EXPLORING THE PERCEPTIONS OF INTERPROFESSIONAL TEAMWORK AND THE BARRIERS AND FACILITATORS THEREOF IN, IN-PATIENT MANAGEMENT AT A TERTIARY HOSPITAL

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A Masters mini-thesis submitted in partial fulfilment of the requirements for the degree of Master of Public Health in the Department of the School of Public Health, University of the Western Cape.

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November 2017

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Exploring the perceptions of IPT
and the barriers and facilitators thereof in, in-patient management at a tertiary hospital.

KEYWORDS

Complex health needs

Health professional

Integrated teamwork

Interprofessional teamwork

Patient-centered care

Patient management services (patient care)

Quality

Teamwork

Tertiary health facility

Tertiary level care

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ABSTRACT

EXPLORING THE PERCEPTIONS OF INTERPROFESSIONAL TEAMWORK AND THE BARRIERS AND FACILITATORS THEREOF IN, IN-PATIENT MANAGEMENT AT A TERTIARY HOSPITAL

N.E Arends

Master of Public Health mini-thesis, School of Public Health, University of the Western Cape.

Background: Quality, patient-centered care are recognised standards for providing health care. Since the landscape of health has changed dramatically, with the unprecedented rise in the burden of disease, South African tertiary level public health facilities health professionals struggle to provide quality, patient-centered care to patients with complex health needs. However, integrated teamwork is strongly advocated for in the care of the patient with complex health needs but, it also has the ability to improve the quality and patient-centeredness of care. To this end, the interprofessional teamwork approach is suggested as an alternative to teamwork approaches currently used in tertiary level health facilities.

Aim: The aim of the research is to explore the perceptions, barriers, and facilitators of interprofessional teamwork amongst health professionals working at a tertiary government hospital.

Research Method: The research employed a qualitative, descriptive, exploratory study design. The purposive sampling method was used to determine the sample to be representative of the typical interprofessional team. Data was collected in the

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form of three focus groups with a total of fourteen participants from several health professions using a semi-structured focus group guide. The data was analysed using Creswell's data analysis framework whereby data was assigned to four pre-determined themes: towards defining teamwork, approach to teamwork, perceptions of interprofessional teamwork, and the barriers and facilitators to interprofessional teamwork. Ethical clearance was obtained from the University of the Western Cape Biomedical Research Ethics Committee and the research department of the facility at which the research was conducted.

Findings: Participants were able to define teamwork and conceptualise its benefit in health care. No standardised teamwork approach is used at the tertiary facility, affecting the way health professionals work together. Participants also had a limited perception of the interprofessional teamwork approach as compared to what is already known about the concept in the literature available. Within the context of tertiary level of care, there are a greater number of barriers such as high patient turnover, lack of human resources, time, hierarchy amongst interprofessional team members, challenges with the referral process, lack of knowledge of colleagues roles and scopes of practice, attitude, communication inefficiencies, language barriers, and professional jealousy found to impede the interprofessional teamwork process and has been recognised to affect efficiency in providing patient care. Within the context of tertiary level care, several facilitators were also found to improve working together such as, increased human resources, communication technology, respect, and relationship building.

Conclusion: It was concluded that health professionals understand the positive value of teamwork in the provision of patient care. However, having a non-

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standardised teamwork approach affects the efficacy of providing patient care. Since the study found that the perceptions of health professionals towards the concept of the interprofessional teamwork approach is limited, much groundwork will need to be done to unify the health professionals' perceptions understanding of interprofessional teamwork, if the approach is to be adopted by tertiary level health facilities with the inclusion of interventions to counteract the barriers that impedes interprofessional teamwork.

Date: 09 November 2017

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DECLARATION

I declare that "Exploring the perceptions of interprofessional teamwork and the barriers and facilitators thereof in, in-patient management at a tertiary hospital" is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Full name: Nicole Erin Arends   Date: 09 November 2017

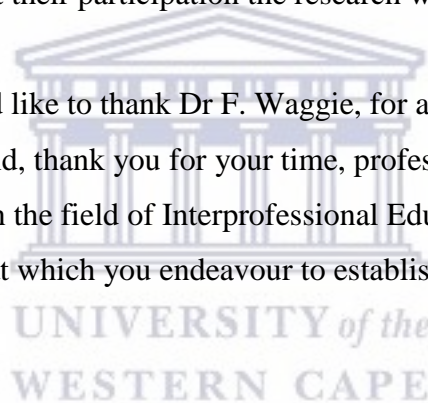Signed..

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ACKNOWLEDGEMENTS

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FOREWORD

To everyone from all walks of life and backgrounds reading this body of research, health, and its mode of delivery are two subjects that affect us all. If truth be told, there is not a single person on earth that is immune to accessing health services at least once in their lifetime to seek intervention for a negatively altered health status, this includes you. Thus when we access health services we do so in the hope of receiving treatment from competent health professionals to provide us with the appropriate patient care and, access to other health services when needed to restore our health. We would also have the expectation that the standard of patient care we receive would be responsive and of quality. In the context of the public health system of South Africa, many individuals have lost a sure amount of faith in the health system, especially where quality and responsiveness of patient care is concerned more so in cases where individuals present with complex health needs. This decreasing lack of faith, especially in acute health facilities, has become an increasing burden to me because it shows that we as frontline health professionals in public health institutions have fallen short of ensuring and implementing the standards of care we promise. Thus, the big question is how do we get back to providing the standard of patient care if the South African public health system is in evident disarray. In this body of research, I suggest that interprofessional teamwork be the approach to providing care to patients amongst health professionals as a means to improve quality and patient-centeredness.

While I know that many people share this burden with me I hope this body of research will illuminate to the powers that be, which is everyone who has some

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responsibility in the provision of patient care, both directly and indirectly, the unique situation that befalls health professionals expected to work together in the provision of patient care in the current climate of health, to hopefully stimulate action and inform intervention.

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GLOSSARY

Climate of health: providing care to people with complex health needs, commonly used phrase in the thesis.

Complex health needs: an individual with a combination of interrelated health problems such as multiple chronic conditions, mental health issues, medication related problems, disability including social vulnerability (Martello et al., 2014)

Health professionals: The research refers to the term "health professionals" as a collective noun used to describe health professionals from a variety of different medical and social science professions

Integrated Teamwork: an interdependent interaction between two or people who share a common purpose, working toward measurable goals that benefit from leadership while encouraging honest discussion and problem solving (Swezey and Salas, 1992)

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Interprofessional care: "the provision of comprehensive health
                                       services to patients by multiple caregivers
                                       who work collaboratively to deliver quality
                                       care within and across settings"
                                       (Government of Ontario, 2007).

Interprofessional team: "are composed of members from different
                                       professions and occupations with varied and
                                       specialized knowledge, skills, and methods"
                                       (Institute of Medicine, 2003:54).

Interprofessional teamwork: as a collaborative interaction among HPs in
                                       an IPT to provide quality, individualised
                                       care for patients (Institute of Medicine,
                                       2003:54).

Patient-centeredness: "is a comprehensive approach to care which
                                       is responsive and organised around a
                                       patients' health needs by HP's" (Stewart
                                       cited in Saha, Beach and Cooper, 2010:2).

Patient management services: Patient management services are health
                                       services provided by health systems through
                                       the component of health professionals
                                       (World Health Organisation, 2007). Patient

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management services will be used

interchangeably as patient care in the thesis

Process of referral: the transfer of care from one health

professional patient from one clinician to

another (E. B., Harrison O., & Efe A., 2015).

Quality: "health professional's achieving optimal

patient outcomes within their available

resources (National Department of Health,

April 2007)".

Quadruple burden of disease: four burdens affecting the South African

infectious disease, non-communicable

disease, mental health and injury burdens

(Househam, 2010).

Scope of practice: "a description of the services that a qualified

health professional is deemed competent to

perform and describes the conditions that the

services may be delivered in (American

Nurses Association, 2017)".

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Teamwork: "two or more people who interact
                           interdependently with a common purpose,
                           working towards measurable goals" (Salas
                           and Swezey as cited in HRH Global
                           Resource Center, n.d.).

Tertiary level care: "specialised consultative care by specialists
                           working in a hospital that has personnel and
                           facilities for special investigations and
                           treatment (Johns Hopkins Medicine, n.d.)".

Tertiary level facility: a tertiary hospital (Kwazulu-Natal
                           Department of Health, 2001).

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ABBREVIATIONS

BOD – burden of disease

FGD– focus group discussion

FGDs –focus group discussions

HP – health professional

HPs – health professionals

IPE – interprofessional education

IPT – interprofessional team

IPTW – interprofessional teamwork

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CHAPTER 1: INTRODUCTION

1.1   Introduction

Dramatic changes have occurred in the global landscape of health over the last few decades (Murray et al., 2013). These changes have largely been influenced by progressive technological, social and environmental change (Labonté, Sanders, Packer, & Schaay, 2017). A number of years ago the prediction of futurist Alvin Toffler (1990) prophetically illustrated due to the rate at which technological, social, and environmental change would occur, periods of stability in society in the future would be short-lived and, in addition, he also questioned whether society would be equipped to cope with the change. This prediction draws a strong parallel to what has transpired in health and the provision of patient management services over the last few decades with the unprecedented rise in the global BOD (Institute for Health Metrics and Evaluation, Human Development Network, & The World Bank, 2013). One of the biggest changes that the BOD has caused, is that patients now live with more complex health needs (World Health Organisation, 2008). As a result, health systems have been forced to adapt the way in which patient care is provided by HP's to cope with the change. The common assertion is that integrated teamwork is required in providing quality, patient-centered care for the patient with complex health needs and is best delivered through the vehicle of the IPTW approach (Oandasan et al, 2006). This approach has been strongly advocated for in the provision of patient care in the current climate of health and considered the benchmark for delivering quality, patient-centered care (Frenk et al., 2010; Reeves, Lewin, Espin, & Zwarenstein, 2010).

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1.2   Background

The public health system has been faced with a high demand for patient care from individuals with complex health needs due to an unpredictable incidence and looming prevalence of a quadruple burden of disease impacting the South African population (De Savigny, 2014; Engelbrecht & Crisp, 2010; Mayosi & Benatar, 2014; Samb et al., 2010; World Health Organisation, 2010a). This demand has destabilised the health system impeding its progressive, yet incomplete, transformation and placed strain on the already limited human resource capacity causing pertinent challenges for HPs to provide quality, patient-centered care (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Sowa, 2016). However, from experience, the researcher makes the assertion that one of the reasons that patient care may be lacking in quality and patient-centeredness is grossly due to the teamwork approaches which HPs are currently utilising (Frenk et al, 2010). Since the potential to improve quality and patient-centeredness in patient care lies heavily within the responsibility of HPs, it is to this end that the IPTW approach is suggested as a plausible alternative to other teamwork approaches that HP's use. Research has shown positive results when HPs use the approach to provide patient care amongst patients with complex health needs, improving quality and patient-centeredness in care (Bosch & Mansell, 2015; Agreli, Peduzzi & Charantola Silva, 2016; Institute of Medicine, 2003).

Therefore, from a South African perspective, of public healthcare, with its complex history of an incomplete health system transformation, coupled with a quadruple burden of disease (not forgetting the pertinent challenges HPs face in providing quality patient-centered care), now is the time to do introspection with regard to the perceptions, barriers and facilitators of IPT's for the future

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development of the IPTW approach as the benchmark for providing patient care in South African public health facilities.

1.3   Problem Statement

The health facility where the research was conducted is an extremely busy tertiary level hospital with high bed occupancy rates occurring throughout most of the year. The high bed occupancy rates is testament to the unpredictable incidence and looming prevalence of a quadruple BOD affecting the population it serves, therefore, causing a high demand for patient care.

The demographic of the population who have access to the hospital often times present with complex health and social needs. These individuals at most need care from several HP's to manage their health and social needs. Teamwork amongst HPs working at the facility is required in theory, however, this does not always occur in practice and, when it does occur in practice, the services provided are often times disjointed with minimal collaboration occurring between HPs and decision making occurs in silos.

Upon observing the teamwork style used amongst HP's, the style resembles that of the multidisciplinary teamwork approach. Multidisciplinary teams are established around a patient's health needs through a process of referral. However, once referrals are made by the primary HP, patient care tends to lack patient-centeredness, integration, and actual teamwork. These occurrences have been observed to hinder quality, patient-centered care.

From the researcher's observations of the functioning of the multidisciplinary team, several problems occur at the point of referral and the establishment of the multidisciplinary team. In order to illustrate these problems, table 1 and 2 are presented below (from the personal experience and logic of the

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researcher) of the plausible reasons for the occurrence of the problems and the
potential negative consequences for the patient, HP, and hospital.

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Table 1: Problems relating to referral practices

Observed problems relating to referral practices	Plausible reasons for the occurrence of the problem	Potential negative consequences for the patient	Negative consequences for the recipient of the referral	Potential negative consequences for the hospital
Inaccurate referral sent to the recipient	Referrer has inadequate knowledge of the roles and scopes of the recipient's profession	The patient waits for assessment and treatment from the appropriate health professional therefore may increase the patient's length of stay, discharge delays, potential to increase hospital costs and	Consumes unnecessary time of the health professional who receives the referral	Incorrect referral usually requires time to correct before the appropriate health professional receives it and can assess and treat the patient thus it may increase the patients length

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Observed problems relating to referral practices	Plausible reasons for the occurrence of the problem	Potential negative consequences for the patient	Negative consequences for the recipient of the referral	Potential negative consequences for the hospital
		the risk of developing avoidable secondary complications,		of stay which impacts the use of hospital resources.
Untimely Referral which does not gauge the time taken for the recipient to perform the scope of their duties.	▪ The referrer doesn't gauge the holistic needs of the patient effectively and timeously in their initial and subsequent assessments of the patient. ▪ Primary managers of the patient are complacent in their	risk of developing avoidable secondary complications, exacerbation of primary medical diagnosis and potential to affect health outcome and affect	It can cause unnecessary frustration for the recipient.	Untimely referral causes health professionals to respond longer before assessing and treating a patient, thus it may increase the patient's length of stay

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Observed problems relating to referral practices	Plausible reasons for the occurrence of the problem	Potential negative consequences for the patient	Negative consequences for the recipient of the referral	Potential negative consequences for the hospital
	response to a patient holistic health needs.	continuity of care.		which impacts the use of hospital resources.

