

Interprofessional working

Katherine Pollard, Julie Bugler and Sally Hayes

Learning outcomes

After reading and reflecting on this chapter, you should be able to:

- Identify why interprofessional working is important;
- Acknowledge your responsibilities and obligations as a registered nurse in relation to interprofessional working;
- Outline different types of interprofessional working within nurse practice environments;
- Identify evidence to support interprofessional working;
- Outline the history of interprofessional working in UK health and social care services;
- Discuss the different forms interprofessional working can take;
- Identify factors that enhance or inhibit interprofessional working.

Related NMC Standards for Pre-registration Nursing Education (NMC 2010)

Nurses must:

- Work in partnership with service users, carers, families, groups, communities and organisations.
- Understand the roles and responsibilities of other health and social care professionals, and seek to work with them collaboratively for the benefit of all who need care.
- Work effectively across professional and agency boundaries, actively involving and respecting others' contributions to integrated person-centred care.

Introduction

Interprofessional working/collaborative practice is seen to be an essential aspect of the delivery of health and social care in general and nursing care in particular. In this chapter we aim to

present a comprehensive overview of the issues you need to consider in order to acquire the necessary understanding and skills to engage in effective interprofessional working.

The chapter is divided into three parts:

In Part 1, we provide an outline of interprofessional working explaining in general terms why it is important, what it looks like, and what sorts of skills and attitudes are needed to make interprofessional working effective.

In Part 2, we further explain the importance for nurses of interprofessional working before looking at how professions in the UK and other countries have interacted in the past. We also investigate specific features of interprofessional working more closely, and examine some of the barriers to effective interprofessional working. Part 2 concludes with an outline of the current evidence base for interprofessional working.

In Part 3, we explore interprofessional working in nursing practice in more depth, and discuss the skills that nurses need to ensure successful interprofessional working. Issues of relationships and communication affecting collaboration are highlighted, as well as nurses' involvement in leadership and co-ordination between different groups of professionals, care sectors and agencies. The chapter concludes with a consideration of the role of the nurse in effective interprofessional collaboration.

Part 1: Outlining interprofessional working

Case 7.1

Mr Blake was admitted to hospital three weeks ago after a failed discharge home three days earlier. This is his fourth admission in as many months with decompensated heart failure. Mr Blake wants to return home. Involved in the discharge planning arrangements are an occupational therapist, social worker, discharge nurse, senior staff nurse in charge of the ward that day, a medical consultant and a junior doctor. They meet to discuss and jointly work out a plan of care which involves, among other things, making some modifications to Mr Blake's home and arranging tele-health and a care package before he

is discharged. Mr Blake's preferences and opinions about his discharge are sought and considered by the discharge team, who will liaise with the general practitioner (GP) and the community nursing team, including a community heart failure specialist nurse. Mr Blake has no children, but his next of kin is his niece Sally, who lives 40 miles away.

Case 7.2

Tom is 15 with a moderate learning disability and severe anxiety. He is an only child living with his mother, Louise, who is struggling after a recent separation from Tom's father. Tom attends a mainstream school and receives one-to-one support, but wants to move schools to gain more life skills and become more independent with cooking, budgeting, travelling and making friends. He has very few friends, but has a girlfriend, Ella, whom he sees at school; they send each other text messages which concern Louise, as they are sometimes sexual in content. Tom suffers from chronic constipation and has faecal leakage, mainly at night. He is prescribed a powerful laxative, but the treatment regime causes both Tom and Louise considerable distress. Recently they have started arguing a lot and she has approached his social worker, Ravi, for help with the general situation. Ravi has referred Tom to the Specialist Services for Children with Learning Disabilities for help with medication, education regarding constipation and guidance around growing up and making friends and relationships. Following the referral, Louise is contacted by Claire, a community learning disabilities nurse from the services, to arrange a meeting for an initial assessment.

Why interprofessional working?

Nurses rarely work in isolation. Typically, as illustrated in the cases of Mr. Blake (Case 5.1) and of Tom (Case 7.2), patients will find practitioners from more than one professional group, and sometimes from more than one organisation or agency, involved in the delivery of their care. Although the range of professionals and practitioners will vary, it is unusual to find healthcare situations where nurses are not involved. Thus it is a fact of professional life that nurses must

work with others in the delivery of care. This recognition is the starting point for effective **interprofessional working** and it is no accident that in both acute and community care settings, nurses are often ideally placed to take on responsibility for co-ordinating processes and procedures involving other professionals and practitioners.

Interprofessional working requires all those involved in care to work collaboratively for the benefit of patients/clients/service users.

What is interprofessional working?

Interprofessional working is understood as a particular way of working with others. The essential feature of interprofessional working is collaboration; hence the use of such terms as collaborative working or **collaborative practice**, which involves both professionals and non-professionals in the provision of care. Thus interprofessional working is more than merely having contact with other professionals involved in the care of a given individual. It requires the recognition that no one professional or practitioner can meet all the needs of any one client. This being so, nurses need to develop the skills and attitudes that foster collaborative ways of working in order to minimise the fragmentation of care that **patients** might otherwise experience.

The term **collaborative practice** is sometimes preferred to 'interprofessional working' because it is more inclusive and explicitly allows for the contribution of non-professionals to the delivery of care (in particular, the service user or the service user's carers).

Patient, client, service user or citizen? Nurses from different areas of care are likely to have a preferred term to describe those in receipt of care. In this chapter the terms patient, client, service user and citizen are used interchangeably.

What skills and attitudes are needed for effective interprofessional working?

A number of barriers to effective interprofessional working have been identified and some of these will be detailed and explored later in the chapter. For now it is enough to say that a commitment to interprofessional working necessarily involves attempting to overcome obstacles to collaborative practice. Effective interprofessional working does not just happen; it requires an active contribution from each member of the interprofessional team as well as an environment that provides the opportunity for all members to participate in discussion and decision-making.

To engage with interprofessional working it is necessary for individuals to have, among other things:

- A knowledge and understanding of the roles and responsibilities of other care providers.
- A willingness to identify personal strengths and weaknesses together with a willingness to accept the need for personal and professional development.
- A willingness to trust, respect and value the contributions of all involved in the delivery of care.
- Well-developed communication skills.

Part 2: Explaining interprofessional working

Why interprofessional working is important for nurses

Interprofessional working is seen as a way of minimising the fragmentation of services that often accompanies the delivery of healthcare when two or more professional groups are involved (and arguably, there is always more than one professional group involved in the care of any one particular service user).

