College of Licensed Practical Nurses of Manitoba

Practice Direction

Interprofessional Collaborative Care

This practice direction was created in collaboration with the Office of Interprofessional Collaboration, Rady Faculty of Health Sciences, University of Manitoba, and the following Colleges (in alphabetical order):

- College of Audiologists and Speech Language Pathologists of Manitoba
- College of Dietitians of Manitoba
- College of Licensed Practical Nurses of Manitoba
- College of Medical Laboratory Technologists of Manitoba
- College of Midwives of Manitoba
- College of Paramedics of Manitoba
- College of Pharmacists of Manitoba
- College of Physicians and Surgeons of Manitoba
- College of Physiotherapists of Manitoba
- College of Registered Nurses of Manitoba
- College of Registered Psychiatric Nurses of Manitoba

Interprofessional Collaborative Care

Practice Direction

College of Licensed
Practical Nurses of Manitoba
463 St Anne's Road
Winnipeg, MB R2M 3C9

Practice directions assist practical nurses in understanding their responsibilities and legal obligations, enabling them to make safe and ethical decisions within their practice. Practical nurses are expected to comply with the information disseminated in practice directions. Failure to do so may result in investigation for misconduct and/or an audit of the nurse's practice.

Purpose

Collaborative care in health care occurs when multiple providers from different professions and disciplines provide comprehensive services by working with persons and their circles of care[1] to deliver the highest quality of care across all settings. To address the multifaceted challenges in complex systems, the goal is to enhance health and social care and services through collaborative, relationship-focused partnerships and to share decision-making around health and social issues. Effective collaboration is required to advance health equity towards culturally safe care with a commitment to truth and reconciliation, and to meet priorities related to diversity, equity, inclusion, and access to care.

The purpose of this practice direction is to further identify the expectations for collaboration with others involved in the provision of care in a team-based environment. The participating Colleges acknowledge the importance of this collective work and have utilized the concepts below to develop a comprehensive, collaborative document for those members of the participating health regulatory Colleges.

The Canadian Interprofessional Health Collaborative (CIHC) is a national group consisting of health organization leaders, health educators, researchers, health and social care providers, and learners from across Canada that identifies best practices based on extensive and emerging knowledge in interprofessional education and collaborative practice. The belief is that interprofessional education, and collaborative and relationship-centered care and services are essential to building effective teams and improving health outcomes and experiences. All members of the team are equal participants with equally valuable contributions.

The *CIHC Competency Framework for Advancing Collaboration* (2024)[2] consists of six competency domains that highlight the knowledge, skills, attitudes, and values that collectively shape the judgment and behaviors essential for collaborative practice. The first two domains *Relationship-Focused Care/Services* and *Team Communication* support the other four domains including *Role Clarification and Negotiation, Team Functioning, Team Differences and Disagreements Processing,* and *Collaborative Leadership.* The competencies within each domain focus on the

[1] Circle of care refers to families, neighbours, support networks, care providers, and communities.

