Interdisciplinary Collaboration: The Experience of a Francophone Interdisciplinary Primary Care Team With the Integration of the Nurse Practitioner Role

by

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ABSTRACT

As life expectancy rises and the rates of chronic diseases increase, we are challenged to transform our vision of health care, particularly in primary care settings. One option to consider is rethinking team composition such as exploring team-based models that include diverse health professionals. In addition, expanding our understanding of what is needed for well-functioning interdisciplinary teams and effective integration of a wide range of professionals is imperative for effective health care services to meet the needs of our population. This case study was done to investigate the factors that impact team functioning with the introduction of a new role by comparing and contrasting perspectives from various professional groups and clients with the aim of better understanding what elements are important in facilitating integration of the new role. Analysis of the interviews and focus group transcripts revealed six primary themes: (1) gradual integration; (2) improved services; (3) perception of support; (4) health care professional specific qualities; (5) influences on team functioning and; (6) site and setting influences. This study highlights the importance of factors such as the new provider's familiarity, experience, and qualities in facilitating the other team members' and clients' acceptance. Another strongly elicited factor was the central role of support in influencing the integration. In addition, the findings reveal the positive impact that the new provider had on improving the services and in promoting the clients' adherence to their plan of care. Finally, recommendations for education, research, practice, and communication related to the nurse practitioner role are offered.

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CHAPTER 1: INTRODUCTION

1.1. Statement of the Problem

Interprofessional health care teams are a topic of interest in health care today. As the human life expectancy rises and the rates of chronic diseases increases, we are challenged to transform our vision of health care delivery (Stone, Dawson, & Harahan, 2004), particularly in primary care settings. The reality is that the complexity of health care needs continues to increase and the effective management of chronic disease requires diverse treatments beyond medications and acute treatments with long-term goals. "The aging of the baby boom generation, coupled with greater life expectancies and increases in chronic diseases and greater frailty, will drive an exponential demand for health and long-term care services over the next half-century" (Stone et al., 2004, p.581). As a result, the health care system must adjust to this increased longevity and growing complexity of care needs (Canadian Health Services Research Foundation, 2007). Potential strategies include rethinking team composition, and exploring team-based models of diverse health professionals that push the vision of health care service delivery beyond the singular focus of the physician role (Brown et al., 2010; Keefe et al., 2009; Lemieux-Charles & McGuire, 2006). This thesis aims to explore the lived experience of professionals and clients with the integration of the nurse practitioner (NP) role within an existing primary care team.

1.2. Background

The growing diversity of health care needs, and demand for quality by clients is driving health system changes, which includes the addition of providers to complement and extend physician skills (Grumbach & Bodenheimer, 2004). The redesign of primary

care to effectively address the needs of people living with chronic illness focuses on interprofessional team composition and the facilitation of roles beyond physicians (Eisenberg, 1997; Kreindler, 2008). For primary care settings, this transformation of health care teams will be essential for two key reasons. Firstly, these health centres face the increasingly complex needs of people with chronic diseases and secondly they provide services for all stages of life. Within these circumstances, there is a need to broaden the range of health care delivery expertise (Brown et al., 2010; Lemieux-Charles & McGuire, 2006).

In the last decade, primary health centres with interdisciplinary teams with doctors, nurses, nutritionists, psychologists, pharmacists and social workers are becoming popular (Desjardins, 2011). The Romanow Report (2002) played a catalytic role in the evolution of interdisciplinary teams (Desjardins, 2011). Documented benefits of interdisciplinary collaborations include better quality of care and improved client safety (Canadian Health Service Research Foundation, 2006). More specifically, it is found that these teams decrease hospitalizations and mortality in heart-failure clients and decreased the risk of death in people with strokes (Kreindler, 2009). As well, these health care teams have an enhanced capacity to deliver diverse services; in particular, those that effectively address the social determinants of health (i.e., social, economic, and housing needs) that commonly benefits marginalized populations (Muckle & Turnbull, 2011). Still, the accessibility of interdisciplinary health care services is at best an emerging reality. Desjardins (2011) reported that in 2007, only 39% of the Canadian population had access to such care. In addition, poor integration of interprofessional practice activities was common in those teams that do exist (Barrett, 2011).

One marginalized group that could benefit from an enhanced capacity to address social determinants of health is the Francophone population as they demonstrate higher rates of risks underlying poorer health status. In Manitoba, when comparing Francophone and Anglophone populations the percentage of people over 65 is 21% for Francophones versus 13% for Anglophones (Allaire, Bouchard, Carbonneau, & Morin, 2010). Studies also suggest that the health of older Francophone adults in Manitoba is not as good as the health of Anglophones of the same age (Chartier et al., 2012). We also know that the older population of Francophone Manitobans has a lower level of education. The statistics show that 52.7% have not completed high school while for the Anglophones, only 44.8% had not completed high school (Allaire et al., 2010). Educational disparity has been linked to poorer health (Gagnon-Arpin & Bouchard, 2011). Finally, there is evidence that Francophone populations in Manitoba do not have access to language appropriate care, which can also negatively influence health outcomes. Only 25% of Francophones in Manitoba have access to French language health and social services (de Moissac, de Rocquigny, Roch-Gagné, & Giasson, 2011). Similarly, La fédération des commauntés francophones et acadiennes du Canada (FCFA) has found that only 35% of Franco-Manitobans over 18 years of age have access to a Francophone medical clinic (FCFA, 2001). A shortage of Francophone health care workers is perceived as being an obstacle to the access of these services (de Moissac et al., 2012). All of these points support the importance of integrating expanded interdisciplinary health care service models within Francophone health care settings.

1.3. Purpose of the Study

This case study uses a descriptive interpretive approach to investigate

lived experiences related to the integration of a new health professional role in one Francophone primary care setting. The study describes role integration from the standpoint of a variety of health providers and management, along with eliciting the clients' voice in their experiences with role integration in the primary care setting. The perspectives of various professional groups and clients have been compared and contrasted with the aim of better understanding the factors that impact interdisciplinary collaboration and team functioning. The study sought evidence of how those strategies could be used to facilitate collaboration and resolution of issues with the introduction of new roles.

1.4. Research Questions

The following five questions guided this study.

1. How do existing team members perceive and live the integration of a new role within their interdisciplinary team?
2. What are the key factors that have impacted their acceptance of the new role?
3. What factors have resulted in better interdisciplinary collaboration?
4. How do clients live the integration of a new role? What is the client's perspective of the integration of the new role?
5. What strategies have worked in facilitating collaboration and resolution of issues in the introduction of new roles?

1.5. Significance of the Study

Growing evidence has emerged over the last 3 decades concerning interdisciplinary teams and conflicts between professions. However, most of the evidence draws on studies conducted in tertiary care with minimal research in primary care settings

(Brown et al., 2010). Only a few studies investigated primary care settings and issues arising from integrating new interdisciplinary health provider roles into existing care teams (Hendel, Fish, & Berger, 2007). In addition, no such studies have been carried out in primary care centres servicing a Francophone community. Lastly, interdisciplinary team functioning within the context of role integration has not explored diverse health professional perspectives. The client standpoint has also not been explored although we know that the client's understanding of a new health provider's role and scope of practice will influence their acceptance, and therefore their utilisation of the new role (Yeager, Dale, Casavant, & Burns, 2006).

Eliciting various perspectives can facilitate the discovery of new problem-solving strategies to circumvent disruption in team functioning when integrating a new role (Lemieux-Charles & McGuire, 2006). It is recognised that there is importance in extending our understanding of factors that influence the team's ability to be effective both clinically and organisationally (Lemieux-Charles & McGuire, 2006). It is also documented that a well-functioning team has many benefits in meeting the increasingly complex health care needs of the aging population and of the people living with chronic diseases (Haines et al., 2010). Conflict amongst members can arise when changes occur in the health care team. These conflicts must be effectively navigated to circumvent negative impacts on the effectiveness of care and client outcomes (Brown et al., 2010; Canadian Patient Safety Institute, 2011).

Seeing that there is no other Francophone primary centre that has extended their team to include a diverse interdisciplinary team, apart from *Centre de santé Saint-Boniface* where I was employed, this was an opportunity to connect with another centre

in New Brunswick. Doing so had the advantage of exchanging resources and expertise in an area that warrants further exploration. Therefore, it is my intention to bring the knowledge gained from this research to other primary care centres that plan to include new roles within their setting.

1.6. Assumptions

The assumptions that I bring to this research are based on my nine years of experience working as the manager of a bilingual primary care centre. During this time, two new professionals were added to our existing team. First the NP was integrated in 2005 and a kinesiologist was then integrated in 2009. Both were welcomed within this environment yet for various reasons, the integrations of the two roles were very different. Issues arose in both situations, which might have been circumvented if our management team had been aware of existing frameworks to guide the process of integration, and subsequently provided more structure to the new members being integrated. The new members required support to ensure their role was well defined and understood by other members so that the new processes could be implemented. Communication about the change and its impact on other team members was crucial for the success of the integrations. Management had a key role in planning, implementing and evaluating the whole process in order to minimize and deal with issues. Another assumption based on my experience is that management teams can greatly influence the integration of new team members by following a framework that helps guide the process. I can say this with certainty as I only became aware of such a framework after the integration of the NP. I was then able to use the framework to guide the process for the kinesiologist's integration. In doing so, we were able to better plan, implement the role, involve other

team members, and provide more support to the new member. It was also clear where I could have made a difference in the experience of the new NP.

In view of the complexity of interprofessional teams and based on my experience, I strongly believe that an educational foundation related to interprofessional team functioning and role integration would significantly benefit all team members and management. In conclusion, my two most important assumptions are that having an understanding of what constitutes good interprofessional functioning and following a framework are two factors that enhance the success of integrating new roles within primary care settings.

1.7. Definition of Terms

Primary Care: The Institute of Medicine defines primary care as, "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing sustained partnerships with patients and practicing in the context of family and community''(Donaldson, Yordy, Lohr, & Vanselow, 1996, p.1). The Canadian Health Services Research Foundation (2007) adds these elements to the definition: "It is a proactive approach to preventing health problems and ensuring better management and follow-up once a health problem has occurred. Primary care is the element within primary health care that focuses on health care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury'' (p.1).

Interprofessional Team: Grant et al. (1995) define the interprofessional team as, a small number of people with complementary skills who are committed to a common purpose, performance goals and approach for which they hold themselves mutually accountable.

Collaboration: The Canadian Academy of Health Sciences (2010) proposes that

interprofessional collaboration "is not a substitution model (i.e., not "nurse instead of physician") but rather one that allows for a group of health professionals to work in a complementary way to improve access to comprehensive person-focused services and care" (p. 23).

Integration: The Merriam-Webster Dictionary (2014) defines integration as the "incorporation as equals into society or an organization of individuals of different groups''. The MacMillan Dictionary (2014) completes this definition by adding that it is also becoming fully involved in the activities of this group.

1.8. Summary

In this chapter the significance of rethinking team composition and exploring team-based models that push the vision of health care services beyond the singular focus of the physician role have been discussed. The increasing complexity of health care needs is driving our need to successfully integrate new members within existing interprofessional teams. As well, the author outlines underlying assumptions and provides definitions of key terms central to this study. The chapter serves as the foundation and rational for the pursuit of this project.

CHAPTER TWO: REVIEW OF THE LITERATURE

2.1. Introduction

A review of research literature concerning the integration of new roles within primary care settings was completed. The goal of this literature review was to identify previous research, to summarize what has already been discovered and to identify gaps (Grant & Booth, 2009). The importance for exploring this topic is discussed prior to outlining the review methodology. In the Results section we focus on how the various sources have defined collaboration, whose perspective has been investigated and which factors can lead to interprofessional conflicts when integrating new roles. Finally, the factors and strategies influencing the integration will be elucidated.

2.2. Background

Chronic disease management, a growing health care priority, is transforming our vision for health care delivery (Stone et al., 2004); particularly in primary care settings. Over the last few decades, there has been an increase in life expectancy and rates of chronic diseases have changed health care consumer needs and demands for health care services (Gould, Johnstone, & Wasylkiw, 2007; Porter-O'Grady, 2004). Reliance on a physician driven health care service has become an insufficient model to address health care needs to manage chronic diseases (Grumbach & Bodenheimer, 2004; Porter-O'Grady, 2004). The increasing complexity of clinical decision-making is challenging and even unmanageable for any single provider; rather, diversity of knowledge provided by multiple professionals better serves client's health care needs (Porter-O'Grady, 2004). Thus, health care service delivery models, which integrate alternative primary care team structures, are emerging as answers to these changing demands and evolving vision for

health care delivery.

Alternate primary care team compositions, inclusive of diverse health professions, have become part of comprehensive health care service models (Lemieux-Charles & McGuire, 2006; Keefe et al., 2009). These teams, a central component influencing the quality of care provided, are recognised as enhancing the use of best practices (Schuetz, Mann, & Everett, 2010). In Canada, the Romanow Report (2002) played a catalytic role in primary care setting changes (Desjardins, 2011), which when supplemented by a growing evidence base of better management of chronic diseases has supported integration of interprofessional teams in primary care settings (Humbert et al., 2007). Moreover, the Canadian Health Service Research Foundation (2006) identifies clear benefits with interprofessional collaborations, such as better quality of care and improved client safety.

Within acute health care settings there is an abundance of literature concerning interprofessional collaboration and various elements that constitute a well-functioning team. Yet, within primary care settings, few studies have focused on interprofessional issues and how to address conflict (Hendel et al., 2007). Interprofessional functionality can be challenged with the introduction of a new role because members of the same discipline tend to identify with their own group to the detriment of the relationship with other professions (Jones, 2006; Mohaupt et al., 2012). Porter-O'Grady (2004) suggests that conflict is inherent in human interactions especially within health care due to the diversity of roles and personalities involved. Although evidence focused within primary care settings is emerging, one notable gap is the investigation of interprofessional collaboration when a novel health profession is added to the team (Bridges & Myer,

2007).

Research that investigates interdisciplinary teams and their functionality within in primary care settings will aid our transforming health care delivery system. Expanding our understanding of well-functioning interprofessional teams, in particular when a wide range of professions are integrated into a primary care setting, is an emergent imperative to best service the health care needs of our current population. Given this assumption, a structured review of the literature was guided by two objectives. The first is to discover what has been learned about the successful integration of new roles within an existing team in primary care settings. The second was to explore the various perspectives on interprofessional issues that arise in the process of integration.

2.3. Methods

A structured literature review was conducted on articles that were (a) published between 2003 and 2013, (b) research focused, (c) investigated the integration of a new team member within a primary settings, (d) published in French or English. The search of subject and key words was conducted using the following terms, *family medicine, general practice, primary health care, delivery of health care, integrated health care, role, attitude of health personnel, collaboration, introduction, integration, cooperation, interdisciplinary communication, teams, teamwork, multidisciplinary, interdisciplinary, interprofessional, conflict*. Multiple data bases were searched: CINAHL, Pub Med, Embase, Scopus, Web of Science, Proquest and the metasearch, One stop; all were accessed through the University of Manitoba's ejournal's and data base. Five articles were identified, from which the reference list was reviewed for additional potential articles that fit the inclusion criteria. The search process produced 11 articles focused on

role integration in primary care.

2.4. Results

All eleven studies included in this review, investigated the integration of a new health professional role within a primary care setting: pharmacists (n=5), Nurse Practitioner (NP) (n=2), chiropractors (n=1), occupational therapists (n=1), psychologists (n=1) and social workers (SW) (n=1). Nine studies used qualitative methods only and two were mixed methods studies. Eight studies originated in Canada, one in England, one in Australia and one in the United States. One study was conducted in a Francophone setting within the Canadian province of Québec.

Data extracted from the eleven articles reviewed is presented through the use of five themes, which together address the review objectives. The themes are: (1) how is interdisciplinary collaboration defined (2) whose perspective is being investigated (3) presence of interprofessional conflicts or issues (4) factors influencing integration and (5) strategies for successful integration. The following section presents evidence from the extracted data framed by these themes.

2.4.1. How is Interprofessional Collaboration Defined?

These studies sought to understand how best to integrate a novel health professional discipline within an existing team as a means to improve the quality of services and client outcomes. The nature of defined interprofessional relations is worthy of reflection when exploring the integration of novel roles in primary care settings. The Canadian Academy of Health Sciences (2010) proposes that “interprofessional collaboration is not a substitution model (i.e., not “nurse instead of physician”) but rather one that allows for a group of health professionals to work in a complementary way

to improve access to comprehensive person-focused services and care" (p.23). Reay, Patterson, Halma, & Steed (2006) define interprofessional collaboration as a process through which different professional groups work together to positively impact client outcomes. The key aspects are that diverse health professional groups work together in a complementary way to improve health care services, which is echoed through the intentions identified in the studies reviewed. Some studies considered that collaboration is an ability to work more closely with other professionals with the goal of developing a professional relationship (Bradley et al., 2008; Freeman, Cottrell, Kyle, Williams, & Nissen, 2012) and to learn from one another's expertise (Garner et al., 2008; Keefe et al., 2009). Collaboration includes activities such as referrals back and forth between the providers and case collaboration on the client care planning (Garner et al., 2008; Turcotte, 2005). Finally, collaboration is associated with care that is more comprehensive and better meets the needs of the population being served (Keef et al., 2009).

2.4.2. Whose Perspective is Being Investigated?

Various professional group perspectives were explored in an attempt to understand factors that impede or improve interprofessional collaboration with novel team member roles. Six of the eleven studies reported on interview or focus group results based solely on physician participants. Two studies involved nurses (Keefe et al., 2009; Turcotte, 2005; Donnelly, Brenchley, Crawford, & Letts, 2013) and two were unspecific as to the disciplinary make-up of "team members"(Kolodziejak, Remillard, & Nebauer, 2010) or "RHA staff" (Reay et al., 2006). One study included "health care consumers" in their focus groups and interviews (Freeman et al., 2012) and another study unsuccessfully attempted to obtain client input (Kolodziejak et al., 2010). Another study sought the

input from the Executive Directors, the physicians, the new post holder and other teams members involved with the occupational therapists being introduced to the team (Donnelly et al., 2013). Finally, three studies specifically sought the newly integrated post holders' perspectives of barriers or facilitators to their role integration (Farrell et al., 2008; Gould et al., 2007; Donnelly et al., 2013). While there is diversity among the stakeholders included in these studies, it is notable that the voice most frequently heard is that of the physician group. This is not necessarily surprising given that physicians continue to be dominant in primary care settings, yet the minimal presence of alternate voices is disappointing and unreflective of the emergent vision for team-based care models (Canadian Academy of Health Sciences, 2010).

2.4.3. Interprofessional Conflicts

Porter O'Grady (2004) suggests that with the diversity of disciplines working in health care, one can expect the existence of conflict. When reviewing the articles, we looked for evidence of conflict. While reporting on conflict was not always the primary goal in the articles, certain realities were brought forth that imply that conflict existed.

Lack of acceptance and competition. Physician reluctance in accepting other professional groups within health care teams is not a new concept. While this reluctance is less pervasive today, the reality continues in primary care settings. Freeman et al. (2012) and Bradley et al. (2008) studies noted the existence of turf wars and reluctance of physicians to fully accept the integration of new team member roles within their family practice. A lack of confidence in the utility of the new role resulted in restricted ability to work effectively and created frustration for new post holder (Bradley et al., 2008; Freeman et al., 2012; Turcotte, 2005). This competition between disciplines was more

pronounced when roles overlapped and the new post holder threatened income in fee for service health care settings (Gould et al., 2007; Turcotte, 2005). Professional insecurity with the new role and power issues on the part of doctors was a distinct theme (Bradley et al., 2008). In the review of twelve studies by Sangster-Gormley, Martin-Misener, Bowne-Wambolt, and DiCenso (2011), six of the studies revealed that physician resistance was as a source of conflict to NP integration.

Lack of knowledge related to the new role. Lack of knowledge related to the scope of practice can create conflict with other team members. Two mechanisms resulting in conflict were: feelings of competition with the new post holder (Reay et al., 2006; Turcotte, 2005) and confusion of how to refer and/or work with the new post holder (Turcotte, 2005). Porter O'Grady (2004) recognised the critical importance of clearly defining of roles in diverting the misunderstanding that frequently underlies team conflicts; similarly Sangster-Gormley's et al. (2011) integrative review reported that role ambiguity influenced team members' resistance and confusion.

2.4.4. **Factors Influencing Integration**

The previous section touched upon reported conflicts, which also hinted at several factors that disrupt full integration of a new health professional role. In this section, factors that reside within both primary care team members and organizational structures are discussed.

Team member influences. There are several key factors that positively impact integration of roles; one is the importance of clear definition of roles (Bradley et al., 2008; Donnelly et al., 2013; Farrell et al., 2008; Freeman et al., 2012; Keefe et al., 2009; Kolodziejak et al., 2010; Turcotte, 2005). Knowing the new post holder's functions

and how these will be carried out within the team promotes collaboration and referrals (Donnelly et al., 2013; Keefe et al., 2009; Kolodziejak et al., 2010; Turcotte, 2005). Knowing what to expect leads to a greater comprehension of how the new role enhances the care provided to the clients and creates a perception that this role is meeting the unmet needs of the population (Donnelly et al., 2013; Keefe et al., 2009; Turcotte, 2005).

Factors that increase the propensity of physicians to support the new role is when value added for the clients is clear along with how the role does not impede their work nor work hours (Donnelly et al., 2013; Keefe et al., 2009; Reay et al., 2006). Physicians appreciated knowing how the enhanced team resulted in better use of health care resources and less use of emergency departments (Reay et al., 2006). Another selling point for this professional group was the new post holder's ability to manage issues that required more time or specific expertise (Keefe et al., 2009).

Post holder influences. The new post holder's characteristics have been shown to influence integration of their role within existing teams (Garner et al., 2008; Turcotte, 2005). The ability to demonstrate professional competence and to establish credibility within the team has been instrumental for successful integration (Freeman et al., 2012; Kolodziejak et al., 2010; Reay et al., 2006). Client's positive perception of competence of a new post holder in undertaking the functions of the role appeared to influence the credibility of new post holder among the team members (Reay et al., 2006).

Beyond professional competence, personality traits also appeared to influence successfulness of new role integration. Demonstration of confidence, social abilities, and the person's openness to learn about and respect the other professional's roles enhanced the new post holder's abilities to fulfill the role (Reay et al., 2006; Turcotte, 2005). A

common barrier noted reflected the level of understanding the new post holders had of the primary care setting environment. When a new post holder had minimal previous experience in primary care settings and had limited expertise in team functioning, chances were the new post holder's ability to carry out their role was impeded (Farrell et al., 2008; Kolodziejak et al., 2010).

Client influences. While client perceived competence of the new post holder was influential, there are two other notable client perceptions. From the clients' perspective the addition of a new role was regarded as positive when the new role improved access and quality of services (Freeman et al., 2012). As well, clients appreciated being served by professionals most knowledgeable in the management of their diverse care needs (Freeman et al., 2012).

Site and setting influences. The majority of studies revealed that being in close proximity and having easy access to the new post holder was fundamental for successful integration of the new role (Donnelly et al., 2013; Farrell et al., 2008; Garner et al., 2008; Keefe et al., 2009; Turcotte, 2005). Regular contact and easy access have been identified as key facilitators to integration for many reasons. First off, proximity has the advantage of facilitating the frequency of contact and therefore familiarity which then promotes confidence (Donnelly et al., 2013; Freeman et al., 2012; Turcotte, 2005). Bradley et al. (2008) suggested that co-location facilitates a greater level of integration and offers professionals greater opportunity to learn from each other. Other advantages identified were an improved awareness of the new role, greater familiarity with each other's skills and finally, enhanced trust and acceptance (Bradley et al., 2008; Gould et al., 2007; Pottie et al., 2008;). Donnelly et al. (2013) identified that having an electronic medical record

was a critical factor as it enabled both formal and informal communication with the team.

Lack of access and time to meet with other team members can create frustration and conflict as the team members have limited opportunity to learn how to work with the new post holder (Pottie et al., 2008; Turcotte, 2005). In a fee for service environment, this barrier was particularly problematic, which was believed to be influenced by physicians in these settings, as they are accustomed to working in silo's and are remunerated by volume of client visits (Turcotte, 2005).

