as a positive communication tool for **connecting** with other HCWs. As improving communication is a frequently cited mantra within teamwork models (Toccafondi et al., 2012; Xyrichis & Ream, 2008), it was not surprising that participants held this goal so overtly.

In comparison, relationship building was not always stated as an overt aim of liaising. Some participants viewed it as an active goal, whereas for others it was a hidden pattern of behaviour that arose as a secondary consequence of liaising around a client. That is, as liaising with other HCWs occurred, relationships were built that had the potential to enhance future liaising and **connecting**.

There's the personal aspect of the therapist building a direct relationship with the case manager, exclusive of me as the team leader. But it's always client driven. 'We need to talk about so and so' And in the process of connecting about a client we build a relationship. (Tracy)

Relationship building enhanced role understanding. This in turn established trust and provided a solid basis for **connecting** and collaboration. This was important when the working context HCWs operated from was one of autonomous practice.

If you're working autonomously, you're got to be able to trust that the other professional working with that client on a different day from you is on the same page as you. The only way to do that is to build relationships together, to talk and liaise about the client frequently. (Julie)

Within the theory of **connecting**, the three main theoretical categories are inter-linked. Liaising is limited by guarding processes (see Chapter 8), but aligns closely with forming-reforming (Chapter 7). Both are positive processes which work to enhance **connecting** and collaborative practices. Underlying the theoretical category of liaising are the three sub-categories of interacting, networking and referring. These are presented in chart form in Figure 5 below.

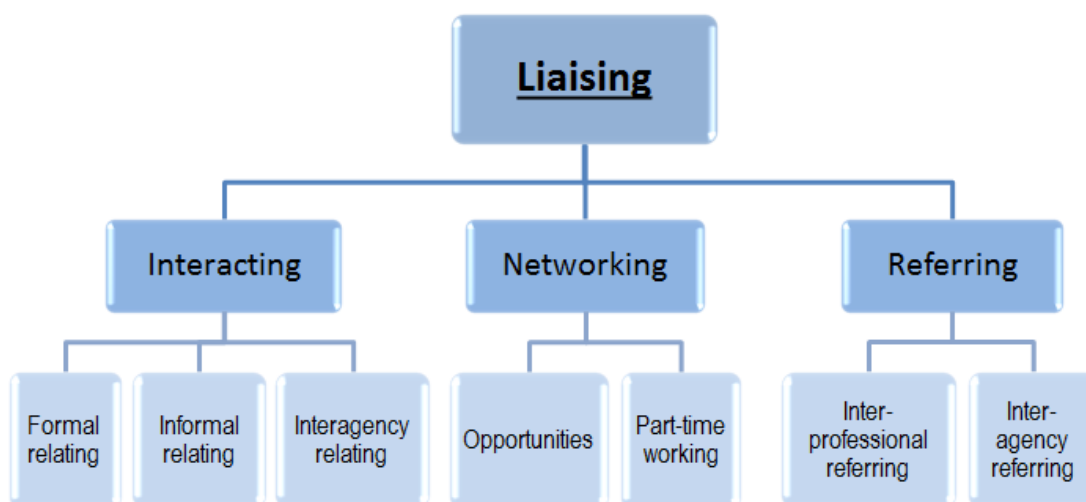


Figure 5: Liaising sub-categories

6.2 Interacting

Interacting was a form of *liaising* that occurred as a needs-based **connecting** process. It arose through both *formal relating* (e.g. team meetings/structured interactions) and *informal relating*, such as corridor chat, or discussions within an office. *Interacting* also occurred with other HCWs in the community as *interagency relating*.

If your nurses are working well, they're interacting well in the community.
(Amelia)

Interacting was very much a relational process that involved **connecting** with others as people, rather than viewing them by their professional label. At times, this meant HCWs needed to reflect on how their own perspectives influenced their interactions.

As you get more experienced, you get a deeper understanding of people and the way that they interact and work. And while we're health professionals, we're also people. And so the way that we react, the way that we work, our values and culture all influence us, and how we interact as well. (John)

Because *liaising* involved interacting with diverse ranges of people, it was complex. HCWs needed to actively consider ways they could *interact* with others and foster **connecting**, thereby managing the relational **complexity** across a multitude of settings.

My feeling is that often there are interactions between the family and each set of the professional teams, but that the interacting between the

professional teams, the sharing of that information, may not be so clear.
(Brenda)

6.2.1 Formal relating

There were differing views of *interacting* that were dependent on team position and individual perspective. Team leaders valued *formalised relating* channels such as scheduled team meetings and case conferences, whereas individual HCWs, operating from a professional perspective, saw more benefit in *informal relating*. Differing perspectives centred on optimal use of time. Team leaders favoured formal team meetings as a succinct way to increase *liaising* opportunities and team **connecting**. However, HCWs often perceived team meetings as unnecessarily taking up time, because the emphasis was more administrative and political, rather than client-focused.

Well, once a month we have a team meeting, that's formal and very political. We don't do anything useful there, and it goes on and on. That's always been a concern for me. You have this meeting and it's so formal - matters arising from the meeting, and all that. It just takes up so much time and I have such little time anyway. (Sara)

Differing organisational structures and working contexts meant team meetings were a condition that shifted **connecting** processes. If staff dissatisfaction with meetings increased, team leaders responded by scheduling time for *liaising* and *informal relating*. For example, data showed some team leaders allocated time at the beginning of meetings for staff to *interact* with each other, with the purpose of building relationships and **connecting** with others.

And actually it's become the main purpose of the meeting now. So we go around and say 'this is where I'm at now'. It can be about work, it can be about anything. It's not a place for discussion, but it opens up the connections. (Denise)

These shifts were dependent on the condition of leadership styles. While not all team leaders took this approach, those interviewed perceived that team meetings fostered *interacting* opportunities, and made it a requirement that all staff worked the day of the regular team meeting. This had the secondary benefit of facilitating *informal relating* before and after the meetings, and increasing **connecting** between full-time and part-time workers.

6.2.2 Informal relating

Despite *formal relating* being promoted, according to HCWs the real work of liaising occurred through *informal relating*, which was supported by **connecting** relationally.

I think it's really important to not have that hierarchical structure going on. That I can connect with you as an equal [That happens] through working alongside each other. Getting to know each other informally. (Cathleen)

Informal relating involved collaborative liaising about clients, professional feedback, and informal mentoring, all of which acted as a check on professional practice. *Informal relating* was observed between HCWs when they engaged in corridor conversations, staff room chat, email, and phone calls.

There's the beginning and end of the day, where there tends to be more interaction between staff. Or you get together in the staff room when you have a break. But it's all informal, it just happens because we're here together. (Georgina)

Opportunities for *informal relating* were optimised through co-location, that is, when HCWs were situated in the same team office, rather than working from a home base. However, even when HCWs shared an office, the working conditions meant they spent most of the time out on client visits. These could provide opportunities for *informal relating* as well, if undertaken as joint visits (i.e. two HCWs undertaking a joint treatment session with a client).

The most obvious way of communicating is when you do a joint visit together and I do encourage joint visits from that point of view. I think it's important in terms of staying connected and knowing exactly what everybody else is doing. (Tracy)

Joint visits were viewed as positive **connecting** opportunities, which enhanced **complexity management** in challenging cases. Yet, due to the conditions of organisational structures and differing work contexts, joint visits were not always possible.

P: We have some interaction in the office, chatting about clients and stuff at the beginning of the day. And it's good if we get to see a child together. But unfortunately when it's face to face treatment time, we don't often get a lot of joint sessions.

I: *Why is that?*

P: Sometimes the family doesn't want so many people there, or you just can't get the timing together. But that's a shame, [because] they're good times to bounce ideas around, and clarify who's doing what. (Paula)

Informal relating resulted in HCWs building relationships that enhanced team morale. This supported individuals to feel less isolated and aided staff retention. As James commented, 'It's about building professional relationships. It's preventing people from leaving the job when you know they're good at what they do. It's stopping that isolation, because we've all experienced it.' For this reason, individual HCWs often initiated *informal relating* opportunities themselves.

Every fortnight somebody brings in some baking and everyone sits down and has a coffee. It's about relating to each other, building relationships aside from work stuff. (Cathy)

A problem that the team members themselves identified was that of staff leaving & staff retention. And so we talked about how we could look after each other better, so we're more connected. Connected to each other and connected to work. And more likely to want to stay at work. (Denise)

Meanwhile, team leaders had a different view of relating. They perceived the main purpose of *liaising* and *interacting* to be focusing on the client, rather than relationship building. The conditions of organisational structures worked to focus team leaders' priorities on client contact time and service outcomes, rather than *informal relating* and relationship building. Additionally, team leaders were not always aware of the smaller tensions inherent in **complexity management**, and hence under-estimated the importance of relationship building for the team.

I guess the structure of community work is focused more around actual clinical hours with a client, so we have to build in extra time for these other things such as meetings, time for communicating generally with each other, and families. I think the structure does not really allow time to build relationships, or make those extra connections with each other. (Julie)

When organisational structures constrained *interacting* and **connecting** opportunities, HCWs occasionally masked elements of their *informal relating* from team leaders. They spoke of working around the system to make time for *liaising*.

I think with our manager, everyone was quite terrified of who [was] going to be in the firing line next. Everyone traditionally kept their heads down, and bottoms up. But now, with new people in the team, I think that we're

protecting ourselves a little bit more. We look after our team and make sure there's time for those informal chats and checking in. It's not official. We're not waiting for management to do it, we're actually doing it ourselves – we just don't let [the manager] know. (Amelia)

Masking of *informal relating* was not common, and appeared to be affected by the working context. For instance, masking was noticeable in teams where client contact time was emphasised, or where funding was linked to contact time. HCWs were under pressure to account for time, and *informal relating* appeared difficult to justify, or invoice. In comparison, *formal relating* opportunities were sanctioned by leaders and organisations as necessary teamwork processes. The distinction between the way HCWs and team leaders perceived and prioritised liaising and relationship building was important, with implications for service delivery. When team leaders did not have a clear idea of how HCWs prioritised and spent their time, effective team management became more difficult. The importance of relationship building is elaborated further in the discussion chapter (Chapter 9).

6.2.3 Interagency relating

Liaising processes became more complex when more than one team was involved with a client. *Interagency relating* was necessary, yet frequently problematic. As established in the discussion on relational complexity (in Chapter 5), during community rehabilitation, multiple agencies may be involved with a client. These ranged from established rehabilitation teams, through to private professionals, lay organisations (e.g. the Stroke Foundation), care teams, and family supporters. *Interagency relating* became very difficult when liaising channels were poorly developed. This occurred when neither HCW nor client were aware of the roles of the various agencies. **Complexity** issues came to the fore and required active management.

The feedback we get from clients is that when they get home [it is] absolute chaos. Because there are so many people involved – We're supposed to have service coordination and it just doesn't happen – There are too many professionals involved doing similar jobs. So, that's what I don't see as cohesive in the way the community system works, because we're all separate teams. (Carol)

As a result, *interagency relating* occurred periodically. HCWs understood that, ideally, interagency teams needed to meet for interacting at the beginning of a client's service provision. This was considered best practice, but did not always happen. When it did

occur, interagency case meetings were used as a means of liaising, **connecting** around service provision, and formalising roles for each client. As Paula noted: ‘So the meeting was a debrief of what was going on, and a way of linking or liaising, but it was also a formalisation of roles.’

Interagency relating also arose as a means of collaborative problem-solving. For instance, interagency meetings were called to discuss concerns or issues with a particular client. Challenges arose when interacting did not occur in a timely manner. HCWs expressed concern that agencies working in isolation from each other blocked **connecting** and made **complexity management** difficult.

I: *And what’s the concern around working in isolation?*

P: The client’s getting mixed messages. There’s no real continuity, no connections going on there. Actually we had someone from a third team, contact us asking us to help get these other therapists on board cause she couldn’t make headway with them either. That’s an example of where collaboration worked after things being so frustrating. It took that person to connect and act as a liaison between us. But it was more complicated than it needed to be, because of how this other team operates. (Cathleen)

Interagency relating and collaboration were promoted within organisational protocols and policies. Yet, at the grass-roots level barriers existed. Data identified barriers to liaising and interacting arising through the conditions of organisational and funding structures, along with differing working contexts. For instance, the different service parameters of ACC and MoH workers made *interagency relating* difficult, with varying rules on attending interagency meetings. Additionally, barriers to *interagency relating* were observed when HCWs worked from a professional perspective, which focused on achieving a particular task, rather than considering the wider needs of the client.

Furthermore, situational factors made *interagency relating* complex. For example, information sharing between teams and agencies could be problematic. While teams within a District Health Board had universal computer software allowing clinical note sharing, other community agencies used differing systems and were not privy to that information. Overcoming these barriers was challenging, as it required HCWs to develop new communication pathways. Sometimes this meant changes to team communication protocols, which required team consensus and an organisational approach. In order to overcome interacting challenges between agencies, individuals

needed to operate out of a holistic perspective, which focused on achieving the best for the client, while still operating within their team parameters. Given the time and energy required for this task, it was not surprising that issues arose.

Another barrier to *interagency relating* occurred with team hierarchies. HCWs appeared to hold assumptions about the value of one team over another. This was particularly noted between hospital and community teams, with participants perceiving that hospital-based workers place less value on their own community work.

That was how I perceived it: “Oh you’re just the community therapist.” It was interesting to be in a full team meeting and have things said to me! From the respiratory physician down to everybody on the hospital team. Being a part of that and feeling quite judged, like “they just work in the community. Their role is not as important as ours.” I guess they think they’re the ones who save the lives. (Sasha)

Hierarchical perceptions were underpinned by role assumptions that affected *interagency relating* and made liaising and **connecting** more difficult. Hospital-based HCWs were perceived to guard their information, while community HCWs reverted to relying on formal communication pathways as a defence mechanism, rather than *informal relating*. This links with the discussion on professional gate-keeping in Chapter 8.

Overcoming team hierarchies and role assumptions was difficult. Organisations attempted to manage this formally through networking (see below), while at the individual level HCWs overcame these barriers by *building relationships*, and liaising and **connecting** with individuals across agencies. As the connections between individuals grew and barriers reduced, HCWs moved to use more informal *interagency relating*. For instance, HCWs would begin liaising with other teams for advice even when they didn’t currently share a client. Yet, it took time to build that interagency respect and required HCWs to acknowledge the differing perspectives of other HCWs and teams.

Building up a good relationship with someone, developing mutual respect is important. And listening comes in here too. Listening to each other’s perspectives, because you’ll all have differing perspectives if you come from different environments. Different budgets, different priorities. (Cathleen)

6.3 Networking

Networking was an active process within *liaising* that focused on developing on-going **connections** between teams and agencies. It was facilitated by creating *opportunities* for networking and impacted by *part time working*. From an organisational perspective the purpose of *networking* was to develop on-going links with other agencies. This was perceived to result in increased efficiencies, as clients could be referred onto other agencies, and knowledge and resources could be shared at times. For HCWs, the purpose of *networking* was to develop **connecting** between HCWs in differing teams. This was perceived to make future *liaising* more effective, and lead to enhanced collaborative practice.

That's why this new local liaison agreement is such a good thing. It shows a commitment to prioritising those networks and connections... to have scheduled opportunities to liaise with other HCWs and agencies. I think those network meetings are invaluable. (Sasha)

6.3.1 Opportunities

Opportunities for *networking* were multifaceted, involving professional, team based, interagency, and regional **connecting**. *Networking opportunities* were influenced by a variety of conditions. These included: having a common professional interest or need; a team culture and leadership style that encouraged networking opportunities; organisational structures that supported networking; and the availability of other organisations within the geographical region.

HCWs prioritised *networking opportunities* within their own profession. They valued building network links with HCWs in the same profession, as they frequently needed to be *liaising* with these professionals for client referrals and professional advice.

Opportunities for *networking* within a profession occurred regularly, arising via scheduled professional interest groups, journal clubs, and professional development courses. HCWs promoted these opportunities to each other as a means of establishing links and **connecting** across agencies.

I've been trying to promote to the physios in that team to make use of the networking opportunities across the region. (Jamie)

Networking opportunities arose easily when HCWs met for professional development sessions, with *liaising* occurring outside the formal part of the meetings. This in turn

established links and connections, which HCWs could draw on for interagency collaboration at a later stage. In an example from the observational data, a participant commented that the networking *opportunities* that arose through a professional interest group supported her to develop interagency **connecting**. These connections, in turn, enabled interagency liaising, when advice was needed at a later stage to manage a complex client.

Opportunities for networking between teams and agencies were usually structured and formal. An example of formal networking observed in this study was the scheduled meetings arranged for rehabilitation teams who worked in the same geographical area. Advocated at a MoH level, and coordinated by the team leaders of each organisation, these meetings aimed to develop better collaboration between local agencies through organised networking *opportunities*. As noted by Sasha, in the quote on the previous page, participants valued these network meetings as *opportunities* for interagency **connecting**.

Nonetheless, HCWs prioritised personal **connecting** over formalised networking. HCWs preferred to use informal links in liaising with HCWs they knew, rather than using a formal networking model. As John noted: 'Often more informal, those links that develop over time. Well there are formal times of network meetings, but you develop your own links, relationships that you rely on.'

Similar to informal relating, some team leaders acknowledged HCWs' preference for informal networking through allocating time within interagency meetings for informal networking *opportunities*.

That informal time within the network meeting is purposeful. It's there to build relationships across the agencies. It's really useful. I often go to catch up with someone about a client. So it's known that that informal time at the end is the time to connect with each other about those things. (Jamie)

This approach was conditional on the leadership style within each team. Not all leaders prioritised interagency networking, with some preferring to focus on **connecting** within their own team. *Opportunities* for HCWs to liaise with each other through networking therefore required negotiating when interagency meetings were planned.

When leaders did agree on interagency networking, the liaising opportunities were affected by the consistency of attendance at these meetings. Experience levels affected networking, as experienced HCWs had usually established their own networks, and hence placed less emphasis on attending networking events. They perceived they had the connections for liaising with other agencies as needed. This presented a challenge when new HCWs arrived on the scene, who needed to network and liaise with others to develop **connecting** and build relationships.

Because they've all been working together for years, they've all got good relationships with each other. They've developed great networks. Sometimes it's hard to break into that. (Rowena)

Experienced HCWs could also reduce networking opportunities, albeit unintentionally. When they displayed disinterest in formal networking, new HCWs were excluded, thereby blocking liaising and **connecting** opportunities. It also became problematic when one of the experienced HCWs left a team, as the networks were then broken. Conversely, team leaders and those experienced HCWs who used a teamworking perspective saw the value in on-going liaising. They viewed network *opportunities* as a means of encouraging newer staff, and strengthening collaborative practice across agencies.

I do think that networking is where you build up relationships with key people. It is very valuable to make those links with the key teams in the region. (Fran)

However, interagency networking was **complex** to manage and coordinate, with organisational structures affecting *opportunities* for networking. For example, while large community rehabilitation teams were well-known, the smaller private teams, and voluntary organisations were less identifiable. This made interagency networking problematic. In this study, lack of interagency knowledge limited HCWs' abilities to work collaboratively, and resulted in misunderstandings about roles. As an illustration, on several occasions HCWs observed that they did not know which other agencies were involved with their clients. In one instance, a HCW had not even heard of the community organisation assisting a client alongside her own service.

To enable interagency liaising and maximise networking opportunities across teams, local knowledge of which agencies operated in a geographic area was vital. This

became difficult when teams operated across several funding streams (e.g. MoH, ACC, private), and there was no coordination of services. Exactly who had the onus to undertake this task was unclear. *Opportunities* for interagency networking and liaising were often instigated by the large rehabilitation teams, but failed to capture the private contractors or smaller teams. HCWs who were independent contractors also reported time and funding constraints as barriers to networking and collaborative interagency practices. Equally, HCWs in large organisations had their own challenges, with time required to negotiate the internal systems, leaving little energy for external networking and **connecting** processes.

I think that the bigger the organisation, the harder it is to be collaborative outside that, because of the sort of juggernaut of the service... And if you are in a big organisation like this, then systems, unfortunately, have to be put in place to make you be collaborative...so much energy has to be spent each day in negotiating the system, following the procedures, but not really connecting. (Sara)

6.3.2 Part-time working

Networking was further impacted when *part-time working* needed to be considered.

This working context was a condition that was common in community teams.

Sometimes *part-time working* arose due to the organisational condition of ACC- funded contracts; at other times HCWs entered the community setting specifically for the opportunity to undertake *part-time working*.

Significantly, *part-time working* often meant HCWs worked for more than one community team. This could be for financial reasons, or due to the specialised knowledge they possessed (e.g. a wheelchair therapist). This dual role provided opportunities for networking and liaising, but also increased the **complexity**, as part-timers had to manage competing obligations to each team.

The thing is with the community sector there's different contracts, so people tend to work across different environments to make up full-time work í It's quite common for staff to do that with two teams and it's manageable. But I certainly discourage my staff from doing more than that. (Nina)

Team leaders acknowledged HCWs needed to work in this manner when full- time roles were not available, yet were concerned at the split loyalties and juggling needed if the person worked for more than two teams or agencies.

Part-time workers were valued by team leaders for their skills in managing **complex** situations. They tended to be experienced workers whose adaptability increased their value well beyond their time input. In a team context however, *part-time working* resulted in liaising challenges which made **connecting** difficult.

When you get too many people working part-time it is hard to work together. But we've worked it so that even though there are lots of part-timers there's three days that we're all together. That allows us to catch up with each other. It's not easy though and it's really up to us to make it work.
(Olive)

The implicit message was that the onus of responsibility to ensure networking and collaboration occurred lay with the *part-time* worker.

From a teamworking perspective, fitting networking around part-time staff was problematic. In the end, team leaders had to organise networking at times that best fitted the organisation. This left *part-timers* having to make a choice between missing liaising opportunities, or attending meetings in an unpaid capacity. While some *part-timers* reported liaising and **connecting** with colleagues beyond their contracted hours, others had differing commitments, meaning networking outside working hours was not possible.

As a result, networking often only captured a part of a team, with liaising having to occur in other ways to connect all HCWs across a team. Team leaders acknowledged that **connecting** *part-time workers* to the rest of the team was a challenge. They addressed this with socialising opportunities, and alternating meeting times to allow for part-timers. Despite this, the onus remained on part-time staff to develop their own connections.

6.4 Referring

In this study *referring* happened when HCWs liaised with other HCWs to ask for their professional advice, or input with a client. This could occur either within a team (*interprofessional referring*) or between agencies (*interagency referring*). *Referring* involved HCWs *liaising* over role boundaries, and passing clients onto other services as required.

6.4.1 Interprofessional referring

Interprofessional referring occurred when clients required more services than a single HCW could provide. Clients were referred onto another HCW either through direct *liaising* between HCWs, or through a HCW suggesting the client contact another professional themselves. Within a team *interprofessional referring* occurred regularly as part of **connecting** and collaborative practice. It was an informal process, with team members *liaising* with others to check whether a referral was appropriate.

It tends to be fairly informal. So I'd have a referral or an approach from a district nurse who will come and talk to me about a client they have concerns around. And then we'd discuss what's going on and then from there a referral is generated or not, if it's not needed. (Amy)

Interprofessional referring was therefore not clear-cut, with differing expectations over role boundaries making *referring* complex. There appeared to be an awareness of professions holding accountability for certain tasks, with HCWs checking in with each other to clarify boundaries. This links with the discussion on role guarding in Chapter 8.

I: *And you talked about taking it back to the physio if you were unsure?*

P: Yeah, checking in, or referring back to her knowledge. Because ultimately there are people who are responsible for making decisions in some professional areas. And I think if we don't do that then that's where the boundaries might get crossed-over. So we do need to refer back when appropriate, because we are accountable to that. (Brenda)

Referring clients onto other HCWs required knowledge of professional skill sets; of individual HCWs areas of expertise; and of service parameters. This was enhanced by induction processes within a team that allowed time for new staff to shadow other HCWs, observing them in action and learning more about each profession's role in that

setting. Job shadowing in this manner acted to minimise role misunderstandings and assisted new staff to begin **connecting** with others.

In addition to the knowledge required, *interprofessional referring* was also conditional on established relationships and opportunities for informal liaising. When these conditions weren't present, *interprofessional referring* tended to be more formal. This was observed in some teams where the team leader controlled the referral process. When a general referral came into the team, for example, it was disseminated by the team leader, as noted by Paula: 'Initially the referrals come to the manager who then refers them onto the disciplines.' In this working context HCWs had little autonomy and received referrals as work tasks, rather than independently judging referral appropriateness. Leaders adopting a teamworking perspective viewed referral control as a means of **complexity management** that moderated HCWs workloads, rather than a removal of HCWs autonomy. This view was not necessarily supported by HCWs, who reported feeling disempowered when referral decisions were made for them.

6.4.2 Interagency referring

Moving beyond the team context, *referring* clients to other agencies occurred when the current team did not possess the skill set, or have the service mandate, time or resources to provide the most effective service for a client. Liaising that involved *interagency referring* could be a formal process, dictated by the condition of organisational service parameters. Equally, HCWs made *interagency referrals* when they perceived the client had a need that was not able to be met by their service alone. *Interagency referring* worked most effectively when HCWs looked beyond their own skill base to consider the wider holistic needs of the client.

Interagency referring involved referrals to both professional and lay organisations. This required knowledge of the other agencies and services in the area, including their organisational structures and service parameters. Similar to the problems identified in networking, ascertaining which community agencies operated in the area was **complex**. Participants assumed this knowledge was facilitated by the condition of experience, with longer-serving HCWs presumed to have better knowledge of other services.

If you're experienced you're more able to see the wider picture, you understand other's roles better. And equally importantly, you understand other organisations. You know what they do, their service contract. And

then you know when to refer on, how to liaise with them, who to contact.
(Elise)

Interagency referring based on previous knowledge of other services was problematic. Experienced HCWs could become complacent liaising with, and referring to the same agencies, and not be aware of new services or changing parameters. Sometimes it required a shift such as HCWs leaving a team, or an agency changing roles, for HCWs to look around for different referral possibilities. For example, in this study, one team had always referred clients onto a particular gym that had physiotherapy input. When this service changed, HCWs had to research other possibilities for their clients, resulting in two new referral options.