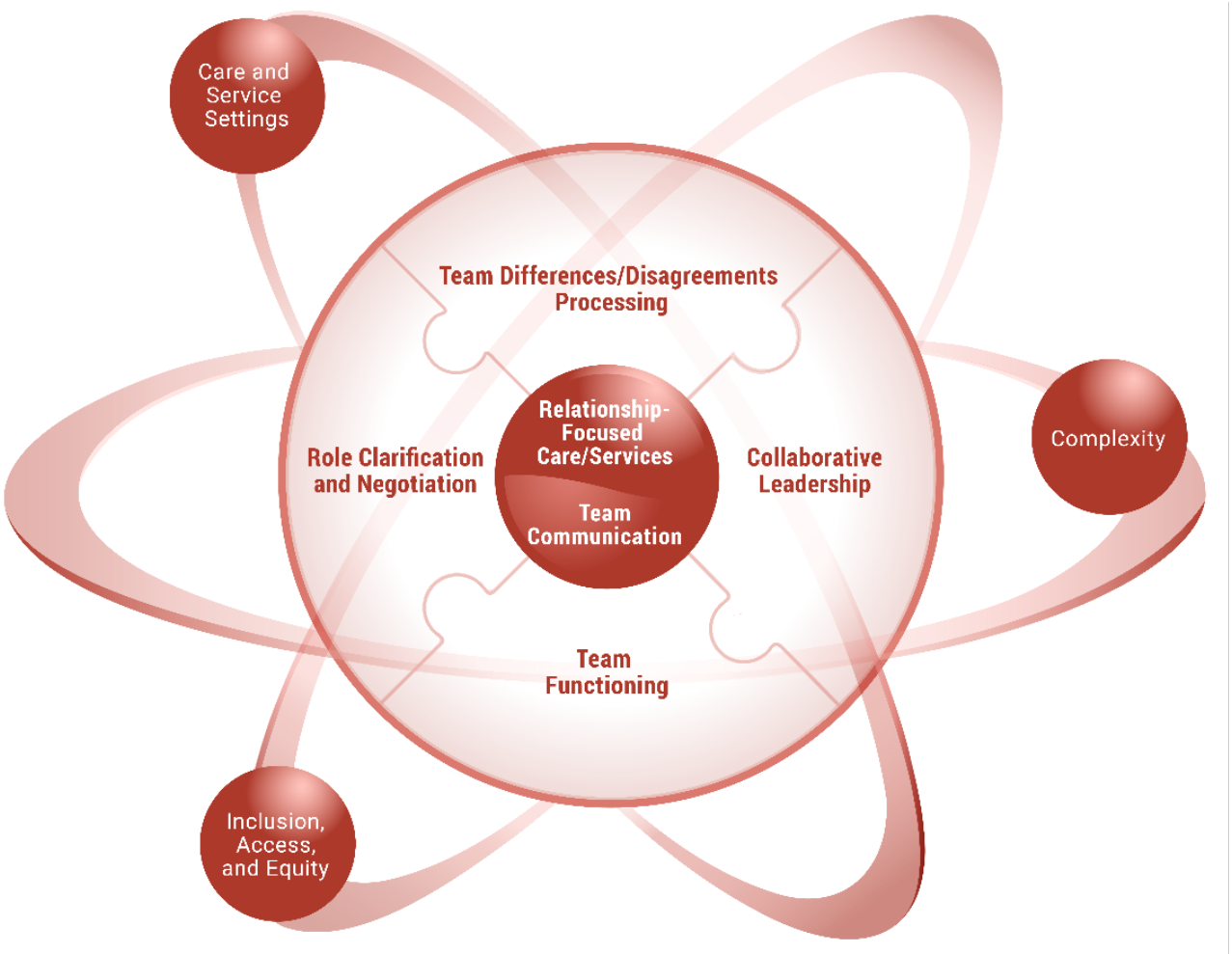
[2] CIHC (2024). *CIHC Competency Framework for Advancing Collaboration 2024*. CIHC Competency Framework for Advancing Collaboration (cihc-cpis.com)

application of knowledge, skills, and attitudes to make decisions and guide behaviors. The following competencies for each domain are adopted from the *CIHC Competency Framework for Advancing Collaboration* (2024).

Factors Influencing Application of Competencies

Equity, inclusion and access to care/services along with the complexity of health systems and the context of the care and service settings influence the way in which the CIHC Framework and competencies are applied. To effectively collaborate, teams must be mindful of the diversity of the team members they are working with, including culture, ethnicity, race, gender, sexual orientation, age, size, religion, (dis)ability, and socio-economic position.

Further, the same characteristics may have an impact on the social determinants of health, and access to health and social care and services for those seeking care. Team members must be aware of potential barriers to accessing care/services, including stigma, language, literacy, health literacy, geography, transportation, and finances. The complexity of social circumstances as well as the care/service setting (for example, co-location compared to a virtual setting) may impact the number of providers involved and the relationship of the team members to one another.