There are obvious dangers inherent in a system in which different professional groups organise themselves in different ways and specialise in particular aspects of care delivery. The most common dangers are the failure to collaborate and the failure to communicate. Sometimes these problems lead directly to tragic outcomes, as reported in the enquiries into a number of

high-profile cases (see, for example, Laming 2003, Laming 2009, Francis 2013). One of the key consequences of these enquiries has been the recognition that no profession or agency has a monopoly on care. Interprofessional working, with an emphasis on collaborative working and effective communication, is seen to be one way of preventing such failures.

The ideal of interprofessional working is that different professionals work together in an attempt to reduce the fragmentation of care as experienced by service users. For example, accurate assessment of a service user's condition or situation is important for the subsequent delivery of appropriate care. The common information available from a single systematic and structured assessment ought to be able to serve as a basis for subsequent profession-specific assessments without the need for a patient to respond to the same questions from three or four different professionals. Yet traditionally professional groups have perceived a need for profession-specific assessment processes. Arguably **the best interests of the patient** trying to rest in a hospital bed are not served by a succession of visits from, for example, a nurse, a phlebotomist, a pharmacist, another nurse, an occupational therapist and a social worker, as well as a ward round of doctors all within the space of a single morning. Attempts to reduce this sort of fragmentation are not new and the ideas of seamless care, integrated care pathways and a unified, co-ordinated assessment process are consistent with and, in some cases, pre-date the move towards interprofessional working. These processes all require professionals to orientate their work in terms of patient benefit rather than on the basis of professional identity and/or boundaries. A key report on the future direction of the NHS (DH 2008) highlighted shared accountability as an important principle underpinning the roles and obligations of all healthcare practitioners.

The best interests of the patient: the crux of interprofessional working is that it focuses on patient-centred care delivery and puts the interests of the patient ahead of the interests of any given professional.

How have professions in the UK interacted in the past?

In the UK the work of health and social care practitioners is highly institutionalised. Acts of Parliament have established professional and statutory bodies for the registration and regulation of different professional groups: the Nursing and Midwifery Council (NMC) for nurses, midwives and health visitors; the General Medical Council (GMC) for doctors; and the Health and Care Professions Council (HCPC) for social workers and allied health professionals (including, among others, radiographers, physiotherapists and occupational therapists). Although similar arrangements exist in most developed industrialised countries, this is by no means a global phenomenon. In some developing countries, such as Haiti, there is no organised health or social care system (St Boniface Haiti Foundation 2015).

Even in the UK, the institutionalisation of healthcare is relatively recent. Healthcare has been organised and regulated for little over a hundred years, while the organisation and regulation of social care has been even more recent (Vatcher and Jones 2014). Across the health and social care spectrum, different professions have different histories with different social trajectories. The most powerful of the professions has been, and arguably still is, medicine. The delivery of healthcare was controlled and directed predominantly by medical professionals during the whole of the twentieth century. Where health and social care practice intersected, the medical profession often retained primacy (Hudson 2002). Medical professionals directed the practice of other health professions even more closely, often controlling their establishment and regulation from the outset (Witz 1992). Although nursing skills have been exercised by individuals for centuries, nursing as a distinct profession was only recognised at the end of the nineteenth century; national regulation of nursing (albeit featuring medical control) was only established in the UK in 1923 (Dingwall *et al.* 1988).

The two major developments affecting the organisation of healthcare in the UK during the twentieth century were the creation in 1948 of the National Health Service (NHS) and of the World Health Organization (WHO). Before the Second World War (1939–1945), health and

social care in the UK was provided by a patchwork of civic bodies, charitable institutions and individual professionals in private practice. Collaboration between these various entities occurred only on an *ad hoc* basis, dependent largely on individual inclination and ability. Recognition that the needs of the population could not be met by such a piecemeal approach resulted in the establishment of the NHS, and the implementation during the 1940s of legislation concerning education and social care for vulnerable groups, including children (Gladstone 1995). However, communication and collaboration between different professions continued to occur in a disjointed manner, often dominated by medical priorities, and still dependent on individual initiative and inclination, rather than on systematic processes (Pollard *et al.* 2014).

In the 1990s UK governments and health and social care professionals started to address these issues in a systematic fashion. However, this period also saw the rise of not-for-profit organisations such as social enterprises, whose involvement in the provision of healthcare services has been advocated by successive governments (Addicott 2011). During the same timescale, private companies were also encouraged to invest in the healthcare ‘market’ in the UK (Pollock 2009). In other changes, some healthcare services have been allocated to different agencies in the public sector; for example, health visiting and other public health services are now the responsibility of local authorities, rather than of the NHS (Stephenson and Wiggins 2014). All these developments have resulted in a landscape where service provision is once again fragmented, so that it becomes increasingly important for healthcare professionals to be aware of their obligations concerning interprofessional collaboration, as well as knowing how to communicate effectively across a range of different organisations (Francis 2013).

Professional interactions beyond the UK

In the wider social context, collaboration between epidemiologists from different European countries has been occurring since the 1920s through the League of Nations Health Organization. The main concern of this body was public health and the incidence and control of communicable diseases across Europe (League of Nations Health Organization 1931). The scope of the organisation expanded after the Second World War, culminating in the

establishment of the WHO, whose aim is that all people everywhere should attain the highest possible level of health. Health is defined in WHO's Constitution as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO 2015). WHO continues its influential role today, and provides a forum through which health professionals from all over the world are able to share knowledge, opinions and perspectives. In addition, governments of both developed and many developing nations aim to implement WHO recommendations.

A closer look at interprofessional working

Case 7.2 (continued)

After the initial assessment, a meeting was called so that all the professionals involved could collaborate to ensure that consistency of care for Tom would be achieved. These included Claire (learning disabilities nurse) and a psychologist from the Specialist Services for Children with Learning Disabilities, Ravi (Tom's social worker), a speech and language therapist, a teacher, and a practitioner from a national charity which provides support and advice about continence for children. Tom and Louise attended the meeting and participated in making decisions. The meeting was held at Tom's school because he felt most comfortable there and didn't want to miss any lessons. Tom chose to come for only part of the meeting during his lunch break. Claire chaired the meeting and ensured everyone contributed their thoughts. Ravi took the minutes. Louise was surprised at how many different services were involved and was able to get a clearer picture of who could support her. The professionals worked together to decide who would be best to do joint work and who best to do individual work.