2.4.5. Strategies to Successful Integration

Providing mentorship to the new post holders. Various strategies to prepare the post holders in a new role have been reported. One strategy is to provide mentorship to the new post holder, which was identified to assist in role and skill development necessary to facilitate functionality of the team (Farrell et al., 2008; Freeman et al., 2012; Reay et al., 2006). In one study, pharmacists received training about the functioning of family practice setting prior to their integration (Freeman et al., 2012), whereas others had an advisor provide ongoing mentorship specific to educational and emotional needs that emerged (Farrell et al., 2008; Freeman et al., 2012). Management assistance in developing strategies to work through the potential and existing conflicts with the team members has been beneficial (Reay et al., 2006), which holds the potential of promoting system navigation in complex settings (Bryant-Lukosis & DiCenso, 2004; Sangster-Gormley et al., 2011).

Providing education for the team members. Role clarity is a crucial element for successful introduction of new roles; teams who understand the functions of the new role are more likely to collaborate with the new post holder role. As Gray et al. (2010)

explained, “acceptance or resistance seems to be related to whether there is role clarity or role uncertainty” (p. 24). Several strategies have been used to enhance role clarity. A common strategy is education sessions on the new post holder’s role functions, which allowed other providers to comprehend the various skills and services provided along with fit with their role (Donnelly et al., 2013; Farrell et al., 2008; Garner et al., 2008; Keefe et al., 2009; Kolodziejak et al., 2010). As a result, referrals from physicians were higher and better integration of the new role was apparent (Garner et al., 2008).

Ensuring regular contact with the other team members. Being in close proximity and having easy access to the new post holder was fundamental for their integration (Donnelly et al., 2013; Farrell et al., 2008; Garner et al., 2008; Keefe et al., 2009; Turcotte, 2005) both of which enables communication and creates mutual respect among team members (Bradley et al., 2008; Freeman et al., 2012). The more exposed, the better the relationship and trust (Bradley et al., 2008; Donnelly et al., 2013). In addition, proximity assists in adapting to new practice patterns (Pottie et al., 2008). Proximity and access to the new post holder can be supported through co-location (Bradley et al., 2008). Equally of importance is to include the new post holder in regularly scheduled meeting, which improved the attitudes and perceptions of team members (Donnelly et al., 2013; Garner et al., 2008). Donnelly et al. (2013) specifically identified the opportunities to collaborate with other professionals related to the care of clients as a factor facilitating integration.

Involvement of stakeholders. Stakeholders are representatives from various groups such as administrators, providers, families, clients and government agencies who have important perspectives to share. (Bryant-Lukosius & DiCenso, 2004). Involving

stakeholders early in the processes of expanding a primary care team "is critical for ensuring commitment to and providing support for the planned change" (DiCenso et al., 2010). The studies reviewed reported on a variety of ways to engage stakeholders. Bradley et al. (2008) involved the general practitioners in the planning stage in order to get early buy in. Garner et al. (2008) solicited input throughout the first two years, which ensured knowing providers' perceptions, opinions and experiences with chiropractic care. Two other studies reported involving all the providers to determine perceived needs of the population being served (Keefe et al., 2009; Kolodziejak et al., 2010), which was used to inform messaging about the new post holder's role and revealed challenges to be addressed with the integration of this role. Finally, Kilpatrick and colleagues (2012), suggested that strategically planned involvement can support the team members in knowing what to expect and consequently be more receptive to the new team member.

2.5. Discussion

A review of the current literature reveals how the integration of a new role in primary care settings is multifaceted. Improving health care services through the integration of new roles will be supported from a thoughtful and systematic planning process that considers individual, role and structural influencing factors. Alternately, through this review we reveal four gaps worthy of further discussion: evidence from Francophone settings, a strong voice from non-physician interdisciplinary team members, the silence of patient voice on new roles, and the educational needs of existing teams.

2.5.1. Francophone Setting Insights

The representation of Francophone settings was minimal in the literature. One study done in Québec, provides insights from a Canadian province where the

majority of the population is Francophone (Turcotte, 2005). In Manitoba, another Canadian province, the Francophone population is a minority and is known to have a high percentage of residents over 65 years of age with poorer health outcomes than the Anglophones (Chartier et al., 2012); evidence from Manitoban primary care settings might provide unique insights. The importance of further investigation of services for Francophone populations is supported by the evidence that they rarely have access to language appropriate care (de Moissac et al., 2011), which can negatively influence health outcomes (Gagnon-Arpin & Bouchard, 2011). Marginalized Francophones could benefit from an interdisciplinary team, which would improve capacity to deliver diverse services and enhance effectiveness to address the social determinants of health (Muckle & Turnbull, 2011).

2.5.2. Professional Perspectives Moving Beyond the Gate Keepers' Views

The doctors' perspective on integrating various new professional groups was dominant in the studies reviewed (Bradley et al., 2008; Freeman et al., 2012; Garner et al., 2008; Keef et al., 2008; Pottie et al., 2008; Turcotte, 2005), which is reflective of their dominance as gatekeeper in primary care. Through this review, we heard the physicians' need to care for their clients in an efficient manner without having to spend too much time in consultations with new post holders. Conversely, they appreciated the ability to seek support from other providers that have an expertise that they do not have (Bradley et al., 2008). There needs to be incentives for physicians to embrace the interdisciplinary teams, which may include: benefits for their clients (Keefe et al., 2009), cost recovery, and long term impact on the health of the population (Reay et al., 2006). Understanding the physicians' perspectives and learning to negotiate these factors will enhance their

openness to collaboration.

While hearing the voice of physicians is important, having greater insight into other health professionals' needs is equally essential to support functionality of interdisciplinary teams. Given the current expanding reality in primary care to include diverse professionals, gaining insights from diverse standpoints is a worthwhile pursuit to support functionality of emerging team compositions.

2.5.3. Silence in Patient Voice

Only one of the ten studies elicited the voice of the client or consumers of care. In this study, the consumer discussed the addition of the role mostly in terms of getting easy access to the provider with the most appropriate expertise to meet their needs (Freeman et al., 2012). The lack of the clients' perspective in the integration of role is a gap and further research is needed to elucidate their perceptions along with needs related to the provision of primary care services.

2.5.4. Need to Educate Existing Teams

Interestingly, the notion of providing the existing teams with education about interdisciplinary functioning prior to the integration was not mentioned as a strategy. Such is the current situation despite the fact that at least one study noted that existing teams lacked the training to develop the skills required for collaboration (Bleakley, 2013). We are in a time where professionals working in teams must have more than an intuitive understanding of what collaboration means (Bleakley, 2013). Thoughtful planning and educational preparation for health care providers to work together and share expertise within a team environment is imperative to enhance health care services (Canadian Academy of Health Sciences, 2010).

2.6. Summary

The successful integration of new roles within primary care has emerged as an imperative and yet, multiple elements remain to be addressed. Gaps identified through this review of the literature reveals limitations in the sources that inform evidence of team functionality within primary care settings when integrating a new role: we have limited insights from client voices, and from provider voices beyond physicians. Perspectives from the Francophone population and from those within these primary care settings are also lacking. Since we know that the emergence of interdisciplinary teams in primary care is imperative to meeting the changing needs of health consumers, evidence to inform thoughtful planning and implementation of strategies is necessary. The improvement of health care services through the integration of new roles must be supported by a thoughtful and systematic planning process that considers influences from the post holder, the stakeholders, and the physical setting. In addition, it is essential to the health care needs of our current population that we expand our understanding of well-functioning interprofessional teams, particularly when a wide range of professions are integrated into a primary care setting (Canadian Academy of Health Sciences, 2010). Effective interdisciplinary teams in primary care are evolving beyond nice luxuries, and are emerging as a necessity in primary health care settings.

CHAPTER 3: CONCEPTUAL FRAMEWORK

The conceptual framework chosen to guide the study is called PEPPA, which stands for the participatory, evidence-based, patient-focused process for advanced practice role development, implementation, and evaluation framework (PEPPA) (Bryant-Lukosius & DiCenso, 2004). This framework was developed to guide the integration of advanced nursing practice (ANP) role in a variety of health care settings, and is pertinent to the field of role integration within health care services. In this chapter, the framework is described along with its applicability to the phenomenon being studied in this thesis.

3.1. Introducing PEPPA Conceptual Framework

The PEPPA framework focuses on the integration of APN roles and is currently one of the few available frameworks concerning the integration of new health professional roles in the literature. This nine-step framework outlines implementation and evaluation process for the integration of a new role (McNamara, Giguère, St. Louis, & Boileau, 2009). Although not yet empirically tested, the PEPPA developed through principles of participatory research, is based on numerous studies on the implementation of APN roles; as well, it is a most comprehensive framework for the implementation of APN roles (Bryant-Lukosius & DiCenso, 2004). It was inspired the work of Dunn and Nicklin, who developed two components to the integration of APN roles: Key Steps for the Nursing Profession to Consider and Steps for Hospitals to Consider in the Implementation of the NP Role (Bryant-Lukosius & DiCenso, 2004). The PEPPA framework was also inspired by elements of participatory research. Sangster-Gormley et al. (2011) describe the model as follows, “The framework demonstrates an organized, interrelated process that moves from initial discussion of what changes to the current

model of care are needed to facilitate an APN role, to implementation and evaluation of the role once implemented" (p.1178). See appendix A for a diagram of this framework.

3.2. The 9 Steps of the PEPPA Framework

Step 1: Define Patient Population and Describe Current Model of Care

The first step is to define the population and describe the current model of care. This first step is important as it reveals the clients' and community's needs. In addition, this step is carried out to delineate how the clients use the services and how they interact with the various professionals (Bryant-Lukosius & DiCenso, 2004)

Step 2: Identify Stakeholders and Recruit Participants

Stakeholders are people who have a vested interest in the change and should be chosen from a range of people who are affected by the introduction of the new role (DiCenso & Bryant-Lukosius, 2004). They are representatives from various groups such as administrators, providers, families, clients and government agencies. They are the key players who have a vested interest in the planned change and who have important perspectives to share for the development of a new model of care (DiCenso & Bryant-Lukosius, 2004). This is a critical step to ensure the commitment from the various stakeholder groups (Bryant-Lukosius & DiCenso, 2004).

The advantages of involving stakeholders are clearly documented in the literature. Involving stakeholders early in the process "is critical for ensuring commitment to and providing support for the planned change" (Canadian Nurse Association, 2006). It will also promote role clarity, integration of the role within the local environment and a culture of shared values and beliefs. This group can also be instrumental in identifying barriers and facilitators (Bryant-Lukosis, DiCenso, Browne, & Pinelli, 2004).

Step 3: Determine a Need for a New Model of Care

This third step enables the organisation or participants to review the strengths and the limitations of their current model and determine how it is meeting the needs of their population (Bryant-Lukosius & DiCenso, 2004). Some of the factors that should be considered when assessing the current model of care are accessibility, client and staff satisfaction, affordability and adequacy of human resources to meet the demands (Bryant-Lukosius & DiCenso, 2004; Canadian Nurse Association, 2006). At this step, community and client support should be ascertained. In addition, it is important to explore how this change will affect the role of other professionals within the environment. Another important question is to ask which type of professional is best suited for the identified needs (Bryant-Lukosius & DiCenso, 2004). Lastly, it is crucial to include the identification of unmet needs as the first step for the planning and implementation of the new role (Dunn & Nicklin, 1995).

Step 4: Identify Priority Problems and Goals

This next step focuses on understanding the needs and setting priorities based on the previously collected information. Doing so provides an opportunity to look at the current model's strengths and weaknesses in meeting the identified needs (Bryant-Lukosius & DiCenso, 2004). With this information, the group can then work toward identifying priorities, setting goals to improve the current model, and identify outcomes in order to evaluate the new model of care (Bryant-Lukosius & DiCenso, 2004). This process forms the basis for evaluating the modified or new model of care and new roles played by the health care team (Canadian Nurses Association, 2006).

Step 5: Define the New Model of Care and the APN Role

This is an action stage whereby the team establishes which changes in the current roles and responsibilities are required to implement the new model of care. The definition of every area of responsibility for the new role is determined and includes the new provider's relationship with other providers (Bryant-Lukosius & DiCenso, 2004).

The team also needs to determine whether the role in question will in fact help achieve the goals established in the previous step (Bryant-Lukosius & DiCenso, 2004).

The team needs to confirm that the new role has the necessary expertise to bridge the gaps in services. Decisions to introduce a new role must involve careful evaluation of the strengths and limitations of the new role as compared to other health care provider roles (Canadian Nurse Association, 2006).

Step 6: Plan Implementation Strategies

This stage involves planning for the implementation of the role through setting goal-related outcomes, and identifying facilitators and barriers (Bryant-Lukosis & DiCenso, 2004). It is known that without a clear definition of roles, it is likely that the stakeholders will define the role based on what they think it should be, resulting in numerous interpretations and implementations of the role (Bryant-Lukosis et al., 2004). Another recommended activity in the development of a plan is collecting baseline data to facilitate the evaluation of the new role. In addition, the resources necessary for the implementation are examined. These resources include administrative support for the role, mentorship, regular contact with management, and evaluation of progress (Bryant-Lukosius & DiCenso, 2004).

The following are examples of questions that were recommended in the planning

stages for the implementation of the NP role: “Have you reviewed, and do you understand the legal, professional and regulatory guidelines and standards in relation to the NP role? Do you understand the role expectations that will increase team effectiveness and improve patient/community outcomes? Are patients aware of the role of the NP, and are they willing to see the NP?” (Canadian Nurse Association, 2006, p.28) These questions could be relevant to most new roles being implemented.

The regulatory mechanisms, which are at the legislative level and at the wider health care system level, need the involvement of the professional body in order to gain regulatory approval. Policies and procedures are other essential elements in this pivotal step toward the acceptance of the NP role (Bryant-Lukosis & DiCenso, 2004).

Step 7: Initiate APN Role Implementation Plan

The implementation of the role is a continuous process evolving over time using the strategies discussed in the previous step. At this point, stakeholders and incumbents are oriented to the role while administrative support, resources, policies and procedures are also put in place (Bryant-Lukosis et al., 2004).

Step 8: Evaluate APN role and New Model of Care

Evaluation is necessary to determine the contribution of the new role and to permit the gathering of empirical evidence for policy development (Sidani & Irvine, 1999). Similarly to new interventions, the introduction of new health care provider roles should be based on evidence documenting the need and effectiveness of the role (Spitzer et al., 1974). As early as 1974, Spitzer et al. had already identified the importance of providing evidence in the introduction of the NP role through descriptive studies, assessment of process, surveys and randomized controlled trials.

Sidani and Irvine (1999) also state that in research, the inability to differentiate the outcomes of the NP from those of other providers impedes on the ability to validate the importance of their role. They also emphasise the importance of looking at structure (resources, physical and organizational environment) and process (types of services and how services are provided) of roles and how these impact outcomes (Sidani & Irvine, 1999). They specify that the outcomes should be both client related and cost related. Yeager et al. (2006) went a step further to propose that assessing and documenting the outcomes of the NP practice in studies, such as their own, are valuable in demonstrating the benefits of using APNs.

Step 9: Long Term Monitoring of APN Role and Model

Each of the nine steps of the PEPPA framework should be reviewed with the goal of making necessary changes to the model of care (Bryant-Lukosis & DiCenso, 2004). By examining the diagram of this framework, it is clear that the process is ongoing.

3.3. Application of the Framework in this Study

The PEPPA framework is pertinent to this study, as it was specifically developed to assist in the integration of advanced nursing practice roles. This framework guided the research in various manners. Firstly, its emphasis on various steps that are important to follow in integration inspired the questions for the interviews and the focus groups. These questions were developed to elicit answers that helped confirm if the research site had included and possessed an understanding of the steps as recommended by the PEPPA framework. Secondly, the framework increases awareness of the barriers and facilitators of role integration. Understanding these factors through the framework helped to draw out the barriers and facilitators through the interview and focus groups questions and also

informed what other pertinent information should be collected and observed during the data collection period. In appendix B, a table displays the framework's nine steps and the key indicators for each step. In addition, this table links the nine steps to questions guiding the thesis, along with sources of data to support the investigation of each step. Although this framework did not drive the analysis, the final chapter discusses the study site's integration process in relation to the PEPPA framework's recommended steps. This discussion also includes the potential impact of having followed these steps more completely during the integration of the new provider's role.

3.4. Summary

This chapter provides a description of the PEPPA framework's nine step. The relevance of this framework to this study is discussed along with a description of its influence and use in guiding the study. It also reveals that the integration of new roles is complex and that the successful implementation of these roles is influenced by a multitude of factors (Sangster-Gormley et al., 2011). This framework serves as an essential foundation for understanding the necessary elements of successful role integration within an existing primary care team.

CHAPTER 4: METHODOLOGY

A qualitative approach was used to explore the integration of a new interdisciplinary role within a Francophone primary health care centre. In this chapter, the research design, the research setting, the sampling strategy, as well as the recruitment and sampling procedures for this qualitative study are discussed. Finally, the data collection procedures, data analysis and measures of rigor are addressed.

4.1. Methods

A case study design that integrates a descriptive interpretive approach to investigate the lived experiences of staff and clients guided this study conducted in one primary care setting. The study sought to explore the experiences of role integration from these diverse standpoints. The case study design "is an evidenced based, empirical approach that focuses on an intense investigation of a single system or phenomenon in its real life context" (Lee, Mishna, & Brennenstuhl, 2010, p.682). This design is recommended when needing to answer questions about an existing phenomenon while taking into consideration the context within which it is occurring (Yin, 2003). Observing the situation firsthand creates the opportunity to capture the nuances of what subjects are living (Flyvbjerg, 2012). In addition, the depth of examination of a single site and the ability to immerse oneself in the organisational processes brings clarity to the various viewpoints (Yin, 2003). Finally, a case study design provides an opportunity for the researcher to collect comprehensive information using various techniques of data collection over a period of time (Creswell, 2003).

A descriptive interpretive approach encourages the researcher to purposefully elicit underlying meanings by asking questions about the participant's perspectives

(Thorne, 2008). Interpretative research aims to explore how people come to view their experiences while considering the context within which they have lived this experience (Denzin & Lincoln, 2003). Thus, integration of a descriptive interpretive approach supports expansion of our understanding of role integration by eliciting diverse perspectives and by exploring participants' lived experiences. As stated by Thorne (2008), the implicit benefit of being attentive to detail is to gain greater understanding that can then be applied to the other practice settings. Thus, in this study an ultimate goal is to bring these discoveries to light so that they can be used by those responsible of the integration of new roles. Both the case study design and the descriptive interpretative approach support in-depth exploration of individuals' lived experiences with the integration of roles within the context of their health setting. The descriptive interpretive method facilitates the elicitation of various perspectives while the immersion in a single case setting enables a holistic view on how that centre facilitated the integration. As Yin (2003) proposed, "the case study allows the investigation to retain the holistic and meaningful characteristics of real-life events" (p.15).

4.2. Sampling Strategy and Rationale

Purposeful sampling was the chosen sampling strategy for this research project, which is recommended in qualitative research because it supports selection of participants or sites based on their ability to best inform the researcher in regards to the research questions (Creswell, 2003; Flyvbjerg, 2012; Patton, 2002). Purposive sampling is particularly advantageous for in-depth study (Coyne, 1997). Yin (2003) proposes that participant selection should focus on those who have lived the experience seeing as they have an understanding and a perspective to share about the phenomenon being studied.

Purposeful sampling also guided case study site selection. My last 10 years of professional experience has been involved in primary care. Through networking, a physician colleague provided a contact from the New Brunswick primary care system. As a result, a key player was identified as being linked with the bilingual primary care centres in New Brunswick. Furthermore, a primary care centre working with an interdisciplinary team that had integrated new roles was found. In this situation, the centre has integrated a nurse practitioner, which means the team members have lived experiences of role integration. Suri (2011) states that with a case study approach, it is common for a key person to identify the case study site where information-rich data can be collected.

Eligibility criteria for staff members willing to participate, was to be employed at the clinic when the new role was integrated into the health care team. In a case study design, Yin (2003) suggests that all or most case site members would ideally participate but that involvement should still be limited to 20 or 30 individuals for a single site. Diversity in the types of professionals who participate was sought in order to obtain various perspectives. Heterogeneity of participants from the case site enables deductions that are have a higher probability of being conveyable to other similar sites (Lee et al., 2010). Alternately, Thorne (2008) suggests that availability of resources and time warrants consideration in purposing sample size.

Eligibility criteria for client participants included: being at least 18 years of age and older, that they were clients at the time of integration, and that they had a health care appointment with the new post holder.

4.3. Research Setting

It is common in case study design to have a single site investigated (Yin, 2003), and in this thesis the site is a Francophone primary care centre. The study site is a health centre attached to a 12 bed hospital that services the north east peninsula of New Brunswick (NB), which includes the Island of Lamèque and the Island of Miscou. The population of this area is of approximately eleven thousand residents, 97% of which are Francophone (Acadie-Bathurst Health Authority, 2004). This region has seen a decrease in population over the last 10 years, as there has been an exodus toward larger centres. An increase of 5.5% in the 65 plus age group has also been noted. The median age for this region is between 48 years of age, and males (49.4%) and females (50.6%) are equally represented with the highest proportion of the population (31.5%) being between the ages 25 to 44 years (Statistics Canada as cited in Savoie, 2003). Almost 28% of families are single parent families, which is higher than all of NB that has a rate of 16%. The level of education is lower in comparison to their Anglophone counterparts in NB. For the age group of 20-34 years, 31.5% have not completed their grade 12; this percentage is 17.1% for the rest of NB. Their socioeconomic status is also lower due to the fact that most people work in seasonal jobs such as the fish, sod and tourism industry. In 2004, the average income for this region was $19,301 per year, which is more than 5,000 dollars less than the whole of NB. This region also has the highest level of unemployment rate in NB (Statistics Canada as cited in Savoie, 2003).

The hospital was opened in 1949 due to the arrival of a motivated Catholic priest who felt that the services of this community were not adequate. He mobilized a congregation of catholic nuns and community members who converted the presbytery

into a hospital (Réseau santé Vitalité, 2014). In its first years, this community had one doctor and three nurses to serve a population of five thousand people. In 1996 the provincial government initiated a pilot project, as many gaps in services were known. The first changes included adding more nursing support to the community (Réseau santé Vitalité, 2014). Nurses were given expanded roles both in the hospital and in the small walk-in clinic. In 2003 the government announced the addition of a Community Centre to the hospital. This added the dimensions of health promotion and prevention, along with chronic disease management and community development. At the same time an advisory committee was formed and an evaluation of needs for this community was carried out. The report identified that the three determinants of health with the most impact on the health of their community are employment, income and education (Acadie-Bathurst Health Authority, 2004). Three priorities were identified; the highest priority relates to chronic disease management and includes smoking, obesity, nutrition, inactivity and mental health; the second priority relates to child development issues and family environment; and the third priority focuses on non-protected sex, dependency issues and air quality. Consequently, services were implemented in an attempt to meet these needs (Acadie-Bathurst Health Authority, 2004). The interdisciplinary team was expanded to include dieticians, nurse practitioners, social workers and physiotherapists. Other professionals that were identified as significant in meeting the community's needs were the speech language pathologist, respiratory therapist, and occupational therapist. Currently, the services being offered at the 12-bed hospital and community centre are:

- Clinic (both walk-in and appointment based visits)
- Chronic disease management team

- Health promotion and prevention
- Diagnostic services

An interdisciplinary team of five doctors, two nurse practitioners, four primary care nurses, one dietician, one occupational therapist, one social worker and two physiotherapists offers the outpatient services included in this centre (Réseau santé Vitalité, 2014). The most recent role that has been integrated is the nurse practitioner role in 2005. This role will therefore be the focus of this study.

4.4. Recruitment procedures

Recruitment began with a two-day pre-study planning visit to the case study site. The first goal of this two-day visit was to meet the team and the key contacts in order to facilitate future communication. The second goal was to ensure that the proposed recruitment procedures were appropriate for this team, and to initiate implementation for recruitment. Lastly, the plans for the details surrounding the focus groups and interviews were discussed. Specific recruitment processes for the clinic staff and clients are outlined below.

