Perceptions of experiences with interprofessional collaboration in public health nursing: A qualitative analysis

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Abstract

In public health nursing interprofessional collaboration has become a goal, however, there is little clarity on the distribution of responsibility or approach to cooperation between the professional groups. The aim of the study was to explore public health nurses' perceptions of their experiences related to interprofessional collaboration. A qualitative content analysis was carried out. An interview study with a purposeful sample of 23 Norwegian public health nurses (PHNs) was conducted. Data were analyzed using semi-structured interviews to identify categories and themes of PHNs' working lives. The data were classified into three major themes: institutionality: the institutional understanding of the professional roles; competence: clarifying jurisdictional borders, and recognition: professionals` recognition of different roles. There needs to be a robust strategy in collaborative working that involves public health nurses among other professionals to avoid role overlap, interpersonal and interprofessional conflict and reduce the damaging threat or stress that comes with informal or ad hoc rules of engagement and status claiming by one profession over another.

Keywords: Competence**,** institutionality, interprofessional collaboration, public health nursing, qualitative content analysis, recognition

Introduction

Today's health challenges have led to more complex and specialized welfare services, and interprofessional collaboration is increasingly the method to meet the health care demands (Rice et al., 2010, Willumsen et al. 2012). Research has shown that collaboration between health and social care professionals can be problematic (Reeves et al., 2013). Each profession has a unique history and culture which can bring challenges into an effective interprofessional teamwork (Hall, 2005). This is the case with public health nursing. With more complex health challenges and increased demand for more specialized knowledge, professions such as midwives, psychologists, family therapists and school counsellors have entered the child health clinics and the school health services. Their tasks are partly overlapping and there is yet no clear distribution of responsibility between the professional groups. In the early years, the Norwegian public health nurse (PHN) was the only professional dealing with disease prevention among children, young people and families, with medical practitioners as their closest collaborators (Schiøtz, 2003). These PHNs were often perceived as the district doctors` right hand (Evang, 1976, p. 73).

PHNs have their knowledge base across public health and nursing (Dahl & Clancy, 2015). According to Abbott (1988) professions have their particular knowledge base and their particular target group, organized within jurisdictional borders. Jurisdictional boundaries create a clear distinction as to who is inside and who is outside the profession, and establishing new jurisdictional fields result in change in other jurisdictional fields. PHNs` professional history reveal loss of monopoly of former public health control tasks (Dahl, 2015), and in possible challenges related to collaboration with other professions on the "new" public health nursing field.

Interprofessional collaboration

Interprofessional collaboration is aimed at making the most of the competence of the various professions to ensure quality of work. Norwegian public documents identify public health nursing as characterized by interprofessional collaboration. However there are both organizational, professional and cultural challenges in the interprofessional collaboration towards children, young people and families (Ministry of Health and Care Services, 2015). The Norwegian Public Health Act emphasizes equivalence, clear agreements, clear mutual expectations and obligations in collaboration (Ministry of Health and Care Services, 2011). In their study of the determinants of successful collaboration in health care teams, San Martin-Rodregues et al. (2005) found that organizational determinants play a crucial role, including a strong leadership, and human resource management capabilities. In addition, the interpersonal process was seen essential in collaboration, which included a willingness to cooperate, trust and mutual respect and communication. A systematic review of midwives` and health visitors` collaborative relationships (Aquino et al., 2016) found interprofessional collaboration to be valuable but challenging. Poor communication, limited resources and poor understanding of each other`s role were barriers. A Norwegian quantitative study on PHNs and collaborators (Clancy et al., 2013) points out that a successful collaboration depends on factors such as trust, respect, collaborative competence and good communication. A study of PHN and midwifery students (Aune & Olufsen, 2014) found that the students developed an interprofessional understanding from sharing reflective notes of their experiences.

Wenger (1998) and his concept “communities of practice” can be useful to explain and understand collaboration processes in practice. Domain, community and practice are central notions in communities of practice. The domain are the shared competences of the professionals making up the community of practice within a profession, and the community are the professionals engaged in reflective activities and who then learn from each other.