Interprofessional working is one of those things that most people agree is a good idea but about which there are multiple understandings. For some, interprofessional working is just a new name for the way nurses have always operated. Looking at the number of different professionals involved in care services for Mr. Blake (Case 7.1) and for Tom (Case 7.2) it is easy to imagine a

nurse saying something like: ‘we have always worked with other professional groups so interprofessional working is nothing new’. While it is possible that this claim may have some basis in truth, there is a good chance that what she or he thinks of as interprofessional working is merely a matter of regular contact with other professionals such as doctors, physiotherapists, social workers and so on.

Effective interprofessional working is more than merely having contact with individuals from other professional groups. Nurses often claim to have different perspectives to those of doctors and interprofessional working assumes nurses can and should make a valuable and valid contribution to patient care. Interprofessional working requires that individuals within an interprofessional team regard each other with mutual respect (Sommerfeldt 2013). A fundamental aspect of collaboration is the recognition that each member has an important contribution to make in meeting the needs of an individual patient or client.

Participation and collaboration

While it is true that during their working day nurses often have contact with other professionals, the current emphasis on interprofessional working suggests that the relationship between nurses and other healthcare professionals may not always be effective.

Case 7.1 (continued)

In handover the nurse in charge of Mr Blake’s care explains to the staff nurse taking over that the team would like a referral to the community heart failure specialist nurse-led service. She also mentions that she has left a sample pot with Mr Blake, as she noticed that he was coughing a lot in the morning and wants to collect a fresh sputum sample. The doctor has reviewed him and is concerned that he has a chest infection, but does not want to prescribe any antibiotics. Mr Blake does not want to take any new medication until the hospital has tested a sample. Unfortunately Mr Blake is transferred to another medical ward that afternoon, in order to ‘free up’ beds for the weekend; the pot is forgotten, and the information is not handed over to the staff.

This simple failure of forgetting about the sample pot can easily happen in a busy hospital environment, but the consequences for a patient can be serious. You may have come across similar examples of poor communication leading to missed opportunities for collaboration resulting in fragmentation of care.

Activity 7.1

Think about healthcare settings you have been in and try to identify the sorts of working between different professionals that took place. Make a note of all the professionals or non-professionals involved.

As you will probably have identified from Activity 7.1, working practices between professional groups can be undertaken in different ways. The essence of interprofessional working, as it is currently understood, is *participation and collaboration*. There are a number of terms used to describe interprofessional working and they are sometimes used as if they are interchangeable. However, these terms can reflect a range of different understandings about the nature of interprofessional working. Although it is true that interprofessional working can take many forms, and can be described using a variety of terms, what is often referred to as *interprofessional* working might be better described as *multiprofessional* working.

Common terms in use are: *interprofessional*; *multiprofessional*; *interdisciplinary*; *multidisciplinary*; *interagency*; and *multi-agency*. A basic **rule of thumb** is that the prefix *inter* implies that all individuals engaged in the process will actively contribute to it, as demonstrated at the meeting held to discuss Tom's care (Case 7.2); by contrast, where the prefix *multi* is used, there is no such implication. *Interprofessional* working implies that communication and decision-making concerning care delivery will involve representatives from each profession, discipline or agency concerned: '[Nurses] must know when and how to communicate with and refer to other professionals and agencies ... promoting shared decision-making, to deliver positive outcomes and to co-ordinate smooth, effective transition within and between services and agencies.' (NMC 2010 p. 21). A *multiprofessional* meeting may mean that individuals from

a range of different disciplines are in attendance, but that not all of them will take an active part. It should also be noted that the term *interdisciplinary* usually refers to collaboration between different disciplines (for example, archaeology and psychology) or to initiatives which promote the sharing of resources and knowledge between different disciplines or professions. The term *interprofessional* refers specifically to situations where individual health or social care professions contribute their own professional perspective to an overall plan or activity (Payne 2000, D'Amour and Oandasan 2005, Parse 2015).

Rule of thumb: the prefix *inter* implies active sharing of resources and/or collaboration whereas the prefix *multi* merely suggests there is more than one group or individual involved.

In the context of interprofessional healthcare practice the term *team* is also in common use but is interpreted in different ways. Teams can vary and can range from close-knit groupings of individuals who work alongside one another on a regular basis, to loose networks of individuals from different agencies and services, who collaborate only when a particular situation demands it. Decision-making processes can vary considerably between different types of teams, and may even differ within a single team. A key feature of successful interprofessional working is that all those involved agree about what sort of collaboration is envisaged, and in particular, what sort of communication and decision-making processes are to be established (Payne 2000, D'Amour and Oandasan 2005).

Interprofessional working does not exclude contributions from non-professional carers

Although the term *interprofessional working* implies collaboration between qualified professionals, a more flexible interpretation is often needed. In most health and social care settings, the **contribution of support workers**, such as healthcare assistants and home carers, as well as administrative staff, is an integral part of care provision. Some professions also have an established tradition of **involving service users** in the planning and delivery of care, for

example social care and mental health services (DH 1994, Social Care Institute for Excellence (SCIE) 2001). More recently in the UK, the NHS Act 2006 and the Health and Social Care Act 2012 have stipulated that all health and social care professionals can and should involve service users and/or carers actively in the planning and delivery of care (DH 2012), as demonstrated in both cases in this chapter.

The concept of the ‘expert’ is very powerful among both health and social care professionals and the wider public, and there remains a widespread assumption that an integral aspect of the professional role is to make decisions regarding the course of action service users should follow, sometimes without engaging them in a consultation process. Some professionals still regard this as normal practice; however, organisations’ mandatory obligation to obtain and act on patient feedback about the care they receive is slowly changing culture in this respect (<http://www.nhs.uk/NHSEngland/>). Awareness of the rights of the individual service user has spread among professions, and it is now widely accepted that the service user voice should be heard in the process of service provision (Donskoy and Pollard 2014). So it is generally understood that the term *interprofessional working* implies collaboration between qualified professionals, support workers, administrative staff, service users and/or carers, in various combinations. For these reasons and because it more accurately describes the kind of working envisaged, there are some who use *collaborative practice*, *collaborative working* or *partnership working* in preference to the term *interprofessional working*.

The contribution of support workers to interprofessional working is both invaluable and indispensable – for example, home care assistants, healthcare assistants and administrative staff.

Involving service users in decisions about their care is an integral and mandatory aspect of interprofessional care.