All staff members (including the Executive Director) that were present at the time of the integration of the NP role were invited to participate in semi-structured interviews. Prior to the invitation being sent out, three presentations were given to staff to provide information about the project. At these times questions were addressed and the researcher's email address was given for future questions. Letters of invitation were left for clinic staff who could not attend and who were present at the time of the integration of the NP role (See appendices C1 and C2). Clinic staff could contact either the researcher or the local contact person with questions and/or set up an interview time. Ideally

interviews were secured with the various disciplines to ascertain varying perspectives by discipline or role. The local contact person established the interview schedule and a confidential location.

The initial visit was also an opportunity to discuss the focus groups and recruitment of clients. Organisation details included: choosing a location, establishing the ideal date and times, and identifying a caterer for the light meal to be provided during each focus group. The recruitment strategy for clients was to provide a letter of invitation to clients visiting the NP who were also clients at the time she was integrated within the team. (See appendices D1 and D2 for the letter of invitation to clients).

I communicated regularly with the local contact person to ensure that the recruitment for the focus group participants was going as planned. Once the focus group details were organized and the interview schedule was completed the next steps were to carry out the data collection processes (as described in the data collection section) that took place during the second visit lasting for 2 weeks.

4.5. Data Collection Procedures

Case study design commonly includes collecting data from more than one source of information (Creswell, 2007; Yin, 2003). For this reason, this thesis study collected data using: semi structured interviews with clinic team members; focus groups with clinic clients; field notes of time spent at the centre; and review of the centre's documents concerning the integration of the new team member. Data collection was conducted over a two-week period. This created the opportunity to gain a better understanding of the team members, their perspectives about the integration, and potentially witness conflicts firsthand. It also provided an opportunity to witness the activities and the functioning

of the team while allowing time to reflect and interpret what is being seen and heard (Creswell, 2003; Denzin & Lincoln, 2003). Each data collection procedure is explained below.

The interview is one of the most important sources of information seeing as the case study design focuses on interactions among individuals at the site (Thorne, 2008; Yin, 2003). In this thesis, interviews with clinic team members elicited data from respondents that have lived the integration of the new roles in order to understand how they navigated the change in comparison to others at the centre. Semi structured interviews were guided by questions (Appendices E1 and E2) to enhance consistency of data collection with the various team member participants (Patton, 2002), and assisted the researcher's focus on key areas of inquiry (Yin, 2003). These interviews provided staff members the opportunity to express their views about the integration of the new role (Thorne, 2008) with a focus on the key topics. Interviews focused on experiences related to the integration of a new team member in general, on how the integration has affected the team functioning, and lessons learned from the integration process that could improve interdisciplinary functioning. Prior to conducting the interview, I ensured that they worked at the study site at the time of the first NP's integration. They were then asked to complete a demographic questionnaire (Appendices F1 and F2) with items concerning their age, gender, their discipline, and the number of years since graduation. The interviews were conducted in person and lasted between 30 minutes to one hour (Whiting, 2008) based on staff member's willingness to share their experience. The interviews were audio-recorded. The guiding question sheet included a participant code so I could use this sheet to make notes concerning the interview. All names and other

identifying information were removed from the transcription before the data analysis. Only their professional affiliation was identified so that differences in disciplines could be noted.

Clinic clients, who have interacted with the new team member, were invited to participate in a focus group discussion. Focus groups were chosen as they have the advantage of bringing together a group of people who have had similar experiences, and by encouraging communication between them it was possible to witness their interactions, their sharing of opinions and comments about one another's experience (Thorne, 2008). This is another method of eliciting the client's perspective and has potential to generate a more genuine picture of attitudes, knowledge and perspectives seeing as engaging in group interactions tends to tap into various modes of commonly used ways of communication (Thorne, 2008). More vocal individuals in this setting often open the way to conversation for more timid people thereby encouraging the conversation toward solutions or identification of sources of dissatisfaction (Pope & Mays, 2006). The questions for these focus groups (Appendices G1 and G2) sought to elicit how they became aware of the new provider in the clinic, their experience of this new role within the centre, both in their interaction with the post holder and how other professionals represented this new role, and any effects on their care or health. Focus group participants were invited to complete a demographic questionnaire (Appendices H1 and H2) with items focused on their gender, marital status, age, and level of education. The focus groups lasted approximately one hour (Patton, 2002).

During this two-week data collection visit to the case study site, the principal investigator recorded field notes each day. Recorded field notes are a way of documenting

what is being witnessed, and make it available for review at a later time with the intention of deciphering what is emerging from all data sources (Mason, 2002; Pope & Mays, 2006). Specifically, the researcher recorded observations of team functioning, interactions among them and the way in which the roles were played out.

A variety of clinic documents were collected as a data source. These included minutes of meetings and official reports (Creswell, 2003). The documents that I requested were the documents that had been prepared for the purpose of communicating the new role to the clients, their families, or the providers. I asked to see if there had been any changes in procedures, policies, or care protocols as the result of having a new professional role. I was also interested in how they proceeded to introduce the role, and how and if they ensured that each stakeholder in that centre had information or documentation to understand the role and their scope of practice. Lastly, I requested copies of relevant meeting minutes and evaluations to better comprehend why they decided to bring in the new professional role. Following my requests, the administrative staff could only find meeting minutes. No memos, posters or policies were found to reflect the changes. I had previously received the community assessment done in 2003, which provided me with valuable information about the community.

4.6. Sample Size

Beyond sampling of the case study site, there are two groups sampled for this case study research. The first was to sample case study site team members (n=13), which yielded 10 interviews with very good diversity in participants. A sample size of 10 is considered (the semi structured interviews with staff members) reasonable for this study, given that a purposive sampling strategy has supported the recruitment of participants

who are rich data sources specific to the desired lived experiences (Flybjerg, 2012), and that this is a master's thesis.

Twelve interviews were scheduled and two participants did not present themselves at the scheduled interview time. Although alternate times were offered to participants, one declined and the other's schedule prevented his participation. One team member did not accept to participate in the study, as she was no longer working at the centre. One of the 10 interviews was with the second NP who was integrated 3 years after the first NP; unfortunately because of technical challenges the interview did not record. Notes were kept from the interview; these were used to represent her experience of the integration. A summary of her responses to the various questions from the interview was sent to her via email with a request to validate or add to the answers. No reply was received therefore the information from this NP will not be used other than to represent obvious differences in their experiences because of the context at the time of their integration.

The second group to sample were clients from the centre, which focused on two distinct age groups: clients of 44 years of age and younger, and clients over 45 years of age. For focus groups, there is a recommendation for homogenous groups as this takes advantage of their shared experiences (Pope & Mays, 2006). This age breakdown was chosen since there is an increase in chronic illness and use of medical services after age 45 (Robitaille, 2012). The participants in each of these groups are more likely to have similar patterns in their use of services and in their state of health. As is recommended, each focus group should involve six to eight client participants (Creswell, 2003; Pope & Mays, 2006). For this study the first focus group had two participants and the second group consisted of five participants.

4.7. Data Analysis

This study primarily generated qualitative data. All interviews and focus group discussions were conducted in French and digitally recorded. The recordings were later transcribed in French to easily refer to the participant's original statements. Following the transcription of each interview, the recording was compared with its transcript to ensure accuracy. The collected data from the interviews and focus groups was entered into an NVIVO compatible computer file, which assisted the organisation of the data into codes (Yin, 2003). The demographic information collected from the focus group participants and the interview participants was organized in tables to provide descriptions of each participant group.

The transcriptions and the audio recordings of the interviews and focus groups were reviewed several times to make sense of the information (Creswell, 2007). Once transcribed, one interview was translated to English in order to discuss this interview with my advisor. After she read the transcription, I met with her to discuss the themes I had identified. This assisted the broadening of my interpretations of what was being said by the participants and helped to deepen the analysis. This discussion also assisted in the identification of themes and subthemes. Another transcription was reviewed with a committee member to guide the identification of themes. Similarly, we discussed the themes I had identified and the ways in which these could be organised in the NVIVO program to facilitate the identification of similarities and differences of the data sets. Means of organising the themes were also discussed so that they could be coherently organized and easily understood by the reader. Following these meetings, I continued to review and compile similar pieces of data and studied them to discover potential

relationships and patterns (Creswell, 2007; Thorne, 2008). While the data sets from participants were analysed individually, similar information from all data sets was inserted in NVIVO and labelled by a same code. There was ongoing comparison between data sets to draw similarities and differences in perspectives from each group and between the focus groups (Thorne, 2008). This is an iterative process and throughout this analysis, information was shared with my thesis advisor to guide me through this process and provide expert advice, further ensuring the rigor of the study (Lee et al., 2010; Whiting, 2008). Data analysis included the refinement of initial codes as the identification of themes and subthemes was realised (Thorne, 2008). Seeing as this is a case study, once the analysis of the various data sets was complete, findings were studied as a collective and presented as three groups (nurse, non-nursing and administration). In case study research, "the researcher seeks a collection of instances from the data, hoping that issue-relevant meanings will emerge" (Creswell, 2007, p.163).

For this project, the results were examined using the PEPPA nine step model. In chapter 6, I will examine the PEPPA model to highlight where the study site has undertaken the activities and steps as proposed by this framework. In addition, there will be a discussion on how having followed these steps could have improved team functioning, and facilitated the integration as well as the evaluation of the role.

4.8. Attending to Scientific Quality

Various methods embedded in this thesis attend to scientific quality; these methods include triangulation, consistent data collection, member checking and self-reflection. The following section will discuss how they pertain to this research project.

Triangulation is an established method of assessing the comprehensiveness and

integrity of results (Pope & Mays, 2006). This research project sought to elicit various perspectives about the topic of interest through focus groups and semi-structured interviews. In addition, the diversity of data sources (documents, field notes, interviews, focus groups) enhanced justification for themes and coherence of data (Creswell, 2003; Lee et al., 2010). The involvement of multiple perceptions to clarify and interpret the meaning of data constitutes another use of triangulation in the data analysis process, and it was done between and among health care providers and client groups of different ages (Patton, 2002). The coding of themes was verified with the thesis committee and with selected participants.

The second component of scientific quality is the consistent use of data collection techniques that was ensured by having a single person collecting data. This is important because ensuring a consistent use of data collection techniques enhances quality (Pope & Mays, 2006). Furthermore, attention was given to the consistent entry of data into the qualitative (NVIVO) data software by the principal investigator.

A third element to consider in enhancing scientific quality of the findings is member checking. Staff participants were invited to confirm that the findings in this study truly reflected their perspective (Creswell, 2003; Denzin & Lincoln, 2003). Following the identification of themes, a committee member reviewed a short two-page report of the findings. This report was then sent by email to eight of the staff participants requesting their validation of the themes. Only one participant replied stating that themes were consistent with their experience but would have liked to have seen more information about issues with physicians that arose during the integration.

Lastly the researcher's ability to self-reflect is crucial to representing the data

accurately. As the data analysis phase is often left to the discretion of the researcher, it was essential that the perspectives of the participants be represented accurately (Jonsen, Siegler, & Winslade, 2002; Mauthner, Birch, Jessop, & Miller, 2002). In order to achieve this, self-awareness on how my assumptions and prior experiences can influence the way in which I represent the data was paramount (Pope & Mays, 2006; Whiting, 2008). Discussing my experiences and concerns with a member of my thesis committee assisted in maintaining this self-awareness. In addition, thinking of my own beliefs and expectations before I begin the study and reviewing these at each time I handled data assisted in maintaining greater self-awareness.

4.9. Ethical Considerations

There are a number of ethical considerations that are essential to disclose. The first one was to obtain ethics and site access approval from the University of Manitoba Nursing and Education Research Ethics Board (Appendix I) along with appropriate processes at the study site. In addition, ethics approval was also sought from the *Bureau de l'éthique du Réseau de santé Vitalité in New Brunswick* (Appendix J). An additional element of primordial importance is the consent form for the participants (Appendices K1 and K2, and L1 and L2). Each participant was given a consent form that specified that their participation was completely voluntary and that at any time they could decide to withdraw from the study (Jonsen et al., 2002; Mauthner et al., 2002). Staff members were informed that their employment would not be affected by their participation and that their information would be kept confidential. Clear information was given regarding the expectations from the participants (Jonsen et al., 2002; Mauthner et al., 2002). More specifically, they were informed that the time commitment was only one hour, and that

the only expectation was that they share their experience of the integration. Participants were informed on how their anonymity or confidentiality would be respected in the context of this research. They were informed that their identity would not be linked to their data (Whiting, 2008). Elements of how they would be quoted and presented were discussed (Pope & Mays, 2006). Participants also received information on how the research findings will be distributed (Whiting, 2008). For this research, the intention is to submit an article for publication and to present at one or more conferences.

Although this research presents minimal risks to participants, I ensured that the participants were comfortable throughout the interviews and focus groups. The well-being of the participants is a priority (Whiting, 2008). Contentious or difficult issues were approached with sensitivity (Denzin & Lincoln, 2003). The environment created for the interviews and focus groups had the goal of making it an enjoyable experience where the participants would feel comfortable and respected when expressing their concerns and perspectives (Mason, 2002). Attention was given to individual responses so that they could feel heard by the group. The chosen room was easily accessible and located in a quiet environment where they could share their confidential information without interruption. A meal was served to assist in creating a welcoming message and also as a sign of appreciation for their participation.

4.10. Summary

This chapter described the highlights of the important elements of the case study research and provided justification for using a descriptive interpretive approach. This chapter has also presented an overview of the methodology used to carry out this research. In addition, it introduced the study site and the rationale for choosing

this setting. Finally, data analysis, ethical considerations, and measures of rigor were discussed.

CHAPTER 5: FINDINGS

5.1. Introduction

Interdisciplinary collaboration in the context of role integration has been shown to be important. The following discussion presents an opportunity to hear from clients and staff related to the integration of the NP role within the study site. After presenting participant demographics, the discussion focuses on a description of the surrounding context in which the NP was integrated. Next, the focus is on presenting the voices of health professionals, management, and clients collectively through six themes. Barriers and facilitators for the acceptance and integration of the new team member are identified. The reader will notice strong similarities among the various participant groups; however, divergent views will also be heard. This study was not about determining who was right or wrong but about representing these various perspectives. It is to be noted that for staff interviewees, some of the professions are represented by one individual; so to protect the anonymity of participants, quotes cited in this chapter will be identified as either nurse, non-nurse, or administration.

5.2. Participant Demographic Description

Between September 30 and October 11, 2013, two client focus groups and 10 staff interviews were completed. Of the 10 interviews with the professionals, there were two primary care nurses, two NPs, two individuals from the management team, one dietician, one occupational health nurse, one doctor and one physiotherapist. All of these interviewees were females. There were seven client participants that attended one of two focus groups: five women and two males. Interestingly, the client participants were not representative of community members; all participants with the exception of one had

either completed high school or a university degree. Based on the 2003 assessment, only about one third of community members had completed high school. The following tables display demographic details for the staff interviews and client focus groups participants.

Table 5.1.

Staff members' demographic information

Years of employment at centre	6-10 years n= 2	Over 10 years n= 7	No longer there n=1	
Age group	31–40 n=2	41–50 n= 6	51–61 n=2	
Equivalent full time	Full time n= 8	Part time n=1	NA n=1	
Years since completion of degree	5–10 years n= 2	11–20 years n= 5	21–30 years n= 2	Over 31 years n=1

Table 5.2.

Clients' demographic information

Sex	Female n= 5	Male n= 2		
Living situation	Lives with spouse n= 7			
Age group	18–30 n= 0	30–45 n= 2	46–60 n= 3	61+ n= 2
Highest level of education completed	Not completed high school n= 1	Completed high school n= 3	University degree n= 3	

5.3. Context at Time of Integration

In 2004, the year before the integration of the NP role, the management group was planning for the transition from designation as Hospital to the designation of Hospital

and Community Health Centre. In preparation for this change, and in anticipation of the addition of new team members, the focus was set on introducing the concepts of interdisciplinary team functioning and on expanding the professional roles beyond the centre to include community initiatives. The administrators' intention was to better serve the community by attempting to meet the needs identified in the 2003 community needs assessment that had justified the addition of the NP to the existing team. Shortly after, in December 2005, the first NP who had already been working there for more than 10 years, completed her exam and began her work as an NP within the Centre. At this time the lack of medical resources was felt both at the study site and in the community. For various reasons, two doctors had left and the study site found itself with only one doctor to service their Family Medical Unit and their External Clinic, which consists of a walk-in clinic for non-life threatening illnesses and traumas. As a result, many clients were being turned away to hospitals in other communities. This reality greatly influenced the role that the NP was to undertake, as the needs for medical support were so acute that she endeavoured to fill the gaps related to this lack of medical services. The NP was initially posted in the External clinic. There, she spent most of her first two months until she realized that these clients needed follow-ups. She then became the point of contact for those clients who were without a family doctor. Her practice subsequently evolved to working three days in the Outpatient Clinic and two days in the Family Medical Unit where she would do the follow-ups. The following quote explains how she started her role as an NP,

> *And back then, when I started as a nurse practitioner, Doctor X passed away. And the other doctor who was with Doctor Y was on maternity leave. So Doctor Y was all-alone. I was the contact person for those patients. So I did follow-ups for*

> *doctors who were on leave. [Pause] In reality, I was treating the patients. I took over the caseload while we waited for them to come back.*

This statement by the NP is indicative that the role functions were initially to assume the doctors' caseload, which is different than assuming a role that was clearly defined for the NP. The next section on results from the interviews reflects this reality and demonstrates how this has influenced the integration of this role.

Please note that professionals refer to the two NPs. Both had the same path, in so far as they worked in the study site prior to their integration as NP, started their NP education at the same time and both did their practica at the centre. The only difference is the time frame in which their integration occurred. The first started in 2005 and the second in 2008. This study focuses on the first integration. It is important to note that even if there were 3 years between the two integrations, the respondents from the interviews and focus groups do not differentiate between the two NPs when they refer to the NP.

The second NP's reality was significantly different. When she arrived the shortage of medical resources had been resolved and as a result she was able to start her own independent practice on the second floor of the centre. This autonomy in practice is the factor that created resistance from the physician group. The first NP had worked closely with the physician in the same physical space; conversely, the second NP immediately went to the second floor and managed her own clients. The role was better known by all due to the fact that it had been implemented in this community and region for 3 years. In addition, more support was available for the new NP; as a result the second NP had more confidence in undertaking an independent practice. The first integration had set the stage

for this role within the centre.

5.4. Communication for the Introduction of the NP Role

When the participants were asked about the types of formal communication that had been done to inform the arrival and functions of the NP role, most professionals and clients from focus groups indicated that there had been minimal formal communication about the arrival and about the NP role. The responses were not definitive and the participants hesitated in answering the question. The time since the implementation is probably a contributing factor for this lack of clear recollection. Many thought that there had been discussions at meetings but these meetings had occurred post implementation of the first NP. The following quotes by two non-nursing professionals help to demonstrate this phenomenon.

> *For the integration of the NP, it was not even discussed anywhere. It was…we could have nurse practitioners to get, get educated. It would be nice if they could join us. (non-nursing 1)*

> *It is starting to be far away in the past but me, what I remember is only that they said: OK: "We have money to hire X number of people". (non-nursing 2)*

The only meeting minutes that included discussions related to the NP were those of the "Internal Functioning Meeting". These included minimal information related to the NP role other than the announcement that they had completed their exams and that they were ready to practice. This was evidenced in the December 2005 minutes where it was documented that the first NP had passed her exam. In one meeting there was mention that the doctors would be assigned more complex types of clients as compared to the NP. No other minutes were found that referred to the role and functions of the NP. A memo was sent to all staff in April 2006. This memo's intention was to inform all staff members of

the new hires within the Centre and this memo included the name of the first NP who graduated. In June 2008 a similar note was sent to all staff members to inform that the second NP had officially received her NP designation. No other details of their functions were included.

Clients also did not recall having received formal communication of the arrival of the NP. As this is a small community, clients mostly reported hearing from various informal sources that two nurses were pursuing their education to become NPs. The main methods of communication were informal and information travelled mostly through word of mouth by other community members. Five out of the seven clients interviewed requested to have an NP as they had had previous exposure or someone they knew had recommended the NP. Certain clients recall having seen posters in the waiting area of the External Clinic and some had also seen television information related to this new role.

5.5. Involvement of Stakeholders

All participants, including the client focus groups, state that they were not involved or consulted in the way in which the role was integrated within this team. The only participant who expressed that more involvement in decisions related to the integration would have been beneficial is the physician. The following section will look at the themes brought forward by the respondents, which provide insights into their acceptance of this role and their lived experiences of the transition.

5.6. Issues with the integration

Few professionals describe having issues with the integration. All reported having a positive experience and saw the NP as a positive addition to this team. Most were aware that the physician group had some resistance with the integration but they did not feel that

this issue impacted them. This dynamic was mostly lived by the NPs and physicians and was most prominent with the integration of the second NP. The gap in medical services no longer existed in the Family Medical Unit and External Clinic and as a result the NP did not work in close proximity to the family physicians since she immediately went to the second floor to establish an independent practice. It is this independent practice that exacerbated the physician concerns. These concerns were two-fold. The first concern was about their level of education. There was the belief on the part of the doctors that it is not possible to acquire the necessary knowledge in the two years of training to manage clients living with chronic diseases. They felt that in two years NPs could not acquire the knowledge that permits to get the whole picture. The following quote explains their perspective,

> *It's the whole person and not about just doing tests, doing X-rays. The X-ray may be normal but what about your exam. If you are a clinician first, your hands, your practice, that's what matters. It's not your labs. Sometimes yes but sometimes it's, it's the, that's [practice] what is difficult and you can't get it. You can't acquire it in two years.*

Their second issue was that independent practice could impede on the clients' safety. The physician emphasized that their concern was not about the NPs managing their own clients but about having enough knowledge or experience to practice safely. The following quote describes the physician's perspective,

> *Well it's not the fact that someone is taking over the patient, but it is always the patient's safety. That is always what they reveal. Well are they, are they OK? Will the patient be OK in their hands? Do they know what to do? Do they know which lab test to request? It is always those questions that I get when other doctors come.*

These concerns on behalf of the physician group certainly acted as a barrier to the full integration of the NP group as evidenced by the lack of collaboration between these two

groups that persists to this day.

5.7. Participants Themes

Analysis of the interview and focus group transcripts revealed six primary themes: (1) gradual integration; (2) improvement in services; (3) perception of support; (4) health care professional specific qualities; (5) influences on team functioning and; (6) site and setting influences. The table below provides a visual overview of the themes along with subthemes, which are then discussed separately.

Table 5.3.

Participants' Major Themes and Subthemes

Major Themes	Subthemes
Gradual integration	• Professionals approaching NP one client at a time • NP explaining their role to clients and professionals one at a time • Informal introduction for clients
Improvement in services	• Access to medical services • Decreased wait time • Care is comprehensive • Improved education support • Increased adherence to plan
Perception of support	• Support to other professionals • NP's perception of support to other professionals • Support from doctors to NP • Feeling heard • Lack of support for the NP
Health care professionals specific characteristics	• New health care professional's familiarity • New health care professional's personal attributes • New health care professional's experience • Other professionals' acceptance
Influences on team functioning	• Improved interprofessional collaboration • Achievement of objectives related to interprofessional team • Barriers to collaboration
Site and setting influences	• Fee for service environment • Expanded role for nurses

5.7.1. Gradual Integration

Professionals approaching NP one client at a time. Most professionals did not feel that the integration was done by formal introductions or by formal communication. Health professionals commonly learned about the role through working with the NP, by consulting with her, and asking her if she could see a particular client. This repeated exposure is the way is which most professionals got to comprehend the NP role. The following two quotes, the first by a member of administration and the second by a non-nursing professional are representative of the professionals' perspective,

> *The fact of having an NP, when they saw what they could do, it happened gradually during their practica. For sure it [the role] was not known, we had questions but, with time, we learned how to better understand their role. (administration 1)*

> *At first it… if I remember correctly...I simply went to see them and I would ask: "Can I refer this to you"? (non-nursing 2)*

NP explaining her role to clients and professionals one at a time. Interestingly, the NP described her role integration in a similar way as the professionals. She stated that the integration was done one client at a time and for the professionals, the same gradual exposure was the principal manner in which others got to know her role. Seeing as there were few formal strategies for the integration, the NP was very diligent at explaining her role to clients and professionals, as she said, "one client at a time for two years". She describes this phenomenon as follows,

> *And at the beginning, during the early years, it was really like, "Hi, I'm Nurse X. I'm a nurse practitioner. Do you know what a nurse practitioner is?" I had to explain what a nurse practitioner is to the clients one by one for many, many months*.