Practice refers to practitioners sharing a joint repertoire for practice. In interprofessional collaboration, the different professional groups can share communities of practice. According to Abbott (1988), the jurisdictional borders of a profession are not static; however, the different professions in a collaboration must develop their professional autonomy and clinical judgement. If not, the profession can be undermined.

Methods

Given there is little understanding of the change in PHN role in Norway, a qualitative approach was selected to explore the PHNs perceptions and experiences of interprofessional collaboration.

Data collection

Data were gather from a total sample of 23 PHNs from small, middle and large communities in two counties in Norway. They worked in child health clinics and school health services. Their practice experience varied from less than 1 year to 25 years (see Table 1).

INSERT TABLE 1 ABOUT HERE

The access to the research field was established through an oral and written inquiry to the leaders of the public health nurses in different municipalities. They informed the public health nurses, who made direct contact with the first author for interviewing. The interviews lasted from 1 to 1.5 hours. We used a semi-structured interview guide with topics derived from literature on public health nursing and collaboration. The interview guide had a narrative approach, and experiences related to interprofessional collaboration were evoked by asking: Have you examples where other professionals have invited you to collaborate? Can you narrate about a situation where you took the initiative to collaborate with other professionals? Have you experienced situations where you have done working tasks when other

professionals were more qualified? It was important to identify the experiences of PHNs as fully as possible so the interview guide was not rigidly applied. The interview encouraged interviewees to open up new directions to the discussion (Mishler, 1986). The first author (BMD) carried out a pilot interview to guarantee the validity of the questions regarding the aim of the study and made minor corrections. The pilot interview was included in the study.

Data analysis

A qualitative content analysis was conducted using Graneheim and Lundman's (2004) analytic framework. Each of the 23 interviews was read several times to obtain a sense of the whole. The text was extracted and brought into one text, divided into meaning units which were condensed and abstracted with a code. After comparing the various codes, based on differences and similarities, the codes were sorted into categories based on the research question. Comparison of the results of the coding increased the level of understanding about meaning. The latent content was then formulated into three themes (see Table 2.).

INSERT TABLE 2 ABOUT HERE

Methodological considerations

The trustworthiness of the study was maintained by including the aspects of credibility, dependability, confirmability and transferability in the methodological consideration process (Lincoln & Guba, 1985). To gain credibility meant that the sample was purposive. The participants were selected from certain criteria, to get variation in the length of service, the type of clinic they worked in and the municipality in which they worked (Table 1.). In this study, a relatively small sample of PHNs were interviewed, and therefore we cannot generalize the findings. A limitation is that the sample consisted of Norwegian female PHNs, educated in Norway, and working in a Norwegian context. The PHNs in the present study

were a heterogeneous group, working in different contexts; however, we found some common characteristics affecting interprofessional collaboration of PHNs even when variation is identified. To show the judgement of similarities and differences in the transcribed text, the findings section presents representative quotations. To reach stability of the data, or dependability, involved questioning the same area for all the informants. A semi-structured interview guide with narrative sections was therefore used. The transferability of the study is ensured by a clear description of sample, the context, the data collection and interpretation process.

Ethical considerations

The Norwegian Social Science Data Services (NSD) approved the study (No. 22315), and the study followed research ethical guidelines. The interviews were tape-recorded following the completion of a consent form by the participants. The interview data were securely kept, ensuring the anonymity of the individual throughout the process. The participants had the opportunity to withdraw from the study at any time and to delete their given information.

Results

The analysis revealed three themes that are related to each other: *Institutionality* (the institutional understanding of the professional roles); *Competence* (clarifying jurisdictional boundaries); and *Recognition* (professionals' recognition of different roles). Details relating to each of these themes are presented below. The findings are supported by quotations by the informants.

Institutionality

This theme is about the decision made at an institutional level about the role of the PHN and the economic efficiency of the institution, that impact on the work of the PHN. Some PHNs in this study spoke of changed tasks, of doing tasks that were the responsibility of other professions. In school health services some school nurses expressed being a connecting link between the teacher and the child welfare services. As one nurse said:

> Because I am easy to get…I think we [PHNs] are used as a channel…We become the person who shall put things straight… Then you realise: Ooh, you made yourself some work (PHN 7, school health services).

