Interprofessional Collaboration:

Annotated Bibliography

SSHRC Ideas Connect

Conestoga College

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A collection of summaries in the form of annotations on articles discussing Interprofessional Collaboration intended to inform the community and inspire discussion.

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(Listed by article title, sorted by author last name)

Title:

Community Collaboration to Improve Schools: Introducing a New Model from Ohio

Citation:

Anderson-Butcher, D., Lawson, H. A., Bean, J., Flaspohler, P., Boone, B., & Kwiatkowski, A. (2008). Community Collaboration to Improve Schools: Introducing a New Model from Ohio. Children & Schools, 30(3), 161-172.

Summary:

The traditional school improvement model has led to schools becoming silos, with each school having their own site-based improvement teams, focusing on a limited amount of improvements at any given time in order to meet mandate requirements. Current policies such as the No Child Left Behind Act (NCLB) guides priorities that “can be traced to top-down mandates emanating from the school district’s central office and, in turn, from state departments of education and the U.S. Department of Education” (Anderson-Butcher et al., 2008, p. 161). These types of policies have led to things like standardized achievement testing focusing on literacy and math skills to show improvement in student achievement.

Anderson-Butcher et al. (2008) refer to this system of school improvement as “walled-in improvement planning [which] reflects traditional thinking about schools as stand-alone institutions focused exclusively on young people’s learning and academic achievement, and it also reinforces the idea that educators are the school improvement experts” (Anderson-Butcher et al., 2008, p. 162). This type of walled-in approach keeps external resources, opportunities, and assets on the outside, limiting the ability of school staff to influence student’s out-of-school time. The walled-in approaches also limit the school and community’s influence on other non-academic factors that are known to impede academic success. Another downfall to the walled-in approach is the ‘change-as-improvement’ outlook that follows a “linear, one-at-a-time planning and implementation” approach which forces improvement teams to choose a few needs when faced with many (Anderson-Butcher et al., 2008, p. 162).

Most problems facing schools and student achievement are intertwined and linked together. By addressing one issue and not the other, it makes the challenge of improvement that much more difficult. Anderson-Butcher et al. (2008) explain, “School improvement is constrained and even impeded because the site-based team lacks the capacity to undertake complex changes mounted simultaneously across several fronts” (p. 162). The Ohio Community Collaboration Model for School Improvement (OCCMSI) is an extension to the regular walled-in school improvement strategies. The OCCMSI looks to empower the community through strategies that foster collaboration by co-locating health, social services, parents, families, and youth development programs into the school community (Anderson-Butcher et al., 2008, p. 162).

The OCCMSI “does not require massive relocations of programs and services at a school. Instead, it places a premium on place-based configurations involving the interweaving of school owned and operated and community owned and operated resources” fostering collaboration with the school and community at large (Anderson-Butcher et al., 2008, p. 162). This allows educators to address issues that affect learning and student achievement outside of school-hours and emphasizes the importance of “community resources for learning, healthy development and success in school” (Anderson-Butcher et al., 2008, p. 163).

School achievement has been linked to developmental risk factors, such as antisocial behaviors, emotional problems, lack of basic needs, and unstable home life (Anderson-Butcher et al., 2008, p. 163). The schools are not equipped to address these types of non-school related barriers. With community collaboration of supports and services within the school, these factors can be addressed in order to help support school achievement and the overall well-being of the students affected (Anderson-Butcher et al., 2008, p. 163).

The creation of OCCMSI was an attempt to address two key pathways for school and academic improvements. Anderson-Butcher (2008) explain, “First students would receive high-quality instruction aligned with academic content standards. Second, students would enjoy optimal conditions for learning, a pathway expressed colloquially as ‘getting the conditions right for learning’” (p. 164). The desire to meet these two key pathways “set[s] the stage for an expanded school improvement model, especially one that would provide a coherent, comprehensive,

and research-supported structure that would unite both improvement pathways" (Anderson-Butcher et al., 2008, p. 164).