CIHC Competency Framework for Advancing Collaboration 2024 (CIHC, 2024)

Domains and Competencies[3]

Relationship-Focused Care/Services

All team members will collaborate, coordinate and cooperate, fostering purposeful relationships among and between care/service partners and persons participating in or receiving care/services. To support relationship-focused care/services all team members will:

- grow and maintain purposeful and trusting relationships to support effective partnerships;
- provide appropriate education to, and support participation of person(s) receiving care/services and their care partners in the planning, implementation, and evaluation of care/services;
- reflect upon, value, and embed diversity of thought, beliefs, talents, literacy, and experiences of people and communities in the planning, implementation, and evaluation of care/services; and,
- share information in a culturally safe, respectful manner in such a way that is understandable, encourages discussion, and enhances participation and shared decision-making.

Team Communication

All team members will communicate with others in a cooperative, responsive, and respectful manner while mindful of the content and relational elements of the communication. To support relationship-focused team communication, all team members will:

- use effective communication strategies, including the use of shared language and avoiding jargon such as health care acronyms and medical terminology;
- listen actively and respectfully, valuing all participants, with emphasis on inclusivity, equity, and diversity;
- foster open and authentic communication accessible to all, with efforts to address potential communication barriers such as psychological harm, language, culture, or literacy and health literacy;
- utilize information and communication technology to convey the right message to the right person(s) at the right time using safe transmission processes; and,
- manage information sharing and documentation for improved understanding and consistency across the team and other teams.

Role Clarification and Negotiation

All team members understand and negotiate their own role and the roles of others, using their knowledge, skills, expertise, and values to establish and achieve collaborative relationship-focused care/services. To support role clarification and negotiation, all team members will:

- share their knowledge, skills, expertise, and values with others;
- seek to understand the knowledge, skills, expertise, and values of team members, including person(s) participating in or receiving care/service;
- recognize person(s) participating in and receiving care/services as experts in their lived experience, and drivers of their care/services and support and integrate them and their care partners as full and active team members;

[3] Note: the competencies below have been modified from the *CIHC Competency Framework for Advancing Collaboration 2024*.

- clarify their own role and that of others and adapt to support context-specific operationalization of roles;
- recognize and respect the diversity, fluidity and overlap of other health and social care roles, responsibilities, and competencies.

Team Functioning

All team members understand the nature of interprofessional teams; that team members work interdependently. Team members bring their shared perspectives to cooperate, coordinate, and collaborate toward shared goals through shared decision-making. Team functioning requires optimizing the efficiency and effectiveness of all members' time, expertise, and contributions. To support team functioning, all team members will:

- facilitate inclusion and participation of all, especially the person(s) participating in or receiving care/services, in the planning, implementation, and evaluation of care/services;
- understand the interdependence with the other competencies in team development;
- respect and apply the principles of equity, diversity, inclusion, and accessibility with an understanding of the positive impact of strong interdependence among team members on shared decision-making;
- identify a shared common purpose built on varying perspectives and values;
- respect ethical aspects of team functioning, including confidentiality, resource allocation, and professionalism;
- collectively reflect regularly on team functioning.

Team Differences and Disagreements Processing

All team members actively engage in constructively addressing disagreements. To support interprofessional team differences and disagreement processing, all team members will:

- acknowledge, recognize, and value the inevitable differences in a team that cause tension, disagreement, and conflict;
- proactively address disagreements and tension(s) among team members to prevent their escalation or unresolved conflict;
- establish a safe environment to express diverse opinions and work towards developing consensus;
- effectively address disagreements, including analyzing the causes and working towards reaching an acceptable cooperative solution.