The PHNs meant that in some cases they were an unnecessary link, caused by the fact that teachers would not take the responsibility (trouble) to report cases themselves. PHNs also spoke about doing tasks that were not their responsibility such as writing reports to specialised services. While this is the doctor's responsibility, one nurse saw this as positive, stating:

> We (PHNs) are not allowed to refer to child and adolescent psychiatry. But it is me who is worried, and I write the appendix to the referral, and then the doctor does this last…I think the referral basis is much more thorough when doing it this way (PHN 7, school health services)

The PHN knew the case, and if the PHN should have referred the child or adolescent to a doctor`s appointment, then they would have to tell everything once again. The PHN felt the doctors looked at the PHNs as a resource, and that their appreciations were taken seriously. Conversely, another PHN was concerned that this was a doctor's job, and that nurses should not do things for which they had no responsibility.

> …that PHNs render the doctors services which I think is wrong. Among other things to write referrals to the child and adolescent psychiatry…and then it is only for the doctor to sign. It is important to discuss this practice with the doctors…I think it is strange that the doctors dare [to let this practice continue] (17, child health clinic & school health services)

When it came to routines around meetings, some school nurses in this study were concerned about their use of limited time. They considered that they could have done a better job talking with schoolchildren instead of attending all the meetings. They felt the meetings could be a waste of precious time. As one nurse stated, "I will rather meet with the children at school than sit in meetings" (PHN 13, school health services).

In addition, the nurses working at the child health clinics spoke of dissatisfaction with the amount of meetings, and were concerned about the role of the PHN in many meetings. In groups established around children with problems, PHNs often took on coordinating, secretarial or administrative functions. One nurse said the governing legislation led to a wide interpretation of their role, whereas she understood that teachers had more strict formulations in their guidelines, and could thus refuse to be a coordinator:

> The teachers just say no. In addition, the educational-psychological service limits themselves a lot; they do not want to be coordinators… We have in a way little defined – so that everything can in a way belong a little to the PHN. They say it also has something with the legislation to do… In the teachers' legislation, the coordination function is not defined. But I lack knowledge about this. (PHN 9, child health clinic and school health services)

However, the PHNs reported that this function was time-consuming.

The data in the present study was from different municipalities in Norway with different child health clinic programs. At some child health clinics, the institutional leadership had decided only doctors should do the child's two-yearly control, whereas the guidelines state that families should have separate meetings with the PHN and doctor at this point. The PHNs argued that this organizational change was due to a cost-reduction and efficiency plans; however, one nurse spoke about the different foci of doctors and PHNs. She was worried about the quality of the doctors' two-yearly control, however not the medical part, but she used to tell the doctor:

> Remember to ask about the language, and listen [to] how they speak...and ask how they are getting on at home and you must at least offer them a public health nurse control (PHN 17, child health clinic & school health services)

Here, the PHN took an educational role toward the doctor. Some PHNs in this study commented that other professionals had taken over their traditional tasks for instance at schools. At some schools, the midwife represented the public health nursing service. The PHN spoke of this removal of PHN involvement as due to a shortage of PHN positions. Decision made at an institutional level impacted here on PHN work.

Lack of time and resources, due to institutional efficiency initiatives was explained as a reason for some nurses participating less in interprofessional collaboration than they felt was needed in a case. The PHNs also considered that there would need to be some organizational changes to ensure that they could use their competencies. For example, one nurse reported:

> We need more time and more resources to be able to work more towards society, promoting ourselves. However, it is difficult to be trusted by the population when we have not time for our basic tasks (PHN 4, child health clinic)

Competence

The meaning of the competence theme was about being able to identify the jurisdictional boundaries related to values, knowledge and skills of the professional. Some PHNs in this study were clear on what their skill sets were and referred cases when there was need for additional expertise. One PHN (2, from child health clinic) said that she referred the service users to more specialized services when she felt that her competence stopped. Another nurse (21, from both child health clinic and school health services) spoke about filling her appointment book as if she could handle everything. She was critical to this way of working, stating that PHNs thought they knew everything. What she meant was that this was not the truth, PHNs knew a lot, but not everything.