Referring a client on to other agencies was complicated by issues of control of the process and control of funds. Funding control was especially relevant when private teams and HCW contractors were involved, as their livelihood relied on referrals. These working contexts resulted in increased liaising at an organisational level, as team leaders focused on **connecting** with other agencies to facilitate and encourage new referrals. Meanwhile, control of the *interagency referring* process was influenced by assumptions of professional hierarchies and service gate-keeping. Some HCWs perceived their profession held more knowledge than others and wanted to control the referral process. This links with the discussion on professional shielding in Chapter 8.

P: I refer to podiatry sometimes, I'd suggest the client goes there, or I'd ring on their behalf. Also the physios, we use them a lot. But GPs get a bit tetchy cause they feel like they've missed out in the process. Like they want the client to come back to them and they will make the [referral] decision.

I: *What do you think that's about?*

P: I think it's about controlling where their client is heading. But it's a problem, cause there's so much delay. And the strange ambiguity of it all is that the GPs trust us enough to take on the service, but not necessarily enough to refer on. So again it's about building that relationship, developing that trust that we'll do it right. (James)

Reducing referral barriers came back to developing relationships, and using liaising to build trust between HCWs.

Interagency referrals were also affected by the condition of organisational service parameters, which dictated where and when agencies could refer clients. In New

Zealand, ACC and the MoH are the two government funded organisations responsible for managing the majority of community rehabilitation. They each have their own service parameters and criteria for referrals. While these parameters provide guidance for HCWs *referring* clients on to other services, HCWs perceived there were grey areas in referral protocols that needed to be resolved through *liaising* on a case-by-case basis. This was exacerbated when multiple agencies were involved, thereby increasing the relational **complexity**.

When more people and agencies become involved it becomes murky and expectations are often implicit and may be at cross-purposes. (Brenda)

Complicating this further, some agencies and rehabilitative services did not receive rehabilitation funding from the main public funders. This might be because the service was new, too expensive to publically fund, or of unproven value. If either HCWs or clients wished to *refer* onto these different services, it became problematic. Clients had to either self-fund, or source funding from compassionate organisations. For most people this meant referral choices were limited to funder-approved options.

6.5 Summary

This chapter has presented *liaising*, the first of the major theoretical categories within **connecting**. The purposes of *liaising* were presented as increasing communication, facilitating information sharing and building relationships. Within the theory of connecting, *liaising* supports and aligns with the category of *forming-reforming*, but is limited by *guarding* processes. The three sub-categories within *liaising* - *interacting*, *networking* and *referring* were also explicated, with supporting data. The subsequent chapter continues the findings discussion, focusing on the second theoretical category of *forming-reforming*.

Chapter 7 Forming-reforming

This chapter begins by defining the second theoretical category within the theory of **connecting** ó forming-reforming, before describing its three sub-categories: *interprofessional practising*, *flexible practice*, and *forming teams within teams*. As in the previous chapter, examples from the interview and observational data are used throughout the chapter in order to ground the category in the data. The influence of HCWs' perspectives and the salient conditions that effected forming-reforming are also explained through the chapter.

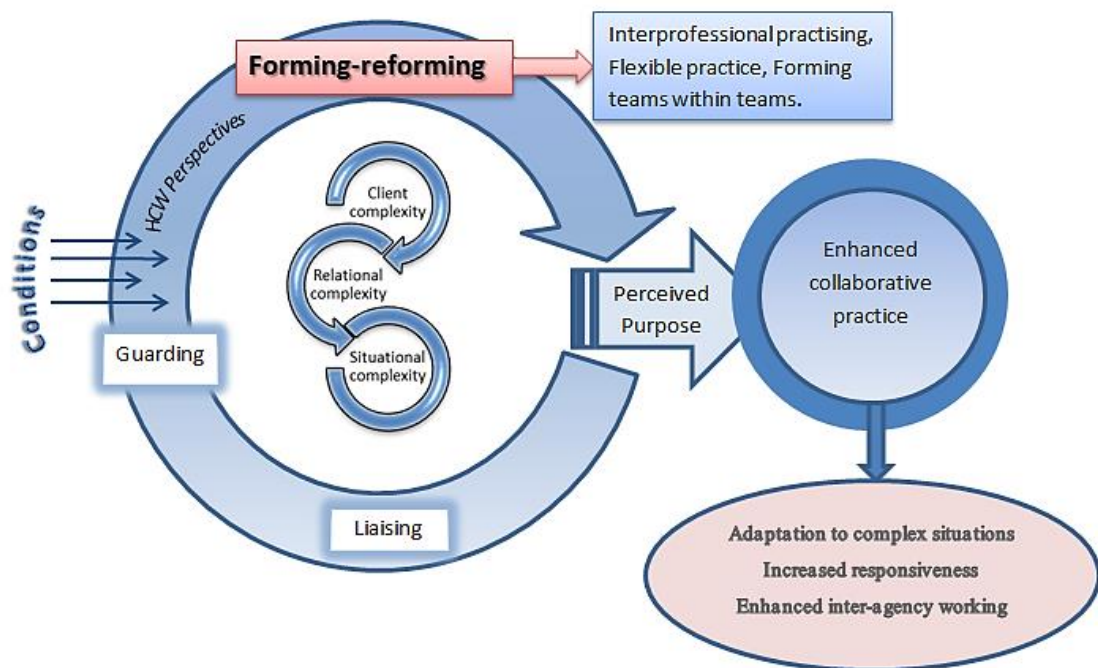


Figure 6: Forming-reforming purpose and processes

7.1 Definition and purpose

Forming-reforming refers to the practice adaptations HCWs undertook to **manage complexity**, as **connecting** developed in their interprofessional work. Adaptation occurred through forming and reforming individual and team practices, using the processes of *interprofessional practising*, *flexible practice*, and *forming teams within teams*. The primary purpose of forming-reforming within teams was to allow HCWs to

adapt to complex situations, which was perceived to enhance collaborative working. Additionally, forming-reforming actions were observed to increase responsiveness to complex needs and enhance interagency working. Forming-reforming actions occurred both as part of everyday interprofessional practice, and as a purposeful response to the **complexity** of community work. The salient conditions of working context, organisational structures, leadership styles and experience levels had a marked impact on forming-reforming actions, as will be noted throughout this chapter.

Within the theory of **connecting**, forming-reforming links with the two other major categories of liaising and guarding. As noted in Chapter 6, the category of liaising involved notions of *interacting*, *networking*, and *referring*. These liaising actions form the platform upon which forming-reforming processes develop. Without effective liaising, the ability to **manage complexity**, and collaboratively form and reform according to client need would be limited. Forming-reforming also relates to the process of guarding, the subject of Chapter 8. While this category has not yet been introduced, it is notable that the processes within forming-reforming worked to influence guarding behaviours, increasing it in some contexts, and moderating it in others.

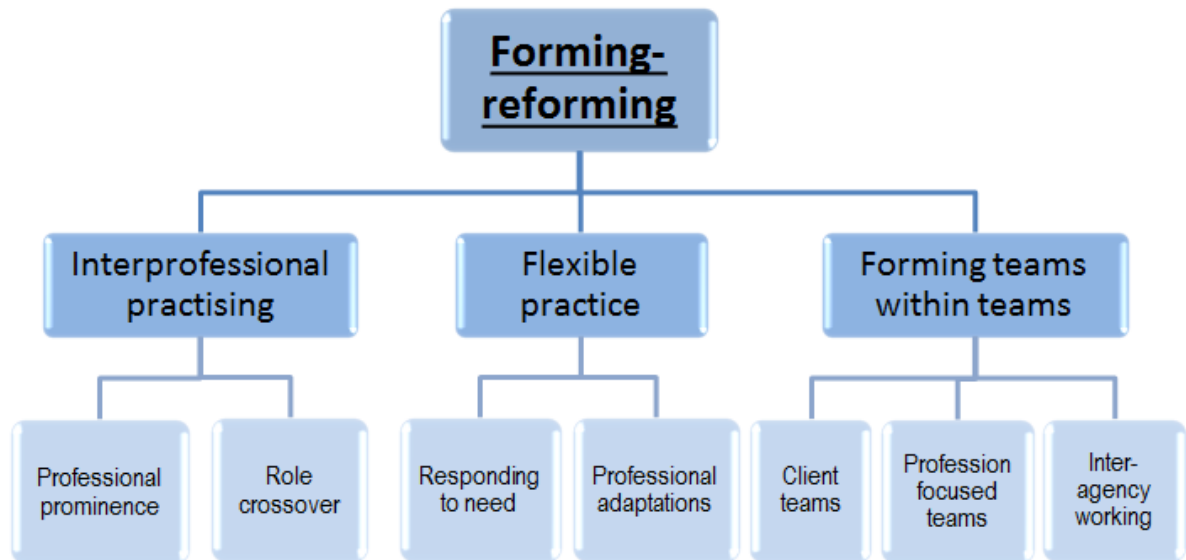


Figure 7: Forming-reforming sub-categories

7.2 Interprofessional practising

Interprofessional practising referred to the collaborative work HCWs undertook when **connecting** within their interprofessional teams. Interprofessional teams were the usual working unit within community rehabilitation, with funding structures across both MoH and ACC supporting these team models. Through *interprofessional practising* in these teams, HCWs formed and reformed their practice in response to **complex** clients, relationships and situations. These practice adaptations were enabled by HCWs that adopted flexible *professional prominence* and *role crossover*.

7.2.1 Professional prominence

When working in interprofessional teams, *professional prominence* denoted the fluctuating input of individual HCWs across the course of a clients' rehabilitation. *Professional prominence* varied according to the changing needs of the client. For example, a client who returned home following a stroke may have initially required occupational therapy (OT) intervention for equipment set-up at home, and intensive physiotherapy (PT) to gain mobility. Later, the OT *professional prominence* declined, while the speech language therapist (SLT) prominence increased, or a changing social dynamic meant the social worker's input became prominent. So interprofessional teams formed and reformed according to clients' shifting needs, with HCWs becoming more or less prominent in the team as required.

You have to be quite flexible and come in and out of seeing the client as needed. I guess it's what collaboration means around knowing what everyone is doing, and why, and how. So it's having that knowledge, as well as being able to adjust what you do. You might be involved for a bit, but then others step in and you back off. (Elise)

This fluidity of professional involvement was a necessary response to **complexity management** that appeared to be central to optimising *interprofessional practising*. Flexible *professional prominence* was a working context that saved resources and maximised HCW input to clients when it was most needed. Resource savings were achieved through targeting HCW input to the identified need, and agreeing where *professional prominence* was required. Thus, one HCW could continue working with a client, while the whole team input declined, as HCWs moved to assist other clients requiring their *professional prominence*.

Targeted *professional prominence* was also a working style that clients reportedly favoured. Apparently, clients reported that they felt overwhelmed with the numbers of HCWs entering their homes at times. As John said, 'there are almost too many people involved at times for the client. They get very confused about, "Who are you? Why are you actually here?" It can be very overwhelming for them.' Adapting *interprofessional practise* by **connecting** over which HCWs would have *professional prominence* moderated this concern.

Too many people coming into the home is a problem. It overwhelms people. You can have caregivers going in for showers, someone in for housework, nurse for cares, physio for walking. It's much better to coordinate who actually needs to be going in at any one time. (Diana)

However, forming and reforming teams according to the *professional prominence* needed at the time, was a **complex** process. It required effective interprofessional communication that was underpinned by understanding the roles of other professionals, and adopting a holistic perspective that considered all of the client's needs. As noted in the discussion on referring (in Chapter 6), HCWs needed to understand when to engage with clients, and when to refer on to other professionals, when to have *professional prominence*, and when other roles took precedence. Yet, establishing this type of role clarity was problematic, since *interprofessional practising* involved working in a **complex** community context where treatment parameters were not always clear.

Nonetheless, some models of *interprofessional practising* were more supportive of role clarification than others. For instance, **connecting** with other HCWs through joint visits encouraged role discussions, informal relating (see Chapter 6), and enabled *professional prominence* decisions to be made. This working context involved two HCWs assessing and treating a client together, collaboratively forming and reforming their treatment strategies, and adapting their *professional prominence* to best fit the need.

When I went to the [community team] there were less professional boundaries than in hospital. It was much more based on your skill and who could best pick something up. And what made the significant difference were the joint visits. An OT and a physio would go and see a client together, and together you would work out what they needed, and together you would decide, 'Well who's going to do it. Does it need both of us? Or can one of us do this?' (Tracy)

While joint visits were viewed as a useful *interprofessional practising* tool for establishing roles and *professional prominence*, they were not always possible. Sometimes referrals came through for just one HCW; the HCWs could not coordinate their schedules; or, the client did not want two people visiting at once. In these situations, HCWs negotiated their prominence and visited clients singly. When visiting clients singly, HCWs needed to be prepared to adapt and reform their practice to meet the need. At times this meant stepping beyond their usual responsibilities, moving in to *role crossover* to assist clients.

7.2.2 Role crossover

Role crossover happened when HCWs undertook some of the more general roles traditionally ascribed to another profession. This was particularly noticeable between professional groups that had areas of role overlap, such as between occupational therapists (OTs) and physiotherapists (PTs), and dieticians and speech language therapists (SLTs). *Role crossover* did not take the place of referral to another profession, but occurred in specific conditions.

One condition precipitating *role crossover* occurred when there was a temporary gap in service, such as an unfilled staff position, or a HCW was away on extended leave. When this transpired, other HCWs from the same profession would attempt to cover the work, but the nature of client and relational **complexity** made this challenging. Clients reportedly did not want new HCWs involved, as they had no connection and

relationship with these people. It was usually preferable for team members who knew the clients to use *role crossover* to undertake aspects of that HCWs more generalist work. Georgina, a PT, provided an example: ‘‘The other week I was away and I got the OT to do the session instead of me, because she’s involved with [the client] also, and there’s some overlap in our sessions.’’ The ability to form-reform practice through *role crossover* was facilitated by the condition of experience, and the development of professional trust that facilitated **connecting**. That is, the HCWs knew each other well enough to entrust another with *role crossover* tasks, assuming their experience levels would maintain professional safety for the client.

Role crossover also occurred for practical reasons. For example, when travel was a factor with clients living in out-lying areas, HCWs might use interprofessional practising in transporting equipment for other professionals. This was a simple form of *role crossover* that was accepted practice by both HCWs and team leaders, as it did not involve clinical decisions.

If we’re going to those outlying areas, it’s a good use of resource for one person to say: ‘‘I can save you two hours of travelling time if you want me to swop that equipment over.’’ So there’s a bit of role overlap there. We cross over a bit. (Carol)

Additionally, *role crossover* was used strategically. For example, when a client had developed trust with one HCW through professional prominence, *role crossover* might occur. In these situations the HCW who had connected with the client could be asked to pass on ideas from other HCWs, or check on a programme. This collaborative form of interprofessional practising was a relatively common situation. It was undertaken to manage the **complexity** of community work, and minimise the impact of so many HCWs engaging with a client in their home setting. As an illustration, when a nurse was going out regularly to dress a client’s ulcer, the OT asked her to check how the client was managing with the chair-raise equipment she had put in place earlier. The nurse would then report back to the OT, liaising over any concerns she, or the client, had identified. At this level of input, *role crossover* was generally accepted. HCWs saw the purpose of this form of interprofessional practising, as it did not take much extra time, or require profession-specific skills.

Role crossover was also used to manage resources efficiently. For instance, when only one HCW was involved with a client, that worker would sometimes adapt their practice,

reforming their role to offer advice outside their usual parameters, rather than refer onto others. Referring to another profession took time and resources (see Chapter 6). Instead, if the query was general, HCWs would respond at the time, using *role crossover* rather than making a formal referral. For example, a SLT might give a client basic advice about diet, rather than referring to the dietician. As part of interprofessional practising, the therapist would **connect** with the dietician, either before talking to the client, to confirm the advice was sound, or afterwards to explain what she had done. This links with the discussion on referring and liaising in Chapter 6.

Forming and reforming of roles through interprofessional practising and *role crossover* was also facilitated by the team and holistic working perspectives. In these conditions, it became about how the team could provide the best solution for the client, with the available resources. Not all HCWs worked in this way, yet for HCWs that operated from a holistic working perspective, *role crossover* appeared to be an intrinsic part of their work.

It's about looking at the big picture to get the best outcome. That's where there's role crossover. Cause when they're going down the steps to greet me, I'm watching them come down. Now I don't know the best way for them to walk, but I'm not ignoring that. I'd ask the carer about it: 'I've noticed J walking like this, has the physio mentioned anything about that?' Now, I don't want to become a physio. But if increasing my knowledge is going to increase my understanding of the client, then surely that's a good thing. And I would always take it back to the physio. (Brenda)

Role crossover appeared to be more common when **connecting** processes needed to be adapted to manage **complex** client needs. With these clients, standard treatments often needed modifying, with HCWs **connecting** to discuss the best solution, and decide which HCW was best placed to assist the client. Forming-reforming around complex clients' differing needs occurred regularly, meaning HCWs were accustomed to working in flexible ways. Moreover, as community rehabilitation involved professional skill sharing, such as training carers in home programmes, this may have influenced HCWs to be more responsive to the notion of *role crossover*. It appeared that knowledge sharing with families assisted HCWs to reduce their role guarding (see Chapter 8), and become more flexible about crossing role boundaries in interprofessional practising.

Obviously there's massive differences between working here compared with hospital settings. For a start, it's much more flexible. And I think that's one of the good things about working in the community – you do whatever you need to do. The lines blur a bit. And having the flexibility to go to the client's home, or workplace, does allow you to be a bit more real about what you do. (Georgina)

Despite the perceived benefits, *role crossover* was not universally accepted. Some participants viewed it as a sensible response to managing resources, and minimising clients becoming overwhelmed by differing HCWs. Others saw an inherent tension between collaborative *role crossover* and professional boundaries (also see Chapter 8).

There's tension between the almost natural desire to maintain one's own professional identity – this is what I do – and the other expectation nowadays that you actually do whatever you can, that you're part of a team that will collaborate: 'I'll do some of your stuff, you can do some of mine.' But the actual boundaries are the things that people fall out over. (Amy)

While some HCWs were prepared to engage in *role crossover* to form new **connecting** relationships with other HCWs, professional bodies (e.g. the NZ Physiotherapy Board) were not so willing to reform existing role parameters. As Olive commented, 'There's professional body input too. It is their role to maintain those boundaries and barriers. Their scope is to guard the profession, the opposite from what we want.' Professional bodies refer to collaborative principles in their protocols, yet in practice appear to support role specialisation rather than allowing forming-reforming adaptations such as *role crossover*.

This professional position contrasts with training organisations that are moving towards collaborative educational frameworks with common first-year training for healthcare professionals. Added to these conflicting views, a shortage of HCWs and burgeoning health costs have seen government policies introduced that will require HCWs to take on a broader range of tasks in future. As more complex rehabilitation is undertaken in the community, it seems that forming-reforming processes will become increasingly important to manage the **complexity**. Some HCWs were aware of these changes, but others seemed confused as to what it would mean for them in practice.

We're actually being asked to work in a far more kind of innovative, flexible manner. That whole Ministry of Health directive will be interesting. -Better, sooner, more convenient or at least that's the ideal. No-one really knows how it will work yet. (John)

With the inconsistent messages surrounding *interprofessional practising* and *role crossover*, it is not surprising that HCWs at the ground level also held conflicting perspectives. Tension appeared to arise between HCWs trying to adapt their practice, based on the holistic and team perspectives, versus those focused on the professional perspective that maintained role boundaries and minimised *role crossover*. Similarly, the conditions of organisational structures, working context and leadership styles could either support, or add tension to *interprofessional practising*. From observational data, it was seen that in teams where organisations and leaders promoted collaborative practise, concerns over *role crossover* were less prevalent, as *forming-reforming* adaptations were standard practice. This was more difficult in contracted teams (ACC/private funded) where funding constraints made *interprofessional practising* more challenging. In these circumstances, *role crossover* could be viewed as limiting HCWs earning potential, as HCWs did not get paid if they allowed others to undertake aspects of their role. Overall though, HCWs appeared to acknowledge the benefits of *interprofessional practising*, and generally used **connecting** processes to adapt to the shifting demands, finding collaborative solutions that worked for them.

7.3 Flexible practice

Flexible practice was a **connecting** strategy HCWs utilised as they formed and reformed their practice around their clients' needs. *Flexible practice* involved HCWs *responding to need*, and making *professional adaptations* to cater for clients and other HCWs' needs. This required HCWs to draw on their team and holistic working perspectives, rather than focusing on the professional perspective of practice. *Flexible practice* was both a mind-set as well as an action. This meant HCWs were prepared to shift from rigid ideas of professional roles to *respond to need* and make *professional adaptations* in a more collaborative manner.

You need to adapt what you do, be open, and able to listen. Not be too fixed into doing a particular treatment. And working in this environment, in the community, it's so contextual. The environment, the resources, the people available is so crucial. That's where your flexibility as a professional comes into play. To be flexible, to look as a team at the context, and to look at the outcome. (Diana)

7.3.1 Responding to need

HCWs *responded to need* by flexibly forming and reforming treatment strategies which collaboratively incorporated other HCWs' priorities. As the comment made by Diana quoted above shows, the working context meant the team needed to consider flexible adaptations to practice, **connecting** with each other to achieve the best outcomes for each client.

At times, *responding to need* involved HCWs flexibly moving out of their professional role, in order to assist clients in non-professional tasks. This meant using a holistic perspective to *respond to need*, rather than only addressing the planned professional task. Participants reported this occurred particularly when they travelled to treat clients in their own homes, where they could be the only external person the client saw.

One of the biggest things is that we're sometimes the only person they see in a day, or even in a few days. So sometimes you might only need to go in once a week, but initially you [go] twice a week. Or you do those little extra tasks they ask you to do. It helps to gain a rapport and develop trust. (Robyn)

Responding to need was an unacknowledged part of community work, yet it impacted on workloads and time pressures. This *flexible practice* included HCWs undertaking extra tasks such as basic home cares, finding a resource, or, more unusually, catching an

escaped pet, or putting in a light bulb. These examples of **complexity management** were rationalised by HCWs as either responding to the current need, rapport building, or as preventing the client from attempting potentially dangerous tasks themselves.

Responding to need outside the referral request was not a uniformly accepted practice. When HCWs worked from a professional perspective they were more inclined to maintain planned treatment strategies rather than form-reform their practice. Sometimes this lack of flexibility appeared to arise from inexperience; at other times, conditions such as time limitations, or organisational structures limited HCWs' ability to respond to differing needs. The condition of leadership styles also influenced HCWs' response to unexpected needs. Where the team leader had confidence in their staff's abilities to manage their workloads, leadership openness increased, allowing HCWs to use flexible practice in responding to differing needs.

Certainly it's not an open call to do what you like. But there's definitely flexibility within the team. I give them [staff] that flexibility to adjust their case loads as they see fit. (Julie)

The experience levels of HCWs provided another condition influencing flexible practice in this study. HCWs who had either professional, or life experience, were perceived as being more likely to flexibly *respond to need* outside their typical role than new HCWs. Experienced workers expressed broader views about where their service fitted within the context of the client's whole life, and were more confident about responding to need in differing ways.

With experience, you probably have less high expectations of how people are going to be able to manage something, so you're a bit more realistic. And that makes you automatically more approachable, because you're being more real. Maybe you're not being so clinically based; you're being a bit more flexible. (Olive)

There was potential for misunderstanding when experienced HCWs using flexible practice needed to work with new graduates, who were not used to *responding to need* outside typical roles. This could be resolved through liaising (see Chapter 6) and relationship building that developed **connecting** across a team.

7.3.2 Professional adaptations

Flexible practice also involved *professional adaptations* that were a response to the relational and situational **complexity** of community rehabilitation. Within a team, *professional adaptations* were observed when individual HCWs shifted their focus to accommodate the needs of another HCW. For example, this occurred when an SLT asked an OT to adapt her client treatment plan, by integrating an SLT equipment trial. *Professional adaptations* were perceived as a positive collaborative strategy for team *forming-reforming* around a client's needs. These adaptations required HCWs to step outside their professional perspective, **connecting** with each other in order to prioritise different professional and client needs.

Using *professional adaptations* also related to HCWs interactions with clients. In order to facilitate **connecting** with clients, HCWs had to use *flexible practice* and *form or reform* their treatments to adapt to clients' schedules, or meet them in differing surroundings, such as a relative's house, or work place. At other times, HCWs reported *professional adaptations* were needed to accommodate home environments that fluctuated from visit to visit. For instance, a specialised chair set up for a client one week, might be being used by a different family member on the next visit. Similarly, a HCW might need to adapt treatment with a child to include their siblings during the school holidays. These examples reflect the relational and situational **complexity** encountered by HCWs in their daily work context.

You often don't know what sort of situation you are going to turn up to... if you are turning up into family's homes then there are a whole lot of things that can impact. You just have to be flexible and be prepared to adapt to whatever. (Nina)

These varying environments meant HCWs needed to use *professional adaptations* with the resources on hand. For instance, *flexible practice* included adapting a home programme using cans as physiotherapy weights, or accommodating the siblings by moving the child's therapy session into the back yard, where everyone could be involved. HCWs needed resourcefulness to make *professional adaptations* that ensured rehabilitation was both achievable and acceptable, within the client's social and cultural context.

I think community work is more real, you're not working from a formula. You're having to adapt your treatment to the space and resources available

and to fit in with the person's timing and needs. So flexibility and resourcefulness, yeah, they're really crucial in the community. (Julie)

The ability to make *professional adaptations* to practice and form-reform treatment strategies was influenced by several conditions. As noted in *responding to need* above, experienced HCWs were able to draw on their knowledge and resourcefulness to facilitate rehabilitation programmes that fitted client needs. Additionally, in an environment with tight funding constraints, the ability to use *professional adaptations* was generally valued and supported by team leaders. The working context of the less structured community setting (compared to hospital), combined with the non-litigious environment of healthcare in New Zealand, may also have facilitated *professional adaptations*. HCWs were not afraid to use flexible practice to form and reform strategies that worked for clients.