Collaborative Leadership

All team members value each other's knowledge, skills, and expertise, and acknowledge that everyone contributes different strengths and perspectives. They value and support each other and are accountable in sharing decision-making and responsibilities to reach common goals and achievable or desired outcomes. To support collaborative leadership, all team members will:

- promote interdependent working relationships among all team members;
- facilitate effective team processes for shared decision-making;
- create a practice culture that values all team members, and supports their physical and mental well-being;
- promote leadership development, sharing of leadership, accountability, and collaborative practice to support effective team dynamics collaborative practice, and innovation.

References

Canadian Interprofessional Health Collaborative (2024). *CIHC Competency Framework for Advancing Collaboration 2024.* https://cihc-cpis.com/new-competency-framework/

Government of Manitoba (2017). College of Registered Nurses of Manitoba General Regulations. https://web2.gov.mb.ca/laws/regs/current_pdf-regs,php?reg=114/2017

Government of Manitoba (2009). *The Regulated Health Professions Act* S. M. 2009, Part 3 Governance Sec 10(2)(i) https://web2.gov.mb.ca/laws/statutes/ccsm/_pdf.php?cap=r117

For More Information

Visit our website at www.clpnm.ca for more information and resources.

Contact us with questions at:
463 St. Anne's Road
Winnipeg MB R2M 3C9
Phone: 204-663-1212
Toll Free: 1-877-633-1212
Email: info@clpnm.ca

About the CLPNM

The CLPNM is the governing body for the licensed practical nursing profession in Manitoba. Mandated to govern its members in a manner that serves and protects the public interest, the CLPNM establishes practice requirements for the provision of safe and effective nursing care.

Appendix A: Collaboration Scenarios

Introduction

A scenario is provided below to illustrate each of the six competency domains. Each scenario will indicate a situation, a solution, and identify collaboration competencies used. The scenarios may contain more than one competency domain from the framework as the domains often overlap in collaborative care and services. The scenarios use language and situations indicative of the diverse practice settings in which healthcare professionals work. Effort has been made to be inclusive, but the authors recognize that not all professions are represented across all scenarios. The reader is encouraged to reflect on the relevance of the scenarios to their own context of practice.

Relationship-Focused Care/Services

Situation

A small community laboratory routinely collects a blood sample to monitor a client's INR. The client indicates that they will be seeing their doctor later in the day and asks if the result will reach their doctor's office by their scheduled appointment time. The medical laboratory technologist (MLT) indicates that it takes about one hour for the result to be available, but the Laboratory Information System (LIS) is down for the day, so the physician's office will not receive the result until the LIS is back up. The client asks if the result can be given to them if they wait. The MLT confers with the physician to confirm the results will be provided directly to the patient.

Solution

After completing the testing, the MLT provides the client with the result to give to their doctor. The MLT also faxes the result so that the physician has the result in hand when the client arrives for their appointment.

Competencies Used

Relationship-focused care/services as well as team communication, including:

- growing and maintaining purposeful and trusting relationships to support effective partnerships;
- providing appropriate education to, and supporting participation of person(s) receiving care/services and their care partners in the planning, implementation, and evaluation of care/services;
- reflecting upon, value, and embed diversity of thought, beliefs, talents, literacy, and experiences of people and communities in the planning, implementation, and evaluation of care/services; and,
- sharing information in a culturally safe, respectful manner in such a way that is understandable, encourages discussion, and enhances participation and shared decision-making.

Team Communication

Situation

The eating disorders treatment team in a large urban centre includes a psychiatrist, dietitian, registered psychiatric nurse, registered nurse, psychologist, occupational therapist, dental hygienist, recreation therapist, and social worker as well as the person and their care partners. The team works together to provide care on an individual and group basis. A person currently attending the day hospital program is at the weight recovery stage of their therapy and is struggling with reaching the bottom end of their individually assessed healthy weight.