The PHNs in this study spoke about overlapping tasks with other professionals. As one PHN stated:

> It can be a bit difficult to know what role we have. I had a home visit together with a midwife and saw it was very much the same things she was concerned about as I (PHN 1, child health clinic & school health services)

In the child health clinic, both midwives and PHNs are employed. Midwives work mostly with pregnant and post-natal women, whereas PHNs work with the family and the newborn child. Some nurses spoke about the reduction of length of stay in hospital after childbirth when the family often comes home after two days. The PHN offers the family traditionally a home visit within 14 days but visits are now as a routine at some child health clinics within 48 hours after homecoming. The PHNs spoke of discussions about whether the PHN, midwife, or both, should do the home visit, referring to different and partly overlapping competencies. In the municipalities in this study, sometimes the PHN carried out the home visit, sometimes the midwife, and sometimes both professionals. One PHN said there was room for both the midwives and the PHNs to do home visits at different times, and the PHN did not want to abandon the home visit. The PHN said:

> I do not want us [PHN and midwife] to compete. There is room for both. We have not talked this specific over…very much can be done…I will not give up the home visit (PHN 8, child health clinic & school health services)

The PHNs found the first home visit to be a very important starting point for their further contact with the family.

In the school health service, PHNs also experienced overlapping tasks. Several nurses spoke of the school counsellor having similar and sometimes seemingly overlapping competences and approaches to the pupils, mostly in mental health matters. The PHNs sometimes experienced not knowing which tasks belonged to whom. As one nurse commented, "...other

professionals do things we could do and vice versa" (PHN 3, child health clinic & school health services).

The PHNs expressed a need for clarifying the different competencies of the various professionals, as one nurse commented:

> "As long as we are clear on what we can do, and others are clear on what they can do, it is excellent to collaborate" (PHN 11, child health clinic)

The data indicated that by having a mutual understanding of each other's competences a fruitful interprofessional collaboration in the best interest of the service user can develop

Recognition

Some PHNs experienced being visible and recognized by collaborators, whereas other nurses sometimes felt ignored by them. One respondent spoke of how PHNs gradually participated in more and more contexts:

> ...we [PHNs] have become a more visible group, and we are more included in many contexts (PHN 20, school health services)

Some PHNs in this study spoke of having substantial interprofessional collaboration, and that mainly, as noted by one interviewee (12, from school health services) this was "unproblematic and enriching" but also with some friction. Another interviewee (10, from child health clinic) viewed recognition as something that needed to be claimed in practice, and stated that PHNs must show that they know something, and dare to take some space. Some PHNs had learned that other professionals realised that PHNs had a contribution to make once they had experienced working with them.

In the present study the school nurses sensed they had to be in the field all the time otherwise the school forgot them or, as one PHN (19, HS) put it, they were "not counted on". The PHNs explained this was due to the brief time per week spent in schools; this might be as little as 2

hours and sometimes only every second week. The PHNs understood they needed to be visible to get recognition for their work.

Some PHNs spoke of disappointment when not being asked by collaborators for information about cases they worked on. They complained that other professions take no notice of them, and several nurses related this oversight particularly to the child welfare service. However, some PHNs explained the ignorance to be person dependent. As one informant stated:

> "The child welfare service does not demand our services... [I] think it is very person dependent too...what they need of our competence (PHN 20, school health services)

When one nurse (6, from school health services) spoke about being recognized, it was about being used, or addressed. That could mean getting an order form a teacher about teaching about anorexia in a classroom; this was appreciated, and the nurse felt useful. One nurse expressed the lack of recognition she felt:

> No other profession has the same education in prevention as us, yet we are sometimes told [by other professionals] that *they* can do that task and *they* can do that task (PHN 20, school health services)

Some PHNs in this study spoke of being taking advantage of, and not being valued for their competence. PHNs in this study feel exploited when doing secretarial jobs in the collaboration team that do not specifically relate to their professional competence. One nurse spoke about the role as follows:

> PHNs at this child health clinic have a very strong public health nursing identity… Still no PHN would say: I am a PHN so that [task] I cannot do (PHN 11, child health clinic)

These PHNs knew what comprised their field of work and wanted recognition for that but at the same time they were open for doing tasks outside their main working area.