Flexible practice and *professional adaptations* were approaches that were not universally implemented, however. While practice *adaptations* were a common approach when HCWs worked with clients, it became more difficult between HCWs in a team. Barriers arose when there was a lack of flexibility and **connecting** between HCWs. This occurred when HCWs stuck firmly to their perceived role (professional perspective), or when HCWs were feeling overloaded due to time, or case-load pressures. Moreover, the working context of HCWs hours of work imposed another barrier, with part-time workers less able to be flexible and adapt their practice around the needs of other HCWs. At times, a lack of flexible practice amongst part-time workers limited **connecting** and led to tension and between full- and part-time workers.

To me it really is a part time job and I do the best I can and then I try and leave it. And I guess some full-timers might not appreciate that. They get annoyed that you can't be at a meeting, or that they have to fit around your hours. (Stephanie)

Similar to the findings in Chapter 6 (networking), it appeared there was an expectation from full-time HCWs that part-time workers would volunteer professional time for **connecting** processes in their teams.

Other barriers to flexible practice arose when HCWs worked in isolation, or had to travel substantial distances to clients. These HCWs were less able to make *professional adaptations* around the needs of their colleagues. This was frequently observed with

contracted HCWs (ACC, or privately funded), who had the added barrier of funding constraints limiting their flexibility for **connecting** with others and adapting their practice.

I'm not that flexible with my schedules. So I can go, 'Yeah, I'm happy to do combined stuff with you.' But it means they have to do it on my day. And for private work the travel does impact on it. I could be more flexible if the travel wasn't an issue. But I'm not prepared to be flexible when I spend two hours unpaid time travelling. (Paula)

Despite these barriers, most participants continued to use the forming-reforming process of flexible practice by *responding to need*, and making *professional adaptations* within their daily collaborative work. They perceived flexible practice as a useful process that assisted the team and individual HCWs to adapt to **complex** situations.

7.4 Forming teams within teams

Community rehabilitation teams consist of multiple professional groups. These may include physiotherapists (PT), occupational therapists (OT), speech language therapists (SLT), dieticians, psychologists, social workers, doctors, nurses, and therapy assistants. *Forming teams within teams* involved groups of these HCWs forming and reforming smaller sub-teams based around *client teams*, *profession-focused teams*, and the needs of *interagency working*.

7.4.1 Client teams

Within community rehabilitation teams, forming *client teams* was a typical strategy for **connecting** HCWs and addressing client need. Client need for professional input was individual and fluctuated across the rehabilitation process. HCWs responded to the **complex** needs of clients by forming teams within teams to best meet individual clients' requirements. As Tracy noted, 'I can see within our team, we have little teams within the team.' These *client teams* were formed around professional indicators of need, the available resources, and the professional skill base of the individual workers.

Client teams initially formed when client referrals were received, indicating which HCWs were required. The team leader often moderated this process, managing the referrals (see Chapter 6), and forming the *client team* based on rehabilitation need and HCW workloads. These *client teams* worked collaboratively together with the individual client, until goals were met. They were then disestablished and reformed with a different configuration for another client or for the same client at a different stage of rehabilitation. While these forming teams within teams processes occurred as an organised practice at the beginning of rehabilitation, they were also dynamic processes evolving according to changing client needs and professional prominence (see interprofessional practising earlier).

The HCWs within these smaller teams formed close connections as they collaborated in their *client team*. Some team leaders encouraged **connecting** by regularly grouping HCWs in the same *client teams*. This was often based around HCWs working in the same geographical area. Others preferred to mix the *client teams*, perceiving it would lead to shared skill sets and enhanced collaboration across the whole team. In smaller teams, where there was only one of each profession, *client teams* still varied as each client needed differing professions involved in their care. So for one client, the team

might involve the PT, social worker and OT, whereas another *client team* might include a psychologist, a nurse and a dietician.

Forming and reforming *client teams* according to individual client need was a contextual element within community work that encouraged *flexible practice*. It also worked to support **connecting**, by building relationships with different HCWs as they collaboratively addressed client need.

7.4.2 Profession-focused teams

While *forming teams within teams* commonly happened around client need, another type of team arose when HCWs formed sub-teams within their own profession. These *profession-focused teams* had a mentoring and supervisory function, whereby HCWs met both formally and informally (see Chapter 6) to discuss professional issues and client treatment concerns. This was possible in the majority of community teams, where more than one individual from a professional group was employed. During data collection, I observed one of these *profession-focused teams* meeting, when a group of three OTs from one team met. The focus was on case studies, solving complex client treatment problems, and sharing professional development opportunities.

HCWs expressed strong affinity to their base profession and prioritised forming *profession-focused teams* within their teams. HCWs perceived that these professional sub-teams provided a means of **connecting**, which led to enhanced professional development. These views are endorsed by professional bodies, such as the NZ Occupational Therapy Board, which actively encourages members to join *profession-focused teams* as part of on-going professional development.

Profession-focused teams were generally encouraged within the wider team structure. However, some team leaders indicated that HCW loyalty to their professional sub-team could be problematic, if it became stronger than their **connecting** with the whole team. Strong professional loyalty was also observed to promote patch protection and guarding-type behaviours (see Chapter 8). Exclusivity became an issue when *profession-focused teams* blocked others from joining in and sharing knowledge. As an example, one of the participants was interested in attending a sub-team formed to discuss hand-splinting, but was not permitted to join because she was not an OT. When guarding actions like this occurred, HCWs were operating predominately from their professional perspective, rather than focusing on what would enhance collaborative

practice across the team. Challenges with relational **complexity** in this manner had the effect of blocking **connecting**, resulting in HCWs retreating into expected professional roles.

Profession-focused teams did not function in the same way when only one HCW from a profession worked on the team. As a case in point, dietitians and social workers were often singly represented on rehabilitation teams. In these situations, individuals still sought out a *profession-focused team*, but needed to form this with others of their profession across agencies. Making *profession-focused teams* work across agencies required commitment from the differing team leaders, who needed to approve time to attend profession specific meetings and *networking* occasions. Where working or organisational conditions made this difficult, HCWs arranged these meetings out of hours, demonstrating their commitment to *profession-focused teams*.

7.4.3 Interagency working

Moving beyond the central team, *forming teams within teams* also included *interagency working*. This meant forming and reforming teams across agency boundaries in order to manage the **complex** needs of clients. As noted in the discussion around **complexity management** (see Chapter 5), in community rehabilitation a multitude of agencies are often involved in **connecting** with the client, and each other. While most participants identified an 'inner team' they regularly worked with, this group often expanded to include HCWs from other agencies.

I think the concept of team is a very broad term. If you're talking about the client and family, and the people that support that, there is a change constantly in terms of who's in that team. And our team members may all be a part of that team. At some point they may be the main team supporting that team and child. But at other points, other professionals may all be part of the client's team. (Nina)

Interagency working meant HCWs **connecting** with individual HCWs from different agencies to form sub-teams around individual client's needs, while also maintaining membership of their own broader teams. These outlying individuals were not considered part of the regular team, but joined the *client team* while working with a particular client. Examples of forming sub-teams included: the community wound-care nurse who became briefly, but intensively involved with the rehabilitation team when

the client had a fall; or the orthotist who became involved to fit new splints for a client, at the request of the PT.

Interagency working that involved forming loose *client teams* across agencies was difficult, as individual HCWs worked under differing team processes and service parameters. Significantly, no-one was typically delegated to coordinate the services across agencies (see gate-keeping in Chapter 8). This gap in resourcing led to confusion for HCWs, who were often left negotiating roles on a case-by-case basis. To support *interagency working*, HCWs needed to operate from a holistic perspective that focused on the needs of the client, rather than team concerns. Issues frequently arose however, around communication pathways, shared goals, treatment priorities, and resource allocation. These differences made *interagency working* an on-going challenge that required managing through liaising and negotiating, as discussed in Chapter 6.

Interagency working was especially challenging when several HCWs from the same profession worked concurrently with a client. For example, during paediatric rehabilitation a child could be seen by a community PT, a school-based PT, as well as a private PT. Forming teams within teams in these instances became important to ensure roles were negotiated, and the client received consistent messages. Issues of power and hierarchical concerns needed to be put to one side. However, this was only possible when relationships of trust had been developed through **connecting** processes.

It's tricky you know. Service parameters are unclear at times. And there is so much role overlap, that you don't always know where you sit in terms of negotiating with families and clients what you can and can't do, and with other agencies over which speechie [SLT] will do what. And you can't negotiate those things very well and clarify expectations if you haven't developed relationships of trust. So it all goes round in a loop. (Elise)

Interagency work was further complicated when some of the agencies and individuals supporting a client were not trained HCWs. Clients frequently received support from lay carers, community support groups (e.g. the Stroke Foundation), church groups, and cultural advisors. While trained HCWs generally understood the need to collaborate and consider the wider context when they formed teams within teams, lay workers and community groups were not accustomed to this model. **Connecting** with these individuals and involving them in *client teams* proved challenging, and the teams that formed generally had minimal input from these groups. These difficulties combined to

make *interagency working* one of the main challenges faced by HCWs in community work. The issues surrounding this are discussed further in Chapter 9.

7.5 Summary

This chapter has expanded on the second of the three major theoretical categories within **connecting: forming-reforming**. Forming-reforming was an active process which involved *interprofessional practising*, adopting *flexible practice*, and *forming teams within teams*, both within a team and across agencies. HCWs used these processes to adapt to complex situations, **connecting** with each other in their everyday community work. The difficulty of **connecting** when working across agencies was identified as a major challenge to collaborative practice in community rehabilitation. The next chapter discusses the last of the main theoretical categories within the theory of **connecting: guarding**.

Chapter 8 Guarding

This chapter presents the last theoretical category within the theory of **connecting**, **guarding**, and explains its relationship to both **liaising**, and **forming-reforming**. Following the same format as the previous two chapters, the purpose and definition of **guarding** is described, before its three sub-categories of *professional shielding*, *negotiating*, and *protecting* are explicated. Variations within the category are discussed throughout the chapter, and the effects of shifting conditions and varying perspectives are also highlighted.

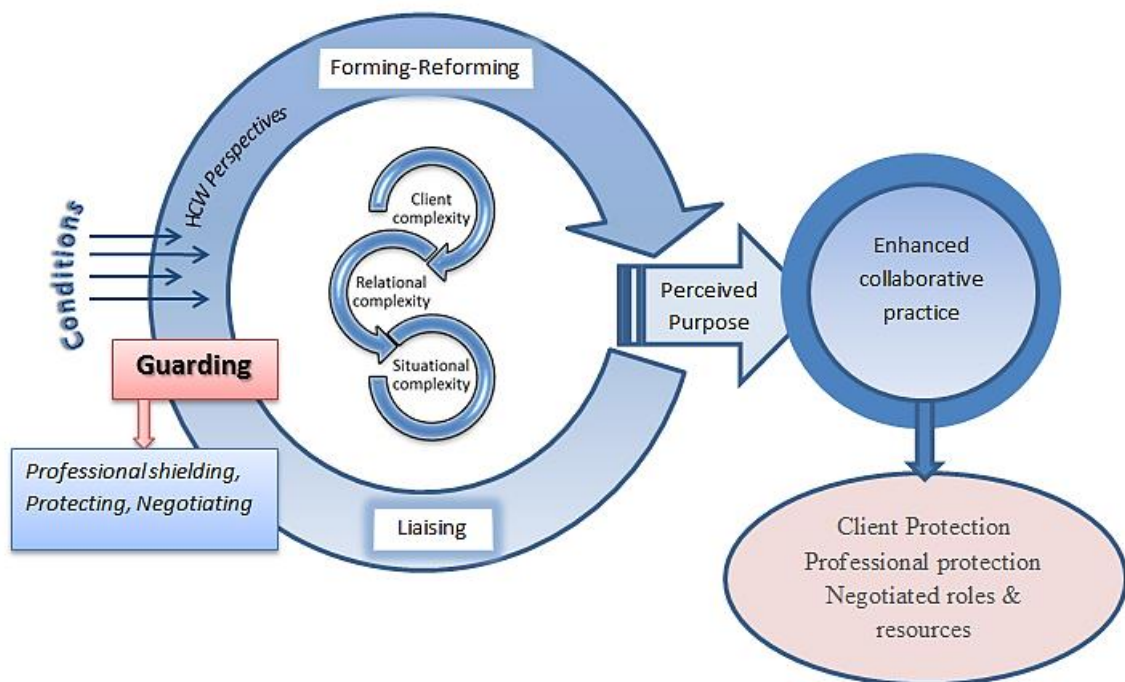


Figure 8: Guarding purpose and processes

8.1 Definition and purpose

Guarding is defined as the *professional shielding*, *protecting*, and *negotiating* that took place as HCWs **managed complexity**. **Guarding** was a valuable process within **connecting**, as it allowed HCWs room to defend, maintain, or change dynamics within their complex work situations. **Guarding** occurred as a purposeful activity in which HCWs guarded their professional roles, protected clients and other HCWs, and negotiated resources. At times **guarding** was used as a way of resisting **connecting**, particularly when the relational or situational **complexity** was difficult to manage.

Hence, instead of using processes which increased **connecting** across teams and agencies, guarding involved constraining actions which maintained the status quo and protected others. Protecting clients and other HCWs was put forward as a positive aspect of guarding and **managing complexity**, which HCWs used to justify their guarding behaviours.

With its dual connotations of negative guarding and positive protecting, guarding differed from the two other theoretical categories (liaising and forming-reforming), which were processes that HCWs perceived as primarily positive actions. When considering the relationship between guarding and the other theoretical categories, guarding was moderated by liaising processes, such as *networking* and *referring*. Meanwhile, the forming-reforming processes of *flexible practice*, *forming teams within teams*, and *interprofessional practising* could either mitigate or cement guarding processes. For instance, when HCWs were using flexible practice, guarding was less prevalent. But when they formed profession-focused teams, or operated from a professional perspective, guarding behaviours increased.

Guarding behaviours were influenced by the salient conditions of community work. For instance, the organisational structures of private contractors operated to entrench guarding of time, funding, and resources. Likewise, guarding behaviours were perceived to increase when the working context increased isolation. In contrast, HCWs perceived that the conditions of life experience and having open, transformational leadership (Hersey & Blanchard, 1977) minimised guarding responses.

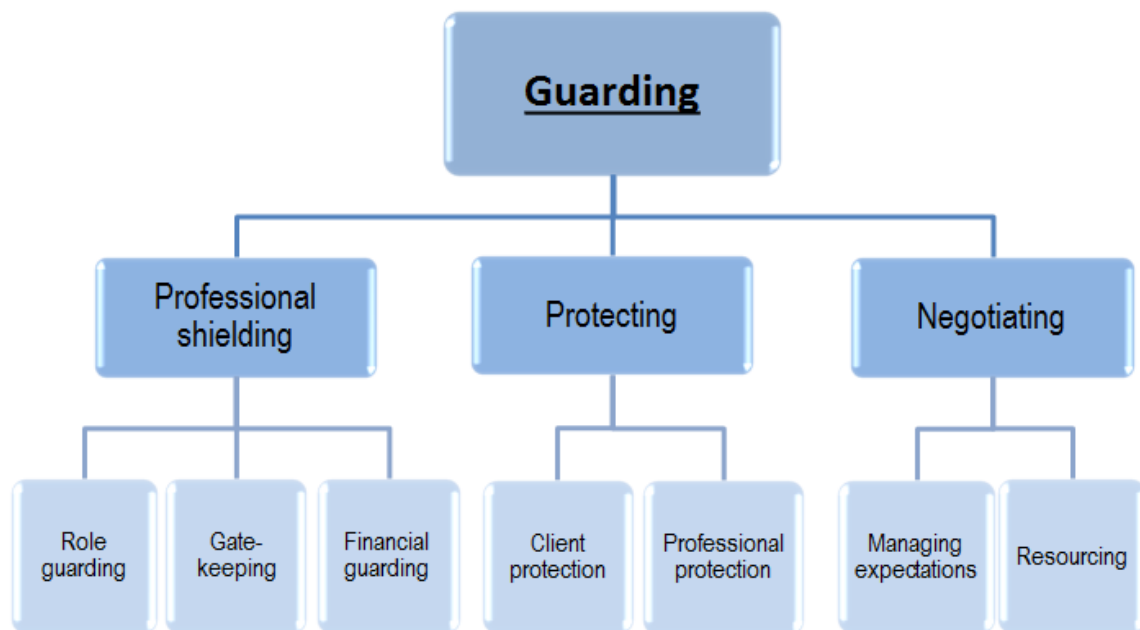


Figure 9: Guarding sub-categories

8.2 Professional shielding

Professional shielding centred on HCWs defending their professional boundaries as a means of managing relational **complexity**. *Professional shielding* arose through *role guarding*, *gate-keeping*, and *financial guarding* behaviours. This occurred when HCWs challenged the right of others to undertake tasks they perceived as belonging to their profession. The challenging occurred both in terms of overt questioning, as well as more hidden pressures.

There is a lot of what I would say is professional jealousy between OTs and PTs. You know, when it comes to motor planning they think it's their area. I've been wrapped over the knuckles, I get told: 'that's OT work. You haven't got their skills and the training to do the visual stuff.' All the OTs got together and one came to me and said, 'Back off doing the visual stuff.' (Paula)

8.2.1 Role guarding

Professional shielding was often driven by *role guarding*. When HCWs guarded their roles, it was commonly viewed by other HCWs as detrimental to collaborative working, and a barrier to managing **complex** situations.

I think it's not helpful, that role guarding. I suspect there are several underlying reasons why someone would choose to have those types of attitudes. But generally, working together and being able to communicate is a better approach. (Georgina)

For others, *role guarding* was much more than a minor obstacle to collaborative practice. Rather, it linked with embedded notions of professional hierarchies and historic roles, and became a significant barrier to **connecting**. Sara commented, "That's the main issue around here. That's totally what it's about - the guarding thing. It's such a problem; it causes real tension." In some circumstances, *role guarding* became such an impediment to collaborative working that staff resigned.

I have always practiced in a very holistic, step-outside-of-the-boundaries kind of way. My first job at hospital drove me absolutely nuts because there was actually competition over who was going to do what type of assessment. Whether it was an OT's, or a PT's responsibility. There was definite guarding of roles, and I left that job vowing and declaring I'd never ever, ever again want to work in a situation like that where there were professional jealousies and guarding. (Tracy)

In other words, the **complexity** of situations and relationships had become such that roles had to be severed altogether.

Role guarding appeared strongest between professions that naturally had some role crossover (see Chapter 7). This was seen between OTs and PTs, as well as between SLTs and dieticians. The working context meant these professional pairings worked closely together, but at times *role guarding* made these relationships complex and professional shielding resulted. This was not always an overt process, with some HCWs confused over why **connecting** was difficult with some HCWs.

The clash that I am seeing is actually the dieticians and speech language workers. They seem to clash and I don't know why this is. It could be slightly personality, but then it might be professional as well. Because of the crossover I think they can have quite similar roles, and it can get quite tense. (Fran)

Role guarding was emphasised when HCWs were adopting the professional perspective. From this perspective, HCWs justified professional shielding as necessary for maintaining the integrity of the profession, as well as ensuring client **complexity** was safely managed. That is, by ensuring HCWs only undertook tasks they were

professionally trained to do. Interestingly, my early assumption that the participants might justify their actions through citing professional scopes of practice was not evident (see Appendix R). Rather, it appeared that some participants presumed certain areas of practice ðbelonged to their profession, and they guarded these areas from other professions. This unspoken assumption affected **connecting** processes, with some participants likening it to an ðelephant in the roomð

The ðelephant in the roomð was about people not collaborating, about role guarding, being protective of their roles. [Itð] about ðyou are a physio, why are you doing hand work? Thatð an OTð job,ö and that sort of thing. (Sara)

Despite participants having a sense of certain work tasks ðbelonging to their profession, there was little consensus on what those tasks were, even within a profession. As discussed under relational **complexity** (Chapter 5), differing role understandings both within and across professions could lead to tensions and defensive *role guarding*. This professional shielding was often attributed to professional insecurity: ðI think it was an insecurity thing, that guardedness. That I was maybe showing them up somehow.ö (Amy)

While generally perceived negatively, *role guarding* could actually be useful as a focus for team dialogue, if acknowledged and discussed. This means of addressing relational **complexity** was dependent on the condition of leadership styles. For instance, rather than letting implicit tensions continue, some team leaders identified the *role guarding* and used it as a discussion point when clarifying HCWsð roles.

There was quite a lot of discussion around professional boundaries. In the end they did find that role guarding still occurred, but if it opened peopleð eyes as to what roles were carried out by each profession, then it was a good thing. (Fran)

In contrast, other participants felt that the situational **complexity** of community work made clarity of roles difficult. The need to form and reform teams within teams made roles more fluid (see Chapter 7). This fluidity may have actually contributed to HCWsð role insecurity, resulting in tighter *role guarding*, as HCWs protected and shielded what they knew.

8.2.2 Gate-keeping

Professional shielding also occurred in the form of *gate-keeping*, whereby HCWs were perceived to guard information and withhold knowledge from others. This could occur at the individual worker level, within a team, or across agencies, thereby adding to the relational **complexity**. Across agencies, *gate-keeping* was frequently referred to as a power or hierarchical issue, with difficulties particularly noted in hospital/community team interactions. *Gate-keeping* across agencies acted as a barrier to collaborative interagency working and **connecting** processes.

My colleague and I have made the same observations with the [hospital] team. It's like we'd like to share knowledge, but when we've approached them they have never got back to us. We've gone to see them, but it's almost like they're guarding their knowledge. Their knowledge and their expertise. There's definitely a sense of hierarchy and guarding. Sort of: 'I'm a specialty therapist and I have this knowledge that I might or might not give you.' (Olive)

Hierarchical *gate-keeping* was also construed as a function of professional identity. Top of the hierarchy were doctors and specialists who were perceived to exhibit *professional shielding* behaviours, such as *gate-keeping* information from other HCWs.

If I think of paediatrician visits, which are historically hierarchical, there is some gate-keeping around that. You know, the doctor as expert. They have these meetings and make these decisions without consulting anyone else involved, which is frustrating. And then they often don't even share that information that changes have been made. (Cathleen)

This was interesting because HCWs in this study did not consider specialists as part of their teams, yet specialist decisions appeared to have a significant flow-on effect on the community team. HCWs were frustrated by the apparent *gate-keeping* and wanted to build relationships with these professionals, yet the **connecting** attempts appeared one-sided.

Despite assumptions of *gate-keeping* being driven by hierarchical concerns, *professional shielding* was not necessarily a conscious action. Client, relational, and situational **complexity** issues such as poor communication channels between agencies, time constraints, complex clients, and isolated working contexts, all contributed to a lack of information sharing. This blocked **connecting** processes and was often construed by HCWs as *gate-keeping*.

Perceptions of guarding and *gate-keeping* behaviours were not solely limited to professional interactions. HCWs reported that clients and their families were also viewed as *gate-keepers* within the context of community rehabilitation. As Diana observed, 'Sometimes families withhold information or choose not to participate in meetings, which I guess is their way of withholding themselves, keeping knowledge that you don't have.' This perception of client and family as *gate-keeper* was interesting and may link with health models of person-centred practice where the client is viewed as the centre of the team, an active participant in their rehabilitation. Through this lens, it is argued that the client was as likely to be a *gate-keeper* of information as other members of the health team. Indeed, possibly more so if the client did not know they held this role, and yet HCWs expected them to pass on information. In this manner clients became *gate-keepers* through unintentionally, or even intentionally, withholding or guarding information.

We've had classic examples where families have under-reported what's going on. Sometimes the rehab specialists don't even know that we're involved, because the parents haven't thought to tell them. You know there's a major, major communication difficulty interagency wise when families don't pass that info on. (Tracy)

Client *gate-keeping* added to the client and relational **complexity** HCWs needed to manage. **Connecting** processes became difficult when awareness of team membership was unclear. When several different agencies were involved, the client and their family were the only people who held all the information, and guarded how and when this information was shared. In effect, clients were required to act as a case coordinator, managing their own healthcare, sharing information and coordinating different agency visits.

P: We'd never specify a parent as being the key worker. It's always, say a therapy team member. But I do think that parents end up being a gatekeeper if you like. If there are multiple agencies involved.

I: *What does being a gatekeeper mean?*

P: It's in terms of passing on information from one to another and the coordination of appointments. I think that's probably what they end up having to do. Families have to coordinate their week and their schedule because we can't do that for them. (Lydia)

Assumptions of client *gate-keeping* increased **complexity** and acted as a barrier to **connecting**. There was a general assumption that the client or their family had a responsibility to *gate-keep* and coordinate the differing health services. This was at odds with HCWs statements that they would not impose a key worker role on clients. Some HCWs recognised that this role occurred implicitly, but despite this acknowledgement, few HCWs took the time to discuss the key worker or case coordinator concept with clients.

Sometimes you may not even know there's another therapist involved. I think a lot of that has to come back to the client and their caregiver though. I think it's important for them to coordinate things. It means more work for them, but they're the ones who need to do that. (Amelia)

While open discussion of the clients' responsibilities was rare, implicit recognition of the *gate-keeping* role occurred occasionally. For example, this was evident when HCWs anticipated the difficulties clients faced with managing multi-agency involvement and suggested practical steps to assist them.

I say to my team, always write in the book or on the calendar when you're next coming in, so other services know when you're next due. And if you've got anything you need to say to the caregiver, write it in the book. It helps the families too, because they can coordinate visits better. (James)

This simple solution not only centred clients and families as the key-workers in the clients' care coordination, but also assisted in improving interagency **connecting** and communication concerns.

8.2.3 Financial guarding

When considered at a less altruistic level, *professional shielding* also involved *financial guarding*. This type of **guarding** was about maintaining contracts, preserving incomes, and competing for funding. *Financial guarding* inhibited collaborative practices across teams and impacted on **connecting** processes.

Guarding's also about funding. They get a little bit tetchy about money. Our referrals dropped away for a bit there because ACC had pulled back funding. And therefore places like [the community team] were holding onto their clients. They were protective and guarding their income. It wasn't necessarily in the best interests of their clients. (Linda)

Financial guarding was strongly influenced by the conditions of organisational frameworks and the working context. As an example, privately funded teams (i.e. not Ministry of Health) who were in competition for service funding were perceived to be guarded towards other teams in order to protect their income streams. Attempts by organisational fund-holders (e.g. ACC) to bring competing teams together to standardise processes met resistance and implicit guarding by team leaders.