Informal introduction for clients. Clients describe a similar experience with

the integration. They did not identify strategies done by the centre to inform them of the arrival of the NP. They mostly spoke of the informal ways in which they heard about the NP. One approach in which this informal introduction occurred, is through the reception staff at the External Clinic who encouraged them to see the NP. In addition, they knew other community members who had an NP and recommended her to them. The NP describes how other nurses explained the role to clients as they visited the External Clinic. The NP explains,

> *And I think it was just, like, the girls in triage who said, "Well, now we have a nurse practitioner," and had to explain a lot every time for at least two years.*

Interestingly, this gradual integration did not elicit concerns on the part of the respondents even if in the beginning there was a lack of clear understanding of the role.

5.7.2. Improvement in Services

Access to medical services. Access was the most frequently mentioned factor related to improvement in services. Interestingly, when staff members were asked the question: Have the clients benefited from the integration of the NP? They all responded that access was the most important factor that impacted the clients. They benefited by having direct access to a provider as described by this non-nursing professional,

> *Ah well, they benefited in the sense that when I had a maternity leave, they could get a follow-up with the nurse practitioner. Ah, at first it was again to try to decrease the overflow at the medical clinic. So there they have benefited. (non-nursing 1)*

The interviews revealed that all staff members were in some way touched by the lack of medical resources. What was most prominent is how it impacted their ability to provide the services that the clients required. This proved to be difficult for them as they could not meet the demands for service and they therefore had to turn clients away

toward other communities. The arrival of the NP helped in reducing this gap as she provided necessary services. The NP describes how her arrival was seen as a relief to the staff members working there,

> *Then the outpatient clinics were open until four instead of six o'clock. So a lot of people had to be turned away. So it was very difficult for the nurses who were at the outpatient clinic, very difficult for the doctors. So when I arrived, I was a bit of a lifesaver… Nurse X is going to see fifteen more patients per day.*

One nurse describes her experience with the inadequate medical resources in the Outpatient Clinic and how this impacted her,

> *And there were still many patients who would present to see the doctor. And we turned many away. But then we would say, go to Tracadie…so there were many dissatisfied patients. So there was lots dissatisfaction, people were complaining. It was hard for nurses to deal with this every day, turning away people every day. We turned away up to 10 people per day… it was not pleasant, the moral was very low. (nurse 1)*

Another factor that was mentioned was the lack of available medical follow-ups. The NP's arrival clearly came at a time where services were minimal. One nurse describes it in this manner,

> *For me it was positive because on the level…if I think about the NP, euh…we here, had a problem with doctors. We were short doctors. One doctors passed away and things like that. And I see a lot of people in my office who require follow-ups, so this helped. For example, the diabetics who are not controlled, I needed lab tests to see how they were doing. (nurse 2)*

In addition, the lack of medical resources created challenges at the Family Medical Unit. The NP also filled the gaps for the clients without family doctors. In the following quote she describes how she came to support these clients,

> *Yes, we had locums but at the clinic, the family medicine unit, people were missing their family doctor there. I was helping out there…*

The lack of medical resources impacting these professionals' reality prior to the

integration enhanced their capacity to accept the role since they could clearly see how her addition came to help meet the needs of the community.

All clients interviewed were also very aware of the lack of access to medical care in the Acadian Peninsula and of the repercussions this had on them and the community. Therefore, access was at the forefront of people's minds and is demonstrated by this client's comment.

> *It is the availability because there are no other doctors here. And I need a family doctor because I take pills for high blood pressure so it I need prescriptions every six months. So I had to find someone else. She was available so I jumped on the opportunity. I could not wait for another doctor, as there were none. There were none [doctors], even if we would have wanted one. (>45 focus group participant 1)*

Clients also benefited with access indirectly through the other providers. Most professionals mentioned that they often required prescriptions or referrals for their clients. They could talk to the NP to get what they needed and their clients were then satisfied. This nursing professional describes this phenomenon,

> *Well they have benefited maybe without knowing because like I was saying, if I see a client that does not have a family doctor and if I need to have an authorization for something or a change, I would see the NP and she would give authorization, it would help me help the client. You know? (nurse 2)*

The NP's ability to refer to specialists was also perceived as another way in which the NP improved their access to appropriate care. Indirect access for clients was expressed in the following manner,

> *What impressed me among other things was like I said before, I got referrals with specialists in Ontario specifically, and it was the openness on the part of the specialists with the nurse practitioners. They were well received. (>45 focus group participant 3)*

Decreased wait time. Decreased wait time was the second factor discussed by

these professionals. Access to the NP on site enabled other professionals to consult with her and this permitted the clients to go across the hallway or the next level and quickly access what they needed. The final result was that the client would get the necessary prescription or referral in an expedient fashion. This non-nursing provider describes this ease of access in the following manner,

> *You know it was fun that we could quickly have appointments with the NPs so those people could…you know get an appointment quick enough to get information of their condition and also if we needed to have their medications stopped, those kinds of things. (non-nursing 2)*

In addition to having access, client consistently indicated that appointments were accessible within a reasonable time frame. In addition, if the need was pressing, an appointment time was found. This participant describes her experience,

> *I called and she took me right away. So she helped my situation, so I was less sick than if I would have had to wait, wait and wait. (≤45 focus group participant 1)*

One of the younger participants was especially appreciative of this quick access as her children were seen very quickly in times of need. Decreased wait times was also significant for clients. For them this also meant that time spent in the waiting room was decreased. The participants almost all stated that wait times are less than what they have previously experienced.

> *There is no wait time. If you have an appointment at 2 o'clock you will be seen by 5 after 2 or 2:10. (>45 focus group participant 4)*

All clients from both groups mentioned this as an important factor for them. In some situations they called with urgent needs and were seen without delay. The combination of decreased wait times and access to medical care enhanced their overall satisfaction of the services they received. There was a tendency for clients to compare them to doctors or to

say, “The NP is my doctor”.

Care is comprehensive. Clients felt that the NP had more time to spend with them. This additional time impacted the length of their appointments and translated in the clients’ confidence that their care is complete. They were confident that she would take the time to refer or send them for necessary tests when they need them. This participant explains it in this manner,

> *You know that she does what she needs to do and that’s it. And you feel… you feel that, you know, that there is no stress. She took the time, took the time to do the test. She took the time to send to a specialist. (≤45 focus group participant 1)*

The additional time gives them reassurance that they will have the necessary follow-up to ensure and assist in their adherence to their plan. They are put on regular follow-up schedules. At every visit the clients are questioned about their self-care, and continuously encouraged to continue their good habits. Both group’s participants felt that being in a salaried environment influenced this factor as the NP has less pressure to see higher volumes of clients.

Improved educational support. All focus group participants felt that the NP did what was required so they could better understand their treatment and issues related to their health. This was perceived as very significant. One client had received a call after a visit to provide follow-up about information requested and was very appreciative of the education they receive. The following quote by a client explains this point,

> *Ah yes, she explains a lot. Everything she gives you, the pill, she tells you what it is for and you know it all. When you leave from here you don’t go on the Internet to research. You understand, you know what your medication is and you know why she gave it to you. (≤45 focus group participant 1)*

Increased adherence to plan. Most of the older participants talked about

being more compliant because they better understood the reasons for following the recommendations. One client explains how he had a greater ability to understand why exercise was important along with following the recommended plan of care.

> *And she told me; she wanted to change my pills. I said, "No, I am not changing them". So she explained that if I did not change, it will be this, this, this and you will have to do this, this and this. So she took the time to tell me what I needed to do if I did not want to change my pills. (>45 focus group participant 1)*

This translated into the client being more motivated to take his health in his own hands. The following quote describes his experience,

> *I've been doing my exercises for two years and that made the whole difference in the world. (>45 focus group participant 1)*

Interestingly the younger client participants did not talk about being more motivated to take care of themselves, they simply felt better educated about their health and that their questions were addressed. When asked if they felt more responsible for their health, one participant responded in this manner,

> *I would say no. Yes, not more not less. It's just that we are more understood when we go there and we also better understand. (≤45 focus group participant 2)*

They now had a better comprehension of the factors impacting their health, which includes their medications, their tests and their self-care activities. This participant elaborated on why education is important,

> *The emphasis is much more on education in nursing…essentially if you want to treat your patient you need to educate him. Education is part of the care as if someone comes to see you for something and you don't explain why it happened or what his medication will do, he will have learned nothing. And he will risk redoing the things that caused his illness. (≤45 focus group participant 2)*

5.7.3. Perception of Support

Support to other professionals. All providers spoke about the reality at the time

of the integration when there was a lack of medical resources. More effort had to be made on their part to find the necessary resources and services that their clients required, which affected staff morale. The arrival of the NP therefore came as a relief and the staff perceived her as providing support not only to their clients but also to them as the providers. Eight of the professionals talked about this support as being very significant to them. The following quotes by non-nursing professionals are representative of all professionals' perspective on the support that the NP provided,

> *And it [her arrival] greatly facilitated our work especially to make the links with clients who did not have a family doctor. And, I see a lot of patients in my office and they need a follow-up, which helped me. So the NP, she, she helped me a lot in that way. (non-nursing 2)*

> *I would have the tendency to say that it is… that it is the lack of access to doctors. yep, that, that we would tell ourselves, now we have another door, exit door, or another entrance door, I am not too sure how to say it but it permitted us to, to get euh, get more services or more care for our patients or more of...yep. (non-nursing 3)*

The fact that these professionals felt the NP supported them by facilitating their work influenced their perception this new role's impact on their own role. They all reported that the addition of the NP did not negatively impact their role functions. The first of the following quotes is from a nursing professional and the second quote from a non-nursing professional. Both are representative of all staff members' perspective on the impact on their role function.

> *My role stayed the same...yes...but it greatly facilitated our lives to have the integration of the nurse practitioner. (nurse 1)*

> *My practice as such has not changed. For sure… no. I did not change the way in which I offered, but I would say that the medical needs for the client was maybe more facilitated. (non-nursing 3)*

In the above statements by the professionals it is clear that this feeling of being supported

was a significant facilitator. They felt supported by her being there as she enabled them to complete the care for their clients. This sense of support was also related to helping the professionals in the various sectors better serve the need for follow-up for their clients. She provided support to the nurses in the chronic disease services, to the dietician, and to the respiratory therapist who were unable to provide the care they wanted as they had difficulty accessing doctors. The professionals consulted with her frequently as she was accessible and open to receiving their requests. Four professionals mentioned her accessibility as being a central factor in facilitating their work. The following quote by a non-nursing member demonstrates the importance of this access to them,

> *What's fun in these two cases is that we do not have to pass by the doctors. It facilitates things so much. And they are accessible. If you cross them in the corridors and they have a minute, they will listen to you. (non-nursing 4)*

NP's perception of support to other professionals. The first NP is very cognizant that other professionals at the Health Centre accepted her with open arms as they felt she provided support to them. She was welcomed with open arms in the External Clinic and strongly sensed her help there was appreciated. She described herself as a lifesaver. The following quote demonstrates how the NP perceived her support to others,

> *We were really in a state of crisis at that time. So when I arrived, I was a bit of a lifesaver… Nurse X is going to see fifteen more patients per day. So that's what really helped. Maybe they would have accepted me anyway.*
> *They are definitely more comfortable with us. So they come see us very often. We see many more patients for… The doctor and the nurse practitioner, even the nurses, work well together when there's a nurse practitioner and even the doctors… When there's a nurse practitioner at Emergency, it's like a weight has been lifted from their shoulders.*

The NP clearly feels that she helps support the team. Since she has been an NP, even the managers come and seek her opinions on topics affecting the organization. This did not

happen before she became an NP. The fact that the current and past executive director had a master's degree and the current manager was completing her master's degree may have an impact on this above-mentioned fact. Higher education is clearly valued in this organization as is evidenced by their inclusion of the NPs in decisions affecting the centre.

Support from doctors to NP. Another example of support within this team that came out very clearly is the support that the first NP felt from the doctors early on in her integration to the team. Even if the second NP experienced resistance from the physicians, the first NP could say without hesitation that they had been very supportive. The following quote clearly demonstrates her recognition,

> *You know. Mhm. But I had good support from the doctors. This was the place to integrate a nurse practitioner because the doctors here were up on the latest and they were all women. And we did our practica here, so they learned what a nurse practitioner was... the role. And they gave us a lot of support.*

She went as far as saying that had she not received the support and acceptance from doctors, she would have probably left. When asked if the doctors supported her, she replied,

> *On every level. That's right. If it hadn't been like that, I would've left. Oh yes, yes. Even so, I thought about not coming back.*

She initially sought their approval, as she perceived them to be the gatekeepers to the success of their integration. Having the support of doctors was helpful in gaining confidence in her abilities. The following quote describes her experience,

> *And, at the beginning, I didn't necessarily take the easiest but what I was most comfortable with. Then later I could take some that I was less comfortable with but I knew the doctor was not so busy so she could help me.*

In addition, having doctors in the immediate environment provided a safety net so that

she could explore and experience various types of situations.

> *But at the outpatient clinic, there was always a doctor who was there [pause] with me. And I saw a lot of diversity, like many different issues and illnesses.*

The doctors kept abreast of her progress as she began to manage her own clients.

Administration was also happy to add this role to their Centre, the arrival of the NP role represented additional resources to meet the needs. The following quote by a member of the administration team demonstrates this,

> *But for us, it [the integration] was not a problem, it was…we were so happy to have those two nurses that...because of the lack of doctors, there was a time where we had difficulty to fill the openings. To have a doctor at the External Clinic…there was a lack of doctors, for sure. But to have the NPs, it was…it was wonderful. (administration 2)*

Feeling heard. All clients' experience of their interactions with the NP was very positive. They felt that the NP was attentive to what they would say which resulted in them feeling supported. They had a sense that they were heard and that the NP had the time to do what was necessary. Essentially, being listened to translated into them being comfortable explaining their health issues and in feeling that what they had to say was important. One participant describes his experience in this way,

> *Like the gentleman said, it is someone that listens. That takes the time to listen to you, that takes the time to do your follow-ups, that will not hesitate for an instant. OK. We will check this…will do this test for this. (>45 focus group participant 2)*

The feeling of being supported by all groups of respondents was a great facilitator in accepting this role at the study site.

Lack of support for the NP. Where this feeling of support is divergent from other professional's view is in how the NP experienced her integration in the beginning. The NP role was new in the whole Acadian peninsula and in their community centre.

There existed few resources to guide her in establishing the role and in devising a plan to integrate the role with their organization and team. Her superiors gave her free reign to decide where to start. This proved to be challenging, as her responsibilities were not yet defined. The following quote by the NP that describes her feelings towards the extent of her responsibilities,

> *Even my superiors, I felt like they didn't really understand. Then they just left me with [pause]… Go for it, like, do what you want. At first I found that hard because I had to come up with a plan, figure out my role in the establishment.*

She was not sure where to spend her time. She would have liked for the administrators to check in with her to see how she was doing and also would have liked to have had more reassurance that she was doing the right thing. There was only one other NP in the Acadian peninsula who worked in a fee for service environment. The NP describes in the following quote how she did not have access to someone who had already lived the integration of the NP role.

> *And there was one in Bathurst and I was the only one in the Acadian peninsula. That meant that there was no NP who could [pause]… I could not depend on an NP to learn the right things to do.*

The NP would have liked to have had more structure and as result found the integration difficult,

> *I definitely found the integration difficult but it was the fact that I was thrown in the lion's den and my role was brand new, it was for everyone who worked with me. It couldn't have happened any other way. But like I said, it was difficult to swim in the ocean, and not to know if I was doing the wrong thing or right thing, or was I heading in the right direction or not? So, that's what I would've liked: more structure. I would've felt more secure like that.*

Administration on the other hand felt they had facilitated their role by providing financial support and coordinating their practica. One administration team member

explains,

> *I was involved directly to ensure that all those people…to facilitate their practica…I was involved directly with the university with the contracts between the region and senior management. To have an agreement because it is the University of Ottawa…We opened the way because after, there were many NPs who did their practica here. (administration 1)*

The integration for the NP demonstrated various ways in which this team provided support to one another. Firstly, it demonstrated the significance of the doctors' support to the NP. The second way in which this was shown was the professional's perception of the NP's arrival as a source of support to provide services to their clients. The NP also recognised that she was a positive addition to this team as she contributed to facilitating client care. Lastly, the clients were feeling supported as they felt they were being heard. Where this experience is different, is in how the NP experienced a lack of support related to being the first NP in the Acadian Peninsula with no mentors available to guide the integration and define the role.

5.7.4. Health Care Professionals' Specific Qualities

New health care professional's familiarity. The NP was well known by most professionals including management, as she had previously worked as a registered nurse at the study site before she became an NP. She had worked at the External Clinic and had also done her practicum with the doctors as preceptors. The first quote, by a non-nursing professional, and the second by a nursing professional, describe their experience as follows,

> *Um, the NP introduction here at the community center, was well done. Uh, in the sense that they were two nurses we already knew, in who we had confidence, we knew...We knew them. (non-nursing 1)*

> *And they were nurses like these two that had already worked here, we knew...we*

> *were comfortable working with them, right at the beginning. And uh…we were very happy. (nurse 1)*

A factor that contributed to the familiarity of the NP is their environment, as this was a relatively small centre, which is conducive to having regular contact with others. One non-nursing professional talked about it in this manner,

> *I think that that it helps... to... you know where people go. Everything is easily accessible. You know it is easy…you hear about it. I think it is because we are a small centre, a small hospital, so wanting to or not, you meet every day. (non-nursing 1)*

The fact that she had done her practicum at the centre also helped the integration as the clients and staff of the External Clinic had already been exposed to the role. The NP explains it as follows,

> *But with my studies, and… because during our studies, we did our practica here. So it was with our people.*

The NP's familiarity was also significant for the clients. The clients in the 45 plus group felt that because the NPs were from their community, it enhanced their interaction with them. They felt that they had a real understanding of their reality. Someone like a locum who had not lived in this community could not understand the culture of the community. The following quote by a client explains this phenomenon,

> *It's better. They better understand the problems from here. Each place has their unique small problems dependent on the jobs you do and everything. You know? (>45 focus group participant 2)*

The professionals' ease in accepting her along with having confidence in her abilities was influenced by having worked with her. They knew what her level of expertise was; they had already developed a relationship with her and therefore were able to approach her with ease. The clients were comfortable with her as she was familiar to

them. This familiarity facilitated the integration of the NP role within this centre.

New health care professional's personal attributes. The NPs were described by others as having a personality that was passionate for their work and who wanted to contribute to their clients and to their teams. They demonstrated a willingness to learn. The main comment by most providers was the ease with which they were able to approach them. The following administration member describes her perspective,

> *When you have your career at heart or you have…that you really believe in it, you will be open to everything that people have to say to improve the services or for, to see how you can help. And I think that that the two NP and social worker, were really open to, to add… They wanted to contribute, wanted to bring support, some kind of help to the population and to support to… uh, to support the hospital, the team they worked with. (administration 1)*

The ability to establish positive relationships with other professionals improved her acceptance within the team.

Clients described the NP's approach as more personal. The younger clients talked about feeling close and accepted in their interactions with the NP. They were comfortable in discussing all aspects of their lives and sharing concerns. One participant describes in this way,

> *You are more comfortable talking about anything from head to toe. There is no issue you know. (≤45 focus group participant 2)*

Another participant in the 45 plus age group explained how important the NP approach is,

> *Well it is like I said, I was saying before, it is much more; it is the approach that is easier. You are not a number. (>45 focus group participant 1)*

Another client explained it in this manner,

> *Oh I find that the NP's approach is much more personalized. She is much closer to her clients, much more friendly. (≤45 focus group participant 2)*

Four clients attributed this approach to the type of personalities that are attracted to

pursuing an NP career. The NP's ability to develop positive relationships with both the clients and the professionals was integral in accepting this role within the study site.

New health care professional's experience: An important challenge identified by the NP was that she was a novice in her role and therefore she did not feel she had the necessary competencies to fulfil the role functions. This proved difficult for her, and the following quote describes her experience,

> *Then I decided to start with the outpatient clinic because, to be honest, at the beginning you don't really know very much. When you start, you realize that you know even less.*

She was attempting to develop confidence in her competencies and abilities but she continued to have many questions related to her practice as an NP. She was feeling that her knowledge was limited given the breadth of her newfound responsibilities. The following quote describes how she felt that the NP education does not necessarily prepare her for the responsibilities they are given,

> *I was swimming in an ocean and I did not see the shore because…. This feeling of lack of parameters became worse once the restrictions were lifted. But it's really [pause] huge. Sometimes I personally feel that it's too much for the little time we have spent studying compared to a doctor. It's not that I want to put down nurse practitioners; it's just that I find it's too much.*

This factor impacted the NP and resulted in a difficult lived experience of the integration.

Other professionals' acceptance. The professionals perceived having an NP in their community health centre as something positive. All professionals expressed openness in accepting the NP role as they felt this role added value to their team and to the services they offered. In addition, team members were generally proud that their health centre was the first in their region to introduce the role. One nursing member describes this willingness to accept the NPs,

> *Oh it it ...it was even very easy [to accept them]. We welcomed them with wide-open arms since we needed them. (nurse 1)*

The NP also felt this openness and acceptance by other team members as is demonstrated by the following quote,

> *The staff had nothing bad to say... they loved that I worked with them, and I was welcomed with open arms by the nurses, receptionists, everyone.*

A factor influencing this acceptance is that the clients gave positive feedback about the NP to other professionals. Through this feedback they generally expressed that were satisfied and they had confidence in the NP, and the comments most frequently heard from clients is that they felt they had more quality time with the NP. One administration member explains it in the following way,

> *But when you add the NP with their knowledge and everything…well…that is what the patients are telling us…that the time with them has more quality, and the patients are satisfied. For us, this is what made it easy for us to integrate them into our environment. (administration 1)*

5.7.5. Influences on Team Functioning

Improved interprofessional collaboration. Most others professionals had a positive perspective related to the way their team functioned. Many felt that the introduction of the NP role had helped them work more collaboratively. The following quote by a non-nursing member describes how the NP integration has impacted their way of functioning,

> *And with the arrival of these two professions [NP and SW], it created more possibilities, more possibilities to work as a team. As I was saying, in the beginning it seemed that we worked more in our own little corners. When that happened [arrival of new professionals], and that all of a sudden we started questioning the role of the NP, we also started questioning my role, what does she do, what can she not do. I think they do, they consult now. But I have difficulty focusing only on the NP role or only the SW. You know, I mean to say that people are getting to know on another's role more and more. But at a certain point, I*

> *think that we realized that a little that instead of working each in our corner, it was easier if we integrated each euh… everyone's expertise if I can say. (non-nursing 3)*

General comments related to team functioning as demonstrated by the above-mentioned quotes, are that the role of the NP helped in questioning their approach and promoted the move towards more collaboration and sharing of expertise.

Achievement of objectives related to the interprofessional team. In 2003, prior to the introduction of the new professionals within the study site, the administrative team had begun the process of discussing and setting the platform and basic principles for interprofessional team functioning. The sessions on teams functioning did not reoccur after this first initiation and few of the participants referred to these in the interviews. When discussing team functioning, one participant from the management group stated that some of the objectives related to interprofessional team functioning had been achieved but some objectives were left unattained. The following quotes describe this statement,

> *I'd say that since 2003, we have introduced the interdisciplinary team with many disciplines at the table. Including the social worker and the NP, but according to me, we have not achieved all our objectives. According to my perception, we had objectives that we wanted to achieve but I think we have partially achieved these. (administration 1)*

Even if the specific objectives to be achieved are not mentioned, with these comments, the manager recognised that more could be done to improve the interprofessional collaboration within this team.

Barriers to collaboration. The only professional that identified barriers to collaboration was the physician. She felt that the larger system did not encourage working together. The government requires that the physicians and NP have independent caseloads

making it more difficult to share clients. The following quote explains this barrier,

> *Well the dynamics here are not the same. Um, we work in silo, they [NPs] work on their side and we work on ours. The only time we cross paths is at departmental meetings. We must have a certain amount of clients assigned to us. So it's hard to say, "Next you or I will see the client next time". So follow-ups [together]…it does not work. (non-nursing 1)*

In addition, it was mentioned that the high demands of their work impacts their ability to work together.