Case 7.2 (continued)

Tom and Louise are active members of a local participation group, where their activities include helping to recruit new health and social care staff; they have learned interviewing skills from Barnardo's staff. They also take part in training new staff about ways to include participation within day to day work. They have been consulted on other new services and given opinions on service leaflets, letters and policies. Tom and Louise have also taken part in films made to educate a wide range of practitioners, which have been shown in the local NHS Trust to help others understand the importance of participation and service user involvement. They have also been to local universities to contribute to teaching sessions for students studying learning disabilities nursing and social work.

As can be seen from Case 7.2, service users' and carers' contributions to collaborative practice can take many forms, and can extend to involvement in education and training for a range of health and social care practitioners.

What gets in the way of effective interprofessional working?

When asked whether interprofessional collaboration is a good idea, most health or social care professionals are likely to answer in the affirmative. However, getting individuals to work well together can be problematic. Possible barriers to effective interprofessional collaboration include:

- Different professional priorities and boundaries
- Lack of understanding of others' roles and obligations
- Communication mechanisms
- Poor interpersonal skills.

(see Day 2013, Keeping 2014)

Different professional priorities and boundaries

When considering the needs of service users, individual professionals are likely to prioritise their own professional perspectives. For example, and broadly speaking, social workers are likely to focus on issues of social support, medical staff will probably remain primarily interested in physical symptoms or disease progression, and occupational therapists will be concerned with the provision of an environment conducive to promoting a person's ability to perform daily activities. In some circumstances the values of different professional groups may be at odds with one another: for example, there may be significant disagreements about issues such as the extent of service user representation or consultation in decision-making. In some contexts, it may not be possible for some professionals to get **their own point of view** taken as seriously by colleagues either as they would wish or as they would consider appropriate. A key aspect for nurses working interprofessionally is to ensure that other professionals appreciate and understand the nursing contribution to interprofessional care (Sommerfeldt 2013).

Effective interprofessional working demands that individual practitioners transcend **their own point of view**, in order to appreciate the views of other individuals involved.

Activity 7.2

Think about all the professions involved in arranging Mr. Blake's discharge (Case 7.1) and care for Tom (Case 7.2). How important do you think it is that consideration is given to each of the different professional perspectives?

Despite differing perspectives, there is often significant overlap between different professionals' spheres of practice, and this can lead to conflict as professionals react to protect what they consider to be 'their territory' (see, for example, Booth and Hewison 2002). However, such issues of territoriality are often a result of habit and accompanying assumptions about who is capable of carrying out a specific task. Once all those involved become accustomed to different ways of working, there is evidence to suggest that time and exposure can result in role overlap becoming a routine and unremarkable element of practice; nurse prescribing is a case in point (Moller and Begg 2005, Parr 2011, Blanchflower *et al.* 2013).

Lack of understanding of others' roles and obligations

Of course, all professional perspectives are important, and should be borne in mind: however, it is sometimes difficult for individual professionals to appreciate one another's concerns, particularly if they have little knowledge of each others' roles or values (Aguilar *et al.* 2014).

Case 7.2 (continued)

Claire (the learning disabilities nurse) visits Tom at home regularly and supports both him and Louise with many of their concerns, but particularly with those around Tom's constipation. Claire liaises effectively with the paediatrician, and on one occasion arranges and delivers a repeat prescription for Tom's laxative to him when he needs it. Tom sees his GP soon afterwards about an unrelated condition and is asked about his constipation. Louise explains that Claire has organized a prescription for him. The GP is concerned, as she is unaware that community nurses can obtain prescriptions for their patients directly from medical specialists, and asks why the nurse visits Tom at home and whether she wears a uniform. Louise relates this incident to Claire, who contacts the GP to explain her role and also sends her a leaflet about the Specialist Services for Children with Learning Disabilities.

While the likelihood is that most professionals have some idea of what their colleagues do, they may over- or underestimate the scope and extent of their spheres of practice and professional responsibility, as demonstrated in Case 7.2 above. In these circumstances, it becomes particularly important that nurses share pertinent details about their role with other professionals (Sommerfeldt 2013). It is obviously also important that nurses find out what their colleagues' role and sphere of practice entail, in order to prevent misunderstanding and inappropriate action, so that patients receive optimum care.

Activity 7.3

Find out how much you really know about the roles and responsibilities of other health and social care professionals by selecting and reading a chapter from *Interprofessional Working in Health and Social Care* by Thomas *et al.* (2014) (see Suggested further reading).

After reading the chapter try to identify:

1. The differences between the role and responsibilities of nurses and those of whichever other professional group you chose to read about.
 2. Any areas of overlap that might lead either to conflicts or duplication of effort.
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Egalitarian approaches to planning and delivering care can be severely hampered by hierarchical structures, which always operate within the context of a power imbalance (McNeil *et al.* 2013, Keeping 2014). In the past there were many healthcare settings where occupational hierarchy determined who was authorised to make decisions. Traditionally, the medical profession dominated this hierarchy, while other professions jostled for position on the lower rungs (Witz 1992). However, this situation has changed significantly since the turn of the 21st century. Although the medical profession still enjoys higher status than many other healthcare professions, non-medical professionals, including nurses, do make decisions about patient care without medical input, and are often in a position to influence medical decision-making (Williamson *et al.* 2010, Traynor 2013).

For nursing, in particular, the drive for professional autonomy coupled with the extension of the nursing role and development of specialist and senior managerial nursing posts has resulted in the profession gaining higher status and an acceptance of nurses' legitimate involvement in decision-making. An expectation that nurses now work in collaborative teams in many healthcare settings has reinforced the perception that nurses are 'professionals in their own right', with concomitant accountability for decisions that they make and care that they deliver (Miers 2010, Williamson *et al.* 2010, Traynor 2013).

Communication mechanisms

There is a considerable variety of mechanisms available for communication between different professionals in different health and social care settings. In some areas of practice, regular meetings are held, attended by all professionals involved in care delivery; in other areas, communication may be haphazard and ad hoc, reliant upon individuals being in the right place at the right time.

In many acute areas information is relayed between professionals in written form. While the written record may be **streamlined** and well-organised with each professional writing in a single set of notes for individual service users, it is still common to find information about clients held in a number of different types of records: for example, nurses may write in one set of notes while medical staff write in another; other professionals may or may not write in either. Since professionals will tend to read only the set of notes in which they write this can result in individual professionals not having all the information necessary to meet the needs of the service user; and of course, this problem will be compounded where individuals neglect to write pertinent information anywhere at all.