There are only so many [private] contracts to go around and there's secrecy around the hush-hush of it, who works for who. It's kept very close, very guarded. (Stephanie)

At the individual HCW level, *financial guarding* also had significant impact when HCWs were contractors rather than salary-based workers. These HCWs needed to weigh up the opportunity cost and financial implications when allocating their work time. This became a barrier to collaborative practice when HCWs prioritised billable treatment time with clients over non-funded **connecting** with colleagues (see Chapter 6).

Financial guarding added an implicit layer of **complexity** to individual and team **connecting** that was rarely spoken about. In the New Zealand setting, as a large proportion of rehabilitation work is contract-based via the ACC system, *financial guarding* became an important consideration in **connecting** processes. There appeared to be a divide between HCWs paid via ACC contracts and those funded through MoH salaries. This created a barrier to collaborative practice that is discussed further in Chapter 9.

8.3 Protecting

Protecting represents the more positive aspect of *guarding*, and as such was put forward by HCWs as their justification for *guarding* behaviours. *Protecting* constrained **connecting**, but was considered a necessary part of managing **complexity**. Protecting in this context was two-fold: HCWs *protected clients*, and HCWs themselves required *professional protecting* in the community setting.

8.3.1 Client protection

Client protection involved shielding clients from information overload, negative treatment, or interagency tensions. This was an active form of *guarding*, which HCWs undertook based on their subjective judgements of clients' coping abilities. When *protecting the client*, HCWs both filtered and withheld information. Those who hold knowledge are in a powerful position, and at times this withholding of knowledge was expressed as a sense of paternalism around *protecting clients*. Paula commented that, 'I'm quite guarded about my clients and my service. Once I get them I'm quite protective of them, of what's said and done.' Contrary to this view, other HCWs felt a paternalistic sense of *protecting* disempowered clients, and limited their autonomy.

You see it sometimes, they're protective. And that's okay- but you're taking something away from the client. You're not allowing them to make any calls about themselves. [HCWs are] doing it for the person. (Brenda)

It seemed that *client protecting* could be viewed either as benign paternalism, or as a maladaptive *guarding* response, depending on the individual perspective. The examples HCWs raised in this study appeared to be at odds with current rehabilitation principles of person-centred practice where the client is meant to hold the locus of control (McPherson & Siegert, 2007; Pryor & Dean, 2012; Pyle et al., 2009).

Another side to *client protecting* involved collegial checking. This occurred when one HCW monitored another HCW's input with a shared client. As HCWs frequently saw clients over a prolonged period of time, they built relationships that fostered **connecting**. They were interested in their welfare and checked in on their progress when they were referred to other professionals (see Chapter 6). However, this paternalistic sense of *client protection* was not always well received, leading to increased relational **complexity** and tension between HCWs.

I don't really like anyone coming onto my patch and checking what I'm doing with [clients]. And in that role, [other HCWs] really are responsible for those clients, they have made a referral to you, so they are guarded about them and what you're doing with their patient. (Stephanie)

Client protecting also involved HCWs guarding clients by intervening in unsafe situations. For example, a HCW may have been the only professional going into the client's home, and when they observed clients in unsafe situations they felt the need to respond. The responsibility of *client protecting* was more than HCWs trained for, but it was felt to be part of the holistic perspective of caring for the whole person, and was seen as responding to client need (see Chapter 7).

You need to keep an eye on what's going on in the home. You'll sometimes get a hunch that things aren't right. I've had two patients I've referred to the elder abuse service, because I just felt things were wrong. I was right both times. It's really hard, but that's what you do in the community. It's about looking out for the whole person. (Diana)

Managing **complex** relationships and situations was an unacknowledged component of community work that added stress to HCWs' daily work. Occupational stress contributed to the need for HCWs to feel supported and protected in their roles, a process supported by interacting (Chapter 6) and **connecting** with other HCWs.

8.3.2 Professional protecting

Professional protecting was needed to manage both professional and personal safety within the community. The situational **complexity** and working context increased risks to HCWs' personal safety (see Chapter 5). As HCWs frequently worked in isolated settings, consideration of how to manage personal safety was paramount. For instance, if given warning of a safety concern, HCWs would use joint visits to clients as a means of *professional protecting*.

If on the referral it's come through that there's a perceived safety risk, then there's always two of us that will go and do that initial visit till we can kind of work out what the risks are ourselves. It's about our safety and also the patient's safety as well. So there's a witness in complex situations. (Carol)

More commonly, *professional protecting* was achieved through **connecting** with clients. HCWs relied on building trust with clients to establish and maintain their personal safety. It was about negotiating through the relational and situational

complexity to find a place for **connecting**. HCWs developed this through establishing respectful relationships and maintaining a sense of being a guest in the client's home.

When you go into people's homes I have always felt like I was a guest in their home. I think that that's a proper way a community therapist should approach a family – I'm a guest and here's what I can offer you, and you take what makes sense to you. You're not forcing it on them. And that helps when you're going into tricky situations. (Cathleen)

At an organisational level, team processes did not acknowledge the importance of **connecting** to manage relational **complexity** and safeguard *professional protection*. Instead, team practices reflected practical strategies to guard their HCWs' personal safety, such as phoning on arrival at a client's house, not parking in driveways, and joint visits when deemed necessary.

There are different considerations in the community. So, for example when I first started community work, I was told never park in the driveway of the house because another car can come and park behind you and block you in, if you ever had to leave the house. (Fran)

While these strategies provided practical solutions to manage physical safety, HCWs had limited professional support to *protect* them from the issues arising from relational and situational **complexity**. In addition to the complex physical and emotional situations experienced daily, HCWs received little mentoring for the on-the-spot autonomous decisions they needed to take. This put them professionally at risk. When the working context meant there were few colleagues alongside to check safe practice and debrief from stressful incidents, participants found ways to guard themselves. They achieved this by establishing their own support and mentoring networks for *professional protection*. Examples of this were presented within the context of situational complexity and *networking* in Chapter 5 and 6.

HCWs also required *professional protecting* from accusations of unprofessional conduct when they treated clients in isolation. Again, this was usually managed through taking the time to develop trust and build a personal **connection** with the client. Despite this, participants reported there was a very small group of clients/families they perceived as difficult in this regard. HCWs used joint visits to guard against these potentially difficult situations by having a witness on hand (see Carol's comment above).

Team leaders responded to the risks of professional isolation by preferentially employing experienced HCWs. This provided a means of both guarding and protecting the client and the rest of the team from potentially poor clinical decisions made by inexperienced staff. It also meant less mentoring requirements, with experienced staff expected to need less *professional protecting*.

However, when they first started in a job, both experienced and new HCWs were perceived to need support and *professional protecting* while they found their feet. The conditions of experience, working context, organisational structures, and leadership styles all impacted on how new HCWs were inducted into a team. Some team leaders acted to guard new staff from the confusion of different organisational structures. They did this by minimising new HCWs need to make external **connections** in the first weeks. Leaders perceived this to be a supportive, protective mechanism that allowed HCWs to learn internal systems before **connecting** across agencies.

P: When somebody is new with my team, I don't encourage them to speak directly with ACC. I think it confuses them because they need to really learn and understand where we sit and what the system is.

I: *Would you say you are protecting them?*

P: I am guarding them from confusion until such time as they find their feet and understand how it works with ACC. So yes, I am protecting them, but in a necessary way. (Amy)

Team leaders played an additional role in *professional protection*, by acting as a gate-keeper of information and services. So, where possible, they directed referrals (see Chapter 6), complaints, and extraneous information through themselves or via an administrator. They saw this as a protective buffer for their staff and a means of protecting both new and experienced HCWs from overload.

8.4 Negotiating

Negotiating was an active part of *guarding* in which HCWs, teams and stakeholders debated their roles, resources and services. Negotiating involved *managing expectations* and *resourcing*. *Negotiating* occurred at the micro level with clients, HCWs, and across agencies, and at a macro level between agencies and stakeholders. The purpose of *negotiating* was **managing complexity** by working towards the optimal service for client or team, while *guarding* one's own time and resources. *Negotiating* involved **connecting**, but could also work to delimit future **connecting** processes, if services were *guarded*.

8.4.1 Managing expectations

Negotiating occurred from a position of expectation. HCWs entered discussions *guarding* their situation and having an expectation of the desired outcome. *Managing these expectations* was considered an important part of **complexity management**, which required *negotiating* at all levels ó with clients, colleagues, and across agencies. This was perceived as a difficult task, as expectations were not always articulated, and were influenced by underlying assumptions and biases. For instance, between agencies, hospital-based workers had *expectations* about the level of rehabilitation service community HCWs could provide. Similarly, HCWs in MoH-funded teams held an assumption that ACC- funded HCWs would provide a greater level of client input, as they received funding per client visit. Meanwhile, within a single team, expectations and assumptions also arose around issues such as professional roles, seniority, and part-time versus full time HCWs. *Managing these expectations* required communication and **connecting** to clarify issues and *negotiate* solutions.

Managing expectations was also influenced by the perspective HCWs were *negotiating* from. For example, when adopting a professional perspective, the HCWs' emphasis was on delivering an optimal professional service, with a focus on *managing the expectations* of clients. This meant *guarding* their time and resources for this purpose, with less importance placed on *managing expectations* of other team members. Meanwhile, those HCWs who operated from a broader team, or holistic perspective, might *negotiate* from a less *guarded* position, in considering the wider needs of team and inter-agency **connecting**.

At the individual HCW level, *managing expectations* occurred between HCWs and clients, as well as between colleagues. HCWs observed that clients held expectations around their professional relationship which required *negotiating*. For example, the HCWs' ability to affect clinical change, as well as the time and resources HCWs could apportion to clients. HCWs attempted to *manage these expectations* with goal-setting meetings with clients, which set service parameters. These meetings were modelled on person-centred frameworks, where the client supposedly held some control in negotiating their needs. Yet, when HCWs *negotiated* from a position of needing to *guard* and manage client expectations, the power balance appeared unequal from the start and **connecting** processes were blocked.

HCWs acknowledged they were unable to always meet client expectation and found service *negotiating* frustrating. The difficulty of client and situational **complexity** contributed to this, with service constraints common. At other times, HCWs perceived clients and carers had unrealistic expectations of service or equipment provision that needed to be managed. Sometimes this was achieved through *guarding*, or with-holding knowledge from clients. For instance, one participant talked about not informing a client about a beneficial new piece of equipment, as the HCW was unable to get it funded. While the HCW justified this as preventing the client from disappointment, this knowledge *guarding* blocked the client from having opportunities to consider other funding sources themselves. *Managing the expectations* of clients represented a contentious component of *negotiating*, which appeared unresolved in practice.

8.4.2 Resourcing

In this study, *negotiating* was also about managing the *resourcing* of time, roles, and services within a team and across agencies. *Resourcing* negotiations were an important process for clarifying roles and individual responsibilities both within a team and across agencies. It links with the category of liaising (Chapter 6) and interprofessional practising (described in Chapter 7).

Resource negotiating needed to occur to clarify roles and goals for each client. Because the working context meant HCWs had limited face-to-face time with colleagues, awareness of other HCWs' input with clients was affected. This increased the relational **complexity** and made confusion over *resourcing* common. Where rehabilitation occurred in a co-located setting (e.g. a rehabilitation clinic), *resourcing* issues were

more easily clarified, but with HCWs in community settings not **connecting** as regularly, misunderstandings did occur.

HCWs held implicit role assumptions which affected their *resourcing* negotiations. As noted earlier in this chapter, some of these roles were guarded and non-negotiable. One participant commented, 'While my team is very open and flexible within their work, there are certain no-go zones that are guarded by each profession.' Differing role assumptions emphasised the need for resource *negotiating*. When *negotiating* did not occur, tensions arose and defensive *professional shielding* emerged. Team leaders tried to facilitate the *negotiating* process through *resourcing* clarification. Leaders also used *resourcing* negotiations as guarding tools to ensure their teams' workloads remained manageable, and resources were contained. Such decisions were not necessarily welcomed.

If someone has gone off on maternity level and they haven't been able to fill the position, surely you should be able to ring one of the other managers and say: 'I'm down a speech therapist. Can I borrow somebody to help us out for a couple of weeks?' But no way will they do that. It's non-negotiable. They're guarding their money, I guess. (Amelia)

Organisational procedures suggested that *resourcing* negotiations occurred during team meetings, or client case conferences. In contrast, HCWs frequently reported that the real work of *negotiating* resources and **connecting** around client need occurred outside these times, often within the context of liaising and informal interactions (see Chapter 6).

It's about not rushing away from meetings. If you've got a meeting with [a HCW], you make sure you've got that extra time after the meeting to chat to them. That's often where the good stuff happens, where you nut out the details. (Barbara)

It was interesting that some HCWs waited till after meetings to *negotiate* the finer details of *resourcing* and **connecting** with other HCWs. It appeared team meetings were sometimes perceived as unsafe places to voice opinions. In teams where this atmosphere prevailed, *negotiating* and planning *resourcing* became a guarded and closed process.

Team meetings are closed with people guarding what they say. So that's why I make those opportunities at other times to have those informal conversations. You know, you negotiate a time and place where it's safe to ask questions and discuss things. That's when real work, real collaboration happens. (Sara)

Despite this commonly held view, team leaders perceived team meetings as useful times for **connecting** with colleagues to discuss *resourcing*. The differing perceptions of team leaders and HCWs regarding team meetings were a strong thread in the data (see Chapter 6). When team leaders and HCWs held differing assumptions about the purpose of meetings, relational **complexity** became difficult to manage and **connecting** processes stalled.

Beyond the micro level, different agencies and stakeholders also had *resourcing* expectations, which they both guarded and negotiated. The main funders of rehabilitation in New Zealand (ACC, the MoH, and sometimes the Ministry of Social Development) negotiated service resources in order to manage the expectations of clients, teams and agencies under their umbrellas. Negotiating occurred at both funder and organisational level, and was linked to political and policy changes within healthcare *resourcing*. In particular, the recent initiative 'Better sooner, more convenient' (Ministry of Health, 2009) has driven funder expectations of greater health and rehabilitation *resourcing* in the community setting.

The outworking of health policies required organisations to negotiate services and resources with community teams and contracted HCWs. While service agreements provided general mandates for delivery of rehabilitation services, there were often grey areas when it was not clear which agency or individual HCW would provide the service. Who was responsible for *resourcing* a service that wasn't written in the protocols? What happened when a client expected a product or service they'd heard someone else received in another part of the country? Situations and clients were **complex** and didn't always fit service parameters. When *resourcing* decisions were unclear, organisations reacted by guarding their funding and resources. To clarify and manage *resourcing* requirements, agencies and individual HCWs needed a robust understanding of the differing service parameters when they **connected** with clients and negotiated services across agencies.

8.5 Summary

In Chapter 8, guarding, the last of the three theoretical categories of the theory of **connecting** was explained, along with its sub-categories of *professional shielding*, *protecting* and *negotiating*. Guarding was a process that differed from the two other theoretical categories, in that it had both positive and negative implications for **connecting** and **managing complexity**. Guarding behaviours limited liaising opportunities and forming-reforming processes. In return, liaising worked to moderate guarding, while forming-reforming could either mitigate or entrench guarding behaviours.

This chapter concludes the presentation of the research findings. This section of the thesis has established **complexity management** as the central challenge in community rehabilitative work. In this study HCWs managed complexity through **connecting** processes. The theory of **connecting** was presented (Chapter 5) along with its three theoretical categories of liaising, forming-reforming and guarding (Chapters 6-8). The final chapter of the thesis discusses the salient points from the findings and considers the implications for practice, education and research arising from this study.

Chapter 9 Discussion

9.1 Introduction

This research aimed to provide a theoretical explanation of collaborative practices in community rehabilitation teams. Through using constructivist grounded theory, a substantive theory of **connecting** has been developed that addresses that aim and adds new knowledge to the interprofessional field. Fundamentally, my research has proposed that:

Interprofessional community work occurs in contexts that involve interlinked layers of client, relational, and situational complexity. To manage this complexity, HCWs use connecting processes involving liaising and forming-reforming actions that facilitate collaborative practice, and guarding behaviours that constrain connecting and protect the status quo, with the ultimate aim of providing efficient and effective healthcare.

To expand on that summation, three key points have been distilled from the findings chapters. Firstly, undertaking community rehabilitative work is complex and multifaceted. Managing the multiple aspects of **complexity** required flexible working practices, which sometimes challenged traditional models of teamwork. Secondly, collaboration in these contexts was found to revolve around HCWs **connecting** with each other. HCWs used **connecting** processes to **manage complexity**, build relationships, and minimise misunderstandings, while maximising resource use. This was perceived to enhance collaborative practice, with the aim of ultimately improving services to clients. Thirdly, community rehabilitation involves both interprofessional *and* interagency work. In this study, interagency work was poorly coordinated, which undermined collaborative practice and affected client care. This resulted in HCWs being uncertain of their mandate, and clients and their families being left in the implicit role of care coordinator.

In the following sections these main points are discussed further. Initially, **complexity** is presented and positioned alongside extant literature. Next, the use of **connecting** in other literature is considered. This is followed by a discussion of salient findings arising from the theory of **connecting**, including relationship building, role crossover, leadership, and interagency collaboration. I also consider the shift in research focus that

is needed to enhance understanding of collaborative practice in the workplace.

Following this, I present the implications of this study for clinical practice, education, and further research. I then reflect on the research process, the limitations of the study, and critique the quality of the research. The thesis finishes with some concluding thoughts.

9.2 Complexity and the extant literature

As established in the findings, it was apparent that **complexity management** was the central challenge faced by HCWs in community rehabilitation. However, participants held implicit assumptions about the notion of **complexity** that led to varied understandings. This mirrors the multiple ways the term 'complexity' is used in the literature. In academia, for example, complexity often holds precise meaning, as seen with *complex adaptive systems* in mathematics (Holland, 1992), and *computational complexity* in information technology (Blum, 1967). Meanwhile, in mainstream media the word resists a generic definition, with complexity commonly relating to multiple, interrelated aspects of processes or objects. Often misused as a synonym for 'complicated', in common usage 'complex' means something intricate, or composed of many inter-dependent parts, as compared with complicated, which refers to things that are difficult to understand.

Despite the lack of a clear definition, the connotations underpinning the general use of complexity assisted me as I uncovered the implicit meaning of **complexity** for participants in this study. Particularly relevant to this research was the notion of complexity concerning systems with multiple layers interacting. This corresponded with my definition of **complexity management** having three interlinked components: client complexity, relational complexity, and situational complexity.

Complexity management in this study relates to the community setting; nonetheless the model has potential applicability and usefulness in explaining complex processes across broader health and social contexts. As an illustration, in hospital ward settings client complexity and relational complexity appear to occur (Lingard et al., 2012), but situational complexity may be present to a lesser degree, as the situation is contained to the structured hospital ward. By contrast, in an intensive care unit, the focus may be predominately on the complex client, with relational complexity and situational complexity temporarily marginalised due to the urgency of the medical need. In a

business situation, however, relational complexity and situational complexity may have more prominence than client complexity, as the client would not typically have multiple health and psycho-social concerns. Extending the study of **complexity management** as defined in this study into other arenas could be a subject of future research.

As the concept of **complexity** appeared so overtly in my data, I expected to find many references to it in literature. However, despite the term being used plentifully as a technical label in other fields, there is a relative paucity of research utilising complexity in the health and interprofessional areas. Examples of complexity usage in other fields range from theoretical constructs in science, information technology, and mathematics (Kolmogorov, 1998; Zayed, Nouvel, Rauwald, & Scherman, 2010), to the study of complex links between systems and structures in business and operational logistics (Axelrod & Cohen, 2000; Nilsson, 2006; Sieijts, Crossan, & Billou, 2010). These definitions are used specifically in ways that are very different to the conceptualisation of **complexity** in the theory of **connecting**.

Meanwhile, when complexity is used in the interprofessional health literature, it appears both as a qualifying descriptive term (DøAmour et al., 2005; Flaherty, Donaghy, & Becker, 2011), and as a central debate (Cilliers, 2005; Hood, 2012; Lingard et al., 2012; Litaker, Tomolo, Liberatore, Stange, & Aronm, 2006; Stevens & Cox, 2008). When complexity is used as a qualifying term, there is a tendency to assume common understanding, with few definitions articulated. It is a term that is often used to cover multiple factors that cannot be easily explained. For instance, complexity is often used as a descriptor for the complex client (Levack & Dean, 2012; McPherson & Siegert, 2007; Rosengard, Laing, Ridley, & Hunter, 2007), to reference the complex environment (Rankin & Regan, 2004), or in relation to complex medical interventions (Craig, 2008). Complexity is also used as a descriptor label in some collaborative practice competencies (Suter et al., 2009). Other authors use complexity more generally, stating that interprofessional interactions are complex, without theoretically examining the meaning of the term (DøAmour et al., 2005; Zwarenstein et al., 2009). When complexity concepts are not clarified, transference of ideas becomes problematic, with readers left to assume meaning.

The term complexity is therefore documented within the interprofessional literature, but remains ambiguous, as it references several different concepts. It appears authors have

used complexity as a generic label when processes were uncertain. Typically, authors have linked complexity with only one process or system (e.g. the client or the environment), rather than considering the multiple processes of interprofessional work presented in the model of **complexity management**. Separating the concept into component parts often adds to the complexity, rather than simplifying it however, as only certain aspects of processes are considered. In contrast, this thesis presents a model of **complexity** where the components of client, relationship, and situation are interlinked and interact with each other.

Where complexity is utilised as a central focus in the interprofessional literature, a trend is observed whereby authors employ *complexity theory* to explain an element of teamwork or interprofessional practice, such as process adaptations in primary care practice (Litaker et al., 2006). Complexity theory is a set of concepts that arose primarily from mathematical and physics origins in the 1950s. It was advanced by organisations such as the Santé Fe Institute in New Mexico (Stevens & Cox, 2008) and entered into organisational and health literature in the 1990s (Buchanan, 2000; Gladwell, 2002; Sweeney & Griffiths, 2002). Fundamentally, complexity theory centres on the study of complex systems and explores how order, pattern, and structure can arise from them. This resonates with aspects of the theory of **connecting**, where HCWs used processes to manage the **complex** systems of interprofessional work.

Complexity theory states systems such as social or health systems operate at the edge of chaos but will not move outside certain boundaries, referred to as 'boundaries of instability' (Haynes, 2003, p. 41). It could be said that because much of healthcare work is chaotic (Hayes, 2003), HCWs prefer not to deal with these concerns, instead labelling issues as 'too complex' to address. This notion is supported by the work of Flood and Carson (1993), who contended that people may perceive complex problems as being unsolvable and unmanageable. Individuals prefer to talk about 'issues', rather than unravel complexity.

Relevant concepts within complexity theory include notions of self-organisation (Halsey & Jensen, 2004), the development of non-linear understanding (Stevens & Cox, 2008; Tosey, 2002), and the idea of emergence (Lewin, 1999; Mihata, 1997). That is to say, behaviour emerges in response to the context in which it is embedded. While this study did not use complexity theory, its components resonate with the symbolic

interactionist principle of people acting out of the meaning they make from objects and contexts (see Chapter 3). Complexity theory also aligns with my positioning of **complexity** as a dynamic, contextual concept. However, unlike Flood and Carson's (1993) findings, HCWs in this study *did* attempt to manage **complexity**. They needed a means of managing these challenges and hence their behaviour adapted to the context (Lewin, 1999). Sometimes this was enacted through the positive **connecting** processes of liaising and forming-reforming. At other times, HCWs used guarding to restrict **connecting** processes. This acted as a means of maintaining the status quo, and thereby contained the **complexity**.

Theoretical concepts similar to complexity theory have also been used to explore complexity issues. Examples of this are seen in the teamwork literature with Activity theory (Engeström, Miettinen, & Punamäki, 1999; Vygotsky, 1986), Network Association (Ovretveit, 1993), and the theory of Knotworking (Engeström et al., 1999; Engeström, 2010; Warmington et al., 2004). Knotworking theory demonstrates some similarities to the forming-reforming processes in **connecting**, with its emphasis on improvised tying and untying of knots of activity in rapidly changing workplaces (Warmington et al., 2004). In knotworking, the centre of the knot (the client) changes, which resonates with the forming-reforming required to manage client **complexity** in the community context.

Despite the use of other models, complexity theory itself remains one of the most popular frameworks for exploring interprofessional and team issues. Cilliers (2005), provided an example of this, utilising complexity theory to analyse and explain why problems in the social world are so difficult to theorise. Similarly, Devaney and Spratt (2009) scrutinised social support teams through the lens of complexity theory. Meanwhile, Cooper, Braye, and Geyer (2004) took complexity theory in a different direction, suggesting its tenets of self-organisation, paradox, and emergence could provide a theoretical basis for interprofessional education (IPE).

Stevens and Cox (2008) used complexity theory in tandem with complex adaptive systems theory (often considered an offshoot of complexity theory), to conceptualise the open, dynamic systems in child protection. They called for health practitioners to recognise that they are a part of a broader system, and drew on the complexity theory components of self-organisation and emergence to conceptualise the issues faced by

practitioners on a daily basis. While not an original theoretical development, Stevens and Coxø (2008) notion of linking practitioner behaviour and the complexity of a system builds a useful bridge between complexity theory and everyday practice. Correspondingly, the theory of **connecting** explains how HCWs practically **manage complexity** in their everyday interprofessional work.

Hood (2012) took a differing approach to complexity, using a critical, realist lens to apply complexity theory to interprofessional working. His idea that 'interprofessional working becomes necessary in order to deal with complex problems that defeat the expertise of professionals working separately' (p. 6) is perhaps simplistic, given that interprofessional teams are established for a multitude of reasons. However, his statement that 'interprofessional working is a response to complexity in the shape of multiple and interrelated problems' (p. 8) resonates with this research. Consistent with my findings, Hood noted that HCWs do not work within stable, defined teams, but rather engage at the intersection of multiple, interacting systems.

Similarly, Lingard et al. (2012) used activity theory and knotworking concepts to discuss the complex nature of hospital workers' interactions, as they sought opinions from different services in order to decide on care provision. Lingard and colleagues called for healthcare research to reflect the inherent complexity of teamwork, and for educators to pass on knowledge about how HCWs practically navigate complex systems. My study concurs with the authors' call for research addressing complexity issues, and goes some way to addressing this gap. By explaining how HCWs use **connecting** to manage the interrelated components of **complexity**, the theory developed in this thesis can be used in both IPE and clinical practice.