> *Our schedules are full. Their schedules are full. So we do not cross paths. (non-nursing 1)*

The doctor and the second NP also mentioned that the second NP has chosen to consult with a doctor that works in an independent clinic outside of the Health Centre. Clearly this speaks to the inability to develop a collaborative relationship that was acceptable to all.

5.7.6. Site and Setting Influences

Fee for service environment. Management clearly emphasized that being a centre where doctors are salaried was a great facilitator as it was known by the administrators that other centres had many challenges with integration of the NP roles when doctors were paid fee for service. The following quotes demonstrates this perspective,

> *As it relates to doctors, if I can just add that at the level of doctors, here they are not paid fee for service. I think that, in places that I, I should say, anyway in the discussions we had, where the doctors were paid fee for service, the process to integrate the NP was even more difficult than where the doctors were salaried. (administration 2)*

Expanded role for nurses. Another facilitator mentioned by both participants from the management group, and by other professionals, was that the nurses in the

External Clinic had already been working in an expanded role; registered nurses could function autonomously,

> *Since 1998, the expanded role for nurses, the practice guidelines were implemented. We had about 29…the conditions where the patient could be evaluated, treated, discharged and in certain cases, there were follow-ups where you did not need to see the doctor. You were seen by the nurse. (administration 2)*

The expanded role of nurses has provided an initiation to the NP role and made the transition from RN to NP more acceptable to all. In addition, management mentioned the fact that the NP had been supported financially by the organization and by the community foundation therefore making it easier for the NP to access their education.

Overall, the six themes demonstrate that the staff members were satisfied with the way in which the role was integrated. They were comfortable with the gradual integration that occurred. The fact that the NP was previously a registered nurse at the centre and that she had also done her practicum there assisted in the acceptance and comfort of this gradual integration. She was well known and liked by the team members, which further facilitated the integration. Feeling supported by the addition of this new role was strongly voiced by all. This was significant for most professionals as it assisted in providing better care to their clients through increased access to medical services. They welcomed the NP and saw her as a collaborator and as someone who assisted in meeting the needs of clients. They have witnessed first-hand the clients' satisfaction because of increased access, less wait time and because of their ability to develop a relationship of trust. This is echoing what the clients have said about the NP services**.**

5.8. Field Notes

During the two-week data collection visit to the case study site, I recorded field

notes in an effort to document my observations. This allowed me to review information at a later time with the intention of deciphering what was emerging from all data sources (Mason, 2002; Pope & Mays, 2006). My observations were more specifically focused on team functioning, interactions among the team members and the way in which roles were played out. I was unable to witness many interactions between providers, yet one instance of collaboration I did observe was a consultation between the NP and another professional in the corridor. This helped confirm the fact that they do take advantage of opportunities to discuss clients informally. However, the interactions I witnessed were more frequently the professionals mingling in the cafeteria. Relationships were amicable and demonstrated good collegiality.

Where I had questions was in regards to the environmental set up. The Family Medical Unit was on the first floor upon entering the centre, set behind locked doors away from the other professional groups. This seclusion gave me the impression that the physicians are a group on their own and that this layout is not conducive to collaboration seeing as no other services were adjacent to this area other than the External Clinic. This brought to mind the comments of other professionals' about the NPs more accessible location. This is certainly the case seeing as their offices are situated in the corridor where others would routinely circulate, making them less isolated despite being on the second floor. This was not the case for the Family Medical Unit.

5.9. Strategies to Successful Integration

Few formal strategies to facilitate the integration were identified by the participants. However, one strategy that was identified is holding regular meetings. There was one particular meeting that was discussed as a strategy to help decrease the

resistance by the family physicians toward the second NP's independent practice. This occurred during the initial phase of the second NP's integration. The administration group had invited the nurse's professional association to do a presentation about the NP's scope of practice. This was helpful in clarifying the message that the NPs were autonomous practitioners with their own insurances. The NP's ability to be an autonomous practitioner was established. Nevertheless, this strategy did not assist in resolving the issues and concerns between the NP and physicians seeing as today, there are still missed opportunities to collaborate between these two groups. The fact that one of the NPs collaborates with a family physician who does not practice within the centre makes it evident that some issues remain unresolved. It also suggests that this team could benefit from the support of interdisciplinary collaboration as a means to further enhance the strengths that already exist. The strategy employed by the first NP to facilitate her integration was to discuss issues as they arose. By doing so, she felt minimal resistance from other professionals. Initially, she struggled due to what she felt was insufficient structure. She then met with the administrative team and requested more support and guidance from them. This resulted in regularly scheduled meetings whereby they were able to discuss issues and establish better plans for her role.

5.10. Participant Recommendations

All professionals who participated in the interviews were asked what they would recommend to someone implementing a new role. The most frequently stated comment was that it was important that the team understand the role. More specifically, they thought it important to clearly define the new professional's role and expertise. The first two quotes, which are by a nursing professional and the third by administration, describe

these recommendations,

> *Maybe talk to them about what she can do like in a meeting. In the External Clinic, well start by presenting her, telling them what she can do, what she cannot do. So they know what her scope of practice is. (nurse 1)*

> *Yes, it is important [to explain the role] because it is worrisome…can she do this? Can she do that? What is her role? What can she do? What can she not do? It's good to tell them before. She can do this. She cannot do that. (nurse 2)*

> *And you need a lot of information. Inform your people…I am talking about the people in you establishment, the professionals but also to inform your community. That is what is important…you cannot do one without the other. (administration 2)*

Another recommendation by a nursing member was that the role needed to be advertised so that all parties involved can understand the role.

> *Well you have to, you have to, wanting to or not, do some publicity, have to sell, have to say that they are there, sell their merchandise, that is for sure. And like they did with different meetings here and there in the community, well there, to talk about them helps people feel more secure about their product is, like I said that helps. You need to put emphasis on the advantages of adding the new role to the team. And you can present the positive aspects that the team will experience. Like less wait time, you can consult her when you are not sure. Uh…patients are satisfied. So you present in a positive way. (nurse 1)*

Holding regularly scheduled meeting was brought forward as an important strategy for the integration of a new role. A non-nursing professional describe it in this manner,

> *I think the integration…the idea of having meetings that we had…so that we could understand one another's role and to work together. That I find, it is…it is primordial. I think that that is where we learned to know one another. Really, wanting to or not, because if everyone works in his or her own offices, you will not get to know the other. But in meetings, it is there when we talk of a certain programs, people will participate…and it is through meetings, through face-to-face contact that we get to know our roles. (non-nursing 1)*

The third point that was elicited as a recommendation was to involve team members at the beginning to ensure that the needs of various departments are understood

so that everyone can share their perspective. This would in turn ensure that the needs would be met. The first three quotes by the non-nursing group and the fourth quote by the administration team member describe these recommendations,

> *In part because it is necessary that we bring our needs from each our department, it is like that. Our, my need is that. You know? (non-nursing 4)*
>
> *Uh, and to participate, participate in the implementation, participate in saying, where, what is it and how will we integrate the role. (non-nursing 1)*
>
> *It is the needs [you need to know] of the members, the existing team and also of the population to be serviced. (non-nursing 3)*
>
> *Uh you also need to involve the person who will be integrated in the team, in the strategy for integration. (administration 1)*

The following are the first NP's recommendations,

> *Of course, about structure. To support her and give structure and communicate with the entire team so they know she's coming on board. What she does, what role she's filling… Even to do… Like what we do for our nurse practitioners now. So that when she arrives, everything is structured for her but not done for her. There should just be… she should have an idea of where she's headed.*

Overall the participants of the focus groups had high rates of satisfaction with the services provided by the NP. This professional met their medical needs in a way that was conducive to their engagement in their own health. They only recommended that the promotion of this role should continue, as it was an asset to their health care system.

5.11. Chapter Summary

This chapter has brought answers to the research questions asked at the beginning of this research project. It has elicited the perspectives of various health professionals and clients and described how they lived the integration of a new role. In addition, it elucidated those factors that impacted the success of the integration and those that have acted as barriers. The following chapter will discuss the implications of these findings.

CHAPTER 6: DISCUSSION:

6.1. Introduction

In the last decades, the redesign of primary care has focused on interprofessional team composition to address the needs of people living with chronic illnesses. The care of these illnesses, which requires frequent monitoring and a range of expertise, is better suited to an expanded team (Kreindler, 2008). This is particularly important for primary health care teams seeing as they are faced with the increasingly complex needs of people living with chronic diseases and must provide services for all stages of life (Brown et al., 2010). To enhance expertise available to clients, a transformation of the care models is essential and must focus on interprofessional collaboration.

The benefits of interprofessional teams, which include better quality of care and improved client safety are valid reasons to expand health care teams in primary care (Canadian Health Service Research Foundation, 2006). Despite this fact, in 2007 only 39% of the Canadian population had access to such care (Desjardins, 2011). Findings from this thesis contribute to the burgeoning body of evidence concerning delivery models within primary care settings and the integration of new interdisciplinary health provider (Hendel, Fish, & Berger, 2007). Specifically, this thesis explores interdisciplinary team functioning and role integration in a primary care centre servicing a Francophone community. Furthermore, this thesis provides the opportunity to hear the perspectives of clients and diverse health professionals concerning role integration within these settings.

In this chapter, the discussion situates findings within the current literature and identifies implications for nurturing expansion of interprofessional teams in primary care settings. The discussion also addresses the original research questions which focused on: team members' lived experience related to the integration of a new role; key factors that impacted their acceptance of the new role; factors that resulted in better interdisciplinary collaboration; clients' lived experience and perspective of the integration of a new

role; and strategies that worked in facilitating collaboration and resolution of issues in the introduction of a new role. In addition, using the PEPPA framework, the study site becomes an exemplar case for the integration of new roles within primary care settings. Finally, the chapter ends with recommendations for nursing practice, education, research, and communication related to the NP role.

6.2. Discussion of Research Findings

The six themes that represent the clients' and the staff members' lived experiences with the integration of the role of the NP are discussed separately. The themes are: (1) gradual integration; (2) improved services; (3) support through the eyes of the new provider; (4) health care professional's specific qualities; (5) influences on team functioning and; (6) site and setting influences.

6.2.1. Gradual Integration

The NP role at the study site was integrated in a gradual manner, with limited formal communication, and no deliberate plans to introduce the role. Even with this reality, the majority of professionals and clients expressed that the lack of formal communication did not impact their acceptance of the role. The ease with which staff and clients at the study site accepted the NP role is not consistent with other studies, which suggests that lack of understanding of the role for other team members leads to ambiguity and resistance (Donald et al., 2010; Sangster-Gormley, 2011; Turcotte, 2005). Role ambiguity can also be a source of conflict among team members (Porter O'Grady, 2004) and hinder role implementation (DiCenso et al., 2003). Furthermore, role confusion can lead to underutilization of the role (Leipert, Delaney, Forbes, Forchuk, 2011). This finding is also contrary to other studies as role clarity is recognised to be essential for clients and their families. Having never been exposed to the role, they are less likely to accept seeing the new caregiver (Yeager et al., 2006). Similarly, public awareness and understanding of role was found to be a facilitator to role integration (Donald et al., 2010).

The staff respondents at the study site did not for the most part mention resistance, conflict, and underutilisation. The lack of planned strategies to integrate the role therefore had less impact than could have been anticipated. Factors that likely mitigated these potential barriers are the first NP's ability to build relationships, her communication skills and her willingness to repeatedly explain her role, along with her familiarity with the staff and community. These personal qualities and familiarity have been identified elsewhere as mechanisms that support receptivity of new roles in primary care settings (Willard & Luker, 2007). Moreover, another factor that influenced the integration of the new NP role was the lack of medical resources at the study site; her addition clearly helped to meet the needs of the community. This is consistent with findings from other studies where team member acceptance of new professionals was enhanced when the new role filled gaps in services (Kolodziejak et al., 2010). For this research site, it is evident that more factors contributed to acceptance than resistance.

6.2.2. Improvement in Services

The importance of quality time spent with the provider and education were noteworthy factors that positively influenced the clients' sense of empowerment with their overall health issues and confidence in the health care received. The case study clients expressed a high level of satisfaction with the care received from the NP, which included feeling comfortable in discussing health concerns, the NP's thoroughness and the extra time spent with the NP at health appointments. These three indicators of client satisfaction with care have been reported in the literature (IBM Business Consulting Services & McMaster University, 2005; Leipert et al., 2011; Roblin et al., 2004; Sangster-Gormley, Martin-Misener & Burge, 2013; Venning, Durie, Roland, Roberts & Lesse, 2000). Alternately, health education with clients has been attributable to client satisfaction and is emerging as an important role within NP practices (Martin-Misener et al., 2010; Reay et al., 2006; Venning et al., 2000). Similarly, in this case study the clients expressed their appreciation for the level of education provided by the new NP. They expressed

having greater understanding of their treatments and health concerns. Consequently, enhanced satisfaction and improved patient education could support improved client adherence to care, as was mentioned by the older age group of clients in this thesis. This is an area worthy of additional research, to investigate associations between adherence to care or motivation for undertaking healthier lifestyles and quality time and educational support provided by the NP.

Clients in this study also mentioned that access to care was paramount for them; this is consistent with previous studies. The addition of a new role is perceived positively when the new role improves access, and when the new provider sees them at or close to the scheduled time (Freeman et al., 2012; Martin-Misener, Reilly, & Robinson-Vollman, 2010; Roblin et al., 2004). Satisfaction with services and access to service by a competent provider was more important than the type of provider for the clients at the study site. The NP was able to provide the medical care they needed, they felt positively towards the interaction, and therefore acceptance unsurprisingly ensued.

6.2.3. Support Through the Eyes of the New Provider

The experience lived by the NP in her initial integration at the study site is similar to experiences of other novice NPs. The initial period is stressful for new NPs, as they experience many uncertainties in their role as they attempt to provide safe and competent care while acquiring additional knowledge to fill the gaps in their competencies (Hill & Sawatzky, 2011). It is recognised that novice NPs require support (Canadian Nurses Association, 2009). The NP's experiences in this case study are consistent with other studies where the significance of management support during the integration has been recognised (Reay et al., 2006). She was looking for more guidance from management whose support enhances role clarity, integration and development of the role (Bryant-Lukosis et al., 2004; Burgess, Martin and Senner, 2011; Sangster-Gormley et al., 2011; Willard & Luker, 2007). Management support for the new team member in negotiating issues at all levels of the organisation is also known to enhance the transition (Bryant-

Lukosis et al., 2004; Reay et al., 2006). Had the NP role not been so new within this setting and had she received additional support from mentors and management, her reality could have been different.

Still, the lived experience of the NP included her expressed appreciation for being supported by the doctors upon her entering this new role. Having doctors in the immediate environment provided a safety net, which allowed her to explore and experience various types of clinical situations. This is consistent with what Poghosyan (2013) found; novice NPs perceive doctors as an important resource for their developing practice. In general, physician support is one of the top three facilitators for the integration of the NPs (Martin-Misener et al., 2010), which may be rooted in good communication and collaboration with physicians (Burgess et al., 2010; Poghosyan, 2013).

Overall, the findings from this study and from other studies demonstrate the influence of support on the team and on the new post holder. Adding a new member impacts everyone and in some respect, a feeling of benefiting by the addition should be generated or created. We need to ask how the team members gain from the integration. For the post holder, consistent support by knowledgeable management will help maximize the benefits for the rest of the team.

6.2.4. New Health Care Professionals' Specific Qualities

Familiarity. As stated earlier, the NP's familiarity with the setting and community influenced acceptance by the team and clients. This is consistent with previous studies, which indicate that if other professionals trust the new professional and see how their skills contribute to the services, they are then more open to value and accept the role (Donnely, 2013; Freeman et al., 2012; Reay et al., 2006; Sangster-Gormley et al., 2013; Scholes & Vaughn, 2002). For example in this case setting, the new NP had previous exposure as a student and as a registered nurse, which provided the opportunity for her colleagues to be aware of her competencies and trust her. For administrators planning to

expand or change the mix of team member roles, one option to consider is supporting the professional growth of someone who is already part of the team. The question is, how important is it to the success of the integration of a new role to encourage someone from within to pursue their studies? Yet, if it is not feasible to hire within the setting, then strategizing avenues to create familiarity with the new person and the new role will be essential. Based on this thesis and from my personal experience, knowing the new provider enhances the integration.

The results demonstrated that the NP's familiarity was also important for the clients. The clients talked about the importance of having someone who is from their community and who understands their reality. This is consistent with research done with Francophones living in Manitoba where 90% of participants replied that it was either important or very important to receive health care services in their language of choice (de Moissac et al., 2011). Even if these clients did not specifically mention language as part of what is important, it can be assumed that receiving services in their language of choice was strong contributing factors in their statements about how the NP understood their reality and that there was a sense of familiarity. This study also demonstrates the importance of culturally appropriate care, with the clients' voice clearly demonstrating the significance of the provider understanding their reality. Grumback (as cited in Haines et al., 2010) has supported this in arguing that in order to improve patient access to the health care system, providers and services should come directly to the patient in a manner that is convenient, timely, reliable and culturally appropriate.

New health care professional's personal attributes. The staff and management respondents clearly appreciated the NP. A factor that facilitated this appreciation was her ability to communicate and to establish positive relationships with other professionals. This is consistent with other studies as it was found that the new post holder's ability to manage interactions with other professionals impacted the ease of relationships and acceptance of the role (Scholes & Vaughn, 2002; Willard & Luker, 2007). It has also

been found in other studies that the new provider's ability to fulfill and be accepted in the role was enhanced by their positive communication skills, strong social abilities and willingness to collaborate with others (Reay et al., 2006; Sangster-Gormley et al., 2013; Turcotte, 2005; Yeager et al., 2006). This factor was a key facilitator in my study and I believe the integration could have been very different had she not been a good team players and collaborator. This is a significant element to address in the recruitment process. Alternately, this finding also highlights the importance of educational experiences related to interdisciplinary teams within the undergraduate degrees.

New health care professional's experience. At this case site, the NP sometimes felt overwhelmed by her newfound responsibilities, which is not uncommon when beginning in a new role (DiCenso et al., 2003; Freeman et al., 2012; Hill & Sawatzky, 2011). Research demonstrates that when a new provider had minimal previous experience in primary care settings, their ability to carry out their role was usually impeded (Farrell et al., 2008: Kolodziejak et al., 2010). In addition, the health care provider's skills and knowledge are necessary facilitators to fulfill role expectations (Garner et al., 2008; Kolodziejak et al., 2010; Scholes & Vaughn, 2002; Yeager et al., 2006). If the NP had prior experience as a NP, she would have likely felt more confident in her skills and therefore her ability to carry out her role. She may have also requested more input from her management team as she would have had clearer expectations of what to negotiate. As stated earlier, all management teams wanting to integrate a new member need to understand the importance of support especially when the new post holder has limited experience.

6.2.5. Site and Setting Influences

The study site is not a fee for service environment. All participant groups in this study recognised this element as an important facilitator. Being in a salaried environment is a well-documented facilitator to the integration of the NP role (Gould et al., 2007; Turcotte, 2005). It is known that primary care continues to be serviced by physician

led models that are based on fee for service and that this model is less conducive to the inclusion of salaried NPs because they compete for the physician's clients and therefore their income (Martin-Misener, 2010). In the case setting, the lack of medical personnel at the time of the NP role being integrated meant the NP was not competing for the physicians' clients but complementing what was available in meeting community needs.

Another setting characteristic that was discussed was the expanded role of nurses in the External Clinic, which was thought to have facilitated staff acceptance of the NP role. The NP role was seen an extension of the expanded role. No other findings were found in the literature to corroborate if others had had the same experience. Most often, roles that are similar tend to have more issues with competition between the roles (Gould et al., 2007; Turcotte, 2005). In this situation the other nurses welcomed this role as they felt it supported them in their work. Again the feeling of being supported by this role and the ability of this NP to collaborate with others assisted in making the integration successful.

6.2.6. Issues with the Integration

The first NP expressed depending on and benefiting greatly from physicians' support and spoke minimally of resistance from them. Interestingly, the same cannot be said of the physician group, who did express resistance to the integration process at the study site. Based on previous studies, the resistance could be identified as turf wars and reluctance of physicians to fully accept the integration of new team member roles within their family practice (Bradley et al., 2008; Donald et al., 2010; Freeman et al., 2012; Martin-Misener et al., 2010). This competition between disciplines seems to be more pronounced when roles overlap (Gould et al., 2007; Turcotte, 2005; Donald et al., 2010; Gray, 2010) which is the case with the NP and physician role. A key concern raised by the physician group in this study was patient safety and lack of their involvement in decision making; there was concern that the responsibility would rest with them if something went wrong. These issues between physicians and other new health care

professionals can be set forward as an opportunity to explore the origin of these concerns with the goal of finding strategies to overcome these. As stated by Riegel, Sullivan-Marx and Fairman (2012), ‘’It is time to put aside professional interests cloaked in the rhetoric of patient safety and for nurse and physicians to grasp the opportunity to work together towards a common goal: the provision of high quality primary care that is accessible and safe for populations worldwide’’ (p. 449). Both parties have an important role to play with this issue. When a new provider comes within an environment, there needs to be consideration and respect for how the roles were being played out in the past. It is important for new professionals to be sensitive to capture the underlying messages expressed in the resistance and by doing so, one can begin to have a dialogue of where to go in the future.

6.3. Conceptual Framework

The PEPPA model is unique and can provide guidance to a primary care setting planning to expand the health care delivery team. In this section, the case study site is used as an exemplar to review the PEPPA model and its utility to aid management in planning changes within their workplace. As can be seen, use of this framework assists in articulating how aligning the integration of the NP role with the steps recommended by this framework could have assisted in building upon the strengths that already existed within this team. In addition, there will be a discussion on how following these steps could have improved team functioning, facilitated the integration and also could have assisted in the evaluation of the role.

The following table delineates the nine steps of the PEPPA framework with a brief description of each step. The last column gives the activities undertaken by the study site related to the corresponding PEPPA framework step.

Table 6.1.
PEPPA Framework

Steps	Description	Activities Achieved in steps
1. Define Patient Population and Describe Current Model of Care	Identify the population for which the new role is being developed and how clients interact and enter the system.	An evaluation of the needs of the population was done in 2003. This permitted for the identification of the important needs of their community. Did not look at current model of care and the way in which the clients were currently interacting with their system.
2. Identify Stakeholders and Recruits Participants	This is the step where all stakeholders who may be affected by the new role are given the opportunity to provide their feedback on how the current model of care will be transformed.	Administration did not engage stakeholders to get their feedback on how best to integrate role of NP. No planning done on the way in which the role would be implemented within this environment.
3. Determine Need for New Model of Care	In this step, the strengths and weakness of the current model are examined in order to create a new model	As in step 2, no engagement of stakeholders to determine weakness in existing model of care with the goal of establishing a new model of care
4. Identify Priority Problems & Goals to Improve Model of Care	In this step the stakeholders are asked to establish priorities and set goals to achieve maximum improvement for the new model.	No identification of priorities was done in a formal way. Used community assessment to add new professionals such as NP but did not plan to make changes in how they delivered care based on these needs.
5. Define New Model of Care & Role of New Provider	This is the action stage where the changes to be made are determined and are put into place. Other key steps are to: Identify enablers and barriers Identify changes required for successful implementation. Review existing collaborative practice arrangements. Identify changes to current roles of other health care providers that will be required to implement new role.	Only planning done is in the hiring of the new providers and the administrative details of doing so. No planning in terms of the role and functions of the NP and how this role would best address the needs of the populations being served.

6. Plan Implementation Strategies	Both steps 6 and 7 are actions steps to ensure the system is ready to accept the new role. In these steps the focus is on looking at barriers and facilitators and to maximize of facilitators.	Did not happen in any significant manner. Staff were hired and started to work. NP had discussions with MD and decided where in the centre she would start. Minimal structure and plans with implementation on behalf of management.
7. Initiate Role Implementation Plan	The steps determined in step 6 are instituted taking into consideration the various barriers and facilitators identified.	Hiring process put in place and other human resources process to ensure in system. No formal plans made here therefore no anticipation of barriers and facilitators.
8. Evaluate New Role and New Model of Care	The model suggests evaluating the roles, the relationships and resources to determine how they have affected the outcomes. The way in which the services are provided and how the new role functions.	Not done. Only survey done with clients to evaluated satisfaction for clients. No evaluation on how the role has impacted outcomes and how the role currently functions.
9. Long term monitoring of the New Role & Model of Care	Long term monitoring is a continuous surveillance as the health care environment is in constant change. Here is the opportunity to go through the previous steps.	No mention of this step by any participants.