Planning is crucial for this model, requiring research, data collection, and a thorough understanding of the situation at hand. The "planning 'process' is a priority and includes partnership building, needs and resources assessment, collaborative infrastructures, initiative and program evaluation, and continuous improvement planning" (Anderson-Butcher et al., 2008, p. 164). Research influenced decision making is very important for school improvement models. In walled-in models, improvement is focused on "academic learning goals and instructional strategies for achieving them", whereas the OCCMSI strategy "encourages exploration of both academic and nonacademic barriers and needs that impede student achievement" (Anderson-Butcher et al., 2008, p. 166). This model realizes the effects of nonacademic barriers and needs on school achievement and encourages input, supports, and collaborates from outside the school. Family involvement is also encouraged in OCCMSI to meet multiple school improvement goals, as reaching out to families and the community only provides more resources and supports in pursuing this objective (Anderson-Butcher et al., 2008, p. 166).

Anderson-Butcher et al. (2008) suggest building school improvement teams by "recruiting stakeholders from multiple backgrounds who have a role to play in supporting student achievement and healthy development" (p. 166). Collection of data about current practices, strategies, and resources available is the next step in the process followed by the identification of needs that are currently not being met due to unavailable resources. Developing new partnerships to address these gaps will be crucial. Anderson-Butcher (2008) explain "collaboration and collaborative leadership structures are fundamental necessities in allowing this process to occur" (p. 167). Regular evaluation is also required to assess the successfulness of the processes being used through this strategy. Anderson-Butcher (2008) identify that "evaluation occurs at multiple levels, school-wide in relation to core achievement data, but also program-specific in relation to an identified strategies targeted outcomes" (p. 167).

The OCCMSI approach addresses and connects five core content components: academic learning, youth development, parent and family engagement and support, health and social services, and community partnerships. According to Anderson-Butcher et al. (2008), "all five core content components are research

supported; all are known to impact student achievement, healthy development, and school success" (p. 168). By attempting to address these five components, OCCMSI can "help schools and communities take stock of programs, services, strategies, and initiatives currently operating in their neighbourhoods and identify important needs, conditions, resources, and gaps through its planning, implementation, and evaluation process" (Anderson-Butcher et al., 2008, p. 169).

Anderson-Butcher et al. (2008) note that OCCMSI "requires significant coordination among individuals working inside and outside of the school, as priorities focus on the integration and alignment of school- and community-based resources and supports for learning" (p. 170). They further go on to explain that school social workers alongside district school leaders are trained to fill the roles required to take on such a model of school improvement. In the case of Ohio, "many school social workers are serving as intermediaries – people who cross professional, organizational, and community boundaries and create mutually beneficial relationships and synergies" (Anderson-Butcher, 2008, p. 170). School social workers have the opportunity to address issues from the inside out, instead of the usual role of working from the community, the school social worker can provide services directly in the school and out to the community. Anderson-Butcher et al. (2008) notes that "these roles and responsibilities for social workers are consistent with their professional education and derive in part from what practicing school social workers already plan and do" (p. 170). The OOCMSI strategy just formalizes these roles and gives school social workers the capacity to do what they have been trained to do.

Key Messages:

- Standardized achievement testing that is meant to track student achievement implemented by the US department of education is an example of how the education system follows a walled-in approach.
- Walled-in approaches keep external resources, opportunities, and assets on the outside.
- The Ohio Community Collaboration Model for School Improvement (OCCMSI) is an extension to the regular walled-in school improvement strategies that looks to empower communities through collaboration of various services.

- The five core components to the OCCMSI’s model are; academic learning, youth development, parent and family engagement and support, health and social services, and community partnerships.

Title:

Interprofessional collaboration: three best practice models of interprofessional education

Citation:

Bridges, D. R., Davidson, R. A., Soule Odegard, P., Maki, I., & Tomkowiak, J. (2011). Interprofessional collaboration: three best practice models of interprofessional education. *Medical Education Online*, 1-10.

Summary:

This article was published in the journal *Medical Education Online* in 2011. It was written by five professionals from various universities that currently offer interprofessional education programs. The authors begin by describing what interprofessional collaboration and practice look like. It is described by the Canadian Interprofessional Health Collaborative as a partnership between a team of health providers and a client in a participatory, collaborative, and coordinated approach to shared decision making around health and social issues. Elements of this practice include responsibility, accountability, coordination, communication, cooperation, assertiveness, autonomy, and mutual trust and respect.