Solution

The registered psychiatric nurse and dietitian take time with this person to actively listen to and understand their concerns, challenges and fears related to the weight recovery stage of their therapy. They have a conversation about the person's history of eating disorder symptoms and weight history and review the assessment and rationale for the bottom end of their individual healthy weight. The focus of this conversation is to help the person understand their individual healthy weight with emphasis on skills to cope or tolerate.

Competencies Used

Team communication, as well as relationship-focused care/services, including:

- listening actively and respectfully, and value all, with emphasis on inclusivity, equity, and diversity;
- fostering open and authentic communications that are accessible to all, integrating efforts to address any potential communication barriers such as psychosocial harm, language, culture, or literacy and health literacy.

Role Clarification and Negotiation

Situation

A person with diabetes presents to a remote northern nursing station with an entrance complaint of a painful right heel. The nursing station team is comprised of many different providers including nurses (LPNs, RNs, NPs), family physician, paramedic, community health representative (CHR), social worker, Knowledge Keeper, dental hygienist, mental health workers, and visiting physiotherapist, dentist, dietitian, psychologist, and medical specialists. The paramedic assesses the individual and determines that they have a large, 2cm ulcer on the right heel. The paramedic learns from the client and their family that their blood sugars are not well controlled, and no member of the health care team has seen them for several months. The family is committed to supporting the client if they are provided the appropriate information/supports. The family expresses confusion about knowing which health care professional to approach with their concerns.

Solution

The paramedic confirms the current knowledge of the client in managing their diabetes and explains everyone's role on the team with the client and family. The paramedic communicates the assessment findings with the physician who with the client's permission, initiates appropriate referrals in the community with the dietitian, the physiotherapist, the social worker, the dentist and the CHR.

Competencies Used

Role clarification and negotiation, as well as team communication, including:

- sharing their knowledge, skills, expertise, and values with others;
- seeking to understand the knowledge, skills, expertise, and values of team members, including person(s) participating in or receiving care/service;
- experience, and drivers of their care/services and support and integrate them and their care partners as full and active team members;
- clarifying their own role and that of others and adapt to support context-specific operationalization of roles;
- recognizing and respecting the diversity, fluidity and overlap of other health and social care roles, responsibilities, and competencies.

Team Functioning

Situation

An 18-year-old pregnant teenager, homeless and living in a shelter, is seen at triage in the midwife clinic for high blood pressure at 32 weeks gestation. Laboratory tests reveal the client has gestational diabetes. The midwife explains gestational diabetes and hypertension management to the client and answers all her questions. The client accepts a referral to an endocrinologist and dietitian and understands that other providers will be included in her care. The multidisciplinary team (MDT) will consist of midwives, obstetrician, endocrinologist, dietitian, social worker, antenatal homecare nurse and shelter staff.

Solution

The midwife is the primary caregiver and responsible for providing holistic care, but because of the complexity of the client's situation, an MDT is required to ensure the client receives comprehensive and specialized care. The midwifery team collaborates with the obstetrician to manage client care as the client requires additional support. The obstetrician provides specialized medical care for monitoring the client's gestational hypertension and any potential complications that may arise. The endocrinologist manages and monitors the client's blood sugar levels, ensuring they remain within safe limits and test results are communicated to the midwife. The dietitian works with the client to ensure she has access to healthy food. They discuss a healthy diet for pregnancy and blood glucose goals to promote adequate fetal growth and maternal weight gain, considering culture and nutritional preferences. The dietitian shares the plan with the MDT. The midwife connects the client with the social worker and Mothering Project who will assist in providing housing and financial support to the client.

Upon discharge from triage, arrangements are made for an antenatal home care nurse to see the client at the shelter to monitor her blood pressure and send reports to the midwife and obstetrician to keep them informed of the client's status. The midwife collaborates with the endocrinologist, dietitian, obstetrician and antenatal home care nurse to ensure a care plan is developed for management of gestational hypertension and diabetes. The client continues with prenatal visits with the midwives in clinic and is booked for a fetal assessment for continuous monitoring of fetal growth. After each clinic visit, the midwife reviews the client's care with the obstetrician to ensure effective management of potential complications.