The study site did well in reviewing the community health assessment that was completed in 2003. This assessment was well constructed; they ensured that the information was from reliable sources such as Census data, Statistics Canada and other local data sources (Canadian Nurses Association, 2006). This community assessment was communicated effectively as most staff members made reference to it during the interviews. Staff members were aware of the community needs and also were able to clearly understand the rationale for adding professionals to meet the needs that were identified. The main purpose of the community assessment is to ensure that needs are clearly understood, but it is also to examine if the current ways of delivering the services are effective in addressing the identified gaps in services (CNA, 2006). There was a missed opportunity for this community centre, as the community assessment was not used to look at the current way in which they were delivering services with the intention

of bringing about change. The administrators had plans to hire more professionals but did not use it to examine and plan different ways of functioning to better service the community. This centre is not different from other primary settings as determining a need for a new model of care has been recognised as lacking in many instances (Bryant-Lukosis et al., 2004).

A key missed opportunity at the study site was to establish a committee of stakeholders, which could have assisted in reviewing how the centre functions in their delivery of services. This was not instituted as staff members unanimously indicated that they were not consulted on the various aspects of the implementation of the NP role. An examination on how best to implement the role and define areas of responsibility was not done, which meant the NP was left to define her responsibilities and functions. This resulted in feeling considerable stress, as is notable when she mentioned feeling like she was thrown in the "lion's den". Having some guidance and a road map to guide her throughout the integration could have alleviated this stress (Hill & Sawatzky, 2011). Clarifying how the role will be operationalized facilitates integration (Donald et al., 2010); in this case, expectations of the role would have been clear, the NP would have known where to start and felt supported by management. In the long term, this support is shown to be fundamental in the growth and the learnings in the new role (Hill & Sawatzky, 2011). Unfortunately, the lived experience at this case study site is the norm and not the exception. For example, in BC, the first NPs to graduate were hired in settings where few team members had experience with this role (Sangster-Gormley, Martin-Misener, & Burge, 2013).

Utilising a more structured approach could come with many benefits and influence interprofessional dynamics between the NP and the physicians; clarified roles and implementation strategies can deflate topics leading to conflict (Bryant-Lukosis et al., 2004). In addition, implementation strategies could open dialogue to support a culture of shared values (Bryant-Lukosis et al., 2004; Sangster-Gormely et al., 2013), which would

also deflate potential sources of conflict. Had a staff forum been held, the stakeholders could have voiced concerns and shared their ideas, and eventually been clearer about implementation strategies. Regular meetings held by this group could assist in negotiating role responsibilities, and educating the stakeholders.

As mentioned earlier, they identified the needs of their populations, but had not prioritised these needs, nor identified outcomes to evaluate the new role or team model. With the absence of set outcomes and goals, evaluation of the implementation of the new role is difficult. The only attempt to evaluate was through a satisfaction survey done with clients. Ongoing monitoring is recognised as important to ascertain if the implementation of this role has achieved the goals it set out to achieve (Bryant-Lukosis et al., 2004). At the study site, the NP role continues to evolve, as the NPs decide what to do next. While this ambiguity can support creative solutions, enhanced guidance through identification of priorities and establishing goals can provide security (Bryant-Lukosius and DiCenso, 2004).

A more comprehensive communication plan, comprised of a detailed orientation for the team members, could create broader awareness of the role, which is beneficial as has been previously shown (Donald et al., 2010). While it was mentioned that information shared at meetings about the arrival of the NP was useful, the sentiment shared in interviews was that information was general in nature and was uninformative regarding the full scope of a NP role. Based on evidence from the literature, regular meetings were effective communication strategies to raise awareness of the new role and functions, along with dispelling concerns (Donnelly et al., 2013; Garner, et al., 2008; Garner et al., 2013). At the study site, an equally useful and absent strategy to communicate these details is development of policies and procedures to support the role. These documents can guide practice and facilitate clarity of the role.

Overall, the leadership team and team members could have benefited by following the recommended steps in the PEPPA framework. Not adopting a formal

process is not infrequent as Willard and Luker (2007) found that, a considerable amount of recommendations exist to guide the process of role integration, yet few health care organisations use these in the implementation process. There are many missed opportunities for this health centre. Following these steps could have impacted the success of the implementation, and could have improved the evolution of the role and the way in which this team functions today. The reality that the second NP does not consult with the doctors within the community centre but with another doctor indicates that the role was not fully integrated within the interdisciplinary team.

The PEPPA framework provides indispensable structure to guide the process of role integration (Sangster-Gormley et al., 2011). An element worth emphasising is that integrating a new role requires additional resources and following all steps of this model requires upfront investment and planning with your stakeholders and administration group. The recommendations in each step are guidance posts and within these steps are various elements to comprehend and negotiate. Investing the time to follow the guidance from these steps, using a framework, and understanding areas of negotiation will support enhanced interdisciplinary collaboration along with effective management of change. It is also recognised that step six and seven are complex and that the best practices for implementing new roles within existing teams are still not well established (Sangster-Gormley et al., 2011).

6.4. Limitations of the Study

All staff participants in the professional group were females; I was therefore unable to get a male perspective on the integration of the NP role. In a case study it is ideal to have as many perspectives as possible to ensure that all points of view are considered (Yin, 2003).

The younger focus group participants were also only females and consisted of only two women, which is a relatively small sample size. Although their perspective on the integration of the NP role was similar to that of the older group, it is possible that

with more participants of both genders, different results would have been elicited. Given that this study was based on a small sample size and a single case study, the ability to generalise the findings is lessened. Some discrepancies existing between the community demographic and the client participants may not have accurately represented this community as a whole. The majority of clients in the focus groups either had high school or university education, which was not representative of this population. This research would have been enhanced by a greater representation from the younger clients, and by a greater representation from clients in the lower socioeconomic status, which is more representative of that community.

An obvious limitation is the time factor. The data collection period took place in October 2013 while the integration of the first NP was in December 2005. This lapse of time can hinder the participants' ability to recall details about the integration. This was evidenced by variability of responses related to communication about the role.

6.5. Recommendations

6.5.1. Recommendations for Education

Increasingly, interprofessional collaboration is being accepted as the gold standard to providing high quality care in primary care (Ateah et al., 2011; Xyrichis & Lowton, 2007). This is especially important for clients with complex needs such as the frail elderly (Colwill, Cultice & Kruse, 2008; Robben et al., 2012). Various studies have demonstrated that less than optimal collaboration can negatively impact outcomes (Robben et al., 2012; Zwarenstein & Reeves, 2002). The issues related to interprofessional collaboration can be linked to insufficient skills in the existing teams (Ateah et al., 2011; Donald et al., 2010). Various educational initiatives are being introduced to increase skills and awareness related to interdisciplinary collaboration, unfortunately, these are not consistently applied across health care settings (Ateah et al., 2011) and there is a need for these initiatives to be more formalised (Burgess et al., 2011). Without concerted efforts to educate health care professionals about each other, it is unlikely that such teams will function at an

optimum level (Ateah et al., 2011). Thoughtful planning and educational preparation for health care providers to work together and share expertise within a team environment is imperative to enhance health care services (Canadian Academy of Health Sciences, 2010).

In addition, there is an identified need for the inclusion of components that address interprofessionalism in the curricula of all health professional education programs (Canadian Nurses Association, 2009; Donald et al., 2010). It is known that these interventions have more success with students, as their attitudes are easier to transform than those who have been practicing for longer periods of time (Robben et al., 2012). Curriculums should provide additional information in order to prepare the new NP for what to expect in the new role, and also give them strategies to soften the transition (Hill & Sawatzky, 2011; Martin-Misener et al., 2010). Participants in the Martin-Misener study suggested the addition of topics such as conflict resolution and NP-physician collaboration to the curricula (Martin-Misener et al., 2010). In this study, this could have facilitated the NP's ability to negotiate her role.

6.5.2. Recommendations for Further Research

Studies demonstrated positive results related to collaboration after interdisciplinary learning opportunities had been provided (Ateah et al., 2011). There still needs to be more research in the area of educational interventions that can positively influence collaboration (Robben et al., 2012). Expanding our understanding of well-functioning interprofessional teams, particularly when a wide range of professions are integrated into a primary care setting, is an emergent imperative to service the health care needs of our current population (Canadian Academy of Health Sciences, 2010). Research should provide the information needed to develop other interventions aimed at improving teamwork and allow us to know which interventions are effective and which interventions are not, and may actually do harm." (Zwarenstein & Reeves, 2002, p.245).

More research is required to elucidate the relationship between adherence to plan of

care and the services provided by the NP. As stated earlier, many studies have demonstrated increased satisfaction related to the quantity and quality of time, access, quality of the interaction and education provided by the NP. I was unable to find studies that demonstrated an improvement in the clients' adherence to care as it relates to the additional time and education received when seen by an NP.

6.5.3. Recommendations for Practice with Minority Groups

An adequate supply of all health care professionals will be required to meet the future demand for services in primary care. Recently, many publications reflect a growing concern for the workforce supply fulfilling this demand (Haines et al., 2010; Robben et al., 2012). This is also true for Francophone health care professionals as only 25% of Francophones in Manitoba have access to French language health and social services (de Moissac et al., 2011). A shortage of Francophone health care workers is perceived as being an obstacle to the access of these services (de Moissac et al., 2012).

The initiative *Accès Santé* is being developed by the stakeholders servicing the Francophone community with the objective of facilitating access to French language services in Winnipeg (Susan Stratford, personal communication, February 26, 2013). A service navigator will be hired to assist Francophones in accessing French language services. It is the goal that all questions related to Francophone services be directed to a single point. This role will need to be integrated within the service delivery model in Winnipeg and within existing primary care teams servicing Francophones so that other professionals know how to effectively utilise this role. This is one of the solutions to assist Francophones in accessing an interdisciplinary team that is culturally appropriate in a time where there is a shortage of Francophone professionals.

6.5.4. Recommendations Related to Communication of NP Role

Lack of clarity related to the NP role persists and is still an issue with the full integration of this role in the Canadian health care system (Donald et al., 2010; Martin-Misener, 2010). There is also confusion with the NP role and the lack of consistent titles

used for NPs within Canada (Donald et al., 2010). These barriers are partially due the absence of systematic planning to clarify the role and to the lack of communication with other health care professionals and the community about the role dimensions (Donald et al., 2010). In my study, even if clients clearly appreciated the NP role, they continued to refer to the NP as their doctor. This demonstrates that clients do not yet recognise the NP as a distinct profession. This confusion was also reported in the Gould et al. (2007) study, and other health consumers continue to experience confusion about this role (Bryant-Lukosius et al., 2004). Promotion of their professional practice is therefore necessary to address the existing challenges related to their role (Poghosyan et al., 2013). The NPs interviewed in a New Brunswick study indicated they were pleased to have an independent role but they recognised that their role was a "blurring of roles between nursing and medicine" even if they expressed they had a distinct philosophy of care from physicians (Gould et al., 2007, p.167).

Donald et al. (2010) recommends that the professional association initiate a Canada wide advisory panel and be given the responsibility to develop a marketing plan to ensure consistent messaging related to the NP role. In view of the reality that the role of NP is still not well defined in the health care system and with consumers, the Canadian Nurses association has recommended that more research be done to "determine the best approaches, and communications and marketing strategies to improve visibility and understanding of the role" (p.30).

6.6. Summary

Rising life expectancy and increasing rates of chronic diseases are pushing the vision of primary health care beyond the singular focus of the physician to the expansion of team-based models that include diverse health professionals. Creating and adopting team-based models necessitates comprehension of what is needed for well-functioning interdisciplinary teams. In addition, understanding how to effectively integrate a wide range of professionals is imperative for effective health care services to meet the needs

of our most vulnerable population. This case study was done to investigate the factors that impact team functioning with the introduction of a new role by comparing and contrasting perspectives from various professional groups and clients with the aim of better understanding what elements are important in facilitating the integration of the new role.

Study findings highlight the importance of the new professional's qualities in influencing their acceptance by existing team members and by clients. These qualities include their ability to establish relationships and their ability to collaborate with others. Moreover, their experience and ability to develop the role with confidence and competence are well recognized as facilitators. The foundation for these qualities are the professional's knowledge and experience with interdisciplinary collaboration. Education on collaboration should therefore be emphasized as essential, and be consistently applied in all existing teams and in undergraduate studies curricula. Acquiring the necessary competence in interdisciplinary collaboration would go a long way in facilitating the integration of new professionals within existing teams and in providing the expanded services that are necessary to meet our population's health care needs.

This study was successful in eliciting the voice of a variety of disciplines within the existing team. Their perspective demonstrated that there was minimal presence of conflict with the integration of the NP role even though this integration occurred gradually with few formal strategies used to introduce the role. They acknowledged that this new role contributed to the team, and expressed appreciation of this role. This is different from what has historically been heard from physicians who expressed more resistance toward other professionals taking on important roles in primary care. Perhaps the integration of new roles will be facilitated, as they will receive greater acceptance by the expanded team.

This case study corroborated findings in the existing literature that relate to the clients' satisfaction with the NP's approach. Quality time spent, and more education have

been associated with a high degree of satisfaction for the clients. What was novel in this study was that clients expressed having greater understanding of their treatments and health concerns, which made them feel more empowered to adhere to their plan of care as a result of the quality time the NP spent on educating them. Subsequently, these clients reported positive changes in their health. This fact helps justify further research on the NPs' approach and its impact on the clients' adherence to plan of care.

Leadership's continuous support to the new team members is recognised as being instrumental in assisting these new members in attaining full integration of their roles, and therefore expanding the potential of the existing team. In order to provide effective mentorship and support, leaders will be responsible for ensuring their own knowledge about optimal team functioning and integration of new team members. This will be essential to guide and influence the future professionals. Furthermore, using a framework such as the PEPPA framework can provide an essential foundation to guide the process of role integration. In conclusion, investing the time to appreciate the guidance from the PEPPA framework, and understanding areas of negotiation will support enhanced interdisciplinary collaboration along with effective change management. Role integration is complex and requires the investment of time and resources to achieve success.

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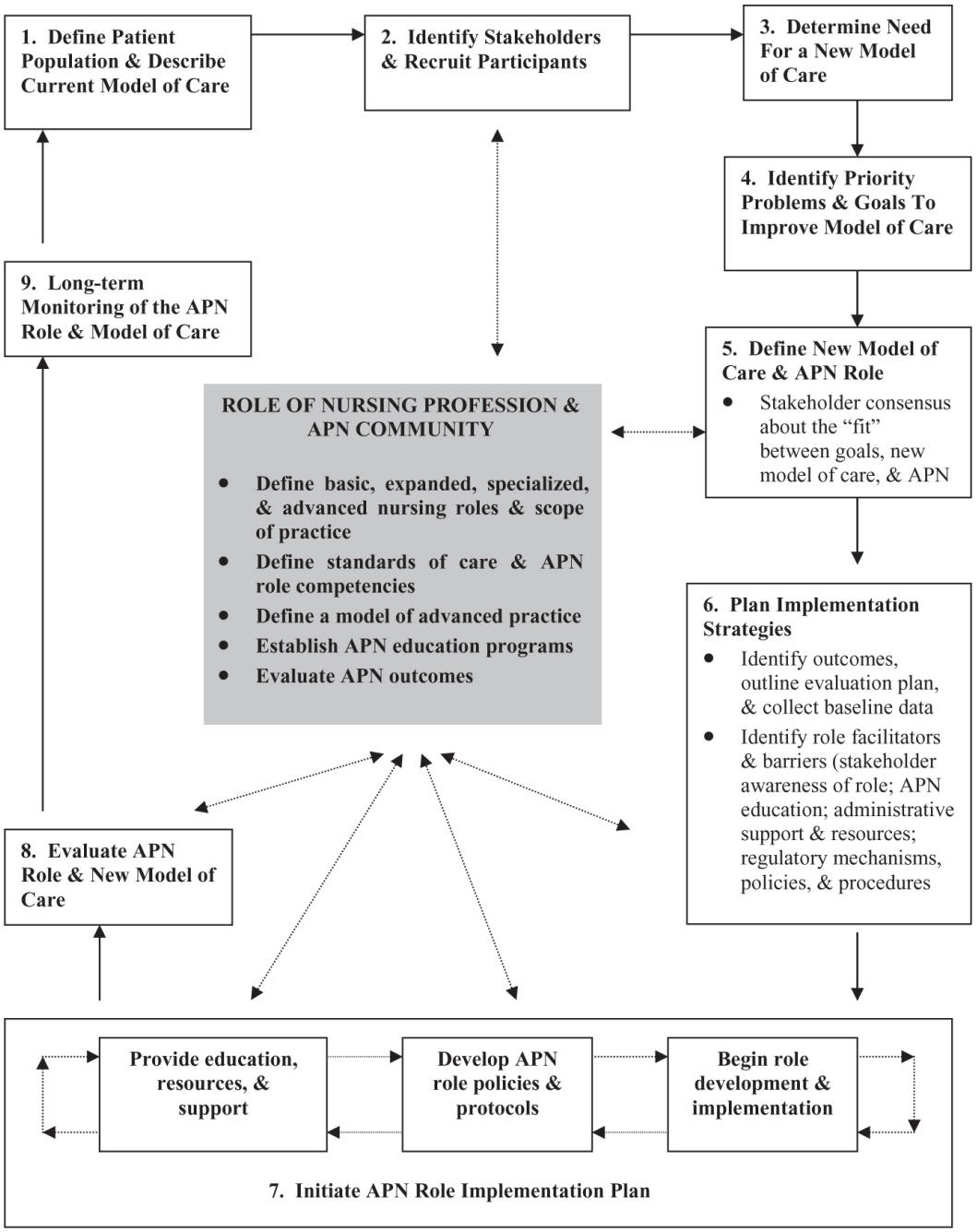
Appendix A: The PEPPA Framework

A Participatory, Evidence-Based, Patient-Focused Process For Advanced Practice Nursing (APN) Role Development, Implementation, and Evaluation



From: Bryant-Lukosius, D., and DiCenso, A. (2004). A framework for the introduction and evaluation of advanced practice nursing roles. *Journal of Advanced Nursing, 48*(5), 530-540. Reprinted with permission of John Wiley and Sons on July 23, 2014.

Appendix B: PEPPA Framework Table

The following table describes the nine steps of the PEPPA framework with a brief description of each step. The last 2 columns link the research questions and data collection source guiding this thesis study to relevant framework steps.

	Steps	Description	Research Question	Data Collection Source
1.	Define Patient Population and Describe Current Model of Care	Identify the population for which the new role is being developed and how do clients interact and enter the system.	Question 2 Question 3 Question 4	-Client focus groups -Staff semi-structured interviews -Clinic documents
2.	Identify Stakeholders and Recruits Participants	This is the steps where all stakeholders who may be affected by the new role are given the opportunity to provide their feedback on how the current model of care will be transformed.	Question 1 Question 2 Question 3 Question 4 Question 5	-Client focus groups -Staff semi-structured interviews -Clinic documents
3.	Determine Need for New Model of Care	In this step, the strengths and weakness of the current model are examined in order to create a new model	Question 2 Question 3 Question 4	-Client focus groups -Staff semi-structured interviews -Clinic documents
4.	Identify Priority Problems & Goals to Improve Model of Care	In this step the stakeholders are asked to establish priorities and set goals to achieve maximum improvement for the new model.	Question 2 Question 3	-Client focus groups -Staff semi-structured interviews -Clinic documents

5.	Define New Model of Care & Role of New Provider	This is the action stage where the changes to be made are determined and are put into place.	Question 1 Question 2 Question 3 Question 4 Question 5	-Client focus groups -Staff semi-structured interviews -Clinic documents
6.	Plan Implementation Strategies	Both steps 6 and 7 are actions steps to ensure the system is ready to accept the new role. In these steps the focus is on looking at barriers and facilitators and to maximize of facilitators.	Question 1 Question 2 Question 3 Question 4 Question 5	-Client focus groups -Staff semi-structured interviews -Field notes
7.	Initiate Role Implementation Plan	The steps determined in step 6 are instituted taking into consideration the various barriers and facilitators identified.	Question 1 Question 2 Question 3 Question 4 Question 5	-Client focus groups -Staff semi-structured interviews -Clinic documents -Field notes
8.	Evaluate New Role and New Model of Care	The model suggests to evaluate the roles, the relationships and resources to determine how they have affected the outcomes. The way in which the services are provided and how the new role functions.	Question 1 Question 2 Question 3 Question 4 Question 5	-Client focus groups -Staff semi-structured interviews -Clinic documents -Field notes
9.	Long term monitoring of the New Role & Model of Care	Long term monitoring is a continuous surveillance as the health care environment is in constant change. Here is the opportunity to go through the previous steps.	Question 1 Question 2 Question 3 Question 4 Question 5	-Client focus groups -Staff semi-structured interviews -Clinic documents -Field notes

Appendix C1 - English

Looking for participant for a research project – Health Professional

Research Project Title: ***Interdisciplinary collaboration: The Experience of a Francophone Interdisciplinary Primary Care Team with the Integration of the Nurse Practitioner Role***

Liliane Prairie, Principle Investigator, is a registered nurse who is currently a Masters Student in the Faculty of Nursing at the University of Manitoba. This project is supported by 3 co-investigators. Dr. Annette Schultz is a registered nurse with the nursing faculty at the University of Manitoba. Dr. Dauna Crooks, is a registered nurse in the Faculty of Nursing at the University of Manitoba. Dr. de Moissac, is a professor in the Faculty of Science at the Université de Saint-Boniface. In this research project, we are interested how a new professional role is integrated within a Francophone primary care setting. This case study project will seek to understand different points of view on how they have lived the experience of having a new health professional role integrated to their team. We are looking for professionals who were working *at l'Hôpital et centre de santé communautaire xxxxxxxx* when the nurse practitioner role was integrated.

It is important you understand that any information provided by you will be kept strictly confidential. As well, your decision to participate or not in this study will in no way influence your employment.

Professional who accepts to participate in this project will be asked to talk about their experience with the integration of the nurse practitioner role by participating in an interview that will last approximately 45 to 60 minutes. You will also be asked to complete a questionnaire, which will take about 10 minutes of your time.

If you would like to participate in this research project by scheduling a time for the interview or would like to have more information, please contact.

Liliane Prairie or Marie-Josée Roussel

Email: XXXXXXXXXXXXX Email : XXXXXXXXXX

Tel.: (XXX) XXX-XXXX

Appendix C2 - French

Invitation à participer à un projet de recherche – professionnels de la santé

Titre du projet de recherche : ***Collaboration interdisciplinaire : l'expérience d'intégration du rôle de l'infirmière praticienne dans un centre de santé primaire francophone***

M^me^ Liliane Prairie, la chercheuse principale, est une infirmière autorisée qui est actuellement étudiante à la maîtrise à la Faculté des sciences infirmières à l'Université du Manitoba. Ce projet est appuyé par 3 Co-chercheures. M^me^ Annette Schultz est infirmière autorisée à la Faculté des sciences infirmières à l'Université du Manitoba. M^me^ Dauna Crooks est également infirmière autorisée à la Faculté des sciences infirmières à l'Université du Manitoba. M^me^ Danielle de Moissac est professeure à la Faculté des sciences à l'Université de Saint-Boniface. Dans le cadre de ce projet de recherche, nous nous intéressons à l'intégration de deux nouveaux professionnels de la santé dans un établissement francophone de soins de santé primaires. L'objectif de ce projet est de comprendre le point de vue de différentes personnes quant à la façon dont elles ont vécu l'expérience de cette intégration au sein de leur équipe. Nous sommes à la recherche de professionnels qui travaillaient à l'Hôpital et centre de santé communautaire xxxxxxx lors de l'introduction du rôle d'infirmière praticienne.