Unlike previous studies this research does not impose a framework of complexity theory purely as a descriptor to explain a situation. Rather I contend that **complexity management** is *the* central challenge faced by HCWs in the community. The emphasis on **complexity management** comprising three interrelated aspects which require active managing provides a broader conceptualisation than previous work, and can be extended into other contexts. I move beyond the literature linking interprofessional practice with complexity theory, and take a separate view from the critical approach of Hood (2012), or the hospital-based context of Lingard et al. (2012). In developing a framework of **complexity management**, I have articulated the main issue faced by

participants in this study. This provides the foundation for understanding the manner in which participants resolved this challenge, conceptualised as the theory of **connecting**.

9.3 Connecting and the extant literature

As has been shown, **connecting** in this study is about liaising, forming-reforming, and guarding processes. This theoretical concept therefore encompasses a broader range of meanings than the dictionary definition. In this section, I explore the existing literature to ascertain how connecting is understood within other arenas, and consider the theory of **connecting** alongside those positions.

When deliberated within other academic literature, connecting is most frequently referred to as an action that joins other processes, rather than as a key theoretical construct. For example, connecting is referred to as a linking process in fields such as mathematics, information technology, and science (Arvis, Mustra, Panzer, Ojala, & Naula, 2008; Hegde & Dewan, 2008). Likewise, in the interpersonal and psychology literature connecting is commonly framed as notions of joining, linking, or engagement. For example, Jacobsen (1995) explored ways to connect psychology and faith. Similarly Shah, Kwak, and Holbert (2001) examined the links between socially connecting and disconnecting around internet use. Weigand and Geller (2004) also discussed how connecting could link psychological concepts such as positive reinforcement with behaviour management. The notion of linking and socially connecting has similarities to the liaising category and building relationships in the theory of **connecting**.

In the differing context of community art and design, De Groot, Parfitt, Reeves, and Waghorn (2010) linked connecting with mutual interests, contending that 'people are connected through a common goal, space, time, and common or complementary interests' (p. 69). Reeves and Waghorn (2010) extended this idea to discuss how people connect through collaboration during joint community projects. Through these articles tentative links between connecting, linking, shared interests, and collaboration can be viewed, albeit in differing contexts from healthcare.

Connecting and collaborating are also linked within leadership and human relations research. Collison (1999) presented an example of how a large organisation connected personnel and encouraged collaboration after a company merger. With a focus on developing connections across a new organisation, this work has parallels with HCWs

desire to build relationships within the theory of **connecting**. More recently, Karabell (2011) challenged business leaders to consider how they were connecting and collaborating with teams and outside organisations, suggesting the ideas still hold relevance for businesses today. Swart, Van den Hooff and van Baalen (2011) considered business connecting through an operational lens, by identifying issues associated with learning and connecting across differing business worlds. In their attention to the way people and organisations connect via structures, technology and social processes, Swart and colleagues provide some explanation of how connecting occurs across organisational boundaries. However, they noted large gaps still exist in understanding how people connect and share knowledge across differing environments. This has parallels with the way the theory of **connecting** addresses information sharing across services, with HCWs **connecting** via liaising and forming-reforming processes.

Moving to the health field, the use of connecting in the literature is sparse. In an early use of the term, Bishop (1994) exhorted nurses to use personal connecting with patients, hospital executives, and organisations, in order to promote nursing services in an era of staffing changes. Bishop's rationale for connecting was professional promotion, implying that nurses as individuals and as a profession would be valued higher by those with whom they had developed personal connections. While personal connecting has resonance with the interacting and relationship building in my theory, developing connections for professional promotion did not arise as a significant component within this study.

In recent times, the United Kingdom's Health Service information technology initiative 'Connecting for Health' (National Health Services, 2013) has seen increased use of the term connecting in the health literature, as authors debate its implementation (Cross, 2006; Richards, Hughes, & Jebreel, 2007). This project aimed to enhance information technologies in order to improve communication and connecting between HCWs and organisations. The findings of my study also highlight the importance of information sharing, particularly when collaborating across agencies. **Connecting** processes were actively used as a means of enhancing interagency communication, in order to manage the **complexity** of community work.

Another example of connecting in the literature is seen with the 'CONNECT for quality' study currently being undertaken in America (Anderson et al., 2012). This

study is focusing on quality improvement measures to prevent falls in nursing homes, using a random controlled trial and the **CONNECT** intervention. This is described as a multi-component intervention that helps staff learn new strategies to improve day-to-day interactions; establish relationship networks for creative problem solving; and sustain newly acquired interaction behaviours through mentorship (p. 2). Of relevance to this study is the way Anderson et al. link HCW interactions with notions of complex adaptive systems, and also the association between connecting and quality, or safety issues. This relates to the earlier discussion of **complexity management**.

In the area of rehabilitation, Kuipers et al., (2008) also used the terms connecting and collaborating in their review of community rehabilitation in developing countries. Recommendations from their synthesis include: community based rehabilitation projects should be more connected and collaborative at governmental; organisational; political and community levels (p. 1). While Kuipers et al. did not expand on how to achieve connection and collaboration, the associating of terms from their review suggests my findings should have resonance within the substantive field.

Resonance is also seen in the way the **connecting** processes in this study relate to the key competencies within the interprofessional field. As discussed in Chapter 2, the Canadian Interprofessional Health Collaborative (2010) identified six competency areas that enabled effective collaborative practice: role clarification, interprofessional communication, conflict resolution, team functioning, patient/community-centred care, and collaborative leadership. The **connecting** processes of liaising and forming-reforming are supported by effective use of all six competencies, while the theoretical category of guarding explains occasions when these competencies are not consistently used.

This summary has established that although the term 'connecting' is commonly used, the academic literature contains little theoretical basis for understanding how connecting occurs, or what the outcomes of connecting are. The theory of **connecting** therefore presents a novel way of considering connecting that increases understanding of collaborative practices in community healthcare, and addressing calls for theory explaining interprofessional processes (Dow, DiazGranados, Mazmanian, & Retchin, 2013; Thistlethwaite, 2012).

9.4 Connecting: Salient points arising from the findings

While the preceding chapters have explained the theoretical categories of **connecting**, and the previous section has considered connecting use in other literature, several points are worthy of further elaboration. These points are considered salient, either for their prominence in the data, or because of their relevance for future work. Firstly, the significance of relationship building and its place in collaboration and **connecting** is addressed. This is followed by a discussion of role crossover, leadership, and interagency collaboration. As issues around interagency collaboration were one of the key research findings (see Chapter 9, Introduction), this discussion is longer than the other segments.

9.4.1 Relationship building

M ori have a saying:  He aha te mea nui o te ao? He tangata, he tangata, he tangata . This translates as:  What is the greatest thing of all? It is people, it is people, it is people.  For me, this timeless statement captures the importance of relationships in any context. Similarly, participant HCWs valued relationship building as a highly desirable outcome of **connecting** processes in their work. It was prioritised because established relationships made **connecting** easier and enhanced collaborative practice. This occurred through increased trust, improved communication and liaising, and less guarding. Participants particularly valued informal liaising as a means of relating, and developing **connecting** within their teams and across agencies. This correlates with work by Wagter et al., (2012), who identified informal interprofessional relating as the preferred means for hospital-based staff to learn from one another.

In considering why relationship building was so important in this research, it is possible that the types of personalities attracted to community work influenced these perspectives (see Chapter 5). Some team leaders acknowledged they actively recruited for personality types that would build relationships across agencies, emphasising the value placed on this ability. Equally, the fact that the majority of participants were female may have contributed to a desire for relationship building (Wilhelmsson, Ponzer, Dahlgren, Timpka, & Faresj , 2011). Despite these possibilities, my findings align with those of other authors, who emphasised the importance of team-member relationships, stating they are a prerequisite to collaborative practice (Harris et al., 2010; Tallia, Lanham, McDaniel, & Crabtree, 2006). Given humans are relational beings, it is not

unexpected that relationships are an important - if not always acknowledged- factor in many work contexts.

Researchers searching for a means of clarifying relational importance within interprofessional work have looked to other fields, particularly the aviation industry, for explanations (Frosch, 2012; Gittell, 2000, 2003). Specifically, the notion of relational coordination is increasingly used in healthcare to explore the importance of relationships, both interprofessionally, and with clients (Gittell, Godfrey & Thistlethwaite, 2013). Drawn from studies of flight control workers, relational coordination involves 'coordinating work through relationships of shared goals, shared knowledge and mutual respect' (Gittell, 2006, p. 74). Teams who scored highly in relational coordination measures (e.g. communication and relationship ties) demonstrated greater efficiencies and higher-quality team functioning, as well as improved job satisfaction (Gittell, Weinberg, Pfefferle & Bishop, 2008). Gittell et al. (2013) note the congruence between relational coordination and collaborative practice, with a common emphasis on information sharing, respect, and communication. Similarly, relational coordination has a synchronicity with the liaising and forming-reforming processes of **connecting**, which emphasise the relational aspects of interprofessional working. My findings also endorse Gittell and Douglass (2012) call for organisations to replace traditional bureaucratic structures with more relational structures and cross-functional teamwork.

While the theory of **connecting** resonates with aspects of relational coordination, an important difference is the finding that HCWs and team leaders placed different significance on relationship building. In this study, HCWs prioritised relationship building, using both unfunded time and masking of clinical time to make relating possible. Team leaders however, gave less priority to developing relationships, viewing it as an optional extra, or something that would result from the main work of treating clients. It is possible that leaders took this position due to organisational and funding structures that focused their efforts on team outcomes. That is, performance measures that were based on clinical outcomes, economic rationalisation, and the number of clients treated, meant leaders placed less emphasis on interprofessional relating. In these situations, leaders were unlikely to respond to calls for more relational structures and opportunities in their teams, as this would take away from hands-on clinical time.

This presents something of a chicken and egg quandary. Team leaders promoted interprofessional work with clients, which incidentally developed relationships, while HCWs contended that the relationships needed to be established first before collaboration was effective. Given the literature indicating that mistakes can occur when HCWs do not collaborate (MacMillan, 2012; Reeves et al., 2010; Sutcliffe, Lewton, & Rosenthal, 2004), it would appear safer to have effective relationships in place before working interprofessionally. In practice, this is not always possible, with new teams forming and reforming around each client. Nonetheless, it would be beneficial for team leaders to be aware of HCWs' preference to build relationships as a prerequisite to interprofessional work, and facilitate this when new HCWs enter the team. Additionally, organisational support for team relationship building could be supported through adopting performance measures that include relational aspects of team functioning, rather than solely client outcomes. This would give team leaders a mandate to develop collaborative practices and might encourage greater emphasis on the relational aspects of interprofessional work.

Though, even when HCWs and team leaders did agree on the benefits of building relationships, the two groups differed on their preferred ways to attain this goal. In this study, HCWs actively pursued relationship building and **connecting** in both informal and formal ways, but preferred informal processes. HCWs perceived the 'real work' of **connecting** and building relationships mostly occurred outside team meetings and organised networking. Meanwhile, team leaders often viewed team meetings and other structured opportunities as the optimal means of increasing staff **connecting** and emphasised their importance.

When HCWs and team leaders had differing relational priorities, HCWs found ways to work around the system to enable relationship building and **connecting**. In effect, they were masking how parts of their working time were managed. The distinction between the way workers and team leaders prioritised relationship building was important, with implications for team functioning and service delivery, which are considered later in the chapter.

9.4.2 Role crossover

Certain health professions have a natural amount of role crossover in their professional skill base, sometimes referred to as common competencies (Barr, 1998; Ervin, 2009; Körner, 2010). This was evident in this study between occupational therapists and physiotherapists as well as between dieticians and speech language therapists. Role overlap and the subsequent lack of role clarity are frequently cited as factors in interprofessional misunderstandings, tensions, and guarding of roles (Delva et al., 2008; Kvarnstrom, 2008; Suter et al., 2009; Zwarenstein et al., 2009). Yet, clarifying roles is difficult, and influenced by factors such as evolving scopes of practice, the team and practice context, and the individuals' skill and values bases (Dean & Ballinger, 2012; Olupeliyawa et al., 2009; Thistlethwaite, 2012a). It also requires a willingness to look outside assumed role parameters to consider interprofessional working, or a thinking outside the box model of practice (Dean & Ballinger, 2012).

Participants in this study indicated that role clarity issues also occurred within their own professions. The lack of consensus over professional role parameters was impacted by international training differences, postgraduate training, and changing undergraduate curriculums. When HCWs within a profession lacked a shared understanding of their role, collaborating with other HCWs became more complicated. Interestingly, Lingard et al. (2012) challenged the notion that stable professional roles exist in collaborative practice, noting frequent role change even in structured hospital teams. Similarly, within community rehabilitation I argue that the need to be flexible and adapt to need means roles are by necessity fluid. Hence, defining role boundaries is difficult, even within a profession.

A pertinent finding in this study was the way some HCWs used flexibility and fluidity to allow role crossover, whereby one HCW undertook tasks typically assigned to another profession. This was an active means of working collaboratively, which occurred in specific conditions. Examples of this were seen when resources were stretched by a staff member being away; when travel considerations meant collaborating would save resources and time; or when collaboration would minimise client overload. Role crossover was facilitated by holistic working perspectives and by the community context, where skill sharing and training others was routine practice.

Role crossover was not an entirely accepted practice, however. Some participants viewed it as a sensible response to managing resources, a view supported by other authors (Best, Hysong, Pugh, Ghosh, and Moore, 2006; Smith, Roberts & Balmer, 2000). Others saw role crossover as a risky encroachment on professional boundaries that they guarded according to their individual perceptions of professional roles. Still despite these varied perceptions, it appeared that role crossover was a part of interprofessional working that was here to stay. Moving it from an implicit undertaking to an explicit part of practice however, might take macro level involvement from organisations and professional regulatory bodies.

Other researchers have highlighted the role regulatory bodies (e.g. NZ Physiotherapy Board) play in maintaining professional boundaries - and by extension limiting role crossover ó through professional scopes of practice (Dean & Ballinger, 2012; Ervin, 2009). Most regulatory bodies endorse IPE and collaborative practice in principle (Thistlethwaite, 2012), but still have a mandate to maintain their role boundaries (Barr et al., 2008). There appears to be an inherent tension between professional regulatory bodies observing role boundaries, and training organisations promoting interprofessional collaborative practice that allows flexible practices such as role crossover, which is yet to be clarified (Barr et al., 2008; Interprofessional Curriculum Renewal Consortium, 2013; Oandasan & Reeves, 2005).

9.4.3 Leadership

Implementing change in collaborative practice within workplaces is challenging. It requires strong leadership endorsement, institutional support, and practitioner understanding and engagement (Fineout-Overholt, Melnyk, & Schultz, 2005; Thistlethwaite, 2012). Leaders are pivotal to the success of implementing collaborative initiatives. Their influence can either support, or hinder collaborative practices within their teams (Andersson et al., 2011). Supportive practices are led by leaders who perceive the value in enhancing interprofessional working (Canadian Interprofessional Health Collaborative, 2010; Frenk et al., 2010), have the knowledge to support change, and are backed by a clearly defined leadership mandate (Reeves et al., 2010).

Leading interprofessional teams can be difficult however, with each profession holding separate roles, responsibilities, and lines of accountability, arising from historic notions of professional hierarchies (Reeves et al., 2010; Lingard et al., 2012a). As noted in the

discussion on role crossover earlier, HCWs held strong, but varying, views about role boundaries. Leaders were required to manage staff and encourage interprofessional practice in teams where, even within a profession, different opinions about role boundaries existed.

In addition, due to the forming-reforming of sub-teams that occurred when **managing complexity**, leadership could be fluid and layered, with different HCWs taking on leader roles at varying times. This corresponds to findings by Anonson et al. (2009) who described interprofessional teams as having shared leadership that was horizontal, relational, and situational. That is, leadership that fluctuates according to the context. McCallin (2003), similarly suggested teams consider leadership as a shared stewardship, which saw all HCWs as responsible for team leadership at different stages. However, while egalitarian notions of shared power and leadership are concepts worth aiming towards, in practice many organisations still demand a definitive leader. This was the case with participants in this research, where all teams had a clear leader, even though HCWs took on leadership or coordination roles at times. Maintaining overall leadership of the interprofessional team, while distributing leadership responsibilities to HCWs in sub-teams, was an on-going challenge. Leaders managed this in different ways, with HCWs attributing their actions to personality traits, rather than purposeful leadership techniques.

Leadership styles acted as a salient condition that influenced collaborative working in this study. Open, relational leaders were perceived to enable positive **connecting** processes and minimise guarding behaviours within their teams. Conversely, those leaders who were seen as bureaucratic and task-oriented risked alienating their staff. These leaders' micro-managing styles were frustrating for HCWs, who felt their professional autonomy and abilities were being questioned. HCWs responded to this style of leadership by adopting the professional perspective, which focused on professional tasks, rather than holistic interprofessional working. They 'got on with the job,' rather than look for opportunities to work collaboratively with other team members. This acted as an unacknowledged barrier to collaborative practice, shifting HCWs practice from holistic interprofessional working back to teamworking that resembled earlier models of multi-professional working (see teamwork models in Chapter 2).

Interestingly, none of the participant leaders had received specific training in collaborative skill development. Most had developed their skills in an era without specific interprofessional learning opportunities. They had evolved their own styles of managing and leading. Changing these established patterns of behaviour would depend upon leaders understanding the value of collaborative working, and desiring a change in practice. This suggests that organisations need to facilitate collaborative skill development for their leaders.

The lack of leadership training observed in this research, mirrors other literature that suggests interprofessional skill development remains a neglected area for health leaders (Martin & Rogers, 2004; Reeves et al., 2010). This is of concern, given that collaborative leadership is listed as one of the core competency areas for successful collaboration (Canadian Interprofessional Health Collaborative, 2010), and organisations are increasingly mandating it in policy documents (Ministry of Health, 2008, 2009). Indeed, models have been developed that assess the collaborative performance of leaders, highlighting that some organisations at least, perceive collaborative leadership development as important (Garman, Fitz & Fraser, 2006). An example of this is seen with the development of the Health Leaders Competency Model (Calhoun et al., 2008). This model considers interprofessional leadership within the three domains of transformation, execution, and people skills, and assesses eighteen behavioural competencies of leaders. While this provides a useful starting point in identifying areas for collaborative leadership improvement, it does not address how these improvements can be made.

It seems that, despite an increasing awareness that interprofessional leadership is an important, and measurable, component of collaborative practice (Canadian Interprofessional Health Collaborative, 2010; World Health Organization, 2010d), what is missing is knowledge of *how* leaders can most effectively implement collaborative practices, support positive attitudinal changes, and up-skill their team members. It appears an opportunity is being missed to consolidate collaboration within teams. This could be resolved by organisations instigating leadership development programmes that equip leaders with the knowledge and skills to advocate for collaborative practice with their staff. This may, in turn, have the additional benefit of providing a supportive atmosphere for new interprofessionally-trained graduates to integrate into established teams.

9.4.4 Interagency collaboration

Throughout the interprofessional literature, the focus is predominantly on collaborative practices within a team, or collaborative working with clients, rather than interagency work. This is not surprising, given a large part of the literature arises from concerns within teamworking practices and the resulting adverse client events. Community HCWs face similar issues within their interprofessional teams, yet it is argued they also face a broader challenge, with interagency collaborations comprising a regular part of their work. Findings from this research indicate that interagency collaboration was a significant challenge for HCWs. Interagency work appeared to be poorly coordinated, with substantial barriers that were not always overcome. As discussed in this thesis, challenges arose from the relational and situational **complexity**, as well as from interagency working concerns.

Interagency collaborative working is becoming more common, driven by a trend in high-level policy that promotes the importance of interagency collaboration for improved services, better client outcomes, and prevention strategies (HCN Unit, 2007a). For example, the New Zealand government is increasingly supportive of inter-sector policies that consider integrated service delivery, or a 'whole of government' approach (Atkinson, 2007). District Health Boards are also moving to **connect** with each other through initiatives such as universal note systems and aligning organisational policies (HCN Unit, 2010). In her review of local health services, Atkinson (2007) highlighted examples where these interagency practices were effective. For instance, the work of the High and Complex Health Needs Unit (HCN Unit, 2007b) demonstrates that formalised interagency practices using a lead agency model can be beneficial when working with children with complex needs.

However, while evidence mounts that effective interagency collaboration can improve the quality of services, operationalising higher-level policy is not easy, and positive outcomes are not assured (Oliver, Mooney, & Statham, 2010; Richardson & Asthana, 2006). Participants in this study found interagency working policies were difficult to enact. Similar to the findings of an Irish review of child health services (Statham, 2011), there appeared to be confusion over what interagency work should look like in practice. A recent review of interagency work in vocational rehabilitation (Andersson et al., 2011) highlighted this lack of clarity, noting at least seven basic models of collaboration

in operation. These included information exchange; case coordination; interagency meetings; multidisciplinary teams; partnership; agency co-location; and pooling of agency budgets. These models varied from informal to formal, with overlap between models, structures, and processes. The lack of a cohesive direction in the literature underscores the relational and situational **complexity** of interagency collaboration. It is therefore understandable that organisations and clinicians struggle to enact these processes.

To address the confusion, authors have promoted interagency collaborative protocols that account for the specifics of local organisational contexts (Griffin, 2010; HCN Unit, 2010). Yet, this study has shown that even when these specific structures and parameters were present, it still took individual HCWs time to develop relationships and trust in the processes. These findings are supported by those of Andersson et al. (2011), who noted trust development and partnership working as essential for interagency work. Again, **connecting** processes were needed before changes were noted in interagency collaboration.

Findings show that interagency collaboration was facilitated when the same teams regularly worked together across agencies, liaising, and building connections. However, because community work is fluid, differing teams and varying individuals need to form and reform around the needs of each client, making **connecting** processes challenging. Organisational attempts to develop partnership relationships across agencies became difficult in these situations. Thompson (2013) likens this to trying to patch together a jigsaw of information. In the theory of **connecting**, the relational and situational **complexity** also meant that interagency processes that held across one organisation were not necessarily the same across another agency. New processes needed to be developed for each interagency relationship.

Additionally, the challenge of working across differing funding parameters of ACC and the MoH acted as a strong obstacle to interagency collaboration. As noted in earlier chapters, issues occurred not just around organisational and team protocols, or funding and service parameters, but also at the level of individual HCWs. The divide between HCWs on ACC contracts compared with HCWs in salaried health teams was a major interagency barrier that was poorly understood. ACC contracts constrained how HCWs interacted, with funding focused on client treatment time rather than collaborative

meetings between agencies. While ACC does have a process where HCWs can apply for funding to attend interagency meetings, the formality of this procedure acted as a barrier. In response, some contract HCWs admitted to *fudging* the system, by over-quoting client contact time to build in a buffer for interagency *liaising*. HCWs needed a responsive, flexible system that allowed them to collaborate across agencies, but this did not exist.

Interagency work was further complicated when the **connecting** needed to occur between the health sector and volunteer or community-led services. This is an area where research is sparse (Kernick & Mitchell, 2009), as acknowledged by recent calls to develop collaborative models that recognise and value non-professional workers (Interprofessional Education Collaborative, 2011). In the area of health and social services, collaborations with non-professional groups are increasing, with government directives encouraging communities to find their own solutions to complex social and cultural issues (Atkinson, 2007). Within community rehabilitation, the predominant International Classification of Functioning, Disability and Health model of considering a person's function within the context of their whole life (World Health Organization, 2001), means interacting and **connecting** with non-health agencies needs to occur on a regular basis.

While these professional and community interagency collaborations are endorsed for client and community empowerment, issues of power, leadership and participatory imbalance frequently arise (Chavis, 2001; McDonald et al., 2012). Differing drivers, professional understandings, organisational protocols and funding constraints lead to collaborative challenges and unclear mandates (Griffin, 2010; HCN Unit, 2010). Additionally, interagency working takes longer than team collaboration and requires commitment from individuals and agencies. Volunteer and community organisations may not be aware of the rationale behind interagency collaboration and require guidance from professional teams, which takes time and energy. It is not surprising then that *collaboration fatigue* is beginning to be noted in the literature, particularly when interagency work is unsupported or expectations vary (HCN Unit, 2010). While participants in this study valued interagency working, when it came on top of a full workload, HCWs prioritised their own team functioning above interagency **connecting**.

So in these circumstances, what happens to the client? When there are a number of different agencies involved, a lack of clarity around roles, and interagency working is not always collaborative, who coordinates the care? Within this study, it appeared that, by default, the client or their family became their own care coordinator. Superficially, this would appear to be a positive concept, as it links with person-centred care models that place the individual at the centre of decision making (Cheeseman et al., 2013; Levack & Dean, 2012), and notions of democratic professionalism (Dzur, 2010, Sullivan, 2000) that promote the engagement of the client and lay carers. However, in practice it was less clear whether clients and their families had the coordination role explained to them, or indeed were willing to perform this function (Gittell et al., 2013; Thistlethwaite, 2012a; Weinberg, William, Gittell, & Kautz, 2007). The self-management literature suggests not all clients are prepared, or able to take on these roles (Du & Yuan, 2010; Effing et al., 2007; Lorig et al., 2001).

Findings from this study concur that while clients and their families were perceived to have a role in coordinating their own care, and indeed act as gate-keepers of their own information, HCWs would not expect all clients to take on this function. Sometimes this expectation appeared to arise from protective notions of benign paternalism. At other times, key worker or care coordination roles were construed as a more guarded action that HCWs undertook to maintain professional control. It was interesting that the HCWs in this study held varying views on this aspect of practice, yet did not openly discuss the client's perspective. It appeared that HCWs made assumptions about what clients could manage in regards to coordinating their own care.

Under the ACC model of practice, the support coordinator performs this role. They act as both gate-keeper and purchaser of services, as well as client supporter. Rehabilitation clients with serious injuries funded under ACC have a support coordinator for the rest of their lives, with much responsibility resting on these individuals. Many support coordinators have no health background themselves, and the complexity of the role sees high staff turnover. This results in clients having to frequently build relationships with new coordinators and to self-manage, or fill the gaps in information transfer that can occur.