Furthermore, Bridges et al. (2011) make note of what interprofessional education is. Their explanation comes from a number of their sources which describes it as members or students of two or more professions associated with health or social care, engaged in learning with, from, and about each other.

From here, Bridges et al. (2011) go to discuss the various interprofessional education programs offered at Rosalind Franklin University, University of Florida, and the University of Washington. From these descriptions, the authors describe how these different education models still hold common elements.

Rosalind Franklin University of Medicine and Science provides an Interprofessional Healthcare Teams Course as a required experiential learning opportunity, where students interact in interprofessional healthcare teams focusing on a collaborative approach to patient-centered care with emphasis on team

interaction, communication, service learning, evidence-based practice, and quality improvement. The course is split into two phases. The first phase has a didactic component, a service learning component, and an optional clinical component. The didactic component teaches students about interprofessional healthcare teams, collaborative patient-centered care, service learning and county health assessments, healthcare professions, and error cases and advocacy. The service learning component requires students to work as an interprofessional team to identify a community partner and engage in a community service project. The clinical component is offered to interested students who form groups and attend four sessions at clinical sites to help put their didactic knowledge into actual patient care practice (Bridges et al., 2011).

The second phase of the Interprofessional Healthcare Teams Course is designed to promote teaching students the importance of the impact of culture on healthcare and its delivery. Students complete two projects as part of this phase. The first project is to work within interprofessional teams to develop a proposal summary for a culturally appropriate patient education tool. The second project involves students performing a mock patient interview (on university volunteers) where they are asked to discuss laboratory findings, collect historical and lifestyle information, and elicit a cultural history (Bridges et al., 2011).

The University of Florida has established an Interdisciplinary Family Health program that are based upon four home visits, completed over two semesters with volunteer families in the local community. The course is designed to primarily demonstrate to students the significant impact of environment and resources on health status, and emphasize the importance of interprofessional collaborative effort in providing services to patients. It focuses on establishing three major competencies: patient care, interpersonal and communication skills, and professionalism. It is designed to give students the opportunity to implement learning activities they have been taught in their didactic coursework (Bridges et al., 2011).

The University of Washington established a Center for Health Sciences and Interprofessional Education in an effort to “integrate better the teaching, research and professional activities of various health science schools, the information school and health science libraries” (Bridges et al., 2011, para. 31). This center has more than fifty collaborative interprofessional offerings for students in health sciences. It involves integrated coursework, co-curricular service learning, and experiential

training. Interprofessional teams are created to collaborate and provide urgent care to simulated patients. These simulations are formative and summative allowing practice and demonstration of team-based skills including communication, mutual support, leadership, and situational monitoring (Bridges et al., 2011).

There are many common elements among the mentioned interprofessional curriculum models. Common learning outcomes are responsibility, accountability, coordination, communication, cooperation, assertiveness, autonomy and mutual trust and respect. All of the programs also have a common developmental goal where students become more immersed in their own education to gain a better and more comprehensive understanding of their role within a healthcare team.

Key Messages:

- Elements of interprofessional collaboration include responsibility, accountability, coordination, communication, cooperation, assertiveness, autonomy, and mutual trust and respect
- These elements are present within the interprofessional curriculum models that are offered by a variety of universities which are listed in this summary

Title:

A Model for Interdisciplinary Collaboration

Citation:

Bronstein, L. (2003). A model for interdisciplinary collaboration. *Social Work*, *48*(3), 297-306. doi:sw/48.3.297

Summary:

Bronstein (2003) borrows her definition of interdisciplinary collaboration from Bruner (1991) who describes it as “an effective interpersonal process that facilitates the achievement of goals that cannot be reached when individual professionals act on their own” (p. 299). In this source, Bronstein (2003) informs the reader about the benefits of having social workers collaborate with professionals from other professions, such as in the health care and education sector. These examples demonstrate how interdisciplinary collaboration can have positive impacts on various sectors. She begins by describing the increasing challenges that face professionals to serve their clients due to an increase in diversity and social problems.