Competencies Used

Team functioning, as well as team communication, including:

- facilitate inclusion and participation of all, especially the person(s) participating in or receiving care/services, in the planning, implementation, and evaluation of care/services;
- understand the interdependence with the other competencies in team development;
- respect and apply the principles of equity, diversity, inclusion, and accessibility with an understanding of the positive impact of strong interdependence among team members on shared decision-making;
- identify a shared common purpose built on varying perspectives and values.

Team Differences and Disagreements Processing

Situation

A team in a small Community Health Centre has an interprofessional team made up of physicians, nurses, a dietitian, occupational therapist (OT), physiotherapist (PT), and a social worker. The team feels that people are treated equally, except for one situation. There is a high incidence of diabetes in the community and the team has developed an education program to address this need. The social worker, OT, PT, dietitian, RN(NP) and the physician all have a role to play in the education program, but the social worker, OT, PT, and the dietitian are consistently the ones who are responsible for advertising, room set up, getting refreshments ready and cleaning up after the workshop. The physician and the RN(NP) come in for a few minutes, present their part of the workshop, and then leave. The routine tasks are not something the physician and RN(NP) volunteer to do, nor are they directly asked to help with them. The social worker, OT, PT, and dietitian are frustrated by this situation and are starting to feel resentment towards the other team members. The team has regular monthly meetings to discuss workplace concerns or issues.

Solution

The social worker, OT, PT, and dietitian articulate the tension(s) and facilitate team discussions by identifying this issue with the rest of the team. Team members respectfully share how they are feeling, and the associated workload attached to the education program. They listen to their team members to better understand everyone's position on the situation and ask clarifying questions. They come to a consensus and find a solution. The team decides to redistribute the workload, which validates the value of each team member's time, and they agree to evaluate the changes after the next time the program

is offered. The team members realize they all have patient or client care responsibilities that are of equal value.

Competencies Used

Team differences/disagreements processing, as well as team communication and team functioning, including:

- acknowledging, recognizing, and valuing the inevitable differences in a team that cause tension, disagreement, and conflict;
- identifying a shared common purpose built on varying perspectives and values;
- listening actively and respectfully, while valuing all participants, with emphasis on inclusivity, equity, and diversity;
- proactively addressing disagreements and tension(s) among team members to prevent their escalation or unresolved conflict;
- establishing a safe environment to express diverse opinions and work towards developing consensus;
- effectively addressing disagreements, including analyzing the causes and working towards reaching an acceptable cooperative solution.

Collaborative Leadership

Situation

A patient is recovering on a post-stroke unit; they speak Tagalog and have minimal English-language skills. They are nearing discharge and wish to return to independent living. The family is concerned about how the patient will manage but wishes to support their choice of returning home.

Solution

The nurse-manager calls a team meeting to get input from the various team members involved in care as to the status of the patient and plan regarding discharge. Input is sought from:

- nursing regarding overall functioning on the ward;
- physiotherapy regarding walking and transfers;
- occupational therapy regarding independence with activities of daily living such as basic food preparation;
- speech language pathology regarding swallowing and communication;
- social work regarding the family's concerns with a safe return home;
- homecare coordinator regarding services at home;
- dietitian regarding food choices and any recommended texture modification at home
- physician regarding stability of the patient's comorbid conditions; and
- the pharmacist regarding medication interactions and alerts.

The nurse-manager arranges a discharge planning meeting that they will chair. Other team members are invited to attend, along with the patient, family and a Tagalog-language interpreter.

Competencies Used

Collaborative leadership, as well as relationship-focused care/services, team communication, role clarification and negotiation, team functioning, including

- facilitating effective team processes for shared decision-making;
- creating a practice culture that values all team members and supports their physical and mental well-being.