The MoH model of community rehabilitation differs from the ACC support coordination framework. During inpatient rehabilitation with the MoH, case

coordination typically occurs, however there are gaps when the client returns home. No single agency manages the long-term needs of these clients, with referrals to community health teams usually coming via general practitioner-directed community needs assessments. The MoH has recently identified lack of coordination as an issue in interagency work and is investigating using local area care coordinators for sub-acute rehabilitation (Benett, 2009; Health Workforce New Zealand, 2011). This follows international practice where case coordination is an established part of rehabilitation (Gardner, Pransky, Shaw, Nha Hong, & Loisel, 2010; Pransky, Shaw, Loisel, Hong, & Desorcy, 2010; Shaw, et al., 2008). However, with the New Zealand model stopping at three months post-discharge, the coordination for longer-term needs will again revert to the client. This finding is concerning and has implications for funding and practice.

9.5 Shifting the research focus

This research focused on collaborative practice in the workplace. However, collaboration does not simply magically occur once HCWs enter the workforce. Rather, as noted in Chapter 2, collaboration is supported by IPE and interprofessional learning (IPL) that encourages undergraduate HCWs to develop collaborative competencies they may use in practice (Reeves et al., 2013, World Health Organization, 2010d). At an undergraduate level, the focus on developing interprofessional communication and teamwork competencies appears to provide a useful basis for collaborative skill development. Nonetheless, I propose that more emphasis is needed on educating HCWs about the relationship development and connecting that need to occur between HCWs, for collaborative practice to succeed. Perhaps this is too high a level of expectation for undergraduates, who have had little exposure to the complexities of health-team working, and hence may not comprehend the relating challenges. Still, I contend that the skills of interprofessional relating and communicating need more nuanced consideration at both the undergraduate and post-graduate levels. This has implications for education and practice that are addressed later in the chapter.

In considering the workplace, I found it very interesting that literature explaining what happens once collaboratively-trained HCWs enter the workplace is inconclusive and limited (Nicol, 2013; Suter et al., 2012). There has been a limited focus on this area, with the literature lacking longer-term evaluation of the impact of IPE/IPL on HCWs' collaborative behaviours (Reeves et al., 2013; Thistlethwaite, 2012; Wilhelmsson et al.,

2009). By transposing ideas from the organisational literature though, one can predict potential challenges when newly qualified HCWs enter the workplace. Newcomer adjustment theory and behavioural plasticity models suggest new team members have less power to implement change, and tend to fit in with established team norms (Cooper-Thomas, Anderson, & Cash, 2012; Saks & Ashforth, 2000; Sluss, Ashforth, & Gibson, 2012). In this study, participants did not refer to IPE/IPL having an effect on their collaborative practice. However, as only eight participants had five years or less work experience, there were few participants who would have received formal interprofessional training. Further work needs to be done to ascertain if undergraduates trained to be practice-ready to collaborate, are able to operationalise this once they enter the workplace (Reeves et al., 2013). In particular, qualitative research that develops our understanding of how HCWs perceive collaboration, and what changes their collaborative actions in the workforce, is needed.

Fostering collaborative understanding and skill development within the workplace is definitely an underdeveloped area (Abramovich et al., 2011; Reeves & Sully, 2007). Thistlethwaite (2012) contends that because the focus of research and education has been on undergraduate and formal IPE, there is limited knowledge of workplace collaboration. She proposes the interprofessional research agenda should shift to explore collaborative practice within the workplace, noting that research in this field has been limited to defined areas such as operating rooms, rather than community settings (Thistlethwaite, 2012, p. 67). I agree with this focus and the theory of **connecting** has been developed to explain collaborative processes in the community workplace and also with the conclusion that more work is required to develop understanding across different working contexts.

One aspect of interprofessional work that impacts across all contexts is that of HCWs' attitudes towards IPE and collaborative practice. HCWs who do not perceive the benefits of collaborative working or hold negative attitudes, can limit interprofessional effectiveness (Legare et al., 2013; Nicol, 2013). From the review in Chapter 2, it was seen that although attitude is an area of research focus, work to date is inconclusive as to whether IPE and IPL result in a positive or negative attitudinal shift towards collaborative working (Pollard et al., 2012; Reeves et al., 2013). The effect of undergraduate IPE on changing HCW attitudes towards collaboration appears to depend

on a myriad of factors (see Chapter 2), which still need further clarification (Gordon et al., 2013; Makino et al., 2013).

Meanwhile, within the workplace, the impact of IPL initiatives on HCWs' attitudes is also being explored. There are some encouraging indicators from low-level studies (Onishi et al., 2013; Robben et al., 2012). Still, there are challenges in consolidating knowledge due to the varying work contexts and small scale of studies (Hammick et al., 2007; Reeves et al., 2010; Thistlethwaite, 2012). High-quality research in the area is needed, in order for resourcing to be effectively targeted, and for HCWs to retain confidence that IPE and collaborative practice are worthwhile endeavours.

I find the lack of conclusive evidence for IPE/IPL outcomes surprising, given the world-wide drive for IPE and collaborative practice, and the resourcing being allocated through under-graduate training. It is interesting to consider why the rhetoric around IPE/IPL continues to be so strongly promoted, despite the paucity of compelling evidence to date. If anything, it appears the collaborative practice message is becoming more pronounced, with recent statements advocating for collaborative practice from organisations representing millions of HCWs (US Institute of Medicine, 2013; World Health Professions Alliance, 2013). Certainly, there is a financial driver behind IPE/IPL initiatives that promote more efficient healthcare, yet this is more likely to be steered by government and funder policies. The international backing of large professional groups implies professional recognition that current forms of healthcare provision need to be improved. This is partly due to resourcing concerns, with an identified shortage of HCWs worldwide. However, it is possibly also due to professional groups recognising that, despite a lack of conclusive evidence about IPE outcomes, there is certainly evidence that *failures* in collaboration can have significant adverse effects for clients (Baldwin & Daugherty, 2008; Heldal, 2010; Richardson & Storr, 2010). Hence, IPE/IPL initiatives that may improve collaborative outcomes are worth supporting, while further evidence is being gathered.

9.6 Implications for practice, education and research

This thesis has contributed new knowledge to the interprofessional field by providing a theoretical model that increases the understanding of how HCWs view collaboration and act interprofessionally in the context of community rehabilitation. It also provides a novel framework of complexity that clarifies the multiple challenges that HCWs need to manage in their daily work. Recommendations arising from this research have implications for clinical practice, policy makers, fund-holders, education and further research. These recommendations are summarised in Table 6 and discussed in further detail below.

Micro level: Clinical recommendations
<ul style="list-style-type: none"> ➤ Enhanced team processes are needed that allow for informal liaising and relationship building. ➤ Team leaders require training to understand the benefits of collaborative practice and how to facilitate this in their teams. ➤ Workplace induction processes that support new graduates to understand the complexity of community healthcare are needed. ➤ Organisations, leaders, and HCWs need to prioritise and actively manage interagency work.
Macro level: Policy and funding recommendations
<ul style="list-style-type: none"> ➤ A shift in ACC funding processes is required to account for the informal connecting HCWs undertake in community settings. ➤ Acknowledgement and clarification of the implicit role of the client as care coordinator at policy and team level is needed. ➤ Direction is needed from professional body groups to clarify the tension between collaborative practice and role boundaries. ➤ Continued efforts to reduce the communication and practice barriers between the main funding bodies are needed at both macro and micro levels.
Interprofessional education and research recommendations
<ul style="list-style-type: none"> ➤ Refining the communication curriculum to include the relational aspects of interprofessional work would assist HCWs to prepare for the workplace. ➤ Undergraduates would benefit from learning about the connecting processes HCWs use to manage the layers of complexity inherent in community work. ➤ Additional research opportunities arise from this study.

Table 6: Recommendations arising from the research

- Enhanced team processes are needed that allow for informal liaising and relationship building.

Findings showed that collaborative practice was enhanced when HCWs built relationships through informal liaising. HCWs prioritised and highly valued these processes. Yet, because team structures and funding parameters focused on hands-on client time, HCWs often concealed the time spent on these activities. Team processes that allow for informal liaising and relationship building are needed. This is supported by team leaders who understand the need for both formal and informal connecting and facilitate these processes.

- Team leaders require training to understand the benefits of collaborative practice and how to facilitate this in their teams.

From this study it was seen that leadership styles were a salient condition that influenced collaborative processes in community teams. Having leaders who not only understand the rationale behind collaborative practice, but who also know how to implement strategies to enhance collaboration in their teams is vital. Organisational training of team leaders is therefore required to give them the skills to implement and support collaborative processes in their teams.

- Workplace induction processes that support new graduates to understand the complexity of community healthcare are needed.

Another clinical implication arises from recruitment concerns. Many participants viewed newer graduates as unsafe to practise in community work. While these concerns are important, planning for future staffing needs consideration. Team leaders and organisations need to consider ways to safely induct and mentor new HCWs in the community setting before experienced staff retire and practical knowledge is lost. These new workers would also bring interprofessional skills from their undergraduate IPE that could enhance overall team practice.

- Organisations, leaders, and HCWs need to prioritise and actively manage interagency work.

Implications for practice also arise with interagency working. In order for interagency collaboration to be effective, HCWs need to develop connections across teams. This is problematic in the community, with challenges identifying who is involved and how to connect, before collaboration can even be considered. Practices that supported

interagency working included structured networking, co-location of agencies where possible and work-shadowing across agencies. In this study, an example of this was described whereby one team had successfully implemented inter-agency work-shadowing as a routine part of the staff induction. Benefits of this were reported as growth in role understanding, relationship building, and knowledge of interagency referrals and processes. Spreading similar practices across other agencies could enhance interagency connecting across a geographic region.

- A shift in ACC funding processes is required to account for the informal connecting HCWs undertake in community settings.

It seems incongruent that collaborative practices are acknowledged to have positive benefits on team and client outcomes, yet HCWs are still not able to openly claim for time spent on these practices. Funding models that reflect actual practice would acknowledge the importance of collaborative processes to client outcomes. This would not necessarily have significant cost implications, as HCWs in this study were already finding ways to claim some of this time as treatment time with the client.

- Acknowledgement and clarification of the implicit role of the client as care coordinator at policy and team level is needed.

As identified in this research, when multiple teams and agencies were involved, the client or their family often ended up as the unacknowledged care coordinator. There was tension in this implicit role, with some HCWs feeling it burdened the client and other participants supporting it as empowering. Sometimes the client was perceived to gate-keep and guard information between services. Hence, the role of client as coordinator needs acknowledging and clarifying. HCWs could also consider ways to educate and support clients in this implicit role. Discussions outlining who is involved in care, and identifying a key contact person may assist. Simple strategies observed in this study, such as the use of client notebooks utilised by all agencies, can also assist clients and HCWs to coordinate services across agencies.

The government has recently identified care coordination as a concern, with a recent MoH proposal for a local area coordinator role that supports people with disabilities (Benett, 2009). This model is currently in use in Western Australia and Scotland, and is similar to the ACC support coordinator role. It is based around person-centred approaches, with an emphasis on participation and contribution as well as choice and

control over supports (Bartnik & Chalmers, 2007; One Scotland & Healthier Scotland, 2008). Wide-scale use of this model would take some of the pressure off clients to maintain their own case coordination. Currently the MoH is investigating how local area coordination could work in the New Zealand setting, with pilot testing occurring in one area of the country. It is hoped the proposed coordination time is extended beyond three months, as clients often have on-going need for support.

- Direction is needed from professional body groups to clarify the tension between collaborative practice and role boundaries.

When considering implications at the macro level, the role of professional bodies, such as the NZ Occupational Therapy Board and the NZ Physiotherapy Board, needs clarifying. Internationally, there is a drive for collaborative competencies to become an auditable requirement at both pre- and post-licensure levels (Interprofessional Curriculum Renewal Consortium, 2013; Thistlethwaite, 2012). Yet, there appears to be a tension between professional bodies that advocate collaborative practice, while simultaneously acting to maintain professional boundaries. HCWs in this study appeared confused by this incongruence, and as a consequence barriers to collaborative practice arose. If professional bodies developed guidelines educating HCWs on how to manage these tensions, interprofessional practice could be enhanced.

- Continued efforts to reduce the communication and practice barriers between the main funding bodies are needed at both macro and micro levels.

At the funder level, findings from this study indicate there is a communication and practice divide between the two main funders (ACC and MoH) at grass-roots level. Organisational and government protocols suggest the two funders connect and communicate but at the practice level there are real barriers and embedded assumptions which restrict collaborative practice. ACC and MoH workers struggle with connecting, and often do not even know the other agency is engaged with a client. Where services overlap, practice protocols are beginning to emerge, yet grey areas remain. Information sharing and role understanding between these organisations is fraught with challenges. For instance, for those HCWs working for the MoH, there appeared to be limited understanding of the roles of ACC funded HCWs. Additionally some HCWs in this study assumed that ACC funded HCWs were better paid and hence could take on more tasks than MoH workers and meet regularly.

However, under the ACC model, HCWs need to apply for extra funding to attend interagency meetings. For these HCWs, allowing time to engage in necessary interagency work without getting prior consent of the support coordinator would support more efficient and effective interagency work.

- In health education, refining the communication curriculum to include the relational aspects of interprofessional work would assist HCWs to prepare for the workplace.

Within the health education field, this study presents findings that can be used in teaching and to inform further research. I believe that the current undergraduate IPE emphasis on communication skills does not adequately address the complexities of interprofessional relating faced by graduates entering the workforce. While there is a limit to the depth of skills undergraduates can learn without immersion in the workplace, further consideration of which communication skills are most pertinent is needed. Evolving the IPE curriculum to move communication training from a task orientated process, to encompass the wider relational aspects of interprofessional work could enhance undergraduates' preparation for the workplace.

- Undergraduates would benefit from learning about the connecting processes HCWs use to manage the layers of complexity inherent in community work.

Additionally, the conceptualisation of complexity management provides a model for understanding and explaining the community context to undergraduates. I concur with Lingard et al. (2012) call for educators to teach undergraduates about complexity in the workforce. Similarly, the theory of connecting provides a means of exploring and understanding collaborative practice in the community context that can be used by educators. This expands the interprofessional literature and can be used by the National Centre for Interprofessional Education and Collaborative Practice for training and extending research areas.

- Additional research opportunities arise from this study.

Further research directions also emerge from this study. Findings suggest HCWs were more likely to work collaboratively when they understood and worked from a holistic perspective. This meant moving away from professional models to consider the clients' whole of life needs. It follows then that encouraging staff to utilise holistic models such

as person-centred practice may also facilitate collaborative practices. Yet, as noted in Chapter 2, literature linking person-centred practice with collaborative practice is sparse and the tension between the two concepts appears unresolved (Hall, Weaver, Gravelle, & Thibault, 2007; Howarth et al., 2012; Suter et al., 2009). Further research into how these two approaches interact is needed. Similarly, I would like to see exploration of the client's perspective of their implicit role as case coordinator and indications as to what would happen should it become explicit. Further development is also needed to expand the knowledge of collaborative practice in different work contexts. It would be interesting to explore doctors' perspectives on collaborative practice, given they were not considered as part of the regular community team by HCWs. Also, the perspectives of the lay/volunteer workers and organisations in community work is deserving of focused study. Similarly, research that clarifies the processes leaders can use to implement collaborative strategies in the workplace would be of benefit. It would also be potentially fruitful to apply the theory of connecting to other fields.

9.7 Research limitations

As with any study, several factors impacted on the research process. Firstly, the choice of a constructivist methodology meant that the findings are not automatically generalisable, and that the context of their construction needs to be considered. While a grounded theory should demonstrate credibility and resonance across diverse situations and populations (Charmaz, 2006; Corbin & Strauss, 2008; Glaser & Strauss, 1967), it primarily needs to be applicable and useful for the studied area. To develop credibility beyond the community health context, people outside the health field were approached for feedback on the theory (see Chapter 4). While their responses suggested recognition of the concepts across their work areas (except for forming-reforming), it would take further work to extend these ideas across other work arenas. Additionally, even within the health field, it is important to note that the setting of this research was quite specific. The New Zealand community health field has unique organisational, funding, and situational considerations that effect HCWs. While several findings of this study were in concordance with international studies (McDonald et al., 2012; Oliver et al., 2010; Statham, 2011) and it is hoped others will draw from this research, readers should consider the context before attempting to generalise to other areas.

The second consideration is my participation in the process. As an emerging researcher, I was learning and exploring as the study progressed. At times this took me down circuitous routes in terms of theorising and skill development. I have tried to be transparent in explicating the development of my thinking and analytical tussles throughout the thesis. Meanwhile, my practical skills for interviewing and observing were also refined during the course of the research as I learnt to think past professional concerns and question processes and assumptions. My development in these areas was evident when I re-interviewed some participants and could apply deeper analytical interview skills. On reflection, I may have gained greater depth of knowledge had the observation stage been longer. This was constrained by an inability to get buy-in from all team members and concern from team leaders that the research would impact on staff time.

Furthermore, my role of clinician-as-researcher added both strengths and limitations to the study. I had prior assumptions from working in the field, which I needed to acknowledge and set aside. Undertaking a self-interview was beneficial, as was listing

my assumptions as a reference point to return to when I was unsure if I was forcing interpretations on the data. Assumptions worked both ways however, and there were certainly times when participants assumed my understanding of a notion, based on my clinical background. Remaining alert for the ‘you know’ comments and probing deeper helped to counter this.

The third point to consider is the participant sample. Grounded theory methods do not use representative sampling and findings are abstracted away from individuals to reflect group patterns of behaviour (Charmaz, 2006). However, given the tenets of constructivist work, it is important to be aware of the data sources. My group of participants were predominately allied health workers and team leaders. While four participants were lay workers (not professionally trained), professional interactions form the basis of most of the data. It would be interesting to extend this work further with lay workers, carers and community organisations.

9.8 Reflecting on the quality of the research

As outlined in Chapter 3 and 4, I undertook this research using Charmaz’s evaluative criteria of credibility, originality, resonance and usefulness as a quality reference point. Returning to these criteria, credibility has been demonstrated with my self-reflection and transparency of process throughout the thesis. I have included both procedural decisions as well as reflections on areas in which I grew as a researcher. Links have also been established between data, analysis and concept development, which are logical and reflect the participant voice, with data presented for each aspect of the theory and categories.

The contributions of this study for practice, education and research have been addressed throughout this chapter. Three key findings have been presented that have implications for practice, education and research. Additionally, directions for future work have been suggested.

Resonance and usefulness are important criteria as they relate to the value of the study for participants and other practitioners. (Konradsen, Kirkevold, & Olson, 2013). I concur with Bryant’s (2009) view that ultimately good research is recognised by having theoretical insights and concepts that are useful and make a difference. This research has addressed resonance by taking the developing concepts back to participants during

the analysis. Through having regular feedback from participants, the categories remained grounded in areas of interest and need, resulting in concepts that participants recognise and ideas that can be put into practice.

Reflecting on my development as a researcher, I have found the PhD journey a time of both challenge and personal growth. I have enjoyed the process, although at times it has felt like a rollercoaster. While I have certainly cultivated my research skills, learning also came in unanticipated ways. Discovering how far I could push myself academically, working around roadblocks, and learning to debate my position have changed how I perceive the world. I acknowledge that this personal and professional development has no doubt impacted the research, and I have addressed this in Chapters 3 and 4. I hope that the completion of this work is not the end, but rather the start of my further development as I extend into new areas of research.

9.9 Concluding thoughts

I began this thesis with an observation by Charles Darwin that “those who learn to collaborate and improvise most effectively prevail.” This research has demonstrated the recurrent wisdom of Darwin’s words. Now, at the very end of this thesis, I would supplement this observation with the following statement by D.B. Reeves:

Collaboration, it turns out, is not a gift from the gods but a skill that requires effort and practice (2010, p. 50).

This research has added insights into how collaboration occurs as a purposeful, skilled process. Discovering and understanding how HCWs used collaborative processes drove this research project. Studying this area was important, as despite years of talking about collaboration and teamwork, mistakes in interprofessional working still occur. The results of this are not just resource inefficiency, but also adverse client events. Additionally, the current shortage of HCWs combined with a surge in healthcare need means new ways of working are needed. While collaborative practice has been advocated as a means of maximising health resources, little information existed about how this was enacted in the community context.

The aim of this study was to provide a theoretical explanation of collaborative practices in community rehabilitation teams, with relevance for clinical practice and for further research. This has been addressed through constructing a grounded theory of connecting and presenting a model of complexity management, which enables greater understanding of the community context.

A fundamental conclusion arises from this research in that: to enable interprofessional work in the complex community environment, connecting processes that enhance collaborative practice are needed. These processes are understood and prioritised differently by clinicians, team leaders, and organisations. The theory of connecting contributes to knowledge by explaining the context, strategies and perspectives HCWs used that resulted in enhanced collaborative practice. Findings can be used in clinical practice, by educators, funders, and for further research. Finally, by rendering an interpretation that people can use in practice, this thesis acknowledges the HCWs who go about the daily work of connecting in increasingly complex situations.

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Appendices

Appendix A: Researcher sensitising ideas and concepts

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Appendix A: Researcher sensitising ideas and concepts

MEMO 20/04/2011: My assumptions/ preconceived ideas pre-data collection

Entering this study I am aware that my professional and personal experiences, along with my broad knowledge of related literature may impact on how I interview participants. To identify this and guard against forcing my own ideas on participants I list the overt assumptions I currently hold here. This will allow me to reflect and compare my assumptions with emerging notions through the data collection.

- Scopes of Practice: I believe that this may arise as a defensive reason participants give for not collaborating. For staying within their professional boundaries and refusing to work outside their scopes of practice.
- Many HCWs in NZ are from overseas origins. Do they understand the local context? Will this impact on how they work with other HCWs? Is their understanding of collaborative practice different? Given the reports stating that poor cultural understanding contributes to health inequality across ethnic groups this is a consideration to be aware of when interviewing.
- Differing views of collaboration depending on the profession. It appears to me that some professions are more naturally aligned and work together well. i.e. physiotherapists and occupational therapists. Will this appear in the data? Is the relationship always positive? What about other professions? What impact could it have on broader team functioning?
- The impact of ACC contracts. I hold a perception that HCWs in ACC funded teams may practice collaboration differently than Ministry of Health salaried workers due to the funding models of paying for clinical treatment time. I need to let this preconceived idea go, and interview ACC funded workers with an open mind.
- Community setting. I begin this study with a perception that community based healthcare differs from that in hospital settings, but I don't know if HCWs perceive these differences, or act any differently because of them. If so, what does that mean to them? How do they identify it?

If these ideas arise during interviews I need to review the transcripts, and see if it was truly participant led, or if my assumptions directed the interview that way (forcing data). My preconceived ideas include both the personal assumptions listed above and the sensitising ideas and concepts arising from the pre-data literature review.

IPC sensitising ideas from the literature review:

- IPC models and processes are continually shifting, with frameworks not well understood by HCWs.
- Research indicates that IPC models can inform collaborative practices, but it is unclear whether these are operationalised within community healthcare.
- Collaborative processes are understood in varying ways such as levels, areas and mechanisms.
- When a team focuses on internal collaboration it may be at the expense of interagency collaborative practices.
- Interagency collaboration is driven by funding and structural issues and is slow to implement.
- Interprofessional education supports new graduates to be practice-ready to collaborate, but it is not known what effect these new workers have on collaborative practices in established teams.
- Interprofessional education may act to clarify and reassert professional boundaries.
- Positive outcomes from collaborative practice are seen in technical and interpersonal areas, impacting both client and worker favourably. However, failures to collaborate continue to occur, resulting in serious adverse client outcomes.
- The client view on IPC is under researched.
- HCWs generally perceive collaboration as beneficial for increasing communication, job satisfaction and retention, promoting a positive work culture and increasing communication and role understanding.
- Barriers to IPC remain and failures to collaborate have ramifications for workers, clients and organisations.

Sensitising concepts from these notions:

- Interprofessional knowledge and terminology was evolving.
- The impact of IPE was unclear at a practice level.
- IPC could positively impact team functioning and client outcomes.
- There was little information about IPC in community rehabilitation contexts.
- Funding parameters, profession-specific concerns and cultural aspects might influence HCWs response to IPC.
- HCWs perceived IPC as useful in principle, but there were barriers to implementation, and failures in interprofessional working continued.

Teamworking ideas from the literature review:

- Transprofessional teamworking is considered a model of practice that supports collaborative practices.
- Environmental structures such as staff co-location and facility resources may impact on IPC, with the effects in the community setting unknown.
- Diversity in team composition may be affected by professional hierarchical concerns. How this impacts community teamwork is less clear.
- Clear, effective leadership supports a positive work culture and enhances teamwork functioning.
- Calls for innovation in teamwork appear at odds with professional scopes of practice which limit role boundaries.
- Team meetings are reported to enhance IPC, yet it is unclear what place meetings hold for community HCWs, as they tend to meet less frequently.
- Teamwork communication failures were the most common cause of adverse client events, with communication seen as a task, rather than a process.
- Teamwork outcome measures are beginning to consider IPC, but at a local level the impact of collaborative practices on teamworking processes is unclear.

Sensitising concepts drawn from these ideas:

- Transprofessional teamwork and collaborative practice models were compatible.
- Teamwork was impacted by leadership performance, and professional hierarchies.
- Professional scopes of practice might influence teamwork processes.
- Teamwork communication failures were the most common cause of adverse client events, with communication seen as a task, rather than a process.
- Team meetings appeared to play an important role in teamworking.
- The environmental context could affect teamwork, with less known about the impact of the community context on teamworking.

Appendix B: Regional Ethics Committee approval



Northern X Regional Ethics Committee

Ministry of Health
3rd Floor, Unisys Building
650 Great South Road, Penrose
Private Bag 92 522
Wellesley Street, Auckland
Phone (09) 580 9105
Fax (09) 580 9001

16 May 2011

Pauline Penny
Great South Road
Albany
Auckland 0794

Dear Pauline

Ethics ref: **NTX/11/05/030** (please quote in all correspondence)
Study title: **Interprofessional collaboration: collaborative practice in community rehabilitation teams, Prot. V#1, 3/11: PIS/Cons V#1, 3/11**
Principal Investigator: Ms Pauline Penny
Supervisor: A/Professor Antoinette McCallin
Localities: Auckland University of Technology, Waitemata DHB

We thank you and your supervisor for attending the meeting on 10 May 2011. This study was given ethical approval by the Northern X Regional Ethics Committee at this meeting. A list of members of the Committee is attached. The Committee considered this study posed no risks to any participants and recognises that collaboration is used all the time in medical practice to the benefit of patients.