When it comes to education, Bronstein (2003) describes that there are many factors that can affect school performance. It is becoming increasingly difficult for teachers to educate students when larger numbers of them come to school hungry, abused, and unable to speak English (Bronstein, 2003, p. 297). Due to these wide range of challenges, educators could find it more difficult to do their jobs. By introducing or increasing collaboration between teachers and social workers, it is hoped that the needs of students, families, schools, and communities can be better addressed (Bronstein, 2003, p. 298). This example demonstrates how collaboration between professionals across various sectors can assist with the overall success and delivery of education.

Bronstein (2003) then introduces how social workers have assisted with the health care and mental health care sector. She states that social workers have played an important role within the health care field over the years. Due to shorter hospital stays and less doctor involvement, much of the work has been picked up by

social workers to assist clients in their health. Bronstein (2003) indicates “more than ever psychiatrists and psychologists in mental health settings are helped enormously in their tasks by social workers. Clients in the mental health system present with more complex symptoms that require the expertise of professionals with diverse educational backgrounds” (p. 298). This is another example of how interdisciplinary collaboration between professionals can help with the delivery of services offered by a sector.

Bronstein (2003) then goes on to introduce her model for interdisciplinary collaboration, which includes a list of five components. The first component is Interdependence which refers to “the occurrence of and reliance on interactions among professionals whereby each is dependent on the other to accomplish his or her goals and tasks” (Bronstein, 2003, p. 299). In order for this component to be attained, professionals must have a clear understanding of their own tasks and goals and use recommendations appropriately.

The second component, “newly created professional activities” refer to collaborative acts, programs, and structures that can achieve more than could be achieved by the same professionals acting independently” (Bronstein, 2003, p. 300). This component places emphasis on expanding collaborations with individuals from outside the same profession which helps to maximize levels of expertise of each collaborator.

The third component is flexibility. The author states that this component “extends beyond interdependence and refers to the deliberate occurrence of role-blurring” (Bronstein, 2003, pp. 300-301). Using the social work and health care example, flexibility is when a social worker uses knowledge gained from working with a health care team to answer patients’ questions. It is noted that this role should “depend not only on a professional’s training, but also on the needs of the organization, situation, professional colleagues, client, and family” (Bronstein, 2003, p. 301).

Collective ownership of goals is the fourth component to this model. This component emphasizes the importance of shared responsibility in the entire process of achieving goals. Using the social work and education example, this component takes place when professionals from different disciplines, along with families and their children, are all active in the process of goal attainment. Bronstein (2003) indicates “to engage in collective ownership of goals, each professional must take

responsibility for his or her part in success and failure and support constructive disagreement and deliberation among colleagues and clients" (p. 301).

The fifth and final component is reflection on process. This component outlines the importance for collaborators to place attention to their process of working together. This includes "thinking and talking about their working relationship and incorporating feedback to strengthen collaborative relationships and effectiveness" (Bronstein, 2003, p. 302). It is suggested that addressing conflicts during this stage is a critical component to successful interdisciplinary teams.

Bronstein (2003) then discusses some of the influences on interdisciplinary collaboration. These influences include professional roles, structural characteristics, personal characteristics, and history of collaboration. Each one of these influences play a role in the interdisciplinary collaboration process and can have either a negative or positive effect.

To conclude, Bronstein (2003) reviews how this collaborative model moves professionals to maximize their expertise. Bronstein explains, "Collaboration among individual professionals is a first step in developing collaborative relationships among community constituents, agencies, and professional groups" (p. 298).

Key Messages:

- A process that facilitates the achievement of goals that cannot be reached when individual professionals act on their own
- The five components model:
    - Interdependence
    - Newly created professional activities
    - Flexibility
    - Collective ownership of goals
    - Reflection on process
- Collaboration between professionals from other fields help to maximize their expertise
- Be aware of the influences that can affect collaboration

Title:

Evaluating a Model of School-based Health and Social Service: An interdisciplinary Community-University Collaboration

Citation:

Bronstein, L., Anderson, E., Terwilliger, S., & Sager, K. (2012). Evaluating a Model of School-based Health and Social Service: An interdisciplinary Community-University Collaboration. *Children & Schools, 34(3)*, 155-165.

Summary:

Bronstein et al. (2012) provide a look at university-community collaboration that examines the experiences of an interdisciplinary group of elementary school staff and grad students. Specifically, in the fields of education, nursing, and social work in a school-based service project in order to support graduation of all students.