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Table 2 Problems related to the functioning of the multidisciplinary team

Observed problems relating to the function of the multidisciplinary team	Plausible reasons for the occurrence of the problem	Type of care patient receives	Consequences of working in a multidisciplinary team	Potential negative consequences for the hospital
Inconsistencies in providing patient care	▪ Lack of an organisational hierarchy in which multidisciplinary teams work. ▪ Ineffective communication. ▪ No policy which supports the functioning of the multidisciplinary team.	▪ Reduced quality of care ▪ May be untimely ineffective and unsafe due to potential medical	Health professionals work antagonistically and interventions may oppose each other	Irrational use of hospital resources. Potential for medical errors which may result in litigations.

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Observed problems relating to the function of the multidisciplinary team	Plausible reasons for the occurrence of the problem	Type of care patient receives	Consequences of working in a multidisciplinary team	Potential negative consequences for the hospital
		errors ▪ Reduced continuity of care. ▪ Care may be uncomprehensive ▪ Lack of patient centeredness.		

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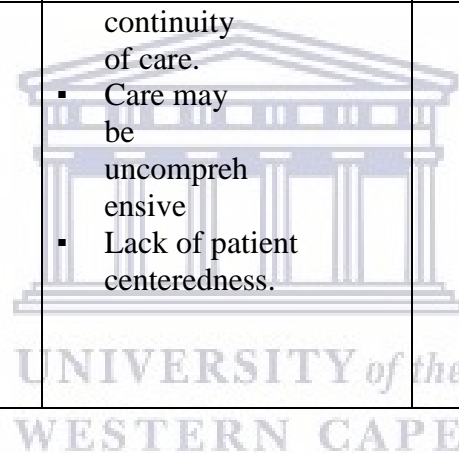
Observed problems relating to the function of the multidisciplinary team	Plausible reasons for the occurrence of the problem	Type of care patient receives	Consequences of working in a multidisciplinary team	Potential negative consequences for the hospital
Health professionals who provide patient care in silo's	Lack of a defined protocol that encourages collaboration to ensure holistic patient management.	▪ Reduced quality of care ▪ May be untimely ineffective and unsafe due to potential medical errors	Potential to execute wrong plan of care with the potential risk of "affecting" patient safety. Goals of health professionals may oppose each other causing frustration amongst health professionals and potential risks for patient safety.	Working in isolation has the potential to affect the quality of care negatively thus medico-legal complaints may increase increasing the potential for litigation.
Lack of an effective	Lack of a protocol or guideline to guide health	▪ Reduced	Potential to execute wrong plan of care.	▪ The potential to execute wrong care

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Observed problems relating to the function of the multidisciplinary team	Plausible reasons for the occurrence of the problem	Type of care patient receives	Consequences of working in a multidisciplinary team	Potential negative consequences for the hospital
communication strategy amongst health professionals managing a patients' health needs	professions on the communication process.	continuity of care. ▪ Care may be uncomprehensive ▪ Lack of patient centeredness.		because of a lack of communication may place patient safety at risk resulting in increased or wasting of resources ▪ Potential increase in medico-legal complaints resulting in litigation.

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In summary, 3 conclusions can be made from the observed evidence provided in the tables:

1. The tables also identifies the potential negative consequences for the patient, health professional and hospital when teamwork is not fluid.

2. HPs work together often times disjointedly overlooking patient-centeredness thus limiting the quality and patient-centeredness of patient care.

3. It can also be concluded that one of the reasons for the limitations in delivering quality, patient-centered care is perpetuated by the teamwork approach HPs use to interact with each other regarding the care required for individuals with complex health needs.

Based upon the conclusions the current teamwork approach used in the hospital is evidently not optimal in providing integrated teamwork, which is a critical component in providing quality, patient-centered care. To this end since IPTW is highly advocated for, for its benefits in providing quality and achieving patient-centered care, it is necessary to understand the perceptions aa well as the barriers and the facilitators to IPTW.

1.4   Aim

The aim of the research is to explore the perceptions, barriers, and facilitators of IPTW amongst HPs working at a tertiary government hospital.

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1.5 Objectives

The objectives of the research are aligned to the aim. Thus, three objectives were formulated to guide the research process and are listed below:

i. To explore the perceptions of ward-based HPs towards IPTW in in-patient management amongst HPs employed at a tertiary hospital.

ii. To explore the facilitators that enhances IPTW in in-patient management amongst ward-based HPs at a tertiary hospital.

iii. To explore the barriers to IPTW in in-patient management amongst ward-based HPs at a tertiary hospital.

1.6 Significance of the research

In the era of providing patient care to patients with complex health needs while maintaining quality, patient-centered care, there has been an obvious need to strengthen the approach to providing care. It has been suggested to this end, on the basis of its benefit, to adopt the IPTW approach amongst HPs providing patient care to patients with complex health needs. This body of research offers insight into how HPs perceive IPTW and, also offers understanding as to what barriers and facilitators HPs currently experience when working together . The information gathered is useful for the hospital in question, if the IPTW approach is to be adopted in the future , then this information will be able to guide the facility managers to develop initiatives to strengthen the HPs understanding of the approach and also develop initiatives to counteract the barriers that impede IPTW.

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1.7   Summary

Chapter one provided the fundamental premise of the research on the assertion that integrated teamwork is required in providing quality, patient-centered care for the patient with complex health needs and is best delivered through the vehicle of the IPTW approach. Chapter two seeks to provide insight on the most relevant concepts of the research pertaining to the provision of patient management services in tertiary level care, the competencies required for being a HP in the twenty-first century, the importance of integrated teamwork in the provision of patient management services in tertiary level health facilities including a global perspective of health care and its provision. The review then observes the fundamentals of IPTW approach and how it is able to improve quality and patient-centeredness in care and it identifies the literature on IPT as it relates to the three objectives on page 20. To conclude the review, teamwork is observed from a South African policy perspective where a short synopsis of the current status of patient management services in South Africa is given and what it will take for health facilities to change their teamwork approach.

Chapter three further illustrates the research design and procedure used to obtain the data needed to satisfy the research aims and objectives. Chapter four, a continuation of chapter three, presents the data obtained under pre-determined themes and discusses the main findings. Chapter five concludes the dissertation with a summary of the findings and concluding comments, providing recommendations and limitations of the research.

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CHAPTER 2: LITERATURE REVIEW

2.1   Introduction

The literature review will build a foundational understanding of the basic concepts
pertaining to patient management services, what constitutes it? who provides it?
and, the nature of patient management services in tertiary level health facilities.
The review also considers the competencies required for twenty-first-century
HP'S as well as why integrated teamwork is necessary in the provision of tertiary
level patient care in the current climate of health. A global perspective of patient
care is described in the context of the BOD touching on the provision of patient
care in HP silos. The concept of IPT is then expounded as the suggested approach
in providing integrated teamwork reviewing its ability to improve quality and
patient-centeredness. The review observes the literature available as it relates to
the three research objectives on page 20. Light is also shed on teamwork in patient
care from a South African policy perspective where a short synopsis of the current
status of patient care is given. The review concludes with a consideration of what
it will take a health facility and HP's to transition to the IPTW approach.

2.2   Patient management services (patient care)

Patient management services exist as a primary function of health systems to
restore, promote, and improve individual and population health, delivered by
several HPs with different scopes of practice in a health facility (World Health
Organisation, 2007). The rationale for its provision is to ultimately safeguard
population health as health is an essential precursor to a sustainable and
satisfactory quality of life and a fundamental human right (Bloom & Canning,

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2008; Parliament of the Republic of South Africa, 1996; World Health Organisation, 1978). Patient management services occur as a complex interaction of health system components and are provided in what is commonly known as a health facility (World Health Organisation, 2007).

Health facilities are physical structures such as hospitals or clinics, through which patient management services are provided by HP's and are classified according to the level of care that it provides, for example, primary, secondary or tertiary level care (Ahmed, Rajagopalan, & Fuller, 2015; MedlinePlus, n.d.; World Health Organisation, 2007). For the purpose of this review, attention is given to tertiary level care provided in tertiary level facilities.

Tertiary level facilities are classified as hospitals where a comprehensive package of tertiary level care is available and provided by several health professions from medical, rehabilitative and social health professions in an acute hospital environment (Kwazulu-Natal Department of Health, 2001). Patients who receive patient care at this level tend to have complex health needs due to life-threatening or life-altering conditions which require rapid medical intervention (Hirshon et al., 2013). According to the work of Martello et al (2014), a patient with complex health needs may have a combination of interrelated health problems such as multiple chronic conditions, mental health issues, medication-related problems, and disability including social vulnerability. Due to the nature of patients having complex health needs, patient care provided by one health professional alone is no longer ideal (Sicotte, Pineault, & Lambert, 1993). Integrated teamwork amongst HP's has thus become a necessity at this level of care (World Health Organisation, 2008b). It is commonly understood that the patient with complex health needs requires the care of several health professions who have different knowledge and skills to contribute to optimal patient care

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(Lumague, Morgan, Mak, Hanna, Kwong, Cameron, Zena, Sinclair, 2006 as cited in Bridges, Davidson, Odegard, Maki, & Tomkowiak, 2011 and Mariano as cited in Hall & Weaver, 2001). Tertiary level care in South Africa characteristically provides comprehensive health and social services which include curative, rehabilitative, preventative and promotive health services based on the definition of health (World Health Organisation, 1978). The ideal form of patient management services in tertiary level care is ensuring that services are provided and coordinated around a patient's health needs, throughout the continuum of care (World Health Organisation, 2010b). The goal of such care is to improve the health outcomes of a patient through the provision of quality patient management services as well as the use of a range of different health professional's knowledge and skills to contribute to patient care (World Health Organisation, 2007).HP's are commonly referred to as the human face of health care, as they provide the human connection between the health system and the patient (Manilall, 2015). The role of the health professional is an integral functional component of health systems as HP's are central to the provision of patient care at health facilities (World Health Organisation, 2017). The overarching role of the health professional is to restore, promote, and maintain patient health in accordance with their scope of practice (McGraw-Hill Concise Dictionary of Modern Medicine, 2002; World Health Organisation, 1978). There are many different kinds of health professional such as doctors, nurses, occupational therapists etc., they differ by their qualifications and scope of practice. However, different HPs have two major responsibilities which are regardless of their scope of practice. One, to provide quality, patient-centered care that seeks to improve, promote, and restore the health status of individuals. Two, to ensure the continuity of care for patients by providing patients with access to other health professions within the health

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continuum when their scope of practice is limited to respond to the health needs of an individual, in a timeous manner, through a process of referral (Health Professions Council of South Africa, 2008). Apart from these major responsibilities HPs also play an integral role in providing quality, patient-centered care (Berghout, van Exel, Leensvaart, & Cramm, 2015; Institute of Medicine, 2003; World Health Organisation, 2017). These responsibilities are essential in the provision of patient care in the twenty-first century (Institute of Medicine, 2003). Since HPs have a responsibility in providing quality, patient-centered care it is of benefit to consider interventions to improve the way HPs function collectively to strengthen the delivery of patient management services in this regard.

2.3   Health professionals of the twenty-first century

In the previous section, it was proposed that since HPs have a responsibility in providing quality, patient-centered care it is beneficial to consider interventions to improve the way HPs function collectively. For this reason, literature was consulted that described the HP of the twenty-first century.

According to the Institute of Medicine (2003), every HP of the twenty-first century should have the following core competencies, regardless of their scope of practice: the ability to provide patient-centered care, work in IPT's, and apply quality improvement. Similarly, the Health Professions Council of South Africa (2014) also developed a set of core competencies similar to that of the Institute of Medicine where the competencies require that HPs work collaboratively in teams to ensure that patient care is patient-centered and of quality (Health Professions Council of South Africa, 2014).

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The stance of the research is that IPTW should be adopted by health facilities as a means to improve the quality and patient-centeredness of care. This notion aligns with the requirement of the Institute of Medicine and the Health Professions Council of South Africa. However, since the landscape of health has changed in the twenty-first century so has the need for health professionals changed in the way in which patient care is provided (Frenk et al., 2010). Thus, there is a global consensus that providing care through IPTW is requisite (Frenk et al., 2010; Zwarenstein & Reeves, 2006). Amidst the consensus, a report from Frenk et al (2010) contributed a useful body of information that shed light on the shortcomings of the inability for HPs to collectively provide patient care in the current climate of health. The report highlights that HPs tend to work in silos, the downside to this is that it decreases efficacy and the quality of patient care and contradicts the consensus by which patient care should be delivered in the current climate of health (Bevc, Retrum, & Varda, 2015; Vatanpour, Khorramnia, & Forutan, 2013). With the reality that HPs have difficulties working together in an interprofessional manner, the field of IPE has thus grown to respond to this need.

IPE is defined as "members or students of two or more professions learn with, from and about each other to improve collaboration and the quality of care and services" (Centre for the Advancement of Interprofessional Education, 2016). IPE is considered fundamental to prepare HPs to work in IPT's (Buring et al., 2009). The field seeks to improve the way health professional associate with one another in while providing care, in a way that promotes resourcefulness based on a common set of values (Thistlewaite, 2012). In this research which focuses on post qualification demographic of South African HPs, IPE is considered a means of continuous professional development.