Approved Documents

- Protocol Version #1, March 2011
- Information Sheet/Consent Form V#1, March 2011
- Invitation to Participate V#1, March 2011

The Committee would also recommend the following

- Application:
- P.1: Professor Kath McPherson needs to be listed as co-investigator
 - Be aware that professional problems may arise

This approval is valid until 1 April 2013, provided that Annual Progress Reports are submitted (see below).

Access to ACC

For the purposes of section 32 of the Accident Compensation Act 2001, the Committee is satisfied that this study is not being conducted principally for the benefit of the manufacturer or distributor of the medicine or item in respect of which the trial is being carried out. Participants injured as a result of treatment received in this trial will therefore be eligible to be considered for compensation in respect of those injuries under the ACC scheme.

Appendix B2: AUT University Ethics Committee approval



MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

To: Antoinette McCallin
 From: Charles Grinter Ethics Coordinator
 Date: 5 July 2011
 Subject: Ethics Application Number 11/144 **Interprofessional collaboration: Collaborative practice in community rehabilitation teams.**

Dear Antoinette

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 13 June 2011 and I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 25 July 2011.

Your ethics application is approved for a period of three years until 5 July 2014.

I advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 5 July 2014;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. This report is to be submitted either when the approval expires on 5 July 2014 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

When communicating with us about this application, I ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of AUTEC, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Charles Grinter
 On behalf of Dr Rosemary Godbold and Madeline Banda **Executive Secretary**
Auckland University of Technology Ethics Committee

Cc: Pauline Penney, Kathryn McPherson

Appendix B3: District Health Board approval

Waitemata DHB Knowledge Centre: Approval of research study 13/07/2011

Dear Pauline,

The Knowledge Centre has now received the relevant approvals for your study:

Title: Interprofessional collaboration: collaborative practice in community-based rehabilitation teams

Registration #: RM 0980711631

Please continue to forward to us copies of any correspondence regarding on-going ethics approval for this study (if required).

Good luck with your study.

Regards,

Knowledge Centre
Waitemata DHB
(09) 4868920 ext 2071

Rose Smart

Decision & Research Support Manager | Knowledge Centre
Waitemata District Health Board
Private Bag 93-503
Takapuna
Phone: (09) 486 8920 ext 2071
Fax: (09) 442 7126
www.knowledgecentre.co.nz

Appendix B4: Second Regional Ethics Committee approval



7 December 2011

Northern X Regional Ethics Committee
Private Bag 92522
Wellesley Street
Auckland 1141
Phone: (09) 580 9105
Fax (09) 580 9001
Email: northernx_ethicscommittee@moh.govt.nz

Ms Pauline Penny

Dear Pauline

Re: Ethics ref: **NTX/11/05/030** (please quote in all correspondence)
Study title: Interprofessional collaboration: collaborative practice in community rehabilitation teams. Prot. V#1, 3/11; Prot/amend V#2, 11/11; PIS/Cons V#2, 11/11
Investigators: Ms Pauline Penny
Supervisor: A/Prof Antoinette McCallin

Thank you for your email of 24 November 2011 with changes to the study.

The amendment and documentation have been reviewed by the Deputy Chairperson of the Northern X Regional Ethics Committee under delegated authority.

Ethical approval is granted to:

- adding observational stage of data collection to the study
- Protocol amendment [version 2, dated November 2011]
- Information sheet/Consent Form (Observational phase) version [2, dated November 2011]
- Team Consent Form [version dated 20 November 2011]
- Participant Observation Form [undated, received 24/11/11]

Yours sincerely

Cheh Chua
Administrator
Northern X Regional Ethics Committee

cc: Waitemata DHB

Appendix C: Māori consultation



NORTH SHORE HOSPITAL

Shakespeare Road,
Takapuna, Auckland, NZ
Private Bag 93-503
North Shore 0740
Telephone: 09 486 1491
Facsimile: 09 486 8908
Freephone: 0800 809 342
www.waitemataadhb.govt.nz

Monday, 21 February 2011

Tena koe Pauline,

RE: Collaborative practice in community based rehabilitation teams

This letter is to advise that your application was discussed at the last meeting of the Nga Kai Tataki Maori Research Review Committee. We are pleased to advise that your application was approved.

This approval is subject to the condition that before proceeding researchers must advise any Maori participants that they should seek support from their own whanau, Kaumatua or Kuia or their local Maori Health Services.

Please send Nga Kai Tataki 'MRRC' a copy of the completed report once your research is finished.

Hei kona mai i roto i nga mihi.

Tanekaha Rosieur
Chairperson
Nga Kai Tataki 'MRRC'

Giovanni Maihi Armanco
Maori Research Advisor
Knowledge Centre

Appendix D: Study protocol

Collaborative practice in community rehabilitation teams



Study protocol

Study Design

This qualitative study uses grounded theory methodology to drive the research design (Charmaz, 2006; 2008). Grounded theory aims to discover the social processes that shape interaction and behaviour. This is appropriate to the aim of this research, which is to construct a theoretical explanation of interprofessional collaboration in community rehabilitation teams. This research follows the tenets of constructivist grounded theory as described by Charmaz (2000, 2006, 2008).

Constructivist grounded theory aims to learn about social worlds (participants' lives and actions), and tries to understand both explicit and implicit perspectives. Salient features of constructivist grounded theory include notions that both data and analyses are emergent social constructions, are value related, and are situated in time, space and culture (Bryant & Charmaz, 2007). This is important for this study, as it allows the significance of the New Zealand community setting to be explored.

Research questions

Grounded theory methodology is inductive, beginning with a broad topic and initial questions that provide a starting point for exploration, rather than hypotheses to answer (Bryant, 2002; Charmaz, 2008). The starting point for this study is the topic Interprofessional collaboration in community rehabilitation teams in New Zealand, and the initial research questions are:

- How do health care workers view interprofessional collaboration in the community rehabilitation teams where they work?
- How do health care workers explain/construct their collaborative actions in community rehabilitation teams?
- In what circumstances do their actions change and why?

Research Methods

Grounded theory utilizes differing sampling methods at different stages of the study. This is a two phase study, commencing with interviews of healthcare workers (health professionals, care assistants, volunteers). The second phase involves field observations of health care workers who have participated in the initial interviews and have indicated that collaborative practices are occurring in their teams.

Sampling: Interview phase

For the interview phase, purposive sampling will initially be used to recruit health care workers from a variety of community rehabilitative health settings. Purposive sampling is used to deliberately source participants who will provide rich data. Hence it fits well as a sampling method in a grounded theory study (Creswell, 2003; Denzin & Lincoln, 2003).

Because the literature to date has focused on nurse/doctor collaborations in the community, I will purposively sample for a wider range of health care workers. For example physiotherapists, occupational therapists, speech language therapists, psychologists, social workers, care assistants, volunteers, as well as doctors and nurses. As the literature review suggested team setting may also be an area of interest in this study, I will initially sample participants from a range of community settings. This may include: travelling community rehabilitation teams; clinic-based rehabilitation teams; ACC contracted rehabilitation teams and private rehabilitation teams.

As the research develops and categories emerge from the data, theoretical sampling will be used, where participants who can add pertinent data to develop the emerging theoretical categories are interviewed (Hesse-Biber & Leavy, 2008). For example, should a category emerge suggesting 'leadership' is an important category, team leaders may be interviewed.

Participants for individual interviews will be sourced from one District Health Board and from private rehabilitation agencies (e.g. ACC contracted teams). Following ethical approval, I will contact the team leader of the organizations to explain the research and ask them to email an invitation to participate to members of their teams. People expressing interest will then contact the researcher who will discuss the study further and send them the information sheet before arranging interviews. Once the first few participants have been recruited, snowballing procedures (Bryant & Charmaz, 2007) may also be used, whereby a participant suggests names of other potential participants for the researcher to contact. During the snowballing and theoretical sampling stage, I will approach the potential participants directly, via phone or email contact, and follow the same procedure of discussing the study and sending them the information sheet before arranging interviews.

Sampling: Observational phase

During the interviews, participants who described examples of effective collaborative practice within their community teams were asked if they would be interested in participating in a possible observational phase of the research. Several people indicated interest. From this, two health care teams have been chosen in which to undertake field observations, after several participants indicated during interviews that effective collaborative practices were occurring in these settings. Up to 5 individuals from each setting will be observed by the researcher shadowing them specifically, with interactions with other team members noted as well. The sample size reflects the number of people interviewed from these two teams who expressed interest in being part of the later observation phase.

Following ethics approval these individuals will be emailed to confirm they are still interested in participating, with new information forms sent. Their team leaders will then be approached again to ask for permission to follow the individual health care professionals, observing their interactions and collaborative practices with other team members.

A team consent form will also be sent to the team leaders, asking for consent from the whole team for the researcher to be present on site, observing professional interactions. This means that even though I am focusing on one person's interactions, I am able to capture observational data on interactions with the whole team. If people come in who are not part of the team and hence have not consented I will not include them in observational data.

Data Collection: Interviews

Data will be collected from individual interviews with health care workers. Approximately 20-25 interviews will be undertaken. This number is based upon Charmaz's (2006) views that in medium sized studies approximately 25 interviews should suffice to reach theoretical saturation, a point in theoretical development when new data no longer reveals further theoretical insights or properties of the core categories (Bryant & Charmaz, 2007). Interviews are expected to take approximately one hour, with permission being requested to hold a follow up interview or phone conversation if the analysis of the first interview indicates it would be beneficial to the emerging theory.

The initial interviews will be non-structured, starting with broad generative questions, based on the sensitizing concepts found through the literature review. These are designed to prompt the participant to respond to the general topic, on their terms. For example: "Tell me about working with others in your team" or "If I was to say, "Interprofessional collaboration, what springs to mind?" Successive questions are based on previous responses so that the participant always leads the interview. This follows the grounded theory principle to remain open to what is actually happening and to allow the participants to discuss issues of relevance to them (Charmaz, 2000). As the study progresses, constant comparison of the data during analysis leads to subsequent interviews become semi-structured, using focused open-ended questions to explore and define the emerging categories (Charmaz, 2006). Data collection will continue until theoretical saturation occurs, as described above. Interviews will be conducted at places and times negotiated between the researcher and participants. Participant consent will be gained for interviews to be tape-recorded and transcribed and notes taken during the interviews. I will transcribe some of the data, with the rest being done by a professional typist, who will sign a confidentiality form (Appendix E).

Data Collection: Observational Phase

Following grounded theory methodological principles, field observations will be used as a means of deepening understanding of my developing theoretical categories, checking perceptions with observed practice and developing further properties within my categories. Interviewing and observations fit well together as a dual means of data collection, with Loftland & Loftland declaring the 'mutuality of interviewing and participant observation as a central technique of naturalistic investigation' (1995; p19). Because participant observation

is used to give direct evidence of observed processes rather than reported accounts, it can assist in triangulating data already collected through interviews, thereby strengthening the overall theory (Ovretveit, 1998).

Data will be collected during field observations using a participant observation form (Appendix J) adapted from Morse and Field (1995), then written up with memos and analyzed using the constant comparison method with the interview data. Observations will be undertaken of professional interactions in settings such as team meetings, informal debriefings, lunchroom chat, and possibly even in the car if health care workers are going out on joint visits. The observations may take place over several days and times to suit the participants, with a maximum total time of one day per person being observed. No observations of clinical treatment or patient/client interactions will be undertaken. The researcher will remove herself from the room during treatment sessions.

Data analysis

In grounded theory, data collection and analysis occur concurrently and iteratively, each informing the other throughout the study in a cyclical process. As data is collected from interviews it is coded into categories using the constant comparative method of analysis. The emerging codes and categories posit potential lines of inquiry, which sends the researcher back for more focused data collection to deepen understanding and ground the developing concepts in data.

Throughout this process, memo-writing is used as a means for the researcher to analyse data. Memoing is a key grounded theory tool, allowing researchers to freely explore their ideas about emerging categories and helping to increase the theoretical level of abstraction (Charmaz, 2006). Memoing continues throughout the study and is used in the final write up to explain to readers how the researcher developed the concepts.

As the researcher continues to categorize and write memos, the conceptual level rises from descriptive to more abstract theoretical categories. To assist with conceptualization both action and analytical questions are asked of the data. In particular, two defining questions are asked repeatedly: 'What is happening here?' and 'What theoretical category are these data a study of?' (Charmaz, 2008, p. 161). If the category has not been fully explored, the researcher may then return to the field for further focused, theoretical sampling (either more structured interviews or observations of a specific area) which extends the properties of the developing categories, always comparing with data to ensure the developing theory is grounded in the data.

Once the final categories are established, the researcher then defines their properties, the conditions under which the categories operate, the conditions under which they change and their relationship to other categories. The most significant theoretical categories become the concepts of the grounded theory (Charmaz, 2001, 2006).

Appendix E: Invitation to participate

Invitation to participate in a research project



Topic: Collaborative practice in community rehabilitation teams

Principal Researcher: Pauline Penney

Kia ora/ Hello,

I am a physiotherapist working in community rehabilitation and undertaking study towards a PhD. I would like to invite health care workers involved in community rehabilitation teams to participate in my study.

What is the purpose of the study?

To develop a better understanding of how health care workers (health professionals, care assistants, volunteers) collaborate in community based teams. The study will explore the processes influencing collaborative practices in local community rehabilitation teams.

What does it involve for participants?

You will be asked to take part in an interview lasting approximately one hour. This will be at a place and time of your choosing. During the interview you will be asked about your experiences and thoughts about collaboration in a community rehabilitation team.

I hope to interview a wide range of people with different professional backgrounds and experiences and from a range of community settings. To participate in the study you will need to be able to communicate in English during an in-depth interview.

Your participation is totally voluntary and you do not have to answer any question you may feel uncomfortable with. All information you give me will be kept confidential and your name will not be known to anyone but the researcher.

How will this study help?

The findings will contribute to an understanding of the ways in which community health teams work. It is hoped that the findings will provide information about collaborative practices and inform future resource management and policy development. Groups to potentially benefit from the findings include community health teams, health funders, Health Workforce NZ and organisations that train health professionals. Developing understanding in this area has the potential to ultimately improve the quality, efficiency and effectiveness of service delivery to clients and their

What do I do if I'm interested in participating in the study?

If you are interested in participating in this study please contact the principal researcher, Pauline Penney

Email: ppenney@aut.ac.nz

Thank you for considering this request – your participation would be greatly valued.

Statement of Approval

This study has received ethical approval from the Northern X Regional Ethics Committee Approval number NTX/11/05/030

Appendix F: Information sheet - Interviews

Collaborative practice in community rehabilitation teams



Participant Information Sheet - Interviews

Kia ora, Hello,

You are invited to take part in a qualitative study exploring collaborative practices in community rehabilitation teams. The study involves two phases: a) individual interviews of health care workers followed by b) observations of a community based team. This information sheet refers to phase A, the interview phase. Should your team be chosen for phase B you will be provided with a separate information sheet and consent form. Please note:

- Your participation in this study is entirely voluntary. You do not have to take part in this study, and if you choose not to take part this will not affect your employment in any way.
- If you do agree to take part you are free to withdraw at any time, without having to give a reason.
- During the interview, you do not have to answer all the questions, and you may stop the interview at any time.
- Information you give me will be kept confidential and your name will not be known to anyone but the researcher.

What is the purpose of the study?

To develop a better understanding of how health care workers collaborate in community rehabilitation teams.

How will this study help?

The findings will contribute to an understanding of the ways in which community health teams work together. It is hoped that the findings will provide information on collaborative practices and inform future resource management and policy development. Groups to potentially benefit from the findings include community teams, government departments, ACC, District Health Boards and organisations that educate health professionals. Developing understanding in this area has the potential to improve team collaborative practices, increase staff job satisfaction and ultimately improve the quality and effectiveness of service delivery to clients and their families.

How are people chosen to be part of the study?

For the interview stage of the study I will be contacting the team leaders of community rehabilitation teams in the Auckland area. They will be asked to email an invitation to participate to all team members who can then contact me to discuss the research further. Participants may also approach me directly if they hear about the research from colleagues.

Who is eligible to participate?

I aim to interview 20- 25 health care workers involved in community rehabilitation teams in one District Health Board (Waitemata DHB) and from private agencies in the Auckland region. I hope to interview a wide variety of people with different backgrounds and experiences and from a range of community settings. For example nurses,

physiotherapists, occupational therapists, speech language therapists, psychologists, social workers, doctors, lay health care workers. To participate in the study you will need to be able to communicate in English during an in-depth interview.

What happens in the study?

If you agree to take part in the study, you will be interviewed about your views and experiences of collaboration in a rehabilitative community health team. I will ask you to talk freely and in detail about any aspects of collaborative working that interest or concern you. The interview will take about 1 hour and will be held at a time and place convenient for you. You may be asked for permission to contact you again at a later stage to clarify points raised through the interview. The interview will be audio-taped. You are welcome to bring a support person to the interview.

What are the possible discomforts and risks?

I do not anticipate any discomfort or risk to you from participating in this study, as the interview is led by you. What you discuss is totally in your control. I hope that you will feel comfortable during the interview, however if you feel that any topic may cause you distress, you do not have to comment on it. In the unlikely event that any discussion raises issues that are distressing or stressful to you, I would refer you to an appropriate professional for support, such as your GP or a counsellor.

Are there any costs to participate in the project?

It is not anticipated that there will be any cost to you except your time. The interview should take approximately 1 hour to complete. I anticipate travelling to a place of your convenience for the interview, but should you incur any travel costs getting to an interview location, this will be reimbursed in the form of petrol vouchers.

How will my privacy be protected?

All information you give me will be kept confidential and your name will not be known to anyone but the researcher. Your interview will be given a code and the answers you give will not be able to be tracked back to you. I will keep the consent forms and interview tapes and transcripts locked in cabinets, in separate locations. You may ask for a copy of your transcript and at the end of the study tapes and transcripts will be destroyed. A summary of the completed research will be made available to participants, health care agencies and the wider community. However, no material that could personally identify you will be used in any reports on this study.

What will happen with the results?

The full details of the study will be written up as a PhD thesis, which will be available to the wider public once completed. I also plan to publish the results of this study in a rehabilitation journal.

Will I be able to have a copy of the results?

If you would like a summary of the completed study it can be sent to you at the end of the study. Because this study is part of a three year doctorate, there will be a delay between collecting information and letting people know about the results. I anticipate completing the study in April 2013.

If you have any concerns or questions?

Please feel free to contact the researcher or my supervision team if you have any questions about this study:

Name: **Pauline Penney**
 Email: ppenney@aut.ac.nz
 Position: Principal Researcher & PhD student at AUT University

Name: Assoc Prof Antoinette McCallin ph 921-9999 ext 7884
 Email: Antoinette.mccallin@aut.ac.nz
 Position: Principal PhD Supervisor

Name: Prof Kathryn McPherson ph 921 9999 ext 7110
 Email: katmcphe@aut.ac.nz
 Position: PhD Supervisor

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact either your professional organisation or a Health and Disability Advocate - phone 0800-555-050. Email: advocacy@hdc.org.nz

To ensure ongoing cultural safety Nga Kai Tataki – Maori Research Review Committee Waitemata DHB encourage those who identify themselves as Maori and who are participating in health research or clinical trials to seek cultural support and advice from either Mo Wai Te Ora – Maori Health Services or their own Kaumatua or Whaea. For assistance please contact the Services Clinical Leader or Mo Wai Te Ora – Maori Health on 09 486 1491 x 2324 or the Maori Research Advisor on 09 4861491 x 2553

Statement of Approval

This study has received ethical approval from the Northern X Regional Ethics Committee; ethics reference NTX/11/05/030

Appendix F2: Information sheet - Observations

Collaborative practice in community rehabilitation teams



Information Sheet for Participant Observation

Kia ora, Hello,

You are invited to take part in a qualitative study exploring collaborative practices in community rehabilitation teams. The study involves two phases: a) individual interviews of health care workers followed by b) observations of a community based team. This information sheet refers to phase B, the observational phase.

Please note:

- Your participation in this study is entirely voluntary.
- If you do agree to take part you may still ask for the observation to stop at any stage
- Information you give me will be kept confidential and your name & team name will not be identifiable in the finished study.

What is the purpose of the study?

To develop a better understanding of how health care workers collaborate in community rehabilitation teams.

How will this study help?

The findings will contribute to an understanding of the ways in which community health teams work together. It is hoped that the findings will provide information on collaborative practices and inform future resource management and policy development. Groups to potentially benefit from the findings include community teams, government departments, ACC, District Health Boards and organisations that educate health professionals. Developing understanding in this area has the potential to improve team collaborative practices, increase staff job satisfaction and ultimately improve the quality and effectiveness of service delivery to clients and their families.

How are people chosen to be part of the study?

I am approaching individuals who indicated during the interview stage that their team used effective collaborative practices in their team working and that they would be interested in participating in the second phase of observations.

What happens in this phase of the study?

I will shadow you as you go about your normal professional practice and observe your interactions with other health care workers (I will also obtain permission from the rest of your team to undertake these observations). This could take place over several small blocks of time or over one day, depending on what suits you best.

I will *not* be observing clinical treatments or interactions with clients, and would leave the room during these times.

What are the possible discomforts and risks?

I do not anticipate any discomfort or risk to you from participating in this study, as I am not observing individual professional practice but rather aiming to observe patterns of typical working practices across team settings. I hope that you will feel comfortable having me present, however if there are any times where you wish for privacy I would of course remove myself from the room.

Are there any costs to participate in the project?

It is not anticipated that there will be any cost to you except your time.

How will my privacy be protected?

All information you give me, or that I observe will be kept confidential. A summary of the completed research will be made available to participants, and the wider community, however no material that could personally identify you or your team will be used in this study.

What will happen with the results?

The full details of the study will be written up as a PhD thesis, which will be available to the wider public once completed. I also plan to publish the results of this study in a rehabilitation journal.

Will I be able to have a copy of the results?

If you would like a summary of the completed study it can be sent to you at the end of the study. Because this study is part of a three year doctorate, there will be a delay between collecting information and letting people know about the results. I anticipate completing the study in April 2013.

If you have any concerns or questions?

Please feel free to contact the researcher or my supervision team if you have any questions about this study:

Name: **Pauline Penney**
Email: ppenney@aut.ac.nz
Position: Principal Researcher & PhD student at AUT University

Name: Assoc Prof Antoinette McCallin ph 921-9999 ext 7884
Email: Antoinette.mccallin@aut.ac.nz
Position: Principal PhD Supervisor

Name: Prof Kathryn McPherson ph 921 9999 ext 7110
Email: katmcphe@aut.ac.nz
Position: PhD Supervisor

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact either your professional organisation or a Health and Disability Advocate - phone 0800-555-050. Email: advocacy@hdc.org.nz

To ensure ongoing cultural safety Nga Kai Tataki – Maori Research Review Committee Waitemata DHB encourage those who identify themselves as Maori and who are participating in health research or clinical trials to seek cultural support and advice from either Mo Wai Te Ora – Maori Health Services or their own Kaumatua or Whaea. For assistance please contact the Services Clinical Leader or Mo Wai Te Ora – Maori Health on 09 486 1491 x 2324 or the Maori Research Advisor on 09 4861491 x 2553

Statement of Approval

This study has received ethical approval from the Northern X Regional Ethics Committee; ethics reference NTX/11/05/030

Appendix G: Consent form - Individual observations

Collaborative practice in community rehabilitation teams



Individual participant Consent Form: Observational phase

- I understand the purpose of the observations and have had the opportunity to read the information sheet about this study and to have any questions answered to my satisfaction.
- I acknowledge that the research will involve the principal researcher following me as I go about my normal working day, observing and taking notes on my interactions with other health care workers. It will *not* involve observations of any clinical treatments or interactions with clients.
- I understand that I can ask for the observation to stop at any time, or for the researcher to leave the room if a sensitive topic is being discussed.
- I understand that I will not be identifiable in the study, either by individual name or by the team being named and that the information gained will be used only for the purposes of this study and the research outputs.

Please complete the following:

I _____ (full name) consent to take part in the observational part of this study.	
Participant Signature	
Date:	
Full names of researcher	Pauline Penney
Contact number for researcher:	
Project explained by:	Pauline Penney, primary researcher

Appendix G2: Consent form - Team observations

Collaborative practice in community rehabilitation teams



Team Consent Form

This team acknowledges that:

- We understand the purpose of the observation and have had the opportunity to read the information sheet about this study and to have any questions answered to our satisfaction.
- We understand that any one of us can ask for the observation to stop at any time.
- We understand that we will not be identifiable in the study, either by individual name or by the team being named and that the information gained will be used only for the purposes of this study and the research outputs.

- *Please indicate your consent below:*

Name	Signature	Date

If you have any questions about signing this form please contact the principal researcher:

Pauline Penney

Appendix G3: Consent form - Interviews

Collaborative practice in community rehabilitation teams



Participant Consent Form: Interview phase

- I have read and I understand, the information sheet (dated Mar 2011) for volunteers taking part in the study 'Collaborative practice in community rehabilitation teams'. I have had the opportunity discuss this study and I am satisfied with the answers I have been given.
- I have had the choice and opportunity to use family/whanau support or a friend to help me ask questions and understand the study if required.
- I understand that taking part is entirely voluntary and that I may withdraw from the study at any time and this will in no way affect my employment.
- I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.
- I understand that the interview will be stopped if I request it, or if it appears to be causing me any type of distress.
- I have had time to consider whether to take part in this study and I know who to contact if any issues arise from participating in the study, or if I have any questions about the study.

Please complete the following:

I _____ (full name) hereby consent to take part in this study.	
I wish to receive a copy of the results	Yes <input type="radio"/> No <input type="radio"/> Please tick
I consent to my interview being audio-taped and transcribed.	Yes <input type="radio"/> No <input type="radio"/> Please tick
Participant Signature	
Date:	
Full names of researcher	Pauline Penney
Contact number for researcher:	
Project explained by:	Pauline Penney, primary researcher
Signature & Date:	

Appendix H: Transcriber confidentiality agreement

Collaborative practice in community rehabilitation teams



Confidentiality Agreement

Principal Researcher	Pauline Penney	Ph:
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For a typist transcribing audiotapes:

- ☐ I understand that all the material I will be asked to transcribe is confidential.
- ☐ I understand that the contents of the tapes or recordings can only be discussed with the researcher(s).
- ☐ I will not keep any copies of the transcripts nor allow third parties access to them while the work is in progress.