Case 7.1 (continued)

When chatting to a nurse caring for him on the new ward, Mr. Blake tells him that on his last discharge his GP had not been contacted by the hospital. On checking the discharge summary, the nurse discovers that, while it had been typed, it was not actually sent to the GP practice. This alerts the nurse to the necessity of checking that details about Mr. Blake's current discharge will be sent to the community-based services.

Many professionals rely on the telephone and/or electronic communications for conveying information, so it is obviously crucial that messages are relayed appropriately. Community practitioners spend a great deal of time away from their office base, and often rely on answer phone messages or e-mails. When these messages are not coherent or do not contain sufficient detail, important information can be missed. When contacting patients directly by means of

mobile phones, it is important that professionals remember that patients may not have enough credit to listen to a voicemail message, but can receive text messages for free.

In all healthcare organisations in the UK, electronic storage of patient/service user information is commonplace (Whitewood-Moores 2011); furthermore, the health status of some patients is monitored remotely through the use of tele-health techniques (British Computer Society 2012). In community settings, patient information is increasingly being recorded on handheld electronic devices (Community Practitioner 2014). However, communication between computer systems in different sectors and organisations is often difficult, if not impossible (Giordano *et al.* 2011, The Lancet 2011); issues of data protection, following the requirements of the UK Data Protection Act 1998, can also make sharing electronic information problematic. E-mails between the NHS and Social Services may need to be encrypted in order to remain confidential. It is extremely important that nurses and other healthcare professionals are aware of pertinent aspects of the electronic systems they and their collaborators use, and ensure that effective communication is not compromised due to technical limitations or idiosyncrasies.

Where communication mechanisms between different professions, care sectors and agencies are not **streamlined**, professionals need to be particularly vigilant about making sure that relevant information is shared with everyone who needs it.

Ineffective interpersonal skills

An examination of the factors listed above supports the conclusion that effective collaboration is fundamentally dependent on both the willingness and the ability of individuals to communicate effectively with others. If any member of an interprofessional working group is not committed to the principles of collaboration problems may ensue, particularly if the member in question holds a relatively powerful position in the organisation. Ineffective interpersonal skills on the part of any member can lead to misunderstandings and unanticipated reactions, which may have knock-on effects on the way care is provided. Language itself can be divisive: most professions

ascribe meanings to words that may be understood differently by members of other professions and, similarly, professionals frequently use acronyms or jargon when they speak. Hence interprofessional collaboration can be hampered by a lack of awareness of profession-specific meanings for a word and by the unintelligibility of professional acronyms. In addition, some professionals tend to colonise service users when, for example, speaking about ‘my patient’ or ‘my client’. If this is interpreted as one profession claiming exclusive responsibility for the well-being of a service user, other colleagues may become alienated from the process of collaboration (Keeping 2014).

Of course, expressing oneself is only one component of communication. If professionals are unwilling or unaware of the need **to listen** to what colleagues are saying, or to give due consideration to individuals’ priorities, then it is unlikely that they are going to be able to work well together (McNeil *et al.* 2013) (see Chapter 14 for more information on communication and interpersonal skills).

The ability **to listen** is an essential skill for effective interprofessional working.

The evidence base for interprofessional working

In the UK, health professionals are obliged to provide evidence-based care and evidence often takes the form of guidelines, in particular those issued by the National Institute for Health and Clinical Excellence (NICE) targeting specific areas of practice. In 2000, the Health Development Agency (HDA) was established to develop the evidence base for care delivery and to help implement that evidence in practice with the stated aims of improving health and reducing health inequalities. A key strategy for the HDA was to work with organisations such as Local Government Associations, which represented local authorities at a national level. In 2005, the functions of the HDA were transferred to NICE. While there is no NICE guideline focusing specifically on interprofessional issues, relevant principles are embedded in a range of guidance, for example, the necessity to ‘ensure clear and timely exchange of patient information’ between

all those involved in someone's care, especially at the point of transfer from one setting/environment to another (NICE 2012).

Support for interprofessional working comes from an assumption that working collaboratively will reduce the fragmentation of care delivery through closer teamworking among the professionals concerned. Yet the idea of interprofessional working is not without its critics, and it has been found that where interprofessional working is ineffectively implemented, it can actually impede teamwork (McNeil *et al.* 2013). Nevertheless, enquiries into high-profile cases identify, among other things, failure of communication between different professionals involved in care as a significant feature contributing to negative patient outcomes (Laming 2003, Laming 2009, Francis 2013). This suggests that service users will benefit from better co-ordination of care and better communication between the professions, as well as from the targeted allocation of resources across different services and agencies. However, despite an increasing focus on interprofessional practice in healthcare settings since 2000, the evidence base to support this assumption is still not well developed (Brandt *et al.* 2014).

One of the reasons for the paucity of evidence concerning the effect of interprofessional collaboration on service user outcomes is that it is a difficult topic to research. Processes that involve communication and joint working between different groups are complex and varied, and involve a number of interdependent factors: these include the effect of individual personalities, differing professional perspectives, the way systems are set up, how decisions are made, and how or whether actions follow those decisions. Other factors that affect care outcomes include service users' conditions or requirements, as well as relevant psycho-social factors such as individuals' social support systems. Because of these and other issues it is almost impossible to isolate and assess the effect of any single factor contributing to this amalgam of conditions and influences.

These difficulties notwithstanding, some researchers have attempted to contribute to **the evidence base** supporting interprofessional collaboration. Problems conducting research into

interprofessional issues can be minimised if settings are chosen where staff turnover is relatively low; where most of the professionals involved in delivering care are located in the same place; and where systems and processes for staff interaction are clearly articulated and understood.

Projects that have attempted to assess the link between interprofessional collaboration and outcomes for service users tend to be conducted within dedicated settings where small teams of professionals provide care for specific service users. For example, in studies of care for renal patients on dialysis (Dixon *et al.* 2011), the intensive care unit (Randall Curtis *et al.* 2012), fast-track hip surgery (Pape *et al.* 2013) and maternity care (Nijagal *et al.* 2015), researchers have been able to demonstrate a positive impact of interprofessional collaboration on service user outcomes.

Carefully planned research can help to build **the evidence base** supporting interprofessional working in health and social care.

Research focus 7.1

Pape *et al.* (2013) report results from a study examining the influence of daily interprofessional meetings on patients' length of stay following fast-track hip surgery in a Danish hospital. Fast-track hip surgery aims to optimise pain management and enable early mobilisation, so as to diminish the length of stay in hospital. A daily interprofessional meeting was introduced for all staff involved in patient care: surgeons, nurses, occupational therapists and physiotherapists. A checklist was used to discuss problems and to identify optimal care strategies. Joint decisions were made about which healthcare profession should take responsibility for specific procedures and tasks. A case control study compared hospital length of stay in 75 patients who received surgery and aftercare before the introduction of the daily interprofessional meeting, with that in 88 patients treated after its introduction. Length of stay in the latter group diminished significantly.