There is a new focus on partnership and collaboration models among services and schools in order to help support graduation rates of all students in schools. These collaboration models vary but may look like “public school-community collaboration [which] include[s] school-linked services (service provided near or at the school), school-based health centers (health services provided at the school), and full-service community schools (integration of health, social and youth development services with the school as a hub)” (Bronstein et al., 2012, p. 156). These types of models are not new, but their implementation into a school settings has been slow and has faced many challenges. Bronstein et al. (2012) explain that “profession-driven differences in expectations regarding confidentiality, turf issues, pre-existing responsibilities, and a lack of understanding of school culture among community-based professionals are some of the barriers to interdisciplinary collaboration in the schools” (p. 156).

The purpose of these types of collaborative community-school based models is to help support students who come from low income backgrounds with inadequate access to services. Students who come to school hungry, sick, unable to properly

see or hear, or are facing forms of abuse are at significantly more risk, yet it is becoming more difficult for schools to support these children (Bronstein et al., 2012, p. 156). According to Bronstein (2012), “In response to these concerns and in collaboration with personnel from the local school district, [the researchers] secured support from a local foundation to establish a pilot project in two elementary schools, bringing together resources from the local public university’s School of Education and Nursing and Department of Social Work to develop, implement, and evaluate a model of interdisciplinary school-linked services” (p. 157).

To begin the project, children were identified as in need of support by school staff and enrolled in the pilot project. At this point, the university graduate students from the Nurses program “conducted a comprehensive health screening to assess each student’s overall health and developmental status. Social work interns then conducted a mental health assessment” (Bronstein et al., 2012, p. 157). Next, a plan for services were determined for the child. Bronstein et al. (2012) indicate that “based on the results of these assessments, graduate students, working in interdisciplinary teams and under the supervision of faculty, determined what, if any, health or mental health services should be provided. Team members prioritized these services and provided them using a school- and home-based service delivery method” (p. 157).

Bronstein et al. (2012) note the importance of weekly meetings involving all grad students, school faculty, university faculty (from grad programs). School social service and nursing staff were fundamental in coordinating service, ensuring coordination, and communication among team members.

To evaluate the pilot project, the researchers used an evaluation design called *process evaluation* which is meant to “aid researchers in overall program improvement by identifying strengths and weaknesses through the use of qualitative methods” (Bronstein et al., 2012, p. 158). Researchers used semi-structured interviews with 10 participants, where there were two interviews each over the course of the study, equaling 20 interviews in total. The researchers intended to “explore the experiences of six school staff members (two school nurses, one school guidance counselor, one school social workers, and two building principals) and four graduate students (two nurse practitioner interns and two social work interns) involved in the project” (Bronstein et al., 2012, p. 158). The interview questions

looked at perceived barriers to and supports for project goals, as well as their opinions about the collaborative process.

Five different themes emerged from this study:

1. Collaboration is important and complex;
2. Differences between schools' adoption of the project makes a difference;
3. There is a need for increased nurse practitioner capacity;
4. There is a need for more parent involvement in the process, and;
5. Roles and purpose must be clarified and refined for participant understanding (Bronstein, 2012, pp. 159-161).

Bronstein et al. (2012) remind us that "even when professionals recognize the value of interdisciplinary collaboration, the process is complex and challenging" and "the organizational culture of the school plays a significant role in what services are provided, how services are delivered, and whether or not partnership relationships are maximized" (Bronstein et al., 2012, p. 161-162). Individuals that participate in collaboration may be guided by "professional discipline", but are also impacted greatly by the school context (Bronstein et al., 2012). Lastly, Bronstein et al. (2012) leave us with the thought that school reform needs more than just a student focus; it needs collaboration in new, different, and meaningful ways across services to be successful.

Key Messages:

- Schools are finding it increasingly difficult to support children with diverse sets of needs such as those who come to school hungry, sick, unable to properly see or hear, or are facing forms of abuse
- There is a new focus on partnership and collaboration models among services and schools in order to help support graduation rates of all students in schools

Title:

A new model in teaching undergraduates research: A collaborative approach and learning cooperatives

Citation:

O'Neal, P., McClellan, L., & Jarosinkski, J. (2016). A new model in teaching undergraduate research: A collaborative approach and learning cooperatives. *Nurse Education in Practice, 18*, 80-84.