Sachez que toute information que vous communiquerez demeurera strictement confidentielle. De plus, votre décision de participer ou non à cette étude n'aura aucun effet sur votre emploi.

Les professionnels qui acceptent de participer à ce projet seront demandés de partager leur expérience par rapport à l'intégration de l'infirmière praticienne lors d'une entrevue qui durera entre 45 et 60 minutes. On vous demandera aussi de remplir un formulaire, ce qui prendra environ 10 minutes.

Si vous aimeriez participer à ce projet de recherche et fixer une date pour l'entrevue, ou si vous aimeriez obtenir plus d'information, veuillez communiquer avec:

Liliane Prairie

Courriel :XXXXXXXXXXXXX

ou Marie-Josée Roussel

Courriel : XXXXXXXXXXXXX

Tél. : (XXX) XXX-XXXX

Appendix D1 - English

Looking for participant for a research project - Client

Research Project Title: The Experience of a Francophone Interdisciplinary Team with the Integration of the Nurse Practitioner Role

Liliane Prairie, Principle Investigator, is a registered nurse who is currently a Masters Student in the Faculty of Nursing at the University of Manitoba. This project is supported by 3 co-investigators; Dr. Annette Schultz, is a registered nurse with nursing faculty at the University of Manitoba. Dr. Dauna Crooks, is a registered nurse in the Faculty of Nursing at the University of Manitoba. Dr. de Moissac, is a professor in the Faculty of Science at the Université de Saint-Boniface. In this research project, we are interested how a new professional role is integrated within a Francophone primary care setting. This case study project will seek to understand different points of view on how they have lived the experience of the change related to the integration of the nurse practitioner within the Hôpital et centre de santé communautaire xxxxxxx.

It is important you understand that any information provided by you will be kept strictly confidential. As well, your decision to participate or not in this study will in no way influence the health care you receive in this community health centre.

We are looking for clients over the age of 18 and who have received services from the nurse practitioner and who were clients when one of these roles was implemented in 2004 and 2005.

Clients who accept to participate in this project will be asked to talk about their experience with the new roles by participating in a focus group that will last approximately 1 hour and 30 minutes. You will also be asked to complete a questionnaire, which will take about 10 minutes of your time.

To thank you for your participation, a light meal and refreshments will be served.

We are booking clients into one of two focus group meetings. If you would like to participate in this research project or would like to have more information, please contact:

Liliane Prairie

Email:XXXXXXXXXX

Marie-Josée Roussel

Email : XXXXXXXXXX

Tel.: (XXX) XXX-XXXX

Appendix D2 - French

Invitation à participer à un projet de recherche- client

Titre du projet de recherche : ***Collaboration interdisciplinaire : l'expérience d'intégration du rôle de l'infirmière praticienne dans un centre de santé primaire francophone***

M^me^ Liliane Prairie, la chercheuse principale, est une infirmière autorisée qui est actuellement étudiante à la maîtrise à la Faculté des sciences infirmières à l'Université du Manitoba. Ce projet est appuyé par 3 Co-chercheuses ; Mme Annette Schultz est infirmière autorisée à la Faculté des sciences infirmières à l'Université du Manitoba. M^me^ Dauna Crooks est également infirmière autorisée à la Faculté des sciences infirmières à l'Université du Manitoba. M^me^ Danielle de Moissac est professeure à la Faculté des sciences à l'Université de Saint-Boniface. Dans le cadre de ce projet de recherche, nous nous intéressons à l'intégration de deux nouveaux professionnels de la santé dans un établissement francophone de soins de santé primaires. L'objectif de ce projet est de comprendre le point de vue de différentes personnes quant à la façon dont elles ont vécu l'expérience de cette intégration au sein de leur équipe. Nous sommes à la recherche de clients qui ont reçu des services à l'Hôpital et Centre de santé communautaire xxxxxxxx lors de l'introduction du rôle d'infirmière praticienne.

Sachez que toute information que vous communiquerez demeurera strictement confidentielle. De plus, votre décision de participer ou non à cette étude n'aura aucun effet sur les services que vous recevez à l'Hôpital et Centre de santé communautaire xxxxxxxx.

Si vous acceptez de participer au projet, vous serez demandé de participer à un groupe de discussion pour parler de votre expérience face à l'intégration d'une infirmière praticienne. Ce groupe de discussion sera d'une durée d'environ 1 heure et demie. On vous demandera également de remplir un questionnaire démographique, ce qui prendra environ 10 minutes.

Pour vous remercier de votre participation, un léger repas sera servi.

Les clients qui veulent participer seront assignés à un de deux groupes de discussion. Si vous désirez participer à ce projet de recherche ou si vous voulez obtenir plus d'information, veuillez communiquer avec :

Liliane Prairie

Courriel : XXXXXXXXXX

ou Marie-Josée Roussel

Courriel : XXXXXXXXXX

Tél. : (XXX) XXX-XXXX

Appendix E1 - English

Interview Questions for Health Professionals

Date: _____
Participant number: _____

In 2004 and 2005 the nurse practitioner role were added to your team at l'Hôpital et centre de santé communautaire xxxxxxx. We are currently doing a research project to better understand the integration of these roles within your team. We are seeking different points of view of people who have lived this experience. If there are no further questions, let's begin.

1. Let's start by talking about adding new members on the team.
   From your perspective what was it like to have the role of the nurse practitioner introduced to your team?
   Probe-Can you tell me how they were introduced to your team?
   Probe-What was your awareness of the scope of their practice within this setting?

2. Now I would like to talk about how you experienced the transition.
   Can you tell me your involvement in the change?
   Probe-Were you asked to share your ideas/thoughts about how these roles could be integrated? I.e. referral process

3. Now let's talk about how your practice was affected by the introduction of the nurse practitioner role.
   Can you tell me how your practice has changed since the nurse practitioner started?
   Probe - Was it clear when you should refer?
   Probe-From your perspective, do these roles have functions that overlapped with yours?
   Probe - Have there been any concerns that you would like to share?

4. Have clients benefited from the nurse practitioner's practice?
   Probe - From your experience, are clients open to seeing these new providers?

5. Now I would like to focus on overall team functioning since the nurse practitioner started.
   When you reflect on the last several years, what stands out regarding how the team of health providers function as a whole?
   Probe - How have the nurse practitioner and the integrated into the team?
   Probe - From your perspective, is there something that could have been done differently?
   Probe - What made it easier for the team members to accept these roles as part of team? Probe - From your experience, what was the most difficult issue

encountered with this transition to the team? How was it addressed?

6. If you were being consulted by another center looking at integrating a new team member, what recommendations would you have for them?

7. Anything else you would like to talk about concerning these new roles?

   Please note: In the event that a participant refers to a situation that includes conflict during this interview, then I will ask the following series of questions

   Can you elaborate on your experience of this conflict?
   How might others have experienced this situation?
   How was this issue resolved?

Appendix E2

Questions d'entrevue à l'intention des professionnels de la santé

Date : _____
Numéro du participant ou de la participante : _____

En 2004 et 2005, l'infirmière praticienne se sont joints à l'équipe des professionnels de la santé de l'Hôpital et centre de santé communautaire xxxxxxx. Nous menons présentement un projet de recherche afin de mieux comprendre comment s'est produite l'intégration de leur rôle dans un établissement francophone de soins de santé primaire. Nous tentons obtenir le point de vue de différentes personnes qui ont vécu l'expérience de l'intégration de ces professionnels. S'il n'y a plus de questions, nous allons commencer.

1. Commençons par parler des nouveaux membres de l'équipe.
   De votre perspective, comment avez-vous vécu l'intégration du rôle de l'infirmière praticienne au sein de votre équipe?
   Question d'approfondissement - Pouvez-vous m'expliquer comment ces rôles ont été introduits dans votre équipe?
   Question d'approfondissement - Que saviez-vous sur l'étendue du champ de pratique des nouveaux membres de l'équipe au sein de l'établissement?

2. Maintenant j'aimerais parler de la façon dont vous avez vécu la transition.
   Pouvez-vous me dire comment vous avez participé au changement?
   Question d'approfondissement - Vous a-t-on demandé de faire part de vos idées quant à la façon dont ces rôles pouvaient être intégrés? P. ex. processus d'acheminement des clients

3. Parlons maintenant de la façon dont votre pratique a été touchée par l'introduction du rôle de l'infirmière praticienne.
   Pouvez-vous m'expliquer comment votre pratique a changé depuis que l'infirmière praticienne ont commencé?
   Question d'approfondissement - Saviez-vous exactement dans quelles circonstances vous deviez diriger des clients vers ces personnes.
   Question d'approfondissement - Selon votre perspective, est-ce que les fonctions de ces nouveaux rôles empiètent sur les vôtres?
   Question d'approfondissement- Y a-t-il eu des préoccupations dont vous aimeriez faire part?

4. Les clients ont-ils bénéficié de la pratique de l'infirmière praticienne?
   Question d'approfondissement- Selon votre expérience, les clients sont-ils ouverts à consulter l'infirmière praticienne?

5. J'aimerais maintenant passer au fonctionnement global de l'équipe depuis que l'infirmière praticienne a commencé.
   Lorsque vous réfléchissez aux dernières années, qu'est-ce qui ressort quant à

la façon dont l'équipe de fournisseurs de soins de santé fonctionne dans son ensemble?
Question d'approfondissement- Comment l'infirmière praticienne s'est-elle intégrée à l'équipe?
Question d'approfondissement - Selon vous, y a-t-il des choses qui auraient pu être faites autrement?
Question d'approfondissement - Qu'est-ce qui a aidé les membres de l'équipe à accepter ces rôles comme faisant partie de l'équipe?
Question d'approfondissement - Selon votre expérience, quel était le défi le plus important associé à cet ajout à l'équipe? Comment a-t-il été surmonté?

6. Si un autre établissement vous consultait parce qu'il s'intéressait à intégrer un nouveau membre à l'équipe, quelles recommandations lui feriez-vous?

7. Y a-t-il autre chose dont vous voulez parler concernant ces nouveaux rôles?

Si les participants font référence à une situation où il y a eu des conflits, les questions suivantes seront posées.
Pouvez-vous nous parler de votre expérience face à ce conflit?
Comment les différents groupes ont-ils géré le conflit?
Comment le conflit a-t-il été résolu?

Appendix F1

Demographic Questionnaire for Staff Members

Date : _____
Participant number:_____

1. Sex
   Male____
   Female__

2. How many years have you been working at this centre?
   0 to 5 years ____
   6 to 10 years ____

3. Is your current position?
   Full time____
   Part time____
   Casual____

4. Please choose the age range that applies to you.
   20 to 30 years____
   31 to 40 years____
   41 to 50 years____
   51 to 60 years____
   61 years and over____

5. What is the highest level of education you have completed?
   Did not complete high school____
   Completed high school ____
   College of Technical Degree/Certificate____
   Undergraduate Degree____
   Master's Degree____
   Doctoral Degree____
   Other_____

6. How many years since graduation?
   0 to 5 years____
   5 to 10 years____
   11 to 20 years____
   21 to 30 years____
   31 years or more____

7. From which post-secondary program did you graduate?

Appendix F2 - French

Questionnaire démographique à l'intention des membres du personnel

Date :_____
Numéro du participant:_____

1. Sexe
   Homme__
   Femme__

2. Depuis combien d'années travaillez-vous à l'Hôpital et centre de santé communautaire XXXXXX ?
   0 à 5 ans ____
   6 à 10 ans ____

3. Est-ce que votre poste est?
   Temps plein____
   Temps partiel____
   Occasionnel____

4. S'il vous plaît choisir la tranche d'âge qui s'applique à vous?
   20 à 30 ans____
   31 à 40 ans____
   41 à 50 ans____
   51 à 60 ans____
   Plus de 61 ans____

5. Quel niveau d'éducation avez-vous complété?
   Pas complété d'études secondaires ____
   Complété des études secondaires ____
   Collège technique / diplôme/degré/certificat en_____
   Degré universitaire_____
   Maitrise au niveau universitaire _____
   Doctorat au niveau universitaire _____
   Autres_____

6. Depuis combien d'années avez-vous terminé vos études?
   0 à 5 ans____
   5 à 10 ans____
   11 à 20 ans____
   21 à 30 ans____
   31 ans ou plus____

7. Dans quel programme post-secondaire avez-vous terminé vos études?

   _____

Appendix G1
Focus group questions for Clients

Date: _____
Focus Group ID: _____

I appreciate your interest in this study and look forward to hearing from you about your experiences with the nurse practitioner at your centre. All focus group participants are asked to pledge that they will not disclose the content of the discussions that occur in the focus group to people outside of the group. We have five areas to discuss during this focus group. Please note there are no right or wrong answers only your perspectives/ experiences and that is what I am interested in hearing. Are there any questions? Address questions…If there are no further questions let's begin

1. Let's begin by talking about the nurse practitioner and your experiences with these people.
   How did you learn that a new nurse practitioner was coming to the Centre?
   Probe- What were the messages given to you about these new health care professional (Posters, letters, pictures, meeting)?
   Probe-What were the reasons other health care professionals suggested you see these people?

2. Now let's talk about how services have changed at the Centre
   Tell me how the services you receive have changed?
   Probe- Tell me how the time you spend at the Centre is different?
   Probe-What has been your experience with making an appointment with these providers?
   Probe-Anything else you would like to add about how this has affected the services you receive?

3. Now I want to focus on how the new practitioners have affected your health
   In your perspective, how has your health been affected?
   Probe-Has your ability to understand your treatment(s) changed?
   Probe-How has this affected your understanding of your health or health concerns?
   Probe-Have you changed self-care practices?

4. I am curious, if you have suggestions for other health professionals that would be good to add to the team? Can you tell what the benefit might be for each?

5. Anything else you would like to talk about concerning these new roles?

   Please Note: if participant refers to a situation where there was conflict in any of the above questions, the following questions will be asked:
   Can you tell me more about your experiences with this conflict?
   How was this issue resolved?

Appendix G2
Questions pour groupes de discussion avec les clients

Date: _____
Numéro d'identification du groupe de discussion: _____

J'apprécie l'intérêt que vous avez pour ce projet de recherche et j'ai hâte d'entendre parler de vos expériences avec l'infirmière praticienne à votre centre communautaire. Tous les participants des groupes de discussion sont demandés de conserver la confidentialité de toutes informations partagées dans le groupe de discussion. Il y cinq sujets dont nous allons discuter au cours de notre groupe de discussion. S'il-vous-plait notez qu'il n'y pas de bonne ou de mauvaise réponse, ce sont votre perspective et vos expériences qui m'intéressent. Avez-vous des questions? Répondre aux questions, s'il n'y as pas de questions nous allons commencer.

1. Commençons en parlant de l'intégration de l'infirmière praticienne et de vos expériences avec cette personne.
   Comment avez-vous appris qu'une nouvelle infirmière praticienne allait se joindre au centre communautaire?
   Question d'approfondissement - – Quels étaient les moyens utilisés pour vous informer de leur arrivée? (affiches, lettre, photos, rencontres)
   Question d'approfondissement - - Pour quelles raisons vous a-t-on référé à cette personne pour des services de santé?
2. Maintenant, parlons de comment les services ont changé au centre.
   Parlez-moi des changements dans les services que vous avez reçus.
   Question d'approfondissement -- Dites-moi comment le temps passé au centre a changé ?
   Question d'approfondissement - – Parlez-moi de votre expérience avec la prise de rendez-vous avec ce professionnel.
   Question d'approfondissement -- Avez-vous quelque chose à ajouter par rapport aux changements dans les services que vous recevez?

3. Parlons maintenant de l'impact de ce nouveau professionnel sur votre santé.
   Selon votre perspective, comment votre santé a-t-elle été affectée?
   Question d'approfondissement – Est-ce qu'il y a eu des changements dans votre capacité de comprendre le traitement que vous recevez?
   Question d'approfondissement – Est- ce que ceci a causé des changements dans votre capacité de comprendre votre santé ou vos préoccupations face à votre santé?
   Question d'approfondissement – Avez-vous changé la façon dont vous prenez votre santé en main?

4. Je suis curieuse de savoir si vous avez des suggestions de d'autres professionnels de la santé qui seraient bon d'ajouter à l'équipe ? Quels seraient les bénéfices pour chacun de ses membres de l'équipe ?

5. Y a-t-il autre chose dont vous voulez parler concernant ce nouveau rôle ?

Si les participants font référence à une situation où il y a eu des conflits, les questions suivantes seront posées. Pouvez-vous nous parler de votre expérience face à ce conflit ? Comment les différents groupes ont-ils géré le conflit? Comment le conflit a-t-il été résolu?

Appendix H1
Demographic Questionnaire for Focus Groups

Date : _____
Participant number:_____

1. Sex
   Male____
   Female__

2. Living situation
   Live alone____
   Live with a spouse____
   Live common law____

3. Please choose the age range that applies to you.
   18 to 30 years____
   31 to 40 years____
   41 to 50 years____
   51 to 60 years____
   61 years and over____

4. What is the highest level of education you have completed?
   Did not complete high school____
   Completed high school ____
   College of Technical Degree/Certificate____
   Undergraduate Degree____
   Other_____

5. How frequently do you access services at this Centre?

   _____

6. What is your primary reason for accessing services? _____
   _____

Appendix H2
Questionnaire démographique à l'intention des groupes de discussion

Date : _____
Numéro du Participant:_____

1. Sexe
   Homme ____
   Femme__

2. Situation familiale
   Vit seul(e)____
   Vit avec conjointe ou conjoint ____
   Vit avec un ou une partenaire____

3. S'il vous plaît choisir la tranche d'âge qui s'applique à vous.
   18 à 30 ans____
   31 à 40 ans____
   41 à 50 ans____
   51 à 60 ans____
   Plus de 61 ans____

4. Quel est votre plus haut niveau d'éducation?
   Pas complété d'études secondaires ____
   Complété des études secondaires____
   Certificat dans un collège communautaire ____
   Degré universitaire____
   Autres_____

5. Comment souvent accédez-vous aux services de l'Hôpital et centre de santé communautaire XXXXXX? _____

6. Quelle est la raison principale pour laquelle vous venez à l'Hôpital et centre de santé commaunautaire XXXXXX ? _____

Appendix I

AP01

UNIVERSITY OF MANITOBA | Research Ethics and Compliance
Office of the Vice-President (Research and International)

Human Ethics
208-194 Dafoe Road
Winnipeg, MB
Canada R3T 2N2
Phone +204-474-7122
Fax +204-269-7173

APPROVAL CERTIFICATE

June 25, 2013

CNFS

TO: **Lilian Prairie** (Advisor A. Schultz)
Principal Investigator

FROM: **Diana McMillan, Acting Chair**
Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2013:057**
"Interdisciplinary Collaboration: The Experience of a Francophone Interdisciplinary Team with the Integration of a New Role"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement (2). **This approval is valid for one year only**.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- **If you have funds pending human ethics approval, please mail/e-mail/fax (261-0325) a copy of this Approval (identifying the related UM Project Number) to the Research Grants Officer in ORS in order to initiate fund setup. (How to find your UM Project Number: http://umanitoba.ca/research/ors/mrt-faq.html#pr0)**

- **if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.**

The Research Quality Management Office may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba *Ethics of Research Involving Humans*.

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/orec/ethics/human_ethics_REB_forms_guidelines.html) **in order to be in compliance with Tri-Council Guidelines.**

Appendix J

Bureau de l'éthique
Ethics Office

Le 23 juillet 2013

Liliane Prairie
Masters Student, Nursing Faculty
University of Manitoba
593, Côté Street
Winnipeg, Manitoba, R2J 0P6

Objet : Interdisciplinary Collaboration : The experience of a Francophone Interdisciplinary Team with the Integration of the Nurse Practitioner and Social Worker Role

Chercheure principale : Liliane Prairie
Site : Université du Manitoba

Approbation finale

Mme Prairie,

Ayant revu et pris connaissance des modifications apportées à vos documents, le Comité d'éthique de la recherche vous accorde l'approbation finale pour l'étude mentionnée ci-dessus. Cette attestation est valide pour une période de 12 mois débutant le 19 juillet 2013. Si toutefois cette étude devait se poursuivre après cette échéance, l'approbation devra être renouvelée auprès du Comité d'éthique de la recherche.

Également, nous désirons vous aviser que tout changement apporté aux documents devra être soumis au Comité d'éthique de la recherche pour approbation. Au moment opportun, veuillez également nous aviser de la fermeture de l'étude afin que nous puissions mettre à jour nos dossiers.

Nous désirons vous rappeler que le Comité d'éthique de la recherche est organisé et fonctionne d'après les lignes directrices des bonnes pratiques cliniques.

Veuillez agréer, Mme Prairie, l'expression de mes salutations distinguées.

Pierrette Fortin
Présidente du Comité d'éthique
de la recherche

/id

cc. Martine Poirier (Bureau d'appui à la recherche du Réseau de santé Vitalité)

Bureau de l'éthique
Ethics Office
1750, promenade Sunset Drive
Bathurst NB E2A 4L7
Tél. / Tel.: 506 544-2506
Téléc. / Fax: 506 544-2533
ethique.ethics@vitalitenb.ca

RÉSEAU DE SANTÉ vitalité HEALTH NETWORK

Appendix K1

UNIVERSITY OF MANITOBA | Faculty of Nursing

Faculty of Nursing
Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone: (204) 258-1311
Fax: (204) 233-7214

Interview Consent Form for staff members

Research Project Title: *Interdisciplinary collaboration: The Experience of a Francophone Interdisciplinary Team with the Integration of the Nurse Practitioner Role*

Researcher(s): Liliane Prairie RN, BN (Principle Investigator, Masters Student, Faculty of Nursing at the University of Manitoba); Co-Investigators: Annette Schultz, PhD, RN (Faculty of Nursing at the University of Manitoba); Dauna Crooks, PhD, RN (Faculty of Nursing at the University of Manitoba):Danielle de Moissac, PhD, (Faculty of Science at the Université de Saint-Boniface).

Declaration of responsibility: The principal investigator is responsible for this research project, and will respect all statements that are stated in the consent form.

Principal investigator's signature: _____

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It will provide a basic idea of what the research project is about and what your participation will involve. If you would like more details about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully.

About this project:

The purpose of this study is to explore the process of integrating the nurse practitioner and social work role within a Francophone primary care setting. This case study project will use a descriptive interpretive approach to investigating lived experiences related to the integration of new health professional roles from diverse individuals at the Hôpital and Centre de santé communautaire XXXXXX; the participants will include staff and clients

from the centre. The study will seek to describe role integration from diverse standpoints along with comparing perceptions of conflict from these various standpoints. The findings of this study will be prepared into reports, scientific presentations and papers. Individual responses will be prepared in aggregate (group) form so that it is not possible to identify individual participants.

My understanding of the Research Activities:

You understand that if you participate in the research project, you will be asked to participate in an individual interview lasting approximately 1 hour. During the interview, you will be asked questions about your perspective of the integration of new roles within your Centre. The interview will be audio recorded for the unique purpose of transcribing your comments at a later date. At no time during the research project will your identity be known, either in the final report or any publications or communications that may arise about this study. The audio recordings and the transcriptions will be stored in a locked file and will only be made available to members of the research team. You understand that the interview will be conducted by Liliane Prairie.

Risks and Benefits:

There are no risks associated in participation in this study. The main inconvenience of your participation is the time that you will spend to complete the interview. You may have concerns related to some of the questions. If you have concerns, you can express these and expect that you will receive the information that you require. Benefits are providing information about role integration and conflict to support understanding how to integrate a new team member to an existing team. You will not receive any compensation for your participation in this research project.

Protecting Confidentiality:

The information you provide is strictly confidential and will be protected in several ways:

1. All interviews will be identifiable by a numerical code only (no names will be attached).

2. You (and individuals referred to during the interview) will not be identified in any records or in written reports from this project.
3. All records will be securely stored in a locked filing cabinet and or/password secured computer files. All files will be destroyed after seven years.
4. Only the identified researchers and the research assistant who is the hired person to transcribe the audio-recorded interviews will have access to records.
5. Findings will be presented in group form so as not to identify individual participants.
6. All researchers accessing the audio-recording or transcripts have completed a Personal Health Information Pledge.