Discussion

Interprofessional collaboration is influenced by a multitude of factors, such as conflicting organisational and professional agendas and resource requirements (Freeth, 2001). The findings revealed that institutional level decisions about what makes up the tasks of the PHN and economic efficiencies made institutions influence PHNs` collaborative working. Confusion over the PHNs` tasks and lack of resources was of importance to interprofessional collaboration, together with the overlap of competences of PHNs and other professional collaborators. The recognition of the PHN role by these collaborators was also important. Matziou et al. (2014) who, in a study of physician and nursing interprofessional collaboration revealed that the main barrier for a good relationship according to the physicians was a lack of recognition of the nursing role support this finding.

The importance of the professional field can relate to the way the institution gives signals of ranking of work priorities. The results indicate PHNs themselves experience having an important role in public health work. The institutional requirements for the profession create an important context for interprofessional collaboration, by facilitating sufficient time and resources in the form of PHN jobs or appointments. The results show PHNs have little time, and must choose between interprofessional collaboration and meeting pupils at schools. In other words, they are compromised by what Crawford & Brown (2011) call “fast healthcare” (p. 3), which places a heightened time pressure on the completion of tasks. A lack of resources and number of job positions make the role of the PHN less visible. In their intervention study to improve interprofessional collaboration and communication among health professionals, Rice et al. (2010) revealed barriers as professional resistance and a fast paced, interruptive environment, and absence of management support.

Freidson (2001) maintains the state controls the division of labor, by the exercise of power, and, as the study showed, a power dimension is present in interprofessional

collaboration, by hiring school counsellors and midwives in traditional PHN positions within school health services. The prestige of the public health nursing profession connects closely with the competence of the profession. For instance, being a doctor has traditionally been more prestigious than being a nurse. The present study shows PHNs have to some extent lost their position in public health control both in the child health clinic and at schools. In line with Abbott (1988), the jurisdictional border of PHNs` work has been transferred. When other professionals stated they could do the same tasks as PHNs, on the one hand, this can lead to PHNs feeling devalued, but on the other hand, the PHNs in this study are proud of their profession , and want collaborators to know what is special about the PHN contribution. Degree of control over working tasks decides how a profession is developing. When being defined as a profession, the professionals have power to prevent others from performing the same tasks (Abbott, 1988, Witz, 1992, Freidson, 2001). The study indicate that the PHN profession can be under threat because they are losing control of their working tasks. Indeed, working conditions favour other professionals such as midwives over PHNs, for instance in schools, and signal that PHNs can easily be replaced. To develop a profession, it is of importance that it is recognized with its specific value- and knowledge field (Abbott, 1988).

To develop a joint understanding of practice a deconstruction of professional concepts and methodology may be needed, for instance the concepts of health promotion and prevention. There is a lack of professional agreement on how to understand these concepts (Dahl, 2015). PHNs together with other professions such as the child welfare service, work with health promotion, but at different levels, and a joint reconstruction of the concepts can be of value for good collaborative work. Hall (2005) maintains each profession has its own culture of values, beliefs, attitudes and behaviours, and specializations within professions has increased the differences. Possibly can more transparency or openness about each profession contribute to develop a constructive interprofessional climate. Community of practices

(Wenger, 1998), where the professions come together, can contribute to a joint understanding of the collaboration issues, and how the work shall be distributed.

In the case with the relationship between midwives and PHNs in terms of who shall carry out home visit, the results show the division of labour related to home visits to families with newborns remains unclear. The poor collaboration between health visitors and midwives revealed in the review study of Aquino et al. (2016) support the findings. Psaila et al. (2015) identified that factors impacting collaboration between midwives and child health and family health nurses included the effectiveness of transferring client information and tension around professional identity and boundaries. The first period after childbirth can be critical in developing competence in motherhood and to succeed in breastfeeding, and professional help can be crucial (Hjälmhult & Lomborg, 2012). Greater clarity about exactly who contributes at this point is needed.