Summary:

A collaboration between a university nursing program and a hospital shows the importance of fostering collaboration and cooperative learning between students and nurses.

Based on Knowles' Adult Learning Theory, a learning model was created that emphasized evidence-based knowledge and co-learning among students and nurses. This approach is called the Collaborative Approach and Learning Cooperatives Model (CALC):

> "An innovative approach in teaching an undergraduate research course was developed to involve hospital administrators working with faculty to design a research project for students with an evidence-based focus and to present at the hospital to educate nurses about the state of the science related to evidence-based guidelines, core measures, and national safety goals" (O'Neal et al., 2016, p. 81).

O'Neal et al. (2016) begin by introducing "a new process of collaborating with agencies to promote a cooperative learning model of knowledge of evidence based care [which] was developed and identified as the Collaborative Approach and Learning Cooperatives (CALC) Model" (p. 80). Using this model, both students and nurses are afforded the opportunity to learn from, and alongside each other. The authors continue by defining the terms collaboration and cooperative. Their description of collaboration comes from Bronstein (2003) who states, "Collaboration

occurs from working together to achieve something that could not be accomplished through individual work" (p. 80).

The O'Neal et al. (2016) then go to define cooperative learning which they claim "happens when small groups actively participate in learning and share what they have learned with others" (p. 80). In keeping with these definitions, the students were put into groups and asked to choose a clinical question to address a problem that interested them. According to O'Neal et al. (2016), "Students conducted a comprehensive review of literature, synthesized and summarized the information and results, identified application to practice, and developed recommendations for the future" (p. 81). The groups then created posters that summarized the information found, which were presented in the College of Nursing. The posters were evaluated, and seven were chosen to be shown for a short time at the "collaborating hospital" (O'Neal et al., 2016, pp. 81-82).

Most of the parties involved in this experience noted that the CALC Model fostered new working relations, promoted co-learning and collaboration among area partners, students, nurses and the community. O'Neal et al. explain "undergraduate nursing students not only met a course requirement, but they stated they had 'fun' applying research principles to 'real issues'" (p. 82). This benefits nurses by having them engaged with evidence-based knowledge that support their practice, without them having to leave their work place for professional development.

Key Messages:

- Cooperative and collaborative approaches to learning between nursing students and nurses can increase the sharing of knowledge
- These practices not only help in the educating of students but also benefits nurses by presenting them with evidence-based knowledge

Title:

Competent for collaborative practice: What does a collaborative practitioner look like and how does the practice context influence interprofessional education?

Citation:

Orchard, C., & Bainbridge, L. (2016). Review Article: Competent for collaborative practice: What does a collaborative practitioner look like and how does the practice context influence interprofessional education? *Journal Of Taibah University Medical Sciences*, *11*(Special issue on Interprofessional Education and Practice), 526-532. doi:10.1016/j.jtumed.2016.11.002.

Summary:

This article was established by the Canadian Interprofessional Healthcare Network in February 2010 in order to outline well-researched, clearly defined, and measurable competencies as a guideline for standardization of interprofessional practice in healthcare settings. It was a cross-Canada collaborative project lead by Carole Orchard of the University of Western Ontario and Lesley Bainbridge of the University of British Columbia.

The resulting National Interprofessional Competency Framework consists of six competencies. The “six competency domains (role clarification, team function, patient/client/family/community-centered, collaborative leadership, interprofessional communication and addressing interprofessional conflict) highlight the knowledge, skills, attitudes and values that come together to shape judgements that are essential for interprofessional collaborative practice” (Orchard & Bainbridge, 2010, p. 528). If all involved individuals followed these six competencies, it is assumed that a patient’s quality of care would improve.

The first competency outlined by the framework is practicing patient/client/family/community-centered care. To accomplish this competency, learners or practitioners seek out, integrate and value as a partner, the input and engagement of the patient/client/family/community in designing and implementing care/services (Orchard & Bainbridge, 2010, p. 528).

The second competency is interprofessional communication. This competency involves learners and/or practitioners from different professions communicating with each other in a collaborative responsive and responsible manner (Orchard & Bainbridge, 2010, p. 528).