There have also been attempts to widen the evidence base supporting interprofessional collaboration. While the emphasis on specific service users has remained, some researchers have

shown effective interprofessional working makes a positive contribution to outcomes where care is delivered in more diverse settings, with less clearly defined processes (e.g. Strandmark *et al.* 2013). Other studies, exploring the views of both service users and staff, have found higher levels of satisfaction (a 'soft' outcome in terms of service delivery) in settings where effective communication and co-ordination of care between professionals has been established (Birkeland *et al.* 2013, Dufour *et al.* 2014).

Research focus 7.2

Birkeland *et al.* (2013) conducted a mixed-methods study to explore the way Swedish interprofessional paediatric cardiology teams work together. Thirty teams completed questionnaires about the organisation of work, relevant tasks and the attitudes of staff involved. Focus groups were held with twenty-nine team members from a range of professions to explore in depth individuals' experiences and opinions about interprofessional working. The questionnaire results revealed positive attitudes to interprofessional collaboration, particularly where a nurse took the team co-ordinator role. The focus group data indicated that all the professionals involved considered interprofessional working to be essential in order to deliver a good service to children in their care. The respondents commonly stressed the need for adequate time to develop relationships and skills within their teams, to optimise the quality of the service offered.

The evidence base has been extended further by reviews examining results from collections of small studies. This can result in a reinforcement of the idea that there is insufficient evidence to support the effectiveness of interprofessional collaboration in a particular area (Britton and Russell 2006). However, some of these reviews have helped to show that good working relationships and integrated practice do contribute to improved service user outcomes (Cameron 2005, Martin *et al.* 2010, Courtenay *et al.* 2013, Colter Smith 2015).

Research focus 7.3

Martin *et al.* (2010) conducted a literature search in PubMed, CINAHL and Cochrane Library in order to review the evidence base concerning the influence on patient outcomes of interprofessional collaboration between doctors and nurses. Two researchers independently found fourteen Randomised Controlled Trials (RCTs) for review. Most of the studies compared outcomes within older patients who had received either collaborative care or usual care. The RCTs compared outcomes involving a range of interventions of varying length, including promotion of community-based services and care co-ordination. Clinical and functional outcomes were commonly measured, as well as social and patient-reported outcomes. Results were mixed across the sample; however, thirteen of the RCTs reported at least one improved outcome which was statistically significant following the interprofessional intervention.

Although it can be argued that much research in the field has not produced results which can be thought of as ‘hard science’, there is a logic in the assumption that improving interprofessional communication and practice to enhance the quality of care will lead to improved outcomes for service users, a view supported by healthcare professionals (Pollard *et al.* 2012). Most available research findings agree with this logic.

Part 3: Exploring interprofessional working

The main rationale for improving interprofessional collaboration is the belief that it will enhance service user outcomes and experience (Pollard *et al.* 2014). So it is crucial to consider factors influencing interprofessional collaboration in terms of the effect on service delivery. It is rare that poor outcomes in health and social services are caused by a single event; it is much more usual to see a cascade of occurrences involving poor relationships, poor communication, poor leadership and/or poor co-ordination (Laming 2009, Francis 2013).

Activity 7.4

Make a list of all the professionals involved in the care of Mr. Blake (Case 7.1) and Tom (Case 7.2). In each case give reasons for who you think should be responsible for ensuring relevant information is passed between the various professionals at different points in time.

One of the things that doing Activity 7.4 should help to illustrate is the complexity of relationships between different professional groups. Although effective communication is a necessary requirement, effective interprofessional working is also dependent on clear understandings about leadership and co-ordination of care.

What does interprofessional working in nursing practice look like?

Nurses contribute to many different types of interprofessional working across a variety of settings. In the acute sector, nurses interact closely and systematically with a range of other health and social care professionals, support workers, administrative staff and service users, particularly in specialist areas such as stroke rehabilitation, neurology and intensive care.

Collaborative episodes involving nurses may be more sporadic in other acute settings (such as within general medical wards) but the effectiveness of collaboration in these environments is equally important.

Case 7.1 (continued)

Over the weekend a number of healthcare professionals have looked after Mr Blake, and have noticed he appears to be developing a worsening cough. His oxygen levels have remained stable, but his respiratory rate has increased, and he feels weak and looks less well. A healthcare assistant on duty, who cared for him the day before, reports her concerns to a staff nurse who asks a doctor to review Mr Blake again. The staff nurse also asks a physiotherapist to assess him and to support him with some breathing exercises.

As Mr. Blake's case demonstrates, nurses' ability to engage in effective interprofessional collaboration may be particularly significant precisely when it is infrequent and/or irregular.

The widespread increase of community-based care at the turn of the 21st century resulted in new patterns of caregiving. However, as a result of major changes in the UK political landscape

over the last decade, different ways of working have moved in and out of fashion. For example, there was a trend towards establishing integrated health and social care teams, such as those whose function was to deliver complete packages of care to service users with learning disabilities (Walker *et al.* 2003). These teams were managed by social services, and typically employed, among others, psychiatrists, psychologists, physiotherapists, occupational therapists, learning disabilities nurses and social workers. Many of these teams were, however, discontinued as services were radically restructured. It is therefore interesting to note that the idea of 'integrated care', the purpose of which is to provide more streamlined care in a more efficient fashion, particularly to older people and those with long-term conditions, is enjoying a resurgence (see, for example, www.nottinghamcity.nhs.uk). However, whatever the formal structure of care delivery, nurses involved in community-based care must liaise and often co-ordinate care with a range of different practitioners: these may include all those mentioned as belonging to the integrated team above, as well as support workers in care homes, general practitioners, other medical professionals, allied health professionals such as dietitians and a range of different nursing groups employed by both acute and community health service providers.

Whatever the settings nurses work in, both cases in this chapter illustrate how complex service users' needs may be. It is therefore crucial that all professionals involved collaborate effectively to provide appropriate person-centred care.

Activity 7.5

Consider the need for nurses caring for Mr. Blake (Case 7.1) and for Tom (Case 7.2) to co-ordinate services and liaise with other professionals. What characteristics and competencies do you think the nurses involved need to possess?