Voluntary Consent:

You understand that your participation in this project is voluntary. You are free to withdraw from the study at any time, and/or refrain from answering any questions, without prejudice or consequence. If you choose to withdraw please contact Liliane Prairie and all information you have provided will be destroyed. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation in the project.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the project and agree to participate in one interview. However, in no way does this waive your legal rights nor release the researchers, or involved institutions form their legal and professional responsibilities. In addition, you understand that you may contact Liliane Prairie (XXX) XXX-XXXX or email XXXXXXXXXX. If you have any concerns, questions, or need additional information. Alternately, you may contact her thesis advisor Annette Schultz (XXX) XXX-XXXX or email XXXXXXXXXX.

This research has been approved by Education/Nursing Research Ethics Board at the University of Manitoba. If you have any concerns or complaints about this project

you may contact any of the above named persons or the Human Ethics Secretariat at (XXX)XXX-XXXX, or email XXXXXXXXXX. The University of Manitoba Research Ethics Board(s) and a representative(s) of the University of Manitoba Research Quality Management / Assurance office may also require access to your research records for safety and quality assurance purposes.

If you have any questions about your rights as a participant in this research or if you wish to discuss this project with someone who is not associated with this research, you may also contact Isabelle Dugas, coordonnatrice du bureau de l'éthique du Réseau de santé Vitalité, XXXXXXXXXXX, (XXX) XXX-XXXX; courriel : XXXXXXXXXXXX

Declaration:

I declare having received enough information about this research project and understand what is expected of me. I have read and understood the consent form and I have received a copy. I have been sufficiently informed about what is expected with my participation in this project. I have had the opportunity to ask questions and these have been answered to my satisfaction.

_____ _____

Participant Signature Date

Please Print Name: _____

_____ _____

Witness's name Date

Please print name: _____

Declaration of the person responsible for obtaining the consent

I,_____hereby declare having explained to the interested participant the details of the current consent. I have answered all their questions related to this document. The participant is aware that they can at any time withdraw from the research project.

_____ _____

Signature of the person responsible for obtaining the consent Date

Printed name: _____

_____ _____

Witness's signature Date

_____

Printed name

_____

Signed at

I would like to receive a copy of the brief report

Yes_____

No_____

Please send the report to:

Name: _____

Address_____

Postal Code_____

Or

Email Address_____

I am extending an invitation to all participants who wish to review the information in the early stages of data analysis to verify that the themes are in accordance with the information you have shared.
This communication will be conducted through Email (with password protected files).
I would like to participate
Yes_____
No_____
If yes, can I contact you through your Email address?
Yes _____

Appendix K2

UNIVERSITY OF MANITOBA | Faculty of Nursing

Faculty of Nursing
Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone: (204) 258-1311
Fax: (204) 233-7214

Formulaire de consentement à une entrevue à l'intention des membres du personnel

Titre du projet de recherche : *Collaboration interdisciplinaire : l'expérience d'intégration du rôle de l'infirmière praticienne dans un centre de santé primaire francophone.*

Chercheuses : Liliane Prairie, IA, B. Sc. inf. (chercheuse principale, étudiante à la maîtrise, Faculté des sciences infirmières à l'Université du Manitoba); Co-chercheuses : Annette Schultz, Ph. D., IA (directrice de thèse, Faculté des sciences infirmières à l'Université du Manitoba); Dauna Crooks, Ph. D., IA (Faculté des sciences infirmières à l'Université du Manitoba); Danielle de Moissac, Ph. D., (Faculté des sciences à l'Université de Saint-Boniface).

Déclaration de responsabilité

Le chercheur principal est responsable du déroulement du présent projet et s'engage à respecter les engagements qui y sont énoncés.

Signature du chercheur responsable du projet : _____

Le présent formulaire de consentement, dont une copie vous sera fournie pour vos dossiers, ne représente qu'une partie du processus de consentement éclairé. Il vous donnera une idée générale de ce en quoi consiste le projet de recherche et de ce à quoi ressemblera votre participation. Si vous aimeriez obtenir plus de renseignements sur des informations mentionnées dans ce document ou des informations manquantes, n'hésitez pas à en faire la demande. Veuillez prendre le temps de lire ce document attentivement.

Au sujet de ce projet :

L'objectif de cette étude est d'explorer le processus d'intégration du rôle de l'infirmière

praticienne dans un centre de santé primaire francophone.

Dans le cadre de ce projet d'étude de cas, on utilisera une approche descriptive et interprétative pour en connaître davantage sur les expériences vécues par différents membres du personnel et de la clientèle de l'Hôpital et Centre de santé communautaire relativement à l'intégration d'un nouveau rôle de professionnel de la santé. L'étude servira à décrire le processus d'intégration d'un nouveau rôle à partir de divers points de vue et à comparer les diverses perceptions de conflit. Les résultats de cette étude seront présentés dans des rapports, des exposés scientifiques et des communications. Les réponses individuelles seront présentées sous forme agrégée (en groupe) de sorte qu'il ne sera pas possible d'identifier les participants individuels.

Compréhension des activités de recherche :

Vous comprenez que si vous participez au projet de recherche, on vous demandera de participer à une entrevue individuelle qui dure de 45 à 60 minutes. Pendant l'entrevue, on vous posera des questions sur votre perception de l'intégration d'un nouveau rôle au sein de votre Centre. Votre identité ne sera dévoilée à aucun moment pendant le projet de recherche, que ce soit dans le rapport final ou dans toute publication ou communication qui pourrait découler de cette étude. Les enregistrements audio et les transcriptions seront sauvegardés dans un dossier verrouillé et seuls les membres de l'équipe de recherche y auront accès. Vous comprenez que l'entrevue sera menée par Liliane Prairie.

Risques et avantages :

Aucun risque n'est associé à votre participation à l'étude. L'inconvénient principal associé à votre participation est celui de donner de votre temps pour réaliser la recherche. Il se pourrait aussi que vous ressentiez de l'inquiétude concernant certaines questions. Dans ce cas, vous pouvez exprimer votre inquiétude et vous attendre à recevoir toutes les explications nécessaires. L'analyse des données aidera à mieux comprendre le processus d'intégration d'un nouveau membre à une équipe existante. Vous ne recevrez aucune compensation pour votre participation à cette recherche.

Protection de la confidentialité :

Les informations que vous fournirez demeureront strictement confidentielles et seront protégées de nombreuses façons :

1. Toutes les entrevues seront identifiables uniquement à l'aide d'un code numérique (aucun nom n'y sera rattaché).
2. Vous-même (et les personnes mentionnées lors de l'entrevue) ne serez pas identifié dans tout document ou rapport écrit sur ce projet.
3. Tous les documents seront conservés dans un classeur fermé à clé ou dans des dossiers électroniques protégés par un mot de passe. Tous les documents seront détruits après sept ans.
4. Seuls les chercheuses nommées et l'assistant ou assistante à la recherche (personne embauchée pour transcrire les entrevues enregistrées) auront accès aux documents.
5. Les résultats seront présentés sous forme agrégée de sorte que les participants individuels ne seront pas identifiés.
6. Toutes les chercheuses ayant accès aux enregistrements sonores et aux transcriptions ont signé une promesse de confidentialité exigée en vertu de la *Loi sur les renseignements médicaux personnels*.

Consentement volontaire :

Vous comprenez que votre participation à ce projet est volontaire. Vous êtes libre de vous retirer de l'étude à n'importe quel moment, ou de refuser de répondre à toute question, sans préjudice ou conséquence. Si vous décidez de vous retirer, veuillez s'il vous plait aviser Liliane Prairie et tous les renseignements que vous avez fournis seront détruits. Votre participation continue devrait être aussi éclairée que votre consentement initial. Vous devriez donc vous sentir à l'aise de demander des clarifications ou de nouveaux renseignements tout au long de la durée de votre participation au projet.

Votre signature sur ce formulaire indique que vous avez compris à votre satisfaction l'information relative à la participation au projet et que vous acceptez de participer à une entrevue. Toutefois, en signant ce formulaire, vous ne renoncez pas à vos droits légaux ni ne dégagez les chercheuses ou les établissements participants de leurs responsabilités légales et professionnelles. De plus, vous comprenez que vous pouvez communiquer avec Liliane Prairie au (XXX) XXX-XXXX ou à XXXXXXXXX si vous avez des préoccupations ou des questions ou que vous voulez obtenir des renseignements supplémentaires. Vous pouvez aussi communiquer avec sa directrice de thèse, Annette Schultz, au (XXX) XXX-XXXX ou à XXXXXXXXXX.

Si vous avez des préoccupations ou des plaintes par rapport à ce projet, vous pouvez communiquer avec les personnes nommées ci-dessus ou avec le *Human Ethics Secretariat* au (XXX) XXX-XXXX ou envoyer un courriel à XXXXXXXXXX. Il se peut que le *University of Manitoba Research Ethics Board* et un représentant du *University of Manitoba Research Quality Management / Assurance* Office aient aussi besoin d'accéder à vos documents de recherche à des fins d'assurance de la sécurité et de la qualité.

Si vous avez des questions concernant vos droits en tant que participant à la recherche ou si vous souhaitez discuter de l'étude avec quelqu'un qui n'est pas relié à l'étude, vous pouvez aussi communiquer avec Isabelle Dugas, coordonnatrice du bureau de l'éthique du Réseau de santé Vitalité, XXXXXXXXXXXX, (XXX) XXX-XXXX; courriel : XXXXXXXXX.

Déclaration :

Je déclare avoir eu suffisamment d'explications sur la nature et le déroulement du projet de recherche. J'ai lu et compris les termes du présent formulaire de consentement et j'en ai reçu un exemplaire. Je reconnais avoir été informé de façon suffisante sur la nature et le motif de ma participation au projet. J'ai eu l'occasion de poser des questions auxquelles on a répondu de façon satisfaisante.

_____

Signature du participant ou de la participante Date

Nom en caractères d'imprimerie : _____

_____

Signature du témoin Date

Nom en caractères d'imprimerie : _____

Déclaration du responsable de l'obtention du consentement

Je soussigné _____ certifie avoir expliqué au participant intéressé les conditions du présent formulaire, avoir répondu aux questions qu'il m'a posées à cet égard, lui avoir clairement indiqué qu'il reste, en tout temps, libre de mettre fin à sa participation au projet décrit ci-dessus.

_____ _____ _____

Signature du responsable de l'obtention du consentement Date

Nom en caractères d'imprimerie : _____

_____ _____

Signature du témoin Date

Nom en caractères d'imprimerie *:* _____

_____

Fait à

J’aimerais recevoir un court rapport

Oui_____

Non_____

S’il -vous-plait envoyer le rapport:

Nom:_____

Adresse_____

Code Postale _____

OU

Adresse courriel_____

J’aimerais inviter tous les participants intéressés de lire un premier rapport afin de valider que les thèmes du rapport soient justes et qu’ils représentent bien les informations que vous avez partagées.
Cette communication se fera par courriel avec des dossiers protégés par un mot de passe.
Oui, je veux participer_____
Non, je ne suis pas intéressé_____
Si oui, est-ce que je peux communiquer avec vous par courriel ?
Oui _____

Appendix L1

UNIVERSITY OF MANITOBA | Faculty of Nursing

Faculty of Nursing
Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone: (204) 258-1311
Fax: (204) 233-7214

Focus Group Consent Form for Clients

Research Project Title: *Interdisciplinary collaboration: The Experience of a Francophone Interdisciplinary Team with the Integration of the Nurse Practitioner Role*

Researcher(s): Liliane Prairie RN, BN (Principle Investigator, Masters Student, Faculty of Nursing at the University of Manitoba); Co-Investigators: Annette Schultz, PhD, RN (Faculty of Nursing at the University of Manitoba); Dauna Crooks, PhD, RN (Faculty of Nursing at the University of Manitoba); Danielle de Moissac, PhD, (Faculty of Science at the Université de Saint-Boniface).

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It will provide a basic idea of what the research project is about and what your participation will involve. If you would like more details about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully.

Declaration of responsibility: The principal investigator is responsible for this research project, and is committed to respect all statements that are stated in the consent form.

Principal investigator's signature: _____

About this project:

The purpose of this study is to explore how the integration of the nurse practitioner role is integrated within a Francophone primary care setting. Client focus groups are one of two data collection methods used in this study. This case study project will seek to understand different points of view on how they have lived the experience of bringing in a new health

professional role within the study site; the participants will include staff and clients from the centre. The results of this study will be prepared into reports, scientific presentations and papers. Individual responses will be prepared in aggregate (group) form so that is not possible to identify individual participants.

My understanding of the Research Activities:

You understand that if you participate in the research project, you will be asked to participate in a focus group lasting approximately 1 hour and 30 minutes to 2 hours. During the focus group, you will be asked questions about your perspective of the integration of new role within your Centre. The interview will be audio recorded for the unique purpose of transcribing your comments at a later date. At no time during the research project will your identity be known, either in the final report or any publications or communications that may arise about this study. The audio recordings and the transcriptions will be stored in a locked file and will only be made available to members of the research team. You understand that that the interview will be conducted by Liliane Prairie.

Risks and Benefits:

There could be minimal to no risks associated to your participation in this study. The main inconvenience of your participation is the time that you will spend to complete the interview. You may have concerns related to some of the questions. If you have concerns, you can express these and expect that you will receive the information that you require. While all focus group participants are asked to pledge that they will not disclose the content of the discussions that occur in the focus group to people outside of the group, we cannot guarantee that any information you disclose during the focus group will not be shared by other focus group participants with people not present at the focus group. However, within the research processes, the focus group content will be held in the strictest confidence and will only be directly shared with the research team and hired staff involved in the project (research assistant and transcribe). Benefits are providing information about role integration and conflict to support understanding how to integrate a new team member

to an existing team. You will not receive any financial compensation for your participation in this research project.

Protecting Confidentiality:

The information you provide is strictly confidential, which will be protected in several ways.

1. You (and individuals referred to during the focus group) will not be identified in any records or in written reports form this project.
2. All records will be securely stored in a locked filing cabinet and or/password secured computer files. All files will be destroyed after seven years.
3. Only the identified researchers and the research assistant who is the hired person to transcribe the audio-recorded interviews will have access to records.
4. Findings will be presented in group form so as not to identify individual participants.
5. All researchers accessing the audio-recording or transcripts have completed a Personal Health Information Pledge

Voluntary Consent:

You understand that your participation in this project is voluntary. You are free to withdraw from the study at any time, and/or refrain from answering any questions, without prejudice or consequence. . If you choose to withdraw please contact Liliane Prairie and all information you have provided will be destroyed. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation in the project.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the project and agree to participate in one interview. However, in no way does this waive your legal rights nor release the researchers, or involved institutions form their legal and professional responsibilities. In addition, you understand that you may contact Liliane Prairie (XXX) XXX-XXXX or email XXXXXXX.

If you have any concerns, questions, or need additional information. Alternately you may contact her thesis advisor Annette Schultz (XXX) XXX-XXXX or email XXXXXXXXX.

This research has been approved by Education/Nursing Research Ethics Board at the University of Manitoba. If you have any concerns or complaints about this project you may contact any of the above named persons or the Human Ethics Secretariat at (XXX) XXX-XXXX, or email XXXXXX. The University of Manitoba Research Ethics Board(s) and a representative(s) of the University of Manitoba Research Quality Management / Assurance office may also require access to your research records for safety and quality assurance purposes.

A copy of this consent form has been given to you to keep for your records and reference.

If you have any questions about your rights as a participant in this research or if you wish to discuss this project with someone who is not associated with this research, you may also contact Isabelle Dugas, coordonnatrice du bureau de l'éthique du Réseau de santé Vitalité, XXXXXXXXX, (XXX) XXX-XXXX; courriel : XXXXXXXXXX.

Declaration

I declare having received enough information about this research project and understand what is expected of me. I have read and understood the consent form and I have received a copy. I have been sufficiently informed about what is expected with my participation in this project. I have had the opportunity to ask questions and these have been answered to my satisfaction.

_____ _____

Participant Signature Date

Please Print Name: _____

_____ _____

Witness's name Date

Please print name: _____

Declaration of the person responsible for obtaining the consent

I,_____hereby declare having explained to the interested participant the details of the current consent. I have answered all their questions related to this document. The participant is aware that the can at any time withdraw from the research project.

_____ _____

Signature of the person responsible for obtaining the consent Date

Printed name: _____

_____ _____

Witness's signature Date

_____

Printed name

_____

Signed at

Appendix L2

UNIVERSITY OF MANITOBA | Faculty of Nursing

Faculty of Nursing
Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone: (204) 258-1311
Fax: (204) 233-7214

Formulaire de consentement à l'intention d'un groupe de discussion pour les clients

Titre du projet de recherche : *Collaboration interdisciplinaire : l'expérience d'intégration du rôle de l'infirmière praticienne dans un centre de santé primaire francophone*

Chercheuses : Liliane Prairie, IA, B. Sc. inf. (chercheuse principale, étudiante à la maîtrise, Faculté des sciences infirmières à l'Université du Manitoba); Co-chercheuses ; Annette Schultz, Ph. D., IA (directrice de thèse, Faculté des sciences infirmières à l'Université du Manitoba); Dauna Crooks, Ph. D., IA (Faculté des sciences infirmières à l'Université du Manitoba); Danielle de Moissac, Ph. D., (Faculté des sciences à l'Université de Saint-Boniface).

Le présent formulaire de consentement, dont une copie vous sera fournie pour vos dossiers, ne représente qu'une partie du processus de consentement éclairé. Il vous donnera une idée générale de ce en quoi consiste le projet de recherche et de ce à quoi ressemblera votre participation. Si vous aimeriez obtenir plus de renseignements sur des informations mentionnées dans ce document ou des informations manquantes, n'hésitez pas à en faire la demande. Veuillez prendre le temps de lire ce document attentivement.

Déclaration de responsabilité

Le chercheur principal est responsable du déroulement du présent projet et s'engage à respecter les engagements qui y sont énoncés.

Signature du chercheur responsable du projet : _____

Au sujet de ce projet :

L'objectif de cette étude est d'explorer le processus d'intégration du rôle de l'infirmière praticienne dans un établissement francophone de soins de santé primaires. Les groupes de discussion avec les clients représentent l'une des deux méthodes de collecte de données utilisées dans le cadre cette étude. Dans le cadre de ce projet d'étude de cas, nous voulons en connaître davantage sur les expériences vécues par différents membres du personnel et de la clientèle de l'Hôpital et du centre de santé communautaire de XXXXXX relativement à l'intégration d'un nouveau rôle de professionnel de la santé. Les résultats de cette étude seront présentés dans des rapports, des exposés scientifiques et des communications. Les réponses individuelles seront présentées sous forme agrégée (en groupe) de sorte qu'il ne sera pas possible d'identifier les participants individuels.

Compréhension des activités de recherche :

Vous comprenez que si vous participez au projet de recherche, on vous demandera de participer à un groupe de discussion qui dure de 1 heure 30 minutes à 2 heures. Pendant le groupe de discussion, on vous posera des questions sur votre perception de l'intégration d'un nouveau rôle au sein de votre Centre. Votre identité ne sera dévoilée à aucun moment pendant le projet de recherche, que ce soit dans le rapport final ou dans toute publication ou communication qui pourrait découler de cette étude. Les enregistrements audio et les transcriptions seront sauvegardés dans un dossier verrouillé et seuls les membres de l'équipe de recherche y auront accès. Vous comprenez que le groupe de discussion sera mené par Liliane Prairie.

Risques et avantages :

Aucun risque n'est associé à votre participation à l'étude. L'inconvénient principal associé à votre participation est celui de donner de votre temps pour réaliser la recherche. Il se pourrait aussi que vous ressentiez de l'inquiétude concernant certaines questions. Dans ce cas, vous pouvez exprimer votre inquiétude et vous attendre à recevoir toutes les explications nécessaires.

Même si tous les participants des groupes discussions sont demandés de conserver la confidentialité de toutes informations partagées dans le groupe de discussion, nous ne pouvons pas garantir que l'information que vous discuté durant le groupe de discussion ne sera pas partagée par d'autres participants du groupe de discussion. L'analyse des données aidera à mieux comprendre le processus d'intégration d'un nouveau membre à une équipe existante. Vous ne recevrez aucune compensation pour votre participation à cette recherche.

Protection de la confidentialité :

Les informations que vous fournirez demeureront strictement confidentielles et seront protégées de nombreuses façons :

1. Vous-même (et les personnes mentionnées lors du groupe de discussion) ne serez pas identifié dans tout document ou rapport écrit sur ce projet.
2. Tous les documents seront conservés dans un classeur fermé à clé ou dans des dossiers électroniques protégés par un mot de passe. Tous les documents seront détruits après sept ans.
3. Seuls les chercheuses nommées et l'assistant ou assistante à la recherche (personne embauchée pour transcrire les groupes de discussion enregistrés) auront accès aux documents.
4. Les résultats seront présentés sous forme agrégée de sorte que les participants individuels ne seront pas identifiés.
5. Toutes les chercheuses ayant accès aux enregistrements sonores et aux transcriptions ont signé une promesse de confidentialité exigée en vertu de la *Loi sur les renseignements médicaux personnels*.

Consentement volontaire :

Vous comprenez que votre participation à ce projet est volontaire. Vous êtes libre de vous retirer de l'étude à n'importe quel moment, ou de refuser de répondre à toute question, sans préjudice ou conséquence. Si vous décidez de vous retirer, veuillez s'il vous plait aviser Liliane Prairie. Votre participation continue devrait être aussi éclairée que votre

consentement initial. Vous devriez donc vous sentir à l'aise de demander des clarifications ou de nouveaux renseignements tout au long de la durée de votre participation au projet.

Votre signature sur ce formulaire indique que vous avez compris à votre satisfaction l'information relative à la participation au projet et que vous acceptez de participer à une entrevue. Toutefois, en signant ce formulaire, vous ne renoncez pas à vos droits légaux ni ne dégagez les chercheuses ou les établissements participants de leurs responsabilités légales et professionnelles. De plus, vous comprenez que vous pouvez communiquer avec Liliane Prairie au (XXX) XXX-XXXX ou à XXXXXXXX si vous avez des préoccupations ou des questions ou que vous voulez obtenir des renseignements supplémentaires. Vous pouvez aussi communiquer avec sa directrice de thèse, Annette Schultz, au (XXX) XXX-XXXX ou à XXXXXXX.

Cette recherche a été approuvée par le *Education/Nursing Research Ethics Board* de l'Université du Manitoba. Si vous avez des préoccupations ou des plaintes par rapport à ce projet, vous pouvez communiquer avec les personnes nommées ci-dessus ou avec le *Human Ethics Secretariat* au (XXX) XXX-XXXX ou envoyer un courriel à XXXXXXX. Il se peut que le *University of Manitoba Research Ethics Board* et un représentant du *University of Manitoba Research Quality Management / Assurance Office* aient aussi besoin d'accéder à vos documents de recherche à des fins d'assurance de la sécurité et de la qualité.

Si vous avez des questions concernant vos droits en tant que participant à la recherche ou si vous souhaitez discuter de l'étude avec quelqu'un qui n'est pas relié à l'étude, vous pouvez aussi communiquer avec Isabelle Dugas, coordonnatrice du bureau de l'éthique du Réseau de santé Vitalité, XXXXXX, (XXX) XXX-XXXX; courriel : XXXXXX.

Déclaration :

Je déclare avoir eu suffisamment d'explications sur la nature et le déroulement du projet de recherche. J'ai lu et compris les termes du présent formulaire de consentement et j'en ai reçu un exemplaire. Je reconnais avoir été informé de façon suffisante sur la nature et le motif de ma participation au projet. J'ai eu l'occasion de poser des questions auxquelles on a répondu de façon satisfaisante.

_____

Signature du participant ou de la participante Date

Nom en caractères d'imprimerie *:* _____

_____ _____

Signature du témoin Date

Nom en caractères d'imprimerie : _____

Déclaration du responsable de l'obtention du consentement

Je soussigné _____ certifie avoir expliqué au participant intéressé les conditions du présent formulaire, avoir répondu aux questions qu'il m'a posées à cet *égard*, lui avoir clairement indiqué qu'il reste, en tout temps, libre de mettre fin à sa participation au projet décrit ci-dessus.

_____ _____ _____

Signature du responsable de l'obtention du consentement Date

Nom en caractères d'imprimerie : _____

_____ _____

Signature du témoin Date

Nom en caractères d'imprimerie *:* _____

_____

Fait à