The third competency described by this framework is role clarification. This competency involves learners or practitioners understand their own role and the roles of other professions and use this knowledge appropriately to establish and achieve patient/client/family and community goals (Orchard & Bainbridge, 2010, pp. 528-529).

The fourth competency, team functioning, discusses learners/practitioners understanding the principles of team work dynamics and group/team processes. This helps to enable effective interprofessional collaboration (Orchard & Bainbridge, 2010, p. 529).

The framework describes collaborative leadership as the fifth competency. This involves learners or practitioners understanding and applying leadership principles which support a collaborative practice model. (Orchard & Bainbridge, 2010, p. 530).

The sixth and final competency outlined by this framework is interprofessional conflict resolution. This competency occurs when learners and practitioners actively engage self and others, including patient/client/family, in positively and constructively addressing disagreements when they arise (Orchard & Bainbridge, 2010, p. 530).

It is suggested that the use of this framework can be used in a variety of contexts. Orchard and Bainbridge (2010) state that this framework can be applied to “education or regulation, or to guide changes in interprofessional learning and practice” (pp. 531-532). Whichever context this framework is used in, it is proposed that it is essential for interprofessional collaborative practice.

Key Messages:

- The six competencies of interprofessional collaboration are: patient/client/family/community-centered, interprofessional communication, role clarification, team functioning, collaborative leadership, and interprofessional conflict resolution

- The six competencies highlight the knowledge, skills, attitudes, and values that are essential for interprofessional collaboration practice

Title:

Personal action potency: early years practitioners participating in interprofessional practice in early years settings

Citation:

Payler, J. K., & Georgeson, J. (2013). Personal action potency: early years practitioners participating in interprofessional practice in early years settings. *International Journal Of Early Years Education*, *21*(1), 39-55**.**

Summary:

This source reports on case study research in the UK by analyzing interprofessional practice among early years staff. Payler and Georgeson (2013) begin by discussing the key role that educators play in the daily lives of children. They also claim that the ways they work interprofessionally are under-researched and underdeveloped (Payler & Georgeson, 2013, p. 39). Payler and Georgeson (2013) make note that interprofessional working has been acknowledged in other sectors such as social work and health care, whereas early years has been left unexplored (pp. 39-40). In order to give their report direction, the authors looked specifically at how early years professionals practice interprofessional collaboration in regards to children with special needs.

Payler and Georgeson (2013) found through case study analysis that when early years staff had concerns about a child's progress, they sought the advice of the local authority early years advisor teacher who would then decide if the child should be referred to other agencies. Payler and Georgeson (2013) state that management from one of the centers had shared their concern for the lack of direct contact their educators were having with other children's service professionals. This supervisor felt that "the early years staff were becoming deskilled by the fact that all referrals and access to other agencies had to take place through the early years advisor teacher" (Payler & Georgeson, 2013, p. 44). This same supervisor that the authors have discussed also believes this has helped shape how agencies and other professionals view and understand the professionalism of early years staff.

According to Payler and Georgeson (2013) one of the care centers analyzed made an effort to develop a network of contacts and relationships with other agencies and professionals. They also “initiated and chased referrals, sought extra resources, and expected to be kept informed of other professionals’ work with children in their care” (Payler & Georgeson, 2013, p. 49). The children’s center teacher manager made direct contact with a list of outside professionals such as speech language therapists, occupational therapists, and psychologists in order to discuss children, voice concerns, and to make referrals if required (Payler & Georgeson, 2013, p. 49). According to the authors, as a result of these collaborations and relationships, the center would be visited by these various professionals on a regular basis to assess children if staff were concerned. As a result of interprofessional practice, early years staff can feel that their professionalism will be well regarded by other professionals through being more involved in the process.

The Payler and Georgeson (2013) conclude by stating, “this paper argues that the potential to act to provide interprofessionally designed and implemented care and education for young children is a shared rather than individual capacity in settings” (Payler & Georgeson, 2013, p. 52). They also suggest that further investigation is now needed to examine how the practice of interprofessional collaboration can be enabled in all settings.

Key Messages:

- Early years staff are often left out of the referral process for children with special needs, even though it is usually the staff that know the children best
- A case analysis of a children’s center in the UK demonstrates how practicing interprofessional collaborations can benefit early years staff and the children attending the center