What do nurses need to do to ensure successful interprofessional working?

Most of the obstacles outlined in Part 2 of this chapter can be overcome if professionals are willing to engage in activities that promote mutual understanding and respect. Although organisational barriers to collaboration may be difficult to change, individuals can enhance collaboration by ensuring that they have a good understanding of their colleagues' professional roles, as well as an understanding of the scope and limits of their own professional practice. An appreciation and acceptance of the differences between various professional perspectives and values is essential, as is the appropriate involvement of all interested parties, including service users. A key feature of effective interprofessional collaboration is the development and implementation of **decision-making processes** that are acceptable to all those concerned. It should be obvious that effective communication skills, combined with attitudes that encompass trust, respect and the valuing of contributions from all parties, play a pivotal role in determining the quality of interprofessional interaction and collaboration (Keeping 2014).

Mutually agreed **decision-making processes** are crucial for successful interprofessional working.

An important starting point for nurses engaged in interprofessional collaboration is an awareness of the different perspectives, priorities and values of other professional groups. Nurses need to have confidence in the value of the nursing contribution, as well as respect for other professionals' points of view: both components are needed if one professional perspective is not to be eclipsed by another.

Traditionally nurses have been subservient to doctors, and this history is reflected in some of the structures within which nurses practise today (Dingwall *et al.* 1988). You may not be in a position to affect some of the wider factors militating against effective collaboration, for example, the professional hierarchy in the National Health Service. However, by equipping yourself with appropriate skills, you can influence the way in which you work together with your colleagues. For example, learning how and when to use negotiation skills and assertiveness techniques can be useful in preventing inappropriate decisions being made which may result in

service users not receiving the most suitable care. A major benefit of developing such skills is that they can help you to avoid difficult interpersonal situations arising from an overly compliant or confrontational stance. Thus it would seem appropriate for nurses to take advantage of the many and varied techniques for developing effective communication skills.

Support may not always be forthcoming for junior nursing staff to contribute constructively to interprofessional interaction. Nursing in the UK has developed from a model drawing on the structures of both the armed forces and domestic service and the hierarchical nature of both remains in evidence (Dingwall *et al.* 1988). It has been found that while senior nurses often communicate and collaborate effectively with colleagues from other professions, nurses in more junior positions are not always included in these processes. In many instances, this situation may simply be a result of habit, rather than any conscious attempt to exclude junior staff from interprofessional interactions. The role of the nurse continues to develop and there is now an expectation that all nurses will embrace professional values, particularly those related to autonomous thinking (Traynor 2013). If junior staff display appropriate communication skills they will, in many cases, be able to establish themselves as full members of the team.

Nurses are in key positions in many areas, often being well placed to have a clear overview of a service user's requirements (Sellman *et al.* 2014). It is therefore essential that nurses engage effectively in interprofessional collaboration, so that these requirements can be clearly stated and considered by colleagues from appropriate disciplines (Sommerfeldt 2013). The antidote to barriers to the nursing contribution resides in individual nurses developing:

- Attitudes of confidence in their own perspective and abilities;
- Trust and respect for their colleagues from other disciplines;
- Appropriate communication skills which enable them to facilitate decision-making in the best interests of service users.

Relationships and communication affecting collaboration

Case 7.1 (continued)

Sally, Mr Blake's niece, arrives later that day. She notices the deterioration in her uncle, and raises her concerns with the staff nurse looking after him. Mr Blake tells his niece he is going home in the next few days when a package of care is organised. Sally is concerned about how he will cope alone at home and asks to see the medical team and social worker the next day to discuss the plan. She is disappointed that they have not approached her before, but the staff nurse explains Mr Blake has capacity and has asked that she not be bothered by the team, and therefore refused permission for them to contact her.

Relationships between patients and carers

Professionals need to remember that relatives or other carers may play a significant role in interprofessional working. Relationships among family members and/or family friends can therefore have a powerful influence on collaboration with and between professionals. Relatives and carers often feel they need to act on behalf of their relatives/friends, just as Sally did in seeking to 'champion' her uncle's need for care. However, professionals must recognise that relatives and carers, even if they think they are acting in the individual's best interests, do not always have the latter's needs as a priority (Donskoy and Pollard 2014). Being aware of differing agendas between the relative/carer and the service user is vital.

While relatives may often want to be involved and informed about a loved one's care, health and social care staff have an obligation to prioritise the service user's privacy above relations' concerns. The Mental Capacity Act 2005 and associated policies (DH 2010) stipulate that all individuals who have capacity must be consulted and involved in decisions about their care; in particular, this principle applies to individuals with mental health difficulties and learning disabilities, as well as those who have suffered neurological trauma (Donskoy and Pollard 2014). This issue always needs to be taken into account when deciding on an appropriate course

of action within collaborative practice. Health and social care professionals should never routinely discuss a patient's care with relatives or carers without the former's express permission and/or involvement to do so.

Relationships between the professionals involved in patient care

Interprofessional teams are often made up of diverse groups of practitioners and even those who work in the same setting may see one another infrequently. In addition, modern professional roles continually change and develop; there is no guarantee that a member of one profession will be aware of changes in the scope or role of another, as demonstrated in Case 5.2 by the GP's concern when learning that Claire had obtained a prescription from the paediatrician for Tom. This is particularly so in the case of doctors and nurses, who have a long history of hierarchical relationships; unless they receive explicit information to the contrary, many doctors are not aware of the practical implications of nurses' increasing autonomy (Dingwall *et al.* 1988, Williamson *et al.* 2010, Traynor 2013).

Individuals who need to collaborate occasionally are often based in different buildings or services with infrequent contact, particularly where formal channels of communication have not been established. Such lack of contact can contribute to a poor grasp of colleagues' roles and responsibilities and to ignorance concerning some details of an individual service user's care, thus compounding problems with interprofessional collaboration and communication.

It is extremely important that nurses develop negotiation skills, so that they can practise to their full capacity. They need to demonstrate this capacity in order to gain the trust of professional colleagues, patients and carers, some of whom may not be conversant with recent developments in the nursing role, and who may therefore lack confidence in nurses' clinical skills and knowledge.