Transcriber's signature:

Transcriber's name:

Transcriber's Contact Details:

.....

Date:

Project Supervisor's Contact Details:

Associate Professor Antoinette McCallin
 Email: antoinette.mccallin@aut.ac.nz
 Phone: 921 9999 ext. 7884

This study has received ethical approval from the Northern X Regional Ethics Committee
 ethics reference NTX/11/05/030

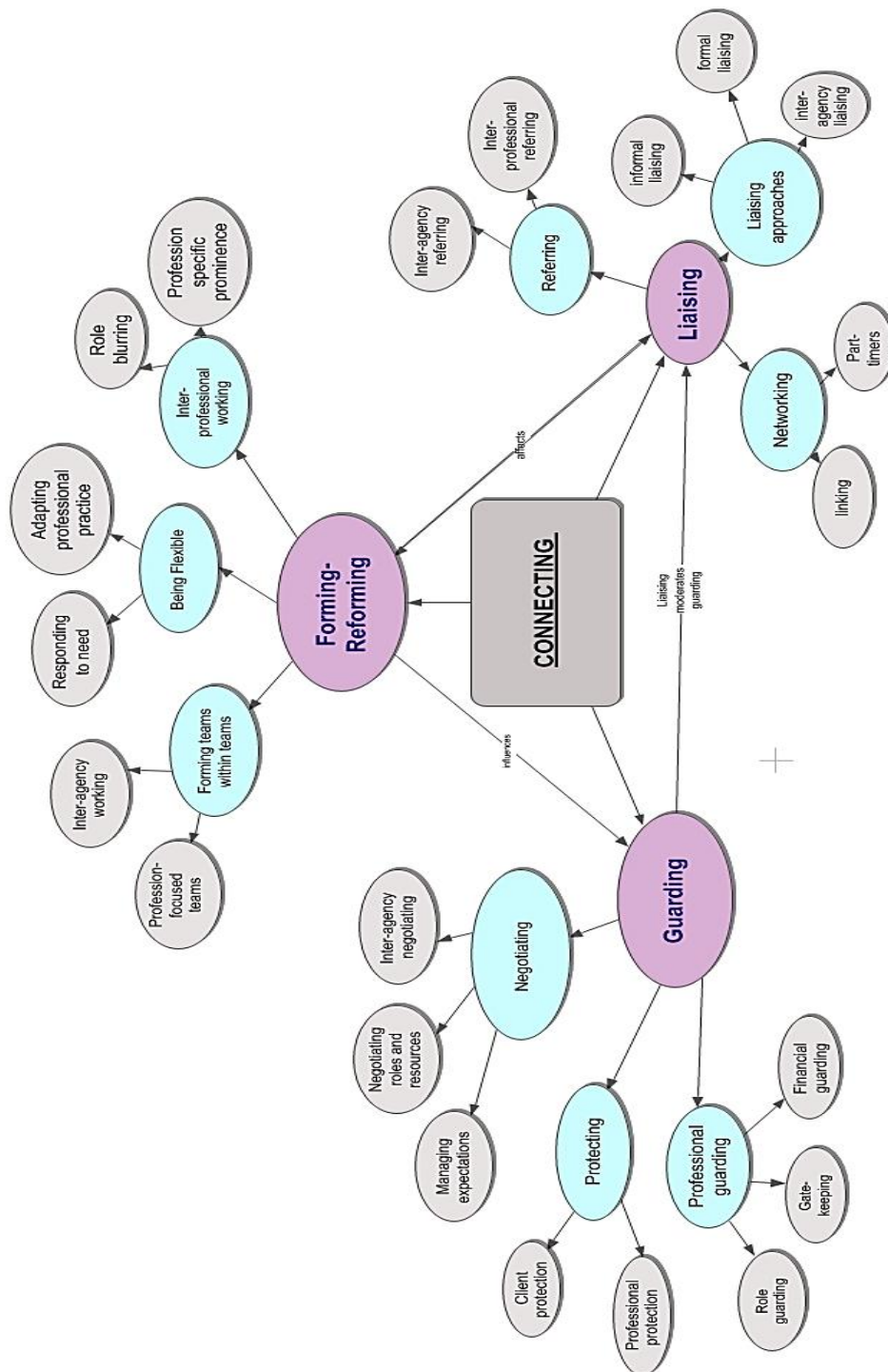
Note: The transcriber should retain a copy of this form.

Appendix I: Memo - Participant interviewing

15/08/2011 Interview Sampling memo I'm under pressure from _____ team to work through their interviews in a reasonably tight timeframe (one month). The team leader does not want the study to be a distraction, and does not want to have interviews going on over several months. Hence, I have to do the interviews with hardly any time between. This means I have to move quickly to code and develop leads and early categories for the subsequent interviews. I'm sure this time pressure impacts the research process (especially my coding and reflexive process), and wonder if it will be noticeable later when I reread these particular transcripts. However, while not ideal, this is research in the real world and represents a condition imposed beyond my control. I must make sure I comment on this in my write-up as a limitation/learning point.

Plan: I will delay organising any more interviews with people from other organisations after this round, to give myself time to absorb and analyse these transcripts before going further.

Appendix J: Cluster diagram - Late stage of analysis



Appendix K: Observation form

Collaborative practice in community rehabilitation teams



Participant Observation form (adapted from Morse & Field, 1995)

Team name:

Date:

Start time:

Finish time:

Location of observation:

Goals of observation:

People present:

Description of environment: (layout, any physical patterns, significant objects, placement of people & furniture)

Non-verbal behaviour: (voice tone, posture, expressions, eye & body movements, forcefulness of speech)

Content of interactions between HCW: (key words, topics, focus, exact phrases that stand out)

Researcher's impressions: (participant responses to topics, people, events or objects)

Analysis: (eg, research questions, hunches, trends in data & emerging patterns)

Situational issues: (eg timing of meetings, interruptions, people coming & going, available material for decision making)

Appendix L: Coding example

Um,...good question... Yeah I think it becomes personality based then. That comes into play, how you personally feel about that. I'm not sure...maybe when you're new in a job, when you're new somewhere you're probably more guarded initially because you're trying to prove yourself in a place. And so you're not quite sure...personally speaking I don't like to see myself as failing and so if people are coming into what I think is my domain, I might defend it more heavily because I might think "Oh god, they think I'm no good at my job – they need to do it for me because I'm not doing good enough" So there can be that perspective. But that's personality based. Some other people that might not bother them, they'd just go "Hey I'm new, I'm here to learn, let me just absorb it and find out where I fit in"

And then when you are experienced in a job does the reverse occur? Are you happy or not for others to do a bit of your 'traditional' role?

Yeah, I think if I feel someone is competent to do that, from my professional judgment then I would be happy with that. I think the more that we're not relying on Mrs Speechie to be in there for things to happen, the greater the support for the individual. Otherwise we're taking away, it's becoming about us and not about them.

And that's what I have to remind myself about. It's not about my limitations, or my expectations of myself, it's about 'what are our expectations as a team for how we can best support this person and their family'

So it's about keeping the focus on the outcome for the client?

Yes, and if we're not clear about what that is, then that's where we can fall down. Because if we don't have a clear team picture of where we're headed then perhaps we can become pigeon holed and focused on doing just our own little bit...and if you were to base line and look 6months later at what the person can do....well maybe you see they can speak a few more high frequency words, but really is that all they've achieved in the time – just your little area of focus?

I see...and when you look at working in the community as opposed to working in say a hospital setting, is there something different about the community that let's that broader working focus occur?

I think we tend to have a stable staff and a stable group of clients...we're seeing them here over a longer period...you get that longevity .so you can go "ok, I don't have to fix this today" And giving yourself permission to say "I don't have to fix this today" is quite a big step for some of us. But it's good to be able to say as a team " ok, we've got time to try and work through some things for this person. Because we're thinking about their whole life, not just discharge from an acute setting. We're not just getting a

Guarding linked to personalities & new job role
↓
insecurity
"not doing a good job"

Personalities
Newness in role
Guarding roles
Guarding self
Guarding ⇒
Newness &
insecurity in role
Personalities again
Absorbing role

Thinking in a team rather than individual way
→ perspective

Role openness
Greater client support

Quote

Clarity – Clear

Clarity in team → client outcomes
Who directs achieving this clarity??

Minimising prof. specific focus

? Longer-term treatments in community
↓
? facilitate holistic work

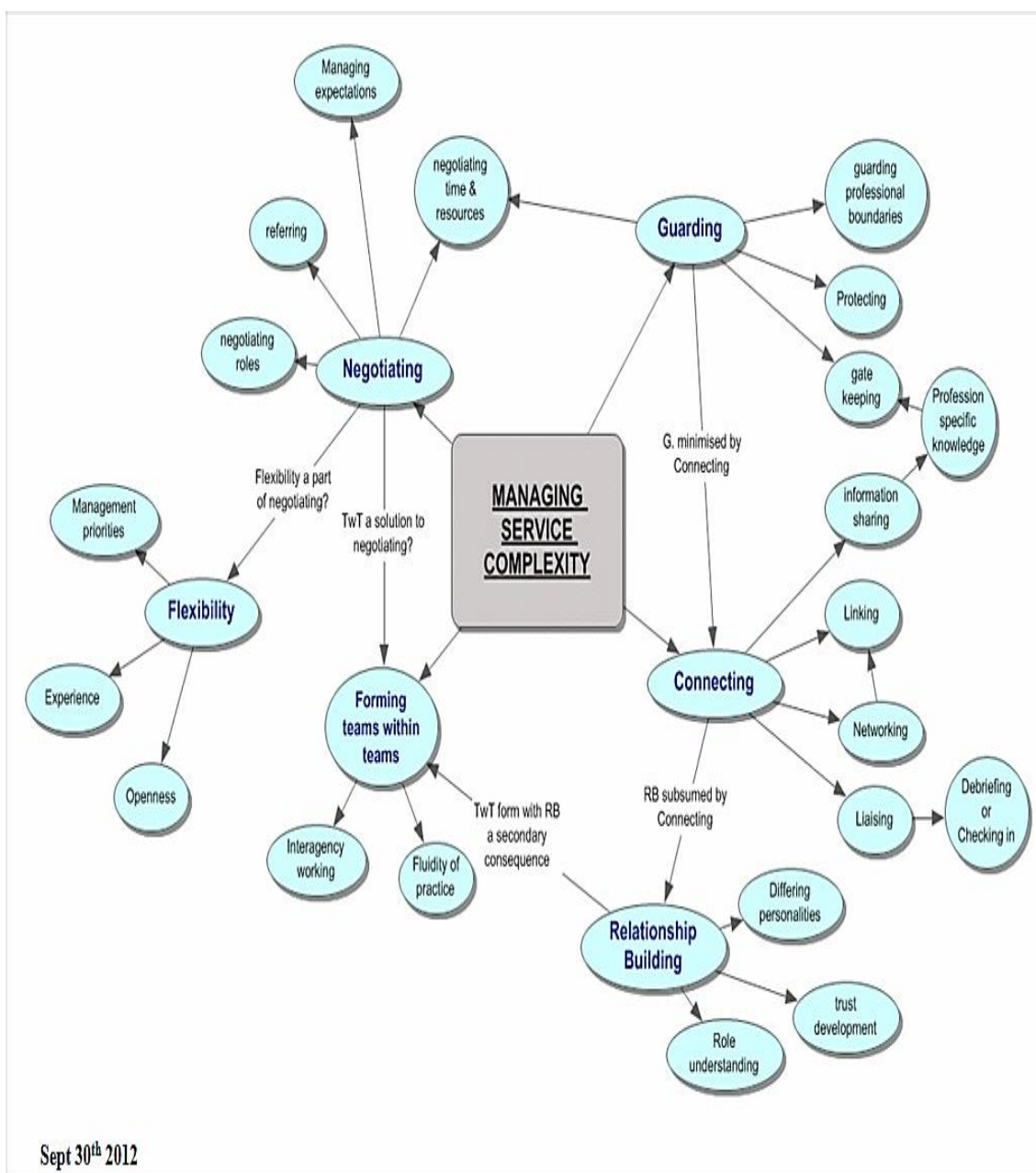
Developing client relationships over time
Self-monitoring
Holistic focus

Appendix M: Coding summary

(Note: The page of coding in Appendix M translates to the summary [in bold] below).

Pg.	My codes, line reference, evidence/ quotes	Memos
1	Interprofessional knowledge, 6 Vision sharing, 7 Joint/integrated notes, 28	CP = common vision & knowing what each other is doing Joint notes work to increase transparency and info sharing. Documentation is needed to increase clarity and planning
2	<i>"I like that system [integrated notes] of being able to delve into the minds of others, without having to bother them. So I can see what they're thinking when it suits me"</i> 1-2 Informal debriefing, 5 Co-location, 8 <i>"So much valuable learning and exchange of ideas and problem solving goes on naturally when you're together in the same building."</i> 8 Professional practice talk / professional debriefing, 19/20 Integrated approach 26 Professional Knowledge sharing 27 <i>"We're all pushing for a more integrated approach here of different disciplines. And so the knowledge has to be shared across those different disciplines. We have to take differing bits of knowledge from differing professions and ask 'well how does that work for the person or their family?'"</i>	Co-location gives natural opportunities to debrief (16). Need to make the time to connect if not co-located – easy to feel isolated (14). Professional PD occurs casually & informally "on the fly" when co-located 22 Collaboration and prof knowledge sharing linked to improving practice/service with the client. Lack of CP leads to unwieldy team practices and poor planning for the client, with a risk of compartmentalising the client rather than seeing their whole needs.
3	Lacking role understanding, 6 Professional labelling and assumptions, 7 Gaining role knowledge informally through working together, 19, 25 Joint visits, 27, 31 Overlapping roles, 36	People's jobs are titles that others understand in differing ways and make differing assumptions about. Need to have experience of working with that profession and that individual to know what that person brings (quote 6-9). Use of role explanation as part of PD aids integration and CP
4	Role guarding, 3 Role openness, 13-14 <i>"I think the more we're not relying on Mrs Speechie to be in there for things to happen, the greater the support for the individual. Otherwise, we're taking away, it's becoming about us, and not about them. And that's what I have to remind myself about. It's not about my limitations, or my expectations of myself, it's about "what are our expectations as a team for how we can best support this person and their family"</i> 14-19 Clarifying team focus, 22 Developing client relationships over time, 31 Holistic focus in community, 34	Role guarding linked to personality, newness in role, trying to prove yourself and confidence (1-9) Role openness increases support for client and empowers client by not relying on one professional. Openness is supported by not thinking about yourself as an individual professional but looking at a team perspective of how best to assist the client Clear team focus on overall client outcomes, minimises profession specific focus

Appendix N: Cluster diagram - Early stage of analysis



Appendix O: Analysis - Conceptualising questions

Questions to consider when analysing and constructing categories

Adapted from Charmaz, 2006 and Glaser, 1978 (6 C's)

1. What main actions/processes are occurring?

2. What is the process of X (category) about? (How does this process develop? How does the participant act while involved in this process? What do they profess to think and feel while involved in this process? From Charmaz, 2006)

3. What are the properties of X category? (Establish parameters; describe how minor categories are incorporated into this category)

4. What are the conditions under which X arises, is maintained & changes? (When, why, and how does this process change?)

X arises...

X is maintained by...

What changes X behaviours?

5. What are the variations in these conditions? (How do differing people think, feel and act while involved in X?)

6. What perspectives might people be acting from when engaged in X?

7. What are the consequences of X? (Observed and predicted consequences to explore further)

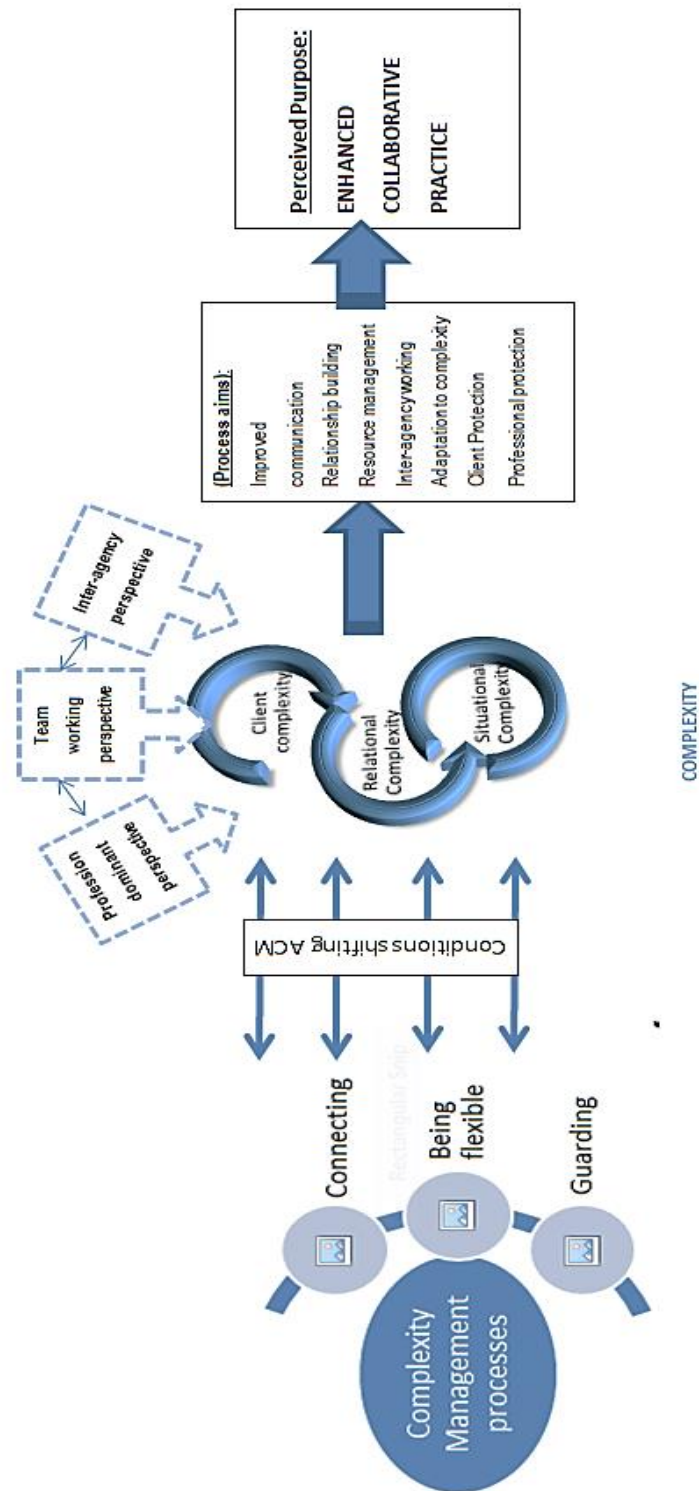
LATER ANALYSIS:

What is the wider context of X in other areas?

Are there pre-existing theories which might explain X? (If so, what is similar, and what is different about this concept from extant literature?)

Appendix P: Theory overview - Mid analysis

Active Complexity Management 09.12.12



Appendix Q: Memo - Perspectives

Date: 15/07/2012

Topic: perspectives continued

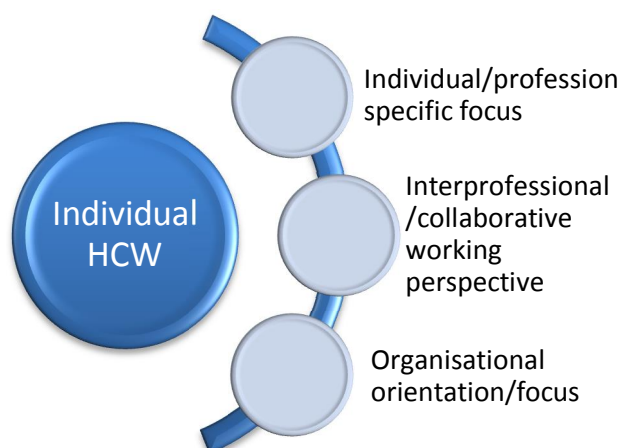
Key words: perspectives, pendulum

Memo:

I am currently considering there may be three main perspectives HCWs can operate from:

- 1/ The HCW as individual professional where a HCW makes decisions based on their individual treatment and discipline specific perspective (e.g. as a physiotherapist)
- 2/ the HCW working interprofessionally/ collaboratively as a member of a team. Here the HCW prioritises working with others. In this perspective the HCW may be more fluid to shift according to need of other team members.
- 3/ The organisational perspective where the focus is on systems and processes, administrative requirements, boundaries, team meetings. QN: Does interagency work fit here?

Under this model, no-one perspective is any better than another, they each have their own contribution and all are needed for HCWs to work effectively in the community setting. A HCW can operate from any or all of these perspectives within one day. At the moment I am thinking about a pendulum to describe the movement and shifts between perspectives (see below)



Relevant authors using pendulum descriptors:

Livneh and Parker (2005) article relating to pendulum models:

"Pendular Models: Developed to account for the often-reported swings between pre-disability and post disability identities or between illness and health, pendular models have sought to portray the process of psychosocial adaptation to permanent disability as a series of gradual changes in self-identity along a pendular trajectory (cf., Charmaz, 1991, 1995; Kendall & Buys, 1998; Yoshida, 1993).

...After reviewing the research of Charmaz (1983, 1995) and Yoshida (1993), Kendall and Buys (1998) concluded that the pendular model aptly describes the constantly shifting self-perceptions of people with disabilities from their pre-disability self to their post disability identity and back again. Similar dual-directional paradigms are found in the literature on coping with the death of a loved one, in which the bereaved person is described as oscillating between loss and restoration-oriented coping (see Stroebe & Schut, 1999)".

QUESTIONS TO CONSIDER:

Under what conditions do HCW locate/focus in one perspective more than other? What causes them to shift? Do some of the concepts such as experience, openness, or guarding influence a shift in perspectives?

If each perspective represents a shift in priority/focus how does this carry across the three main categories ? (connecting with others/fluidity in IP practice/teams within teams.) Do the three main concepts differ in emphasis based on the perspective?

For example: when I am focused on working under the individual professional perspective

Connecting with others might have a lesser role than at other times. This perspective might involve 1:1 direct contact with others to report on profession specific knowledge about a client, present PD to peers or write a report to send to another professional. *Fluidity in IP practice* is likely to be low, as the priority is on ensuring the profession specific tasks are being completed, with an insular focus rather than IP working. *Forming teams within teams* from this perspective might emphasize your professional role as a member of a sub-team and how your skill set and knowledge may contribute to this sub-team

This needs more work, and time back in the data. I'd also like to have a conceptual brainstorm with A. to get a differing view on this, and/or with GT group.

Plan: Discuss at supervision, plus organise a time to present this to GT group next month to clarify my ideas and get challenged!

Appendix R: Memo - Early analysis

20/12/2011 Memo: Guarding behaviours/patch protection

What main actions/processes are occurring?

Guarding is about protecting knowledge, skills, and roles. It is a defensive means of protecting the status quo, and holding onto perceived role boundaries. HCWs justify guarding as necessary to protect professional identity and ensure client safety, by ensuring that certain professional tasks are only undertaken by those HCWs trained for that task.

What is the process of guarding about?

Guarding appears to develop as a result of challenges in personal and professional work. The potential for misunderstanding and professional tensions is common in the community. People work autonomously, there are time constraints, and a lack of clarity and transparency over role expectations/assumptions, which can lead to unacknowledged tensions (‘the elephant in the room’ quote). Guarding behaviour may then arise, often due to professional insecurity and resentment at the perceived slight of ‘stepping on toes’ i.e. taking on a role someone else sees as their domain.

To overcome this, openness and transparency, and a desire to be flexible and fluid in one’s professional practice are needed. HCWs perceive this flexibility is more easily achieved by those with experience, although not just professional experience. Life experience is viewed as enabling people to be more flexible, to build relationships, to be less precious and rigid, thereby enhancing CP. In contrast, if you feel professionally vulnerable and unsure of your abilities, you become guarded in what you communicate, and how you ask for assistance with complex clients.

What are the conditions under which guarding is maintained & changes?

Guarding is maintained by...

- Being precious: holding tightly onto professional knowledge; presuming only your profession has the skills to undertake a task; or, by placing professions in an implicit hierarchy (e.g. the comment in Interview 7 about OTs not having as much

training as other professions, suggested that OT perceived her profession had less worth, or was perceived that way by others).

- Processes and structures both within and external to the team. This includes management/leaders, co-location, note sharing, lack of note sharing, lack of joint visits, staff orientation, and interagency practices

What changes guarding behaviours?

These factors impact on guarding and cause it to shift:

- Community setting
- Systems and processes at all levels (e.g. MoH/ACC; interagency; intra-team processes).
- Team environment (transprofessional working, or rigid professional boundaries)
- Management/Leadership (constraining or opening)
- Resources (lack of resources such as time or staff increase guarding)

What are the consequences of guarding?

Guarding appears to limit collaborative practice (CP).

- If someone is guarding, they are just õgetting on with itö, not making waves (Interview 2). So, what are the implications of that? Decreased communication? Reduced job satisfaction, or staff turnover? Less effective practice? I need to gather more data to consider this in greater depth.
- Is there something about community rehab work that facilitates CP, rather than guarding behaviours? I need to look into this further with the next interviews- maybe consider a probing question about whether participants consider community work the same as hospital work?

What about the Health practitioners Competency Assurance Act (HPCA)?

Do the scopes of professional practice in the HPCA work as a barrier to CP? Or do they help HCWs identify and clarify specific professional roles and skills? Do people use the scopes of practice as a shield to guard their profession? Do they justify role guarding with the HPCA?

I am surprised that comments around the HPCA have not yet arisen in interviews.

Entering the study I held an assumption that scopes of practice might be raised by HCWs in relation to their interprofessional work. However, participants seem to assume that others know what their profession's roles and boundaries are ó plenty of room for misunderstandings and increased tension there! I need to clarify this further in subsequent interviews. Are these assumptions always hidden patterns of behaviour, or do certain events make them overt? What happens when other HCWs cross perceived role boundaries?