The reputation of the individual PHN can play an important role, determining whether they are viewed as competent. Some PHNs in this study feel collaborators appreciate their competence, whereas others feel this is disregarded. They noted how they struggle to be recognized as competent collaborators or have their skill sets recognized by other professionals, as was the case with the child welfare service. Some nurses experienced a lack of recognition for their work, and viewed this as person dependent. Almås and Ødegård (2010) maintain that nurses bring their personal and professional culture, competence and interaction style into the work setting. The findings in the present study indicate that the reputation of the individual professional, independent of profession, is of importance for the extent of success of the collaboration.

The PHNs experienced they had to be physically present for the other professionals to recognize them. This finding is in line with Willumsen (2007), who argued that interprofessional collaboration can be dependent on the professionals' preparedness, in terms

of networking, developing trust and flexibility. Trust and collaborative competence were also main findings in the collaboration study of Clancy et al. (2013). While providing different interventions, it can be important to understand and recognize each other's work and collaborate in the best way for service users. This can be maintained when professionals know and have trust in the competence of the collaborating professions, and physically meet and get to know each other in interprofessional communities of practice.

To reflect on practice situations in communities of practice (Wenger, 1998) based on PHNs' joint education in public health nursing, integration values, knowledge and skills, they can become what Schön (1991) names "reflective practitioners". Thus, PHNs can develop their competence and jurisdictional boundaries to other professions. The present study identified that PHNs took part in interprofessional collaboration. They were practitioners among different professions, sharing an interest in the case, however in the case with the midwives the interprofessional collaboration and jurisdictional boundaries was not well developed. PHNs in this study reflected on current problems in collaboration practices, but it was not clear whether they reflected *together* with interprofessional collaborators.

In the present study, the PHNs were clear on what their competence was and when to refer a case. However, PHNs were not sure whether other professionals knew their competence. Developing communities of practice between interprofessional collaborators as the school health services and the child welfare service can contribute to advanced understanding of each other's competence and professional focus and increased collaboration, thus meeting the governmental goal. Wackerhausen (2009) maintains it is necessary to establish interprofessional reflection. The discussions and learning climate determines whether they develop a joint understanding in a case to the benefit of the service users. Reflection on joint practice situations can contribute to learning, competence and developing practice (Wenger, 1998).

Midwives work closely with PHNs in the child health clinic, and in a time of transition in health care, a learning environment can strengthen the professions in combining productively to meet both institutional requirements and the needs of the families. There is a need to develop a joint understanding among professionals that every professional contributes to a shared repertoire of practice. In this way, in collaborating with other professionals, PHNs may experience recognition and begin to feel that their expertise is welcomed.

In relation to study limitations, the analysis of the interviews with PHNs about experiences related to interprofessional collaboration settings may not be automatically applicable in another country, yet the findings can be transferred to similar contexts. A further limitation of this study is that both authors BMD and PC are a PHN and Registered Nurse (RN) respectively. While this prior training and preunderstanding could lead to bias in the analysis of the data, both researchers set out to "let the text talk", which means not to impute meaning to the text that is not there (Graneheim & Lundman, 2004, p. 111). Focus group interviews rather than individual interviews could have given the PHNs the opportunity to reflect together and generate possibly richer data of the collaboration process. However, there is also the possibility that the PHNs would have been less forthcoming in describing personal experiences. We therefore chose interviews to get accounts that are more personal.

Concluding comments

Interprofessional collaboration in public health nursing needs support at an institutional level to ensure optimism and provide adequate time and resources. There needs to be a robust strategy in collaborative working that involves PHNs among other professionals to avoid role overlap, interpersonal and interprofessional conflict and reduce the damaging threat or stress that comes with informal or ad hoc rules of engagement and status claiming by one profession

over another. The institutional level also plays a role in recognizing the competence of the PHN profession as valuable in public health, in the form of making resources and job positions available. The importance of being familiar with a joint understanding of relevant concepts can be seen as a challenge that professionals need to work through to ensure benefit of the service users. The study indicates that the public health nursing role is challenged by the fact that the profession is often invisible and disregarded in the context of interprofessional service configuration.

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