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Although there is not much evidence available to show how interprofessional education helps working together in IPT, there is one study by Curran, Sargeant and Holland (2007) which shows that interprofessional education as a continuous professional development initiative is beneficial in "fostering positive attitudes and respect for the interprofessional teamwork approach" (Barr as cited in Carpenter & Dickson, 2016).

From an African perspective, there has been a growing interest in IPE in sub-Saharan Africa including South Africa with the recent launch of AfrIPEN in 2015 (AfrIPEN, n.d.). AfrIPEN is an organisation consisting of individuals and institutions committed to establishing IPE through pre and post graduate HP training and education in Africa. The organisation has been active in gathering baseline information to inform future endeavours to help establish and develop HPs to work together with an obvious focus on the African health context. Their vision is to advocate, promote and share good practice on IPE to enhance the way HPs provide care in African health settings.

2.4   The importance of integrated teamwork in the provision of patient management services in tertiary level care

Integrated teamwork is an essential component in the provision of tertiary level patient management services since patients admitted for care at this level, often times have complex health needs (Leggat, 2007; Mayo & Woolley, 2016). By nature of its definition integrated teamwork implies an interdependent interaction between two or more people who share a common purpose, working toward measurable goals that benefit from leadership while encouraging honest discussion and problem solving (Swezey & Salas, 1992). The benefit of integrated

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teamwork is that it maximises the collective intelligence pooled from several HPs which brings a diversity of knowledge, skills, and capabilities to improve the quality of care (Mayo & Woolley, 2016).

The growing advocacy for the use of integrated teamwork approaches and its benefits in improving quality and patient-centeredness in the current climate of health makes IPTW a necessity in tertiary level care (Maslin-Prothero & Bennion, 2010). Thus it is important to understand the perceptions of health professionals to the IPTW approach and the barriers and facilitators thereof, of working together to provide care.

2.5   Global perspective of health care and its provision

In the space of a few decades observation and evidence shows that the unprecedented rise in the BOD has changed the global landscape of health care dramatically (Institute of Health Metrics and Evaluation et al., 2013). Several consequences can be associated with the unprecedented rise in the BOD. Patients now present with complex health needs which has placed great strain on health systems more specifically health facilities as there is a greater demand for patient care. Together with this, there is an associated, increased dependency for health professional consultation (Deloitte, 2017). As a result, a burden has also subsequently been placed on human, fiscal and physical resources needed to provide care (Makube, n.d.). This burden is due to the demands that patients place on health facilities for patient care (Makube, n.d). These consequences are ever-present in the South African public health system which is plagued by a quadruple BOD consisting of infectious, non-communicable, mental health and injury, disease burdens (Househam, 2010).

With the change in the global landscape of health, a study by Frenk et al (2010) found that HPs were not prepared for the implications the BOD posed on the

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provision of care (Frenk et al., 2010). The unpreparedness described as HPs
lacking the collective aptitude to respond to the new complexity in the provision
of patient care for the individual with complex health needs (Frenk et al., 2010).
Since HPs come from multiple health professions where each profession has its
own professional culture and identity, one thing that cripples the provision of care
today is HPs who work in health professional silos (Frenk et al., 2010; Kreindler,
Dowd, Star, & Gottschalk, 2012; McCartney, 2016; Newhouse & Spring, 2010;
Pollard, Thomas, & Miers, 2010).

Working in silos implies that HPs from different professions do little to
integrate their knowledge and skills in a way that is beneficial to patient care with
a limited understanding of the implication of their independent actions on other
professions (Duke University School of Medicine, 2016). For example, silos can
be understood as the cessation of collaboration between HPs once a patient has
been referred from one health professional to another. However working in silos
contradicts the global consensus in which holistic patient care should be provided,
especially in tertiary level care (World Health Organisation, 1978). As described
previously, the patient with complex health needs requires the input of several
HPs working collaboratively in integrated teams, the reason for integrated care
elucidated. However, HPs struggle to provide integrated care (Brown, 1992; Hall,
2005). Working in this manner opposes the ideology envisioned in the Declaration
of the Alma Ata which advocated for comprehensive health services marked by
integration of which, teamwork is listed as a requirement (World Health
Organisation, 1978).

The Alma Ata and its intention is crafted in the fabric of the policies of the
South African health system and is used as a compass to direct the vision for
achieving the provision of comprehensive patient care. Even though

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comprehensive health services are available at tertiary level public health facilities, the provision of quality care is still one of the challenges of the public health system as reported by The Commissioners Diagnostic Report (as cited in National Planning Commission, 2011) As part of the National Development plan strengthening the health system is a priority to improve the quality of patient care (National Planning Commission, 2011).

Thus, if the South African health system wants to improve the quality of care then perhaps policymakers should go back to the drawing board and find the best approach to collectively achieve the vision of comprehensive primary health care. Policymakers should not only try to achieve this vision through programmatic interventions alone, but also consider interventions which place direct focus on the HPs who are required to provide the services.

2.6   The interprofessional teamwork approach

The concept of IPTW is not a new approach in health care; it has been developing over the last century and gaining popularity in the last few decades for its wide-scale benefit in the provision of patient management services (Bosch & Mansell, 2015; O'Brien, 2013). The Institute of Medicine (2003) formally defines the concept as a collaborative interaction among HPs in an IPT to provide quality, individualised care for patients. What makes the IPT unique is that each team is structured around the patient's health needs harnessing the collective knowledge and skills of team members in an interdependent, integrated approach, sharing responsibility to provide the best possible care (Institute of Medicine, 2003). A possible reason why this approach is now considered better than other teamwork approaches is that the approach relies on interdependence and

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integration amongst HPs, which are two important attributes, required in the provision of patient management services in the current climate of health.

Grant and Finnochio (1995) summarise the advantages of IPT as being threefold, it has advantages for patients, HPs and health systems. Research has shown that when HPs work in IT's the advantages for patients is improved health outcomes and continuity of care as the approach provides the platform for HPs to provide integrated care (Hall, 2005; Oandasan et al., 2006). The advantages for HPs are increased job satisfaction and it enables continuous professional development (Leape et al., 1999; World Health Organisation, 2010a).

For the health system, IPT provides a vehicle for improving the quality of care; it promotes the rational use of resources; it is also able to decrease the burden on HPs for consultation; and reduce hospital readmissions (Jacobson, 2012; Oandasan et al., 2006).

As the interest in the IPTW approach has grown over the last few decades much research has gone into its development. Several competency frameworks have been developed which identifies the knowledge, skills, and attributes required for IPTW (Canadian Interprofessional Health Collaborative, 2010, Interprofessional Education Collaborative, 2011).The Canadian Institute for Collaboration (2010) identified six essential competencies for HPs functioning in IPT's these are the ability to communicate with each other, provide patient-centered care, understanding the roles of everyone on the team, team functioning, shared leadership and the ability to resolve interprofessional conflict. Apart from the competency frameworks, there is also a growing database of tools available to measure IPT attitudes, knowledge, skills, capabilities, behaviour as well as organisational culture and readiness for IPTW (Canadian Institute for Collaboration, 2012). These tools are also useful in developing IPT's. In addition

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to this several IPTW models have also been developed to help facilitate IPTW at different levels of care (Virani, 2012).

Like any other teamwork approach the success or effectiveness of the team's ability to function does not exist without favourable conditions. Much literature has been devoted to the conditions that facilitate IPTW which are discussed in a later section of the review on pages 38 and 39.

2.6.1   Interprofessional teamwork in quality, patient-centered care

Quality, patient-centered care even though they may be two separate concepts they cannot be acknowledged apart from one another. Thus each of the terms is defined and discussed in terms of their dimensions.

Quality, with regard to the context of the research, is defined as HPs achieving optimal patient outcomes within their available resources (South African Department of Health, 2011). According to the World Health Organisation (2007) quality is a multidimensional concept which requires that patient management services be effective, efficient, accessible, patient-centered, equitable and safe.

Patient-centered care is defined by Stewart (cited in Saha, Beach, & Cooper, 2008) as a comprehensive approach to care which is responsive and coordinated around a patient's' health needs. It also has several dimensions three of which relates directly to the provision of patient management services being continuity, coordination and access to care (Picker Institute, 2013). From the dimensions of quality and patient-centeredness, a relationship is visible. Since patient-centeredness is a dimension of quality, if patient-centeredness improves one can also assume that quality will also improve. Several studies have proved the relationship shown that patient-centeredness improves quality in terms of

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access as well as the coordination and continuity of care (Davis, Schoenbaum, & Audet, 2005; Greenfield, Kaplan, Ware, Yano, & Frank, n.d.; Meterko, Wright, Lin, Lowy, & Cleary, 2010). However, the same goes for patient-centeredness when patient-centered care improves it also improves quality (Australian Commission on Safety and Quality in Healthcare, 2010). Therefore in the current climate of health it is acknowledged that achieving quality, patient-centered care, cannot be achieved without integrated teamwork, thus the researcher has suggested the IPTW approach as a means to achieve this (Epstein, 2014; South African Department of Health, 2011; Whittaker, Shaw, Spieker, & Linegar, 2011)

2.6.2 Perceptions of interprofessional teamwork

In chapter one, the first objective of the research is to explore how HPs understand and interpret the concept of IPTW in comparison to the concept defined in the literature (Oxford Dictionary, n.d.). No literature was found which evaluated how HPs perceive and internalise the concept of IPTW for themselves. The articles consulted in the literature mainly were focused on the perceptions of IPT member relationships amongst different health professions i.e. how a doctor perceives IPTW with a nurse.

It is imperative to scrutinise the health professional's perceptions of IPTW, should the approach be adopted. After such scrutiny, one would be able to conclude whether HPs have adequate, limited, or possible misperceptions regarding the IPTW concept as compared to what is known in the literature. However, since the IPTW approach is suggested as a plausible approach for providing quality, patient-centered care, evaluating HPs who understand the IPTW concept (as it relates to the delivery of patient management services) is imperative to conclude whether HPs have adequate, limited, or possible

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misperceptions about the IPTW approach as compared to the literature. As a result, the research asserts that the IPTW approach is a plausible alternative to other research thus gauging this information is important.

2.6.3 Barriers and Facilitators to interprofessional teamwork

Striving for a perfect or optimally functioning IPT's is in the interest of any health facility. In theory, one can envision the perfect or optimally functioning IPT whereas, in reality, the case is often different. Due to the nature of the IPT process, and function, it is inevitable that there may be barriers which would affect the optimal functioning of the IPT. These barriers are contextual and unique to the environment in which the IPT functions. The recognition of the barriers which affect IPTW within a health facility is beneficial for the provision of interventions which counteract the barriers (Green and Johnson, 2015). A barrier is defined as a circumstance, obstacle or problem that makes IPTW unsustainable (Merriam-Webster, 2017).

Ample evidence is available from several qualitative studies which identifies the barriers that impedes IPTW such as poor communication, poor referral processes, poor documentation practices, poor identification of team members scopes of practice, lack of leadership, poor team cohesion, changes in team consistency, time and space and lack of organisational support (Borrill, West, Shapiro, & Rees, 2000; Cashman, Reidy, Cody, & Lemay, 2004; Poulton & West, 1999). Professional culture has also been identified as a barrier in IPTW from differing professions based on the values, beliefs, and customs of the profession and is often times seen as a challenge in IPTW (Hall, 2005). Other barriers were noted in IPT amongst physicians and nurses were issues such as not confronting the reasons for medical error, differing perceptions of teamwork,

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hierarchical relationships, and junior members' contributions to care not always being accepted by more senior members (Sexton, 2000). West and Field (as cited in Poulton & West, 1999) found that barriers to IPTW in primary health care existed in the failure of health care teams meeting regularly to define the objectives of the team, clarifying the of roles of the team members, delegating tasks, encouraging engagement amongst team members and adapting to change. The same study also noted that other underlying reasons for ineffective IPTW were status, power, differing educational backgrounds, the assertiveness that team members possess and the lack of leadership training (West and Field as cited in Poulton & West, 1999; Xyrichis & Lowton, 2008)

Even amidst the barriers that IPT's may face there are also several facilitators documented in the literature to facilitate the effectiveness of IPT's. A facilitator is defined as a circumstance or action that makes IPTW possible (Merriam-Webster 2017). Facilitators such as personal motivation and commitment; trust and work satisfaction; professional autonomy in all disciplines and the importance of accountability structures which measure teamwork were found to facilitate IPTW (Mickan cited in Barrett, Curran, Glynn, & Godwin, 2007).

Organisational support from the organisation in which IPT's function was also found to facilitate the team process (Borrill et al, 2000). Another study identified that evaluating team performance facilitated IPT (West & Markiewicz, 2008).

Although ample evidence is available on the barriers and facilitators of IPTW one should remember that these are all contextual and may not be an accurate reflection of the barriers and facilitators in other settings due to social, economic and environmental differences. Since the purpose of the research is to help align current teamwork approaches to the IPTW approach, should the approach be

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adopted, it is imperative to collect data to understand what barriers or facilitators exist in the South African tertiary level care context, as there is no current evidence available.

2.7   Teamwork in patient management services: A South African health policy perspective

Providing patient management services in South Africa is not a haphazard consideration. Careful thought and planning go into the provision of these services to maximally benefit the health of the patients accessing them. Since the South African public health system is a decentralised health system, governance is awarded to each of the country's nine provinces, thus making each province responsible for providing patient management services within its geographical boundary (Pillay, McCoy, & Asia, 2001). For this reason, policy from the Western Cape Department of Health, the governing authority of the facility where the research was conducted, was scrutinised to identify their stance on teamwork in the provision of patient management services.

In a nutshell and without going into too much detail the Western Cape Department of Health's "Healthcare 2030: Road to wellness" outlines a strategic, comprehensive service plan where the vision is to provide patient-centered quality care (Western Cape Department of Health, 2014:33). The Department acknowledges that integrated teamwork among HPs is necessary for patient-centeredness to occur and to improve the quality of the health services the department provides. The suggested approach to integrated teamwork in the policy envisions that teamwork amongst HPs be interprofessional, therefore,

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placing emphasis on interprofessional collaboration as a key component in the functioning of the IPT (Western Cape Department of Health, 2014). Consulting the literature there is no conclusive information available that discloses what approaches HPs use to provide patient management services in South African health facilities. However, judging from observation and evidence HPs tend to work in professional silos with minimal integration (Future Health Index, 2017). The disadvantage of providing patient care where HPs work in silos is that it decreases efficacy and the quality of patient care (Vatanpour et al., 2013). It is to this end that adopting the IPTW approach has been suggested.

2.8   Status of patient management services in South Africa

Public health facilities in South Africa provide patient management services to approximately 84% of the population (Blecher as cited in Rispel, Jager, & Fonn, 2016). It is also the portion of the population carrying the greatest BOD (Jobson, 2015). At present, the demands for tertiary level care on the basis of bed utilisation rates are quite high (Bloem, 2014; de Vries, Raubenheimer, Kies, & Burch, 2011).

Government officials such as the current Minister of health, Dr. Motsoaledi and others have been candid about the status of providing patient management services in public health facilities acknowledging that the standard of quality is poor (Future Health Index, 2017; Moyakhe, 2014). However, despite efforts to improve quality most of the policy interventions and strategies rarely consider how HPs might work collectively in providing care to improve this. Even amidst the challenges in providing patient management services the Western Cape Department of Health welcomes new innovative ideas to improve its quality (Dr. Nomafrench Mbombo, 2017). Given the openness of the Department of Health to

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new innovations to improve quality, suggesting the IPT approach to providing patient care on basis of its benefits seems fitting.

2.9   What will it mean for health facilities to change their approach?

Since the IPTW approach is suggested as the means to improve quality and patient-centeredness one cannot overshadow that the transitioning from other teamwork approaches will be smooth. Thus forethought has been given to what it will mean for health facilities to change their approach in the provision of patient management services. From the literature that considers what it will take for a change in approach, there are a number of fundamental organisational conditions to establish. Firstly if the approach is to be adopted by a health facility then, buy-in from HPs is essential, firstly from doctors who in tertiary level care are seen as the primary providers and coordinators of patient care. Gaining buy-in is the starting point however, incorporating the conditions listed below will also determine effectiveness (Reeves, Lewin, Epsin and Zwarenstein, 2010).

- Building community, encouraging an inclusive culture amongst all HPs regardless of scope of practice (Sterrett, 2010)
- Making meaning of IPT and the benefit it yields in the provision of patient care (Sterrett, 2010)
- Encouraging an environment of mutual respect amongst HPs (Sterrett, 2010)
- Encouraging open dialogue amongst the HPs (Davies, 2000)
- Breaking down the barriers which cause hierarchical relationships (Davies, 2000)

In addition to the organisational conditions required to occur, should the approach be adopted, Davies (2000), proposes conditions for HPs too. These are that HPs

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need to welcome the challenge of working together across professions and be confident of stepping into something new.

Taking into consideration what it will take for the IPTW approach to be adopted, is fundamental, and can be used in conjunction with the IPTW approach as according to the "Healthcare 2030: Road to wellness" policy.

2.10   Summary

There is a growing advocacy for the use of IPTW for its overall benefit, and more specifically, for its ability to facilitate quality and patient-centeredness in the provision of patient management services globally. According to the objectives of this study, the literature provides no empirical evidence for health professional perceptions of IPTW as a concept; however, the evidence is clear on the types of barriers and facilitators HPs experience when working in IPT's. The barriers and facilitators identified are however contextual and cannot be concluded to be the case in all health contexts. Therefore, the data which this research aims to collect is deemed as necessary, if the research facility in question aims to align itself with the Western Cape Department of Health's vision and the approach to providing patient care outlined in the "Healthcare 2030: Road to wellness" policy.

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CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.1   Introduction

As the foundation for the research has been laid and the necessity of the research clarified and emphasised through the literature review, the following chapter seeks to describe the research setting and substantiate the choice of the research design, sampling technique, data collection and analysis method used to satisfy the aim and objectives as outlined in chapter one. In this chapter, the measures used to ensure rigour and ethics are also discussed.

3.2   Research Setting

The research setting was a tertiary hospital situated in Cape Town. It functions under the auspices of the Western Cape Provincial Department of Health under the regulation of the South African National Department of Health (Western Cape, 2013). The hospital provides tertiary level care to a population of over 2.6 million individuals who live within a predetermined geographic boundary, also known as a drainage area (Western Cape Department of Health, 2013). The drainage area also extends intermittently to individuals outside of the boundary where those individuals have limited access to specialised medical treatment. The hospital offers a comprehensive range of specialist and subspecialist patient management services based upon a comprehensive primary health care package. Medical, rehabilitative, mental and social health services are routinely available and delivered by over 2000 qualified HPs and an undetermined number of HPs in training. The in-patient facility of the hospital houses approximately 1384 active beds in 67 adult and paediatric wards with 10 intensive care units. These services are delivered in an acute, round-the-clock care setting.

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3.3 Research Design

The research employed a qualitative, descriptive, exploratory research design. The qualitative nature of the design was ensued based on the fact that qualitative designs are flexible and, it allows one to examine all aspects of a given problem in a natural setting (Uys and Basson cited in Mambo, 2009; Van Wyk, n.d.). Qualitative designs are known to lend itself to studying the perspectives of individuals on a given subject matter (Husserl, cited in Lester, 1999). The descriptive nature of the design aims to accurately represent the factors relating to the research objectives on page 20 (Van Wyk, n.d.).The exploratory nature of the design addresses the fact that research pertaining to the topic has not been done before in the particular setting thus, exploring the topic will help to contest probable uncertainty and ignorance regarding the topic (Van Wyk, n.d.). Exploratory designs also uncover pertinent issues or phenomena that may be relevant to understanding the research topic (Van Wyk).The research design was also chosen on the basis that it is effective in describing the experiences of individuals without them having a foundation of preconceived ideas or hypotheses (Husserl as cited in Lester, 1999). Exploration in qualitative designs allows one to identify new knowledge, facts and ideas as well as provide depth about a particular subject matter (Babbie, 2010; Brink and Wood as cited in Mambo, 2009). For the aforementioned reasons, the above design is most applicable in order to fulfil the aim and the objectives of the research.

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3.4   Population and Sampling

3.4.1   Population

Based upon the research aims and objectives the population of interest was all HPs from all health disciplines providing in-patient care and working actively in the wards (see Table 3).

Table 3: Health Disciplines

Health Discipline	Population size (n)
Medicine and surgery	603
Physiotherapy	19
Social Work	21
Dietetics otherwise known as the Department of Human Nutrition	15
Speech and Language Therapy	5
Nursing	1905
Total Population	2568

3.4.2   Sampling Technique

The sampling technique was chosen based on the aim of the research which focuses on the IPT and the nature of the IPT structure. Since IPT's are typically established for individuals with complex health needs and normally consists of several different HPs from several different health professions, the sampling technique had to allow for a pre-defined criteria to be established which characteristically resembled a typical IPT. Therefore the purposive sampling method was used to determine the sample since purposive sampling allows one to

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use a predefined criteria to obtain the sample of interest (Mack, Woodsong, McQueen, Guest, & Namey, 2011). Since the data collection method was in the form of FGD's the rationale for choosing purposive sampling is that the participants in the FGD would be representative of the typical in-patient IPT thus, table 4 outlines the inclusion and exclusion criteria. .

Table 4: Exclusion Criteria

Exclusion Criteria	Reason for exclusion
HPs who work night shift at the time of data collection as data collection occurred during the day	Data collection was restricted to HPs working during the day as the all the departments are active during the day time.
HPs working in a part-time position under a locum agency	Part-time and locum positions comes with a number of functional restrictions for the health professional filling the post. Their experiences of teamwork would be limited because of the intermittent nature of their employment
HPs who work in out-patient departments.	The research specifically focused on health professionals working in the in-patient setting since there are distinct differences in the type of care in this setting, as opposed to the outpatient setting

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3.4.3   Participants

According to Burns, Grove and Gray (2011), one's sample size within the qualitative research approach is determined by the point of data saturation. Data saturation refers to a point in data collection where no new information is generated by the participants (Fusch & Ness, 2015). Thus data collection continued until data saturation was reached and no new data was generated from the participants. This point was reached at the point of three focus groups. The breakdown of the sample size is given in Table 5 below.

Table 5: Sample Size of the FGDs

Health Profession	Focus Group 1 (n)	Focus Group 2 (n)	Focus Group 3 (n)
Medicine	0	1	1
Physiotherapy	1	0	0
Dietetics (Department of Human Nutrition)	1	1	1
Speech and Language Therapy	0	2	1
Registered Professional Nurses	0	1	
Registered Enrolled Nurse	1	0	1

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Registered Enrolled Nursing Assistant	1	0	0
Social Work	1	0	0
Total Participants per FGD	5	5	4
Total sample size		14	

3.4.4 Recruitment of Participants

3.4.4.1 Pre-recruitment logistics

Prior to recruiting participants for the study, permission was sought from the Department of Research at the research facility in February 2017. The approval to conduct the research was received on May 14, 2017 in the form of a letter (see appendix A). Prior to receiving approval the internal approval process of the hospital gave all the health departments a chance to scrutinise the research proposal and give the Heads of Department with their subordinates the opportunity to participate. However, several departments opted not to participate for reasons pertaining to staff shortages, operational requirements, and commitments to other research projects at the time. Thus, affecting the representativeness of the HPs required for focus group.

As part of the pre-recruitment logistics a focus group venue was secured on the hospital premises for the three focus groups, in a boardroom in a secluded area of the hospital.

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3.4.4.2 Recruitment Process

The recruitment process started late in the month of May 2017 due to the process of gaining permission from the Human Resources Department. The head of the Human Resource Department was formally contacted to gain permission to obtain a digital database of HPs in the hospital. Verbal permission was given and a digital database of HPs was received in May 2017. The database haphazardly contained information regarding HPs, the departments in which they functioned including their professional rank. For this reason, the database was reorganised in a systematic format which grouped HPs according to their profession and rank.. Once the data base was functional for the recruitment of the HPs, the recruiting process was ensued.

3.4.4.3 Recruitment Procedure

The recruitment procedure to recruit the health disciplines constituent to the structure of the focus group was cyclic in nature. The method for recruitment was per telephone call or the hospital's internal bleeping system using a caller guide which provided the researcher with all the pertinent information that needed to be communicated during the call as well as a checklist based on table 4, page 43, was used to determine whether the individual being called fit the criteria of the participants required for the study. Participants were recruited via the modified health professional database as per rank at least one week prior to the FGD. In cases where a prospective participant in a rank declined or was unavailable to take part in the research, the prospective participant was offered another date to join another FGD or, the next health professional in the database was contacted. The procedure was repeated until at least one person from the specified health disciplines was recruited to take part in the research. For health disciplines such as medicine and nursing, at least two participants were recruited although only one

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was required. Of the positive responses to the invite, some of the HPs did announce (disclaimer) that should their individual operational requirements be excessive it may affect their ability to attend the focus group discussion to which they were recruited as the gauging of operational requirements could not be predetermined. In order to ensure, that prospective participants who had given telephonic consent attended, they were either sent a text message reminder, email or given a hand-delivered letter with a reminder card. Each method gave logistical information regarding the focus group the participant was recruited into (please see appendix B).

3.5   Data Collection Method

Data collection occurred in the form of FGD's, which enabled participants to freely vocalise their opinions on the research topic (Oliveira, Jenkins, Popjoy, 1998). The number of focus groups was determined by the nth number of focus group at which data saturation occurred. The data collection process was ensued after receiving permission from the research department of the hospital. Permission was received in May 2017, please see appendix A.

The data collection consisted of three FGD's, by the third focus group data saturation occurred. Focus groups took place on June 2, 2017, June 12, 2017, and June 14, 2017, at a standard time of 12:15 where each session lasted for approximately ninety minutes. Each focus group was moderated by the primary researcher where a semi-structured FGD guide was used to facilitate the FGD's. Each discussion was recorded on two separate recording devices, a laptop, and a professional handheld digital audio recording device. The FGD venue was held in a boardroom within a quiet area of the hospital secluded from major hospital activity to ensure that there were no unwanted disruptions during the discussions

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and the recording thereof. The representation of individuals in each of the focus groups is outlined in table 5 on page 44.

3.6   Data Analysis

According to Creswell's (2009) framework for analysing qualitative data several steps are described. The first three steps consisted of the procedures relating to data editing and data coding where the remainder of the steps relates to the analysis of the data.

3.6.1   Data Editing

Data editing is an important procedure before analysing qualitative data. According to Creswell's (2009) framework, the data editing steps consists of firstly organising and preparing the data for the analysis process and, secondly reading the transcripts to get a general sense of the data and reflecting on it. In order to organise and prepare the data which was collected in the form of three digital audio recordings, the following procedures were ensued for each of the recordings: Data editing for each of the FGD's commenced immediately after the discussions. Each recording was backed-up on several external digital storage devices. The digital audio recordings were sent to an external transcriber to reduce bias in the transcription phase of data editing. All digital audio recordings were transcribed verbatim.

Once the digital transcriptions were received each of the transcriptions were reviewed and read several times by the primary researcher and external co-coder against the digital audio recordings to ensure correctness and accuracy of the transcript. Necessary changes were made where the transcriber may have

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misrepresented a participant's contribution in the transcript. In instances where the audio was unclear or clarity was required from certain participants with regard to their contributions, participants were contacted and respondent validation was ensued.

3.6.2   Data Coding Procedure

According to Creswell's (2009) framework for the analysis of qualitative data, coding occurs as the third step. Coding the data assisted in processing and disseminating the qualitative data into smaller units of information to reveal its characteristic elements and structure (Dey, 1993; Rossman & Rallis, 2003). Therefore before the codes could be analysed thematically per Creswell's (2008) framework, the researcher and co-coder listened to the audio recordings while reading the transcripts several times to become familiar with the content from each focus group. The codes generated were in relation to the questions from the focus group guide (see table 6).

Table 6: Focus Group Guide: Questions asked to satisfy the objectives of the research

Focus Group Guide: Questions asked to satisfy the objectives of the research	
1	How would you define teamwork?
2	Can you identify the teamwork approach currently used in patient management in the wards?
3	Can you describe how you see/perceive IPT amongst different HPs, as it relates to managing patients in the wards?
4	What facilitators can you identify that enhances IPT
5	What barriers can you identify that exists that prevents efficient IPT

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Probes: Professional relationships, hierarchical relationships, communication, teamwork protocol, referral system, conflict resolution, knowledge of scope/role clarification, lack of leadership, culture of teamwork

For the themes "defining teamwork", "approach to teamwork" and "perceptions of IPTW", responses for each of the codes were easily extracted for interpretation. For the "barriers and facilitators of IPTW" the process was more complex because as the FGD's unfolded, participants made references to either barriers or facilitators in relation to other questions and the exploration thereof. Since many codes unfolded in the "barriers and facilitators" theme, codes were placed into 4 categories. For each of the themes, the codes were corroborated by the primary researcher and an external co-coder. Once the categories and codes were corroborated the primary researcher and co-coder used Atlas Ti version 8 to disseminate the transcripts further extrapolating participant contributions in the form of quotations which had most relevance for the interpretation of the data.

3.7 Rigour

Rigour is an essential consideration in qualitative research (Loh, 2013). It acts a measure to ensure trustworthiness and credibility of the research findings (Loh, 2013). Trustworthiness is defined as the believability of the research based on coherence, insight and instrument utility (Lincoln and Guba cited in Creswell, 2008). However, credibility seeks to determine the congruency between the research findings and reality (Shenton, 2004). Thus the measures used to ensure trustworthiness and credibility occurred in three phases.

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3.7.1 Phase 1: Data Collection

i. Focus groups were conducted using the same format and delivered in a consistent manner.

ii. Each focus group was conducted with the same FGD guide to ensure consistency between the three different focus groups. However, since the research was exploratory in nature, the exploration of themes in each of the different focus groups was different.

3.7.2 Phase 2: Data Editing

i. Digital audio recordings were transcribed verbatim by a professional transcriber unaffiliated to the research to ensure accuracy in the transcription.

ii. Transcriptions were verified for accuracy by reading the transcript against the audio recordings several times by the researcher and an external co-coder.

iii. For purposes of analysis and interpretation of the data, respondent validation was ensued where audio recordings were not clear or clarity was needed from the participants with regards to their responses (Barbour, 2001).

3.7.3 Phase 3: Data Analysis

i. An external co-coder was employed to assist the primary researcher during the data analysis phase to reduce bias. The co-coder also assisted by ensuring that the definition of the codes remained consistent throughout the analysis as well as validating the codes and the themes.

3.8 Ethics Considerations

As ethics is an important consideration in protecting the identity of participants recruited into the research a number of provisions were made to ensure that the

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research fell within the bounds of ethical correctness. These provisions have been summarised chronologically according to the various phases of the research.

3.8.1 Ethics considerations before the commencement of the research

i.   Ethics clearance was applied for through the Biomedical Research Ethics Committee in October 2016 and received in December 2016. Please see appendix C.

ii. Permission was obtained by the research department of the hospital in May 2017 after going through a formal application process in February 2017 (please see appendix A)

3.8.2 Ethics considerations during the recruiting and data collection phase of the research

3.8.2.1 Ethics Considerations during the recruiting phase

i.   Each focus group participant received an information sheet and a confidentiality binding form on the day the participant was recruited to join a FGD. Please see appendices D & E. Anonymous demographic data was also obtained from participants using a demographic data questionnaire, see appendix F.

ii. The information sheets explained the nature and purpose of the research and assured the prospective participants of the following:

   ▪ That their confidentiality and anonymity would be respected by the researcher at all times.

   ▪ That confidentiality may be breached by other participants who participate in the focus group.

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- ▪ Participants were also informed that they could withdraw from the study at any time without consequence.
- ▪ Since the research required participant interaction, the researcher acknowledged that disagreements may occur between participants and if in the event of any adverse effects caused by the discussion in any way, appropriate intervention would be made available for the participant affected.
- ▪ It was transparent that the research yielded no direct benefit to the participant and much less harm.

iii. Once participants agreed to participate in the research and queries pertaining to the research were answered, each participant was expected to sign a confidentiality binding form (a type of informed consent used in focus groups). Ethical conduct in respect of autonomy of participants was adhered to by obtaining informed consent (Shahnazarian, Hagemann, Aburto, & Rose, 2013).

3.8.2.2 Ethics Considerations during data and post collection phase:

Audio recordings including their digital transcriptions have been stored on three separate password protected devices. Hard-copies of the transcriptions were stored in a locked briefcase. Access to audio recordings, digital or hard-copy transcriptions was only given to one individual authorised to take part in the analysis of the data. The individual recruited to take part in the data analysis was obliged to sign a declaration of confidentiality prior to accessing the data, please see appendix G. As per protocol, the data will be kept for a minimum of five years before it will be disposed of manually in December 2022.

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3.9   Summary

The chapter illustrated the research design and methodology and, the rationale for the approach used in the sampling procedure, data collection, and analysis, including the efforts made to ensure trustworthiness of the research as well as the efforts made to ensure that the research did not breach ethical requirements. In summary, the research assumed a qualitative, descriptive, exploratory design in the form of three FGDs with a total sample 14 HPs at a tertiary hospital. Each discussion was aimed at satisfying the research aim i.e. "exploring the perceptions of IPT and the barriers and facilitators thereof in, in-patient management at a tertiary hospital". Data collected from the FGDs was edited and analysed using Creswell's framework (2009) and data was coded thematically using Atlas Ti Version 8, according to four pre-determined themes. Chapter four continues to present the findings with an integrated discussion based on the data collected, according to the four pre-determined themes.

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CHAPTER 4: FINDINGS AND DISCUSSION

4.1   Introduction

A major premise for the research was to suggest that IPTW be the vehicle for providing patient care amongst HPs who provide care to patients with complex health needs. As a reminder the aim of the study was to explore the perceptions of IPTW amongst HPs and the barriers and facilitators they experience thereof at a tertiary government hospital. The chapter begins with a description of the participants and research setting, followed by a chronological presentation of the findings in the form of themes with the inclusion of an integrated discussion.

4.2   Participant Characteristics

A total sample of 14 participants sacrificed their much needed patient time to participate in the research. Several health professions were represented in FGD's from the Departments of Nursing, Medicine, Physiotherapy, Occupational Therapy, Speech Therapy, Social Work, and the Department of Human Nutrition. The representativeness of the professions is outlined on page 44, table 5. All the participants who attended the FGD'S were qualified HPs with experience in the provision of patient care from 6 months to 26 years.

Focus group one, consisted of a staff nurse, social worker, dietician, physiotherapist and an enrolled nursing assistant. This specific group of participants really displayed a genuine concern for the direction in which patient care is currently being provided in the facility, especially, as some of the participants have experienced and have been a part of the transformation process

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of the health system in South Africa. One could also sense a genuine frustration in the atmosphere as participants engaged in the FGD as they commented on some of the barriers which prevented them to effectively perform their respective scopes of practice.

Focus group two consisted of two speech therapists, an intern, a dietician, and a registered nurse were in attendance. This group of professionals were found to be navigating their way around the health system of the hospital being relatively young in the system.

The third focus group consisted of a dietician, speech therapist, intern, and an enrolled nursing assistant. This group of participants were particularly vocal about standards and protocol within the hospital with a particular drive to improve the quality of patient care.

4.3   Description of the Research Setting

During the analysis of the FGD recordings a number of descriptive statements were made about the participants' working context. These statements allow one to have a better understanding and sense of the context in which the focus group participants operate. The hospital was described in terms of size as being *a "vast area"* [FGD1]. The participants also commented about (alluded to) the environments in which they provide patient care. From these statements one can deduce some participants, specifically medical and majority of the allied HPs, except for nurses who are occasionally transferred when there is need elsewhere, operate in the wards on an intermittent basis providing patient care. One participant stated that *"we cover more than one ward* [FGD3]", another participant expressed a similar sentiment *"I'm not always in a set ward for the*

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year, I move between (wards) [FGD3]" denoting that some HPs work on a rotational basis and not always bound to one ward in the hospital.

During the focus group discussions a number of statements were made that led the researcher to believe that the focus group participants work under pressure, they also described the pressure. A common statement amongst the various discussions spoke of the "*high turnover of patients* [FGD1]" giving one a sense that the hospital operations in terms of providing patient care is fairly demanding in terms of the number of patients referred to the hospital for care.

In terms of establishing IPT's, one could deduce that teams are formed on the basis of referral through the hospital's referral system. Some of the participants indicated that they worked in teams on a semi-regular basis and often attended ward rounds with other HPs to discuss the course of patient care to optimally restore patient health.

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4.4   Themes

The findings of the research is categorised into four predetermined themes: towards defining teamwork, approach to teamwork perceptions of interprofessional teamwork, barriers and facilitators of interprofessional teamwork. Categories were only given to the "defining teamwork" and "barriers and facilitators to interprofessional teamwork " themes as a means to group the data obtained from each focus group systematically. Codes were given to the theme "barriers and facilitators to interprofessional teamwork" to further group participant responses systematically.

Table 7: Themes, categories and codes

Theme	Category	Codes
Defining teamwork	Definition Purpose Importance Benefit	
Approach to teamwork		
Perceptions of Interprofessional teamwork		
Barriers and facilitators to interprofessional teamwork	Contextual and organisational	▪ High patient turnover ▪ Human resources ▪ Time

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Table 7: Themes, categories and codes (continued)

Theme	Category	Codes
Barriers and facilitators to interprofessional teamwork	Interprofessional teamwork structure	▪ Team member organisational hierarchy

	Interprofessional teamwork process	▪ Referral process
		   i. Responsibility of referring
		   ii. Referral content
		   iii. Untimely referral
		▪ Knowledge of roles and scope of practice
		▪ Goal setting

	Interprofessional team member relationships	▪ Respect ▪ Relationship building ▪ Attitude ▪ Communication, language and communication technology ▪ Professional jealousy

4.4.1 Defining teamwork

As a point of reference for the successive development of the FGD's around IPT, each focus group commenced with the same introductory question asking the participants to comment on how they defined teamwork. From the responses, participant's defined teamwork by its physical characteristics and also by its purpose, importance, and benefit as it relates to patient care. The participants who defined teamwork by its characteristics said: "*a team can consist of two people or it can consist of many people and often each person brings a different aspect to the playing field*" [FGD3]. Other participants defined teamwork by nature of its

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purpose "*to work together in order for the aim of what you are doing* (patient care) *to be good* (optimal)*" so that "the mission can go further*" [FGD3].

Other participants also defined teamwork by the nature of its importance saying teamwork in "*hospital is very important because every person's role forms part of the end result* [FGD 2]" in relation to providing patient care and a patient's health outcome. Participants acknowledged that there are many aspects of providing care that requires a team effort.

There were also other participants who defined teamwork by nature of its benefits. There was an agreement that "*teamwork is working together to benefit the patient* [FGD2]" identifying that "*the patient can heal faster if you are working as a team*" [FGD3]. Whereas another participant commented on another general benefit of teamwork saying that teamwork "*either make(s) things go faster, or to make things possible that wouldn't be possible or that aren't possible.*" [FGD3]. Another benefit of teamwork was identified, specifically for the health professional, in terms of relieving heavy workloads. One participant expressed that: "*I think it (teamwork) also makes your work light in a way* [FGD 2]" the participant continued to explain that "*if I know that the physio is doing her work well, then it actually has such a big impact on myself as a speech therapist, so I want my team to function well, it will help me.*" The participant basically tried to express that by her providing patient care, much of her interventions to improve a patient's health outcomes was dependent on the interventions of other HPs. Thus, one can conclude that the provision of patient care amongst HPs is to some degree interdependent.

There is no doubt that literature signifies the importance of teamwork in the provision of patient care in the current climate of health (Leggat, 2007; Xyrichis & Ream, 2008). The ascertaining of whether participants understood the

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definition of teamwork in comparison to its standard definition being, "two or more people who interact interdependently with a common purpose, working towards measurable goals", deemed imperative even though it was not necessarily an objective for this research (Swezey & Salas, 1992). It is evident, however, by comparing participant responses to the standard definition of teamwork that participants have sufficient grasp of the definition. In addition to this the participants' ability to define teamwork by nature of its purpose, importance and benefit also shows that they are able to conceptualise the concept of IPTW in its entirety as it relates to the provision of patient care.

4.4.2   Approach to teamwork

Enquiring which approach the participants used in the provision of care for complex patients needed to be foregrounded. Thus, participants were asked to identify the teamwork approach they used in the hospital when working with other HPs from other health professions. The responses from participants were varied. One participant responded that in her opinion, the teamwork approach "*definitely differs from ward to ward*" [FGD3]. Another participant also remarked that in her opinion, "*I think we're constantly adapting* (the teamwork approach) *to the setting* [FGD3]". The same participant described two reasons for this, saying that "*you're constantly realigning to who you're working with, the situation within which you are working* [FGD3]" she also acknowledged that "*there is no clear structure to the approach that we're supposed to have*" [FGD3]. Another response was that the teamwork approaches used is "*specific to each person depending on their moral values and their goals for the patient*" [FGD2]. Another participant described the approach she used as the "*multidiscipline* [FGD1]" teamwork approach. One participant also had an amusing way of describing the teamwork

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approach she is accustomed to using: "*Stop, drop and grab the phone, you call someone you need at the time …* [FGD2]" however the same participant also said in the same breath stating that "*there's no clear picture* [FGD2]" of the teamwork approach used in the hospital. There was a general agreement that the approach to teamwork in the hospital was unclear, one participant conveyed that "*nobody tells you this is our approach* [FGD3]". It is evident that, from the participant responses, there is no standardised teamwork approach used in the hospital when HPs provide patient care to patients with complex health needs. Based on the responses the researcher explored the theme further by asking participants if there was perhaps a standardised teamwork approach and protocol available at the research facility. One of the participants speculated that: "*there isn't a standardised, maybe there is an ideal one that was decided on by management, but there's no standard one being followed by each ward*" [FGD3]. Another participant had a different answer which related generally to her job description she commented that "*it's* (the teamwork approach) *is written on your contract* [FGD1]". Clarity on whether the teamwork approach was written on all the participants' contracts could not be gauged.

The lack of a standardised approach amongst the HPs leaves room for ambiguity and assumption amongst HPs which may negatively impact patient care. Although this research does not gauge the impact of having a standardised teamwork approach, evidence is available to show the impact of standardising teamwork approaches in healthcare, in terms of its benefit to a patient's health outcome and a HPs job satisfaction (Epstein, 2014). According to literature, standardising is defined as a service product, or in this context, ensuring that the provision of patient care remains the same every time (Gyurácz-Németh, n.d.).

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The researcher has suggested that the IPTW approach be used as the approach to teamwork; therefore, this in itself suggests a process of standardisation. In other words, the teamwork approach amongst HPs should be the same in each ward in cases where it is required that HPs rotate. The benefit of having a standardised teamwork approach for health means that they do not need to orientate themselves to new teamwork approaches as they rotate in the hospital.

One participant alluded to the impact of having no standard approach to teamwork and rotation on time, "*you shift wards every month and every four months you shift disciplines. And every month when you get to a new place, it takes you about two days to figure out the new protocols in this ward [FGD3]*". According to the nature of the standard to which the "Healthcare 2030: Road to Wellness" seeks to provide patient care, it makes sense that a standardised approach would apply to ensure that all elements of the promise is delivered at all times. Also, according to the nature of the benefits of standardisation, standardisation has been known to maximise quality and safety in several different settings (CTI Reviews, 2016). Based on these benefits it only makes sense to get all HPs to work together using one standardised approach (Loftus, 2016).

4.4.3   Perceptions of interprofessional teamwork
Participants were asked about their perceptions of IPTW in the hospital. There was a general hesitancy in answering the question, a hesitancy, determined by facial expressions, was more a state of confusion for some, as some participants were not familiar with the term "interprofessional teamwork" but more with its synonymous counterpart "interdisciplinary teamwork". One of the participants perceived IPTW to be "*teamwork that's within* (between) *professions, which*

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means that each individual member is qualified or has a certain speciality or a certain field, which automatically indicates that they bring something to the table that the other people in the team do not. So it means, and they wouldn't be part of that team if it (their presence in the team) *wasn't of value. So interprofessional teamwork is* (an) *interaction of knowledgeable people of relevant fields towards a common goal*" [FGD3]. Another participant perceived IPTW by nature of its goal:

> *I think to me it is where each member of the team does what is required of them, so that we can work out a plan to benefit the patient... ultimately from my side get the best rehabilitation outcome and also the best ongoing care for the patient even after discharge.* [FGD1]

Another participant perceived IPTW by nature of a relationship characteristic between IPT members:

> *I believe it is respecting everybody on the team. Really listening to someone's input regardless of their profession. So you have to be in respect of anybody in the team valuing everyone on the team* (and) *the decision that's going to benefit the patient the most [FGD1]*

The objective of asking participants how they perceived teamwork was to compare their responses to what is already known about the IPTW concept as described in Chapter two, pages 30 to35. What can be concluded is that some of

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the participants have some form of understanding of the IPTW concept with a limited ability to articulate its characteristics. In addition, there were participants who weren't aware of the concept of IPTW at all. Thus the participant's perception of IPTW can be regarded as being limited. According to Freeman, Miller and Ross (2000) they found that altered perceptions of the same teamwork concept has the ability to cause a breakdown in team function. Therefore, if the IPTW approach is to be adopted as the approach to providing patient care in future, its effectiveness will lie in the HPs' having a similar perception of what IPTW is and what it hopes to achieve, to be similar.

4.4.4   Barriers and facilitators to interprofessional teamwork

The following theme presents the results for the second and third objectives of the research in a combined manner. The objectives were as follows: "to explore the facilitators that enhances IPTW in in-patient management amongst ward-based HPs at a tertiary hospital" and "to explore the barriers to IPTW in in-patient management amongst ward-based HPs at a tertiary hospital." The barriers and facilitators were categorised into the following four categories: contextual and organisational, IPTW structure, IPTW process, IPT member relationships.

4.4.4.1   Contextual and Organisational

4.4.4.1.1   High patient turnover

 "*A high turnover of patients* [FGD1]" was regularly referred to as a barrier to IPTW amongst participants. Participants expressed that the high patient turnover meant heavy workloads thus limiting their time to engage in teamwork activities

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such as attending ward rounds or team meetings. One of the participants gave insight as to why patient turnover is high in the hospital:

> *I find sometimes a lot of what we do, and a lot of the overload of our services tend to be stretched a bit thinly, because of the poor distribution of the levels of care, they have a direct impact on our teamwork and what we are supposed to be doing.* [FGD 3]

The participant was referring to the suboptimal functioning of the primary healthcare system. Participants were in agreement with this fact and speculated that if the primary healthcare system functioned better it would reduce the pressure on tertiary level healthcare (Mohapi & Basu, 2012). Even though the suboptimal functioning of the primary healthcare system is not an internal hospital related problem, it must be acknowledged that until the primary healthcare system improves HPs would still have to deal with the overflow of patients. Participants found the suboptimal functioning of the primary healthcare system to "*have a direct impact on our (their) teamwork* [FGD3]" and the ability to provide coordinated care. One participant said that in times when the hospital is at capacity, *"sometimes patients don't get the care they need* [FGD2]" and said this is one of the reasons for patient readmissions into the hospital.

Having a high patient turnover is a barrier that the facility has little control over. Thus, needing to work efficiently is necessary to ensure that patients receive maximal benefit of the services available to restore their health. The literature is not clear how the IPTW approach will affect high patient turnovers however a number of research articles have shown IPTW to reduce patient readmissions and

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to improve efficiency, a dimension of quality (Hardin, Kilian, & Spykerman, 2017; World Health Organisation, 2010a).

4.4.4.1.2   Human resource

With respect to the previous barrier, the lack of human resource also emerged as a barrier to IPTW as there is an inadequate number of HPs to cope with high patient turnover and daily workload. Throughout the discussion participants expressed that "*there's too little hands* [FGD1]" where the hospital is "*running short of staff* [FGD1]", as participants discussed how staff shortages affected their ability to cope with their own daily workloads. One of the participants expressed that she "*can't actually be the team player for a specific discipline (department)* [FGD3]" because of a scarcity of human resources. Two consequences resulted as a result of staff shortages. Participants described that often times they perform "*things [duties] out of my [their] scope of practice* [FGD1]". The other consequence of having staff shortages was that HPs often times missed important elements in the provision of care such as referring a patient to allied health departments timeously.   However, there was a general consensus that having more human resources would also be a facilitator and reasoned that "*more (human) resources would definitely have a cost-effective, cost-saving effect on the burden of the patient's' hospitalisation and time* [FGD2]."

Resource shortages is not a new problem in South African health facilities due to health worker migration, poor retention and budget constraints (Blecher et al., 2017; Labonté et al., 2015). IPTW has shown potential benefit in assisting with workload issues which may benefit HPs with heavy workloads because of

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the aspect of sharing responsibilities (Interprofessional Educational Collaborative, 2011).

4.4.4.1.3 Time

Acknowledging the limits of time as a barrier to IPTW was a common theme amongst participants. One of the participants commented that "*the one resource that's the biggest barrier is time* [FGD3]." Time was acknowledged to be affected by the high patient turnover and again participants made reference to the suboptimal functioning of the primary healthcare system. One of the participants stated that:

> *Clinics are over-burdened, doctors don't have time to spend*
> *on patients* [FGD2]" and continued to speculate that, "*I think*
> *maybe the problem is sitting with clinics and we (the*
> *hospital) are basically dealing with everything that's coming*
> *in from outside (the community).* [FGD2].

Time in any healthcare setting is a precious commodity that needs to be used well, as the time taken to perform certain patient activities has an impact on patient outcomes especially at tertiary level care. Time is thus a critical factor, not only because of the nature of the type of care given at the facility but also because of the high patient turnover experienced. There is no evidence that suggests how IPTW will influence time but based on the aspect of shared responsibility it may relieve time (Supper et al., 2014).

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4.4.4.2 Interprofessional teamwork structure

4.4.4.2.1 Team member organisational hierarchy

Interprofessional team member organisational hierarchy also filtered through as a barrier to IPTW. One of the participants identified that she works in "*a very hierarchical system* [FGD2]" simultaneously acknowledging that because of the hierarchical nature of the system, stating that the hierarchy she experiences "*can be a hindrance to patient care* [FGD2]" and "*it impedes it teamwork a bit*." The participant continued by expressing her own experiences within the hierarchical structure because of her rank as a junior:

> *I've had experiences with people telling me because I'm a junior person in my field, so people, where I phone and I'm trying to refer a patient, tell me I don't speak to juniors. You can ask a senior person to phone me, I'll say but they'll give you the same information I'm giving you and they just say they don't speak to junior people.* [FGD2]

For the participant, hierarchy limited communication and the participant's ability to provide patient care. As literature has shown communication is the basis of any interprofessional relationship and the consequences of hierarchy have been documented to be related to poor patient care and outcomes (Feiger and Schmitt as cited in Institute of Medicine, 2004; Walton, 2006). Participants in general felt the same about the hierarchy with regards to doctors dominating patient care.

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Participants expressed that sometimes they felt undervalued for the recommendations they make to doctors when providing patient care in the IPT.

According to the literature, hierarchies are considered a common barrier amongst HPs working together in an interprofessional manner because of the general mix of health professions, their capacity and rank (Walton, 2006). It is important to note that organisational hierarchies are not necessarily bad, it defines the chain of authority (Walton & Dawson, 2001). However, organisational hierarchies in a team can become toxic when members of the team considers their weight in the team greater than the weight of others or when having power is not necessarily used to the maximal benefit of the IPT's goals and the patient's' care (Anderson and Brown, 2010; Walton & Dawson, 2001).

In this instance, based on the results, it is also recognised that organisational hierarchy is a barrier to communication. The literature is vocal about the consequences of poor communication in patient outcomes because it is fundamental to discussing the course of a patients care (Institute of Medicine, 1999; O'Daniel & Rosenstein, 2008; Pressman & Dickinson, 2016; World Health Organisation, 2008). A core component of IPT's is that equal value is placed on all members of the team and their input regardless of profession or rank (Virani, 2012). The value of placing equal value on team members is to breakdown the hierarchy experienced amongst HPs (MacNaughton, Chreim and Bourgeault, 2013). Therefore, if the IPTW approach is to be adopted then the health facility should make a concerted effort to identify the causes of hierarchy amongst HPs through further research, to develop interventions that will help to breakdown the causes of hierarchy that occurs between HPs in ways that it would be meaningful for the IPT to function optimally.

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4.4.4.3   Interprofessional teamwork process

4.4.4.3.1   Referral Process

The referral process is considered vital in the provision of patient care, this surfaced as a barrier several times (Gandhi et al., 2008). After judging the tone of the conversations around the referral process, an element of frustration precipitated, especially, amongst participants from allied health professions. From the discussions participants agreed that referring is "*ten out of ten, it's very important* [FGD3]" they also agreed that "*it's the first thing that you do, if you pick up … your scope of practice doesn't cover this, you refer immediately*" [FGD3]. As participants explored this theme, several issues emerged to be barriers within the referral process. Participant's found the responsibility, appropriateness and the clarity of the referral to impede the IPTW process before the team is even established. They also found that untimely referral as a barrier for them to play their part in the IPT. Each of these barriers is explored separately as the: responsibility of referring, referral content, and untimely referral.

i.   Responsibility of referring

During the discussions, an issue arose where some participants had a question among themselves i.e. whose responsibility is it to refer patients? As the discussions continued there was a general consensus that it was the doctor's responsibility to refer where the "*doctor makes a decision about (patient care)* [FGD1]" and the doctor "*refers to this one, he refers to that one*" [FGD2]. Another participant agreed saying "*it is only the doctors who are referring*" [FGD1]. However, one participant did not agree, she felt that she should "*be able to receive referrals from anybody that works with the patient*" [FGD1]. The

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participant felt that the referral process should not be restricted to doctors only but also be extended to other professions working with patients. Another participant also questioned "the doctor-only referrals" from her professional scope of practice as a first line practitioner. According to Diener (2010), being a first line practitioner apart from all other duties, states that referring patients is a duty when one has assessed a patient health problem outside of ones scope of practice. She expressed her confusion about "the doctor-only referrals" because it placed a limit on her being able to follow through on a responsibility to refer as a first line practitioner. Another participant expressed how she took matters into her own hands by referring regardless of the doctor-only protocol, she expressed forthrightly that she "*also started to refer because I don't think there is any law against me referring* " [FGD1].

In this particular setting referring is the primary means of non-verbal communication amongst HPs. It is a process that is undertaken mostly by doctors when an individual presents a health need that the medical profession cannot solve. However, ambiguity surfaced around whether all HPs, regardless of their scope of practice could refer. According to the major responsibilities of the health professional, as referenced in Chapter 2, states that it is the responsibility of a health professional to refer a patient when such patient's health need is beyond their scope of expertise (Health Professions Council of South Africa, 2008). Upon the scrutiny of ethical policies from statutory bodies of HPs, referring is considered an ethical requirement for most health professions where there are some limitations to referring in the nursing profession with regards to rank (Health Professions Council of South Africa, 2008; South African Council of Nursing, 2004). Therefore, the ambiguity should be addressed by the departmental managers, taking into consideration the various ethical policies to which health

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professions are subject to and make the necessary changes to organisational and departmental policies regarding whose responsibility it is to refer.

ii.   Referral content

A participant also identified that referral content was a barrier in terms of legibility, clarity, and accuracy. The legibility of the handwriting was described as "*horrific* [FGD2]." Participants stated that when referrals are illegible, "*it takes so much time to figure it* (the referral) *out* [FGD2]". Illegibility of referrals in this instance causes frustration for the recipient using up an already scarce resource of time deciphering the content and affects the recipient's ability to respond adequately to the referral (Sokol & Hettige, 2006).

Another barrier identified related to the clarity of the referral saying that if "*the person that's referring is not quite clear why they're referring, that's a big barrier. So not self-informing themselves* [FGD2]" to the recipients scope of practice. In addition to this, participant's found that another barrier was that referrals were sometimes "*totally inappropriate* [FGD1]" with regards to the reason for the referral. Participants explained that a major cause for referrals unclear or inappropriate was that sometimes the referrer was not aware of the roles and scopes of practices of the recipient of the referrals profession. Understanding the roles and scopes of other professions is a fundamental competency of IPTW. The rationale for the orientation is essential in ensuring that HPs know and can better articulate why a patient is being referred. Unclear and inappropriate referrals were found to delay the process of patient care. Therefore, from a logical standpoint, when a health professional is orientated to the roles and scopes of other professions it would increase their accuracy of referring to the

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most appropriate HP (MacNaughton, Chreim, & Bourgeault, 2013). As a result, if the health facility adopts the IPTW approach it would improve the HPs' orientation to the roles and scopes of practice of other professions thereby improving the referral process.

iii.   Untimely referral

Participants also recognised untimely referral as a barrier to the IPTW process. After an assessment of the tone of discussions, "untimely referral" seemed to be the greatest source of frustration amongst allied HPs. One of the participants expressed that referring on time is "*extremely important to us because things cannot get done properly if it's* (referring) *done at the last minute*" [FGD1]. The same participant explained how untimely referral affects her ability to perform her scope of duties effectively:

Especially with physiotherapy, you cannot refer a patient to me on the day of discharge, or even depends on what the patient's condition is. The earlier I am aware of the patient, the more time I have had to evaluate the patient holistically and know this patient so that I know what the patient needs ultimately. And so that that can be sorted out before the patient leaves. But now as it happens very frequently, you can't, we are receiving referrals even two days, three days prior to the patient's discharge, and everything needs to be sorted out within that time, and I can't even guarantee that I have actually done anything worthwhile in terms of treatment within that short period of time. [FGD1]

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Another of the participants shared the same sentiment by sharing her experience when the doctor does not refer on time. She passionately emphasised that she "*could do much more building a relationship with the patient and seeing him on a few times, than just once off at discharge* [FGD1]", she felt that it was not ideal for the patient. The participant also felt that sometimes when doctors are ready to discharge a patient her recommendation to keep the patient in hospital longer is "*totally ignored*" [FGD1]. She explained that often times the patients who she has recommended to stay gets readmitted for the same health problem. She explained that it "*is very frustrating for* (her) *me if that happens, but it does happen*" [FGD1].

During the discussion of this theme one participant gave insight as to why doctors do not always refer timeously:

> *I think they [doctors] have their set of priorities, there's various cases with regards to that question. There's some patients where feeding is not even thought about after a week, two weeks of the patient not being able to eat. So that to them is not a priority, they're treating more of the medical, that actually goes hand in hand. The other referrals are when the patient is for discharge and then they expect you to perform miracles within 24 to 48 hours. Or maybe they don't expect you to, but you feel like they do, and then you do the patient a bit of an injustice. So very late referrals does affect the patient and time does definitely have an effect.* [FGD2]

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Another participant gave insight as to the referral practices of doctors by saying that it was dependant on the behaviour of the doctor or consultants

> *I think also it all depends on which consultant is working*
> *with the patient. Certain doctors are actually much better*
> *with referring than others, but ja, it just depends. I find that*
> *very often with specific wards, depending on who the*
> *consultant is, they refer quite early on and then there are*
> *others who refer up against discharge and then they have to*
> *make a quick plan for the patient.* [FGD2]

In exploring the theme of "untimely referral" when the participants were asked whether untimely referral affected the continuity of care for patients, participants responded with a unified "*yes*" *[FGD 1]*.

Based on these responses untimely referral infringes on a HPs ability to perform the duties of their scope of practice effectively, which subsequently affects the general quality of care. Untimely referral has been shown in various scenarios to impact patient outcomes (Levin, 2006). Therefore, if the IPTW approach is to be adopted as the approach to providing patient care , in future, orientating HPs to the roles and scopes of other professionals will be essential in ensuring that HPs write appropriate referrals (Brault et al., 2014; Hudson et al., 2017).

Even though IPTW does not encourage referral as it seen as "passing the buck" from one health professional to another with no collaboration in the provision of care, this particular hospital cannot go without a referral system as it is an important means of non-verbal communication (Buckley, 2008). Therefore it

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suggested that instead of removing the referral process, that the culture around the process of referral be changed by ensuring that collaboration between HPs extends beyond the process of referral to improve the quality and patient-centeredness of care.

4.4.4.3.2 Knowledge of roles and scopes of practice

A common barrier that seemed to emerge throughout the focus group discussions was that often times IPT members did not have a clear understanding of the roles and scopes of practice of their colleagues from other professions. This theme was identified earlier in the "referral process" barrier. Exploring the theme further, participants were asked whether or not a protocol or document existed that all HPs had access to which contained the information on the role and scopes of practice of the various health professions. One participant responded "*that there is one* [FGD3]" he continued to explain that "*when we (interns) were orientated, there was one that was presented to us.* [FGD3]". Another participant from the same focus group discussion recognised this document as "*the interns manual* [FGD3]". The same participant who recognised the document made reference to her familiarity with the document as she is asked to update it every year. She also confirmed the availability of the roles and scopes of practice of the different health disciplines in the document by commenting "*your details are in there, dietician, physio, social worker*" [FGD3]. As a means to gain further clarity regarding the availability of the document to all other health professions participants responded with a unanimous "*no*" [FGD3]". As the discussion around the knowledge of roles and scopes of practice built up one participant readily explained that she gets to know of the roles and scopes of other professions through "*trial and error. I get to find out how they* (other professions) *work by*

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chatting in the passages… they (colleagues from other professions) *get to find out how we operate by trial and error*" [FGD3].

The researcher asked whether the availability of such a document as the intern's manual would be beneficial to the IPTW communication process, there was a general consensus that it would. One participant acknowledged that:

> *Then we will then know what is an appropriate referral. The*
> *same way I would know if I refer to speech, what is an*
> *appropriate referral or not.* [FGD3]

The researcher explored further to find out whether participants felt that having such a document would benefit the provision of patient care. One participant expressed: "*I do. Essentially it will* [FGD3]" another participant agreed that "*I think it's important for patient care and I think it helps streamline what we do* [FGD3]" she continued her contribution by suggesting:

> *I think even just a massive poster. Not even a document. A*
> *poster in the ward which you can go to with that speech*
> *therapy, this is what you refer to, this is the referral method,*
> *okay. Clinical care pathway and things, so if you just see, if this*
> *is the team and you see all the different options.* [FGD3]

It was evident, from the discussion that HPs are not always confident in identifying the roles and scopes of other professions where operating by trial and error is not the most efficient way of educating one's self of another HPs scope of

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practice. Literature places emphasis on knowing the roles and scopes of practice of other professions in order for IPTs to work effectively, improve their performance, and improve patient outcomes (Youssef & Kadamani, 2017). Therefore, if the IPTW approach is to be adopted as the approach to providing patient care in future, it is imperative to ensure that team members are orientated to knowing each other's roles and scopes of practice.

4.4.4.3.3 Goal setting

The lack of collaborative goal setting amongst IPT members was also identified as a barrier. One participant described what the ideal situation would be versus the current situation:

> *I find that in our setting we are supposed to sit down and put our goals down together as a team, but what is happening at the moment is each profession makes their own goals and sets their own goals and works towards those goals.* [FGD2]

Another participant expressed a similar sentiment that "*everybody needs to have the same goal and from my experience sometimes a patient is sort of just passed onto the next team member*" [FGD2] the participant also acknowledged that most times patients are "*just passed on to the physio, the dietician where the actual goal isn't specified*" [FGD2]. It is quite clear that collaborative goal setting does not readily occur amongst IPT members. The reason as to why collaborative goal setting does not occur is not entirely clear, however, one can speculate on the basis of the barriers previously identified, that perhaps time could be the issue.

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From the literature, if collaborative goal setting does not occur it leaves room to create conflicting goals which may result in unsatisfactory patient outcomes and potential safety risks affecting the quality of care. According to the nature of the characteristics of IPTW, goal setting is fundamental in IPT (Swezey and Salas, as cited in HRH Global Resource Center, n.d.). Therefore, if the IPTW approach is to be adopted as the approach to providing patient care in future, it is imperative to explore the reasons as to why collaborative goal setting does not occur amongst HPs.

4.4.4.4   Interprofessional team member relationships

4.4.4.4.1   Respect

Respect was identified as a facilitator to IPTW amongst the focus groups where one participant captured that "*respect is very important in teamwork*" [FGD3]. Respect is a core value of IPTW and one of seven organisational values of the hospital (Interprofessional Education Collaborative, 2011; Western Cape Department of Health, 2013). It is considered foundational to interprofessional relationships where collaborative care is delivered by several health professions (Interprofessional Education Collaborative, 2011). It is also a fundamental value of effective teams and positively impacts collaboration (O'Daniel and Rosenstein, 2008). No literature is available on its effect as it relates to interprofessional patient care but, we can assume since respect positively impacts collaboration where collaboration is a factor for improved patient outcomes that, respect amongst HPs may have a positive effect in the way patient care is delivered. Thus, fostering an environment where HPs are continuously encouraged to respect other health professions for their role in providing patient care can only be to the benefit

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of improving IPTW practices in the hospital (Interprofessional Education Collaborative, 2011).

4.4.4.4.2   Relationship building

There was a general consensus that when HPs build interdependent relationships with other professionals that it facilitates IPTW:

> *I also find that it's easier to get things done when you build relationships with people, and show interest in them and I find when we do that, build relationships with various people within the professions, it's much easier to manage the patients, because then you can quickly ask so and so would you please see that patient because you have a relationship with that person, then it's much easier to get the person to assist you* [FGD 3]

When the participant was probed on how building interdependent relationships benefits patient care, the participant's response was that building interdependent relationships "*facilitates better care for the patient*" [FGD3].

Relationship building is important amongst HPs providing patient care with interdependent relationships being the most advocated type of relationship in the current climate of health (Interprofessional Education Collaborative, 2011). Interdependent relationships are relationships where two or more people are mutually dependent on one another (Windmere, n.d.). The provision of healthcare in the current climate of health has become increasingly complex, thus interdependence is an as an approach to achieve the impossible especially where

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people with varied skills, knowledge, and experience collaborate. Building interdependent relationships is also a competency suggested by the Interprofessional Educational Collaborative (2011) as a means to improve team member relationships. Therefore, if the IPTW approach is to be adopted as the approach to providing patient care in future, it is imperative to create an environment where HPs are able to build interdependent relationships.

4.4.4.4.3 Attitude

From the FGD's, one of the participants stated that "*I think a barrier is attitude* [FGD2]", in the same breath she also gave her insight on why it is that having the not having the right attitude limits IPTW:
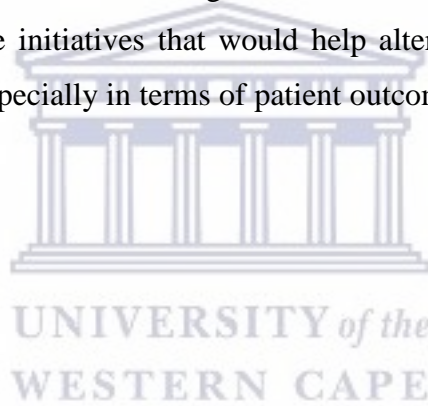
> *If you don't have a good attitude towards the person that you*
> *are working with, they are not going to want to help you and*
> *unfortunately then the patient suffers.* [FGD2]

As concluded from the aforementioned, having the right attitude is also regarded as a facilitator to IPTW. In another focus group where some frustrations arose during the discussion about the attitude of HPs towards teamwork as a barrier, one participant asserted that:

> *If the doctor is the head of the team, and his attitude about*
> *teamwork is right, everything will be right.* [FGD1]

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Attitude is defined as one's disposition towards something (Merriam-Webster, 2017). Based upon the responses one cannot determine whether the participants' attitudes towards working in an interprofessional manner are positive or negative as that wasn't an objective of the research. However, one can assume that, from the first participant's response, that participant may have interacted with other HPs who may have had negative attitudes and therefore from that perspective identified attitude as a barrier. As it has been asserted IPTW becomes the approach to patient care, it is therefore imperative to understand why HPs in this setting would potentially have a negative attitude towards the concept. Literature available regarding negative attitudes of HPs toward IPTW shows that negative attitudes normally exists when the professional does not see the benefit for it or perceives it to be time-consuming (Thomas, Sexton, & Helmreich, 2003).

If similar attitudes exist amongst HPs at the hospital, then it is imperative for the facility to use initiatives that would help alter their attitudes, to see the approaches benefit especially in terms of patient outcomes and health professional job satisfaction.

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4.4.4.4.4 Communication, language and communication technology

Lack of verbal communication was an undisputed team relationship barrier identified earlier in either of the focus group discussions and an underlying barrier to other barriers. It was a strong, recurring barrier that all participants agreed to as being a problem. A participant commented that:

> *One of the barriers is that we do not have is fluid*
> *communication between all of the departments.* [FGD2]

Another participant described the quality of communication:

> *We don't always have good communication between all of us*
> *regarding particular (complex) patients.* [FGD3]

Another participant said she knows teamwork is not optimal because "o*f (a) lack of communication*" [FGD1]. Another participant illustrated with an example of how non-fluid communication affects patient care in dietetics:

> *All the different disciplines, we don't always have good*
> *communication between all of us regarding particular*
> *patients, because I'm just thinking, say for example I have*
> *assessed the patient and then written up a specific guideline*
> *for their eating plan, it's easy for me to make contact with the*
> *dietician and ask them would you be able to adjust the*

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feeding plan on this one? That's fine. It's okay for us to communicate to the nurses and tell them look, this is the plan of the patient and tell the doctors so that is all right. But then we have maybe a shift change of the nursing staff. Maybe today's nurses follow the feeding plan quite well, but then the next day the previous group maybe did not communicate to the next group, then they take the patient back onto nasogastric feeds and then the feeding plan backtracks, then we have to communicate again. Communicate to the nurse, communicate to the doctor, communicate to that one and then we find that we often have to repeat the recommendation in order to get the progress that is required for the patient. It's challenging but that is the reality of our system. So just in terms of communication, I find it's not always fluid.
[FGD2]

When the researcher probed participants regarding the consequences of non-fluid communication for the patient one participant responded that non-fluid communication may result in "*longer hospital stays* [FGD1]" another recognised "*that it could negatively impact the patient* [FGD2]". Another participant based upon similar experiences stressed that:

My years of experience has taught me communication is very important. [FGD3]

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The participant found that communication facilitated IPTW specifically in trying to ensure the smooth running of services and preventing problems that would affect a patient's care and health outcome. There was a general consensus that communication facilitates "*better teamwork*" [FGD3].

Lack of communication as a barrier between interprofessional team member relationships is a common barrier identified in the literature (O'Reilly et al., 2017; Registered Nurses' Association of Ontario, 2013). After assessing the tone of the discussions surrounding the lack of interprofessional communication amongst health professions, it seemed to be a cause of frustration especially when pertinent information regarding a patient's condition or plan for care is not always readily shared. Reasons as to why this occurs may be because HPs may be working in professional silos or may not place adequate value on the necessity for communication or perhaps current communication systems does not facilitate effective communication. However, literature asserts that communication is fundamental precursor to IPTW and also has the ability to affect patient outcomes, i.e. patient outcomes in terms of misinterpreting information which could lead to incorrect understanding or even executing the wrong care plan which may risk the patients' health (O'Daniel & Rosenstein, 2008).

There was also some debate about language as a barrier to IPTW with regards to ward rounds and general interprofessional communication:

> "*Another one* (barrier) *is* (the) *language barrier, some have problems, some are dealing more with Afrikaans, which the other team members won't understand.*" [FGD1]

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In a country with eleven official languages, it is possible for language to be a barrier amongst HPs, as everyone's mother tongue may be different and the comprehension of other languages may be limited. This poses a unique challenge for HPs in South Africa (Van den Berg, 2016). There is also no available evidence that illustrates how language barriers affect interprofessional communication. Most of the studies regarding language as a barrier in patient care mostly considers the impact of the language barrier between patients and health professionals. However, one could possibly assume that the language barrier between HPs working in an interprofessional manner may have an impact on patient outcomes, in terms of misinterpreting information which could lead to incorrect understanding or even executing the wrong plan of care which may risk patient care and health outcomes.

In this category one facilitator was identified to aid IPTW is communication technology as a form of communication technology. One of the participants described a way she shares information via technology "*using a WhatsApp group for a teamwork, so that we can share (information) with each other as we go* [FGD1]" she described the benefit of using Whatsapp by saying that:

"*it's (sharing information) just quicker, easier*" [FGD1]

Identifying communication technology as a facilitator is commonly cited in the literature as a means to close the communication gap and improve information sharing amongst HPs (Rouleau, Gagnon, & Côté, 2015; Shrader et al., 2016). The benefits of using communication technology is clear, it creates the space for HPs to communicate and share information especially, in instances

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where HPs have limitations in attending team meetings or ward rounds because of time and it facilitates learning (Pimmer, Mhango, Mzumara, & Mbvundula, 2017; Raiman, Antbring, & Mahmood, 2017). Literature also promotes the use of Whatsapp as a feasible medium for communication and sharing information between HPs because of the apps available functionality in text, sharing videos, and images to groups or individuals it is also free to download (Kamel Boulos, Giustini, & Wheeler, 2016).

At present, the hospital does not utilise any other formal means of technology besides telephones and emails for communication between HPs, thus the use of WhatsApp, as suggested by the HP, is a personal choice. Since communication is necessity for collaboration in IPT and since time also impacts teamwork, utilising such communication technology may deem beneficial in the provision of patient care using as it useful in saving time and improving collaboration therefore strengthening teamwork (Dale, Newman & Ling, 2010).

4.4.4.4.5   Professional jealousy

Another participant pointed out, based on her experiences that another team member relationship barrier which impedes IPT member relationships is "*professional jealousy*" [FGD1]. One of the participants readily explained why she thought it occurred:

> *It [professional jealousy] is existing, definitely in the hospital*
> *over all the years. It differs between persons but I know*
> *there was a time between occupational therapy and*
> *physiotherapy and social work. You know, this is now my*

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turf and now I'm on your turf… you get that out of the way,

and even sometimes with nursing, and then you get that out

of the way also and allow team work to flourish. [FGD1]

Professional jealousy refers to the common issue regarding protecting one's "turf". An explanation from the literature describes it as over protecting the scope and authority of one's profession (Grant & Finnochio, 1995). Why this particularly occurs at the facility is not entirely understood, however speculation, based on the discussion which ensued around this topic leads one to believe that there may be an underlying power struggle amongst the various professions. Literature asserts that turf protection may be due to an overlapping of scopes of practice, autonomy, professional identity, and the need for one's profession to be exclusive (Safriet, 2002). No evidence is available on the impact of professional jealousy on IPTW or how it affects patient outcome in tertiary level care. Since professional jealousy does exist, it contradicts the principles of IPTW as it impedes the HPs ability to collaborate, share skills, and information. Thus, creating an environment where HPs do not feel threatened in terms of the uniqueness of their profession and encourages to respect the uniqueness of another's profession is imperative for the optimal function on an IPT.

4.5   Summary

In summary of this chapter, these are the main findings:

1. Participants are able to define teamwork and conceptualise its benefit in the provision of patient care.

2. There is no standardised teamwork approach used at the tertiary facility and this affects the way HPs work together in an interprofessional manner.

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3. Participants have a limited ability to articulate the benefits of the IPTW perception of the concept IPTW versus literature that defines what in IPTW is.

4. Within the context of tertiary level of care there are a greater number of barriers affecting IPTW such as high patient turnover; lack of human resources; lack of time; hierarchy amongst IPT members; challenges with the referral process, lack of knowledge of colleagues roles and scopes of practice, attitude, communication inefficiencies, language barriers, and professional jealousy were found to impede the IPTW process and has been recognised to affect efficiency in providing patient care.

5. Within the context of tertiary level care several facilitators were found to improve working in an interprofessional manner such as increased human resource, respect, relationship building, and communication technology.

With respect to the aforementioned findings, the final chapter (Chapter 5) concludes with final concluding comments, providing several recommendations to better align current teamwork practices to the IPTW approach with an inclusion of the perceived limitations of the research.

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CHAPTER 5: CONCLUSION

5.1   Summary

In this, the final chapter and in the consolidation of the body of research, a short summary of the chapters are presented to consolidate the chapters, which is followed by a list of several recommendations based on the findings and concludes with a list of research limitations.

Chapter one was on the orientation to the research where the assertion was made that integrated teamwork is requisite in providing quality, patient-centered care for patients with complex health needs and is best delivered through the vehicle of the IPTW approach. Chapter two built a foundational understanding of patient care, the health professional of the twenty-first century, the reason why integrated teamwork is important in tertiary level care and the global perspective of health care and its provision. The review then considered the IPTW approach, its benefit in providing quality, patient-centered care including a review of the literature with regard to the perception, barriers, and facilitators of IPTW amongst HPs. The review also considered the "Healthcare 2030: Road to wellness" policy which stipulates that patient care be delivered using the IPTW approach and gave a short synopsis of the status of patient care in South Africa. Chapter two concluded with considering what it will mean for a health facility to change their approach to the IPTW approach. As a reminder, the rationale for the research was to do introspection for the future development of the IPTW approach. Thus, the aim of the research was to explore the perceptions, barriers, and facilitators of IPTW amongst HPs working at a tertiary level hospital.

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Chapter three gave an in-depth overview as to how the aim of the research was to be achieved with qualitative research methods. Chapter four presented the findings that were obtained to satisfy the research aim. Therefore, in light of the research findings it can be concluded that HPs understand the positive value of teamwork in the provision of patient care. However, having a non-standardised teamwork approach affects the efficacy in the provision of patient care. Since the study found that the perceptions of HPs towards the concept of IPTW is limited, where much groundwork will need to be done to unify the HPs' perceptions and understanding of the IPTW approach amongst HP's. The research also found that high patient turnovers, human resource shortages, lack of time, hierarchy amongst different professions, referral processes, attitude, lack of verbal communication, different first languages and professional jealousy to be barriers to IPTW. The research also found several facilitators to improve IPTW these were having more human resources, respect, relationship building amongst the different professionals and the use of communication technology.

Thus, to gain maximum benefit of the findings and for the research to be of value to the hospital, specifically those in departmental management positions, these findings can be used as a means to understand the unique struggles of different health professions who are expected to work together. The findings also provide a basis of information that departmental managers can use as means to strengthen patient care and align it with the "Healthcare 2030: Road to Wellness" policy and the vision of achieving quality,

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patient-centered care. Therefore, in light of the research findings several recommendations have been generated to act as a catalyst to improve IPTW in the provision of patient care at the hospital. The recommendations are categorised according to the following categories, organisational, IPTW structure, IPTW process and IPT member relationships.

5.2   Recommendations

The following recommendations are made bearing in mind the "Healthcare 2030: Road to wellness" policy which states the use of IPTW as the approach to the provision of patient care. The recommendations are made should the health facility adopt the IPTW approach as the means to providing patient care.

5.2.1   Organisational recommendations

In the midst of high patient turnovers, resource shortages and limitations to time, if the hospital adopts the IPTW as a vehicle to provide patient care then the following is recommended:

- Establish an organisational culture that encourages IPTW between the different professions, promoting its value (Eggenberger, Sherman, & Keller 2014; Körner, Wirtz, Bengel, & Göritz, 2015). Also, establishing an IPTW culture would entail providing HPs with information through a series of lectures on the IPTW approach; ensuring that the departmental heads drives home the message of working together in an interprofessional

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manner in meetings they have with staff and use innovative ways such as mass media to promote IPTW amongst HPs.

- ▪ Adjusting HPs job descriptions to include working in IPT's as a requirement of the job and provide training as to what it means to work and be a part of an IPT in tertiary level care.

- ▪ Revise the current referral process, in terms of the barriers recognised, to develop ways to improve the referral and communication process.

5.2.2   Interprofessional teamwork structure recommendations

Explore through the means of research the reasons as to why IPT member hierarchy exists and use the information to develop initiatives that can break down the hierarchy amongst HPs. This can be achieved using the recommendation in

5.2.3   Interprofessional teamwork process recommendations

Many recommendations arose based on one of the themes in the FGD's which was identified as a barrier; this was the inability for HPs to accurately recognise the roles and scopes of other health professions impacting the quality, accuracy, and timeliness of referrals amongst the professions. The recommendations based upon this barrier are as follows:

- ▪ It may deem beneficial in making a document or poster which identifies the roles, scopes and the type of services the different HPs provide and have this visible in each of the wards purely as a means of reference. This will assist in streamlining the process of referral and communication amongst HPs (FGD 3 contribution).

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- In conjunction with the fore mentioned recommendation having a standardised referral procedure throughout the hospital will also be of benefit especially in cases where HPs are required to rotate in different wards (Reichman, 2007)

- A third recommendation, in conjunction with the first two recommendations, is to establish a care pathway guideline for certain classes of patients for HPs to help patients gain access to services that would be of maximal benefit to them across the healthcare continuum (Laguna-Pérez, et al, 2012; Scaria, 2016; Deneckere et al).