The interface between the acute and primary sectors

Another crucial component for improving care delivery is the establishment of effective, functioning systems and relationships between the acute and primary sectors. Although both are staffed and run by health and/or social care professionals, the nature of the environment, the professional role and the relationships with service users vary considerably between them (Sellman *et al.* 2014). Many professionals working in the community will have worked in hospitals at some time during their career; however, because of a greater emphasis on community provision of care, it is no longer unusual to find newly qualified practitioners employed in community posts. Hospital-based staff may never have had any experience of community practice. In particular, nurses working on hospital wards and those working in the community may hold different priorities, expectations and experiences concerning the nature of the nursing role (Sellman *et al.* 2014). Just as it is important for professionals from different disciplines to understand each other's roles, it is equally important that practitioners from the same profession, but who are based in different environments, understand the implications for co-ordination of care delivery when service users move between different facilities.

This situation becomes even more complex when health and social care practitioners working collaboratively are employed by a combination of NHS organisations and non-NHS organisations in the public, private and/or voluntary sectors. It is crucial for effective collaboration that everyone involved understands and appreciates the varying organisational demands and priorities influencing workers' capacity to act, as well as the differences in professional obligations and cultural norms (Francis 2013, McNeil *et al.* 2013).

Nurses' involvement in leadership and co-ordination

Issues of co-ordination and leadership within an interprofessional team are extremely important (Laming 2009). A common cause of ineffective interprofessional working is a lack of clarity regarding roles and responsibilities within the team. A decision about who is best suited to take on the lead role is vital as this person is ultimately accountable for the plan of care. In addition, for the service user and/or carer it provides a single point of contact. Clear guidelines need to exist for ensuring that one named member of the team takes the lead in co-ordinating care.

In many cases, nurses are particularly well-placed to co-ordinate care, and to take on leadership in their professional roles (Sellman *et al.* 2014). There is increasing expectation that they will do so, although nurse leaders do not yet always receive sufficient interprofessional support and recognition in practice to enable them to function to their full capacity (Franks 2014). However, evidence is starting to appear that demonstrates the benefits of nurse leadership in multiprofessional settings (Birkeland *et al.* 2013, Clarke 2014, Lloyd *et al.* 2015) and formal initiatives have been established to promote leadership skills among nurses as well as among other healthcare professionals (<http://www.leadershipacademy.nhs.uk/>).

Leadership in the community

Case 7.1 (continued)

Sally meets with the medical team and the social worker the next day. She expresses her concerns about her uncle's discharge home. The team explain they have sent all the relevant details to his GP and have also arranged for tele-health monitoring. In addition, they have contacted the community heart failure specialist nurse, who will be visiting him within two days of discharge. Mr Blake knows the community heart failure specialist nurse, as she visited him soon after he went home following his previous admission. However, on that occasion, the GP felt that her input was not required, so she was not able to continue offering him care.

General practitioners have traditionally been considered gatekeepers in providing medical care in the community, although increasingly, specialist nurses working in collaboration with general practitioners are taking more of a lead role (Sellman *et al.* 2014). However, where there is an overlap in practice, as demonstrated in the case of the GP and the community heart failure

specialist nurse in Case 7.1, negotiation may be required to establish who has **responsibility** for providing care in particular circumstances.

Every individual has to share **responsibility** for team tasks if interprofessional working is to succeed.

Case 7.2 (continued)

Louise is still anxious about Tom's relationship with his girlfriend, Ella, and worries that they may be becoming sexually active. She discusses her concerns with Claire, saying that she has no idea how to handle this situation. She finds it very difficult to consider Tom as an adult, particularly in this area. Claire gives her information about services which can help educate and support young people with learning disabilities with regard to sexual and relationship issues. Claire also gets permission from Louise to share her concerns with Ravi (Tom's social worker), so that he can also support both her and Tom with this situation.

As can be seen in Case 7.2, leadership can involve a variety of different activities and responsibilities. The professional who co-ordinates care and support for a service user not only needs to liaise directly with other practitioners involved as appropriate, but must also be aware of the range of existing services, some provided by the voluntary sector, which may be able to offer citizens assistance with specific issues. It is also important that the lead professional knows how service users and/or carers can access such services.

Activity 7.6

Who do you think is the most appropriate professional in the community to take the lead role in providing care to Mr. Blake or to Tom? Why? If you were the district nurse caring for Mr. Blake, or the community learning disabilities nurse caring for Tom, what steps might you take to ensure that an appropriate system for co-ordinating care between all the relevant professionals was in place?

The cases of Mr Blake and Tom illustrate the need for professionals (including, and perhaps particularly, nurses) to be aware of a number of key factors concerning **leadership and co-ordination** if they are to promote effective care delivery for service users. These factors include:

- The need for clear guidelines for leading and co-ordinating a team successfully.
- The need for all involved to know and agree about who should be the overall co-ordinator of care.
- The need to ensure clear lines of communication about who is responsible for which particular aspects of care.
- The need to ensure no one professional's input is being ignored or overlooked.
- The need to recognise that different practitioners based in different environments may have different priorities, expectations and experiences of their role, even when they belong to the same profession.
- The need for practitioners based in different environments to understand the implications for co-ordination of care delivery when service users move between them.

Appropriate **leadership and co-ordination** are essential components contributing to good interprofessional working.

It would be unrealistic to assume that all professionals will equip themselves with the requisite skills and knowledge to promote effective interprofessional collaboration so that service users receive the care they need. However, in most healthcare settings, nurses are well placed to take on co-ordination if not leadership roles within interprofessional teams (Birkeland *et al.* 2013, Sellman *et al.* 2014). If nurses take it upon themselves to develop appropriate skills and to practise as part of an integrated interprofessional team, then they can make a real difference to the way that care is co-ordinated and delivered on the ground.

Conclusion

This chapter has attempted to illustrate the importance of interprofessional working and some of the factors that can hinder or help in the development of effective interprofessional care. By reading this chapter we hope that you will have come to recognise that you can influence the quality of care given to patients, clients, service users and citizens and that you can contribute to effective interprofessional working by following a relatively simple course of action that includes:

- Involving service users in plans of care.
- Consulting service users about their circumstances and in particular finding out which other professionals are involved in their care.
- Making sure that you understand the nature and scope of colleagues' professional roles.
- Ensuring all professionals involved with service users remain informed about issues affecting care.
- Taking care that communication between different individuals, both professional and non-professional, is both effective and reliable.
- Providing sufficient detail to colleagues about the nursing role, particularly in areas where assumptions may be operating, for example, the limits to the scope of nursing practice.

This may seem to imply that nurses must single-handedly take on the responsibility for improving interprofessional collaboration. This is not so; but if nurses are to fulfil their professional obligations to their patients, then they must lead the way and demonstrate an awareness of and capacity for effective interprofessional working.

Suggested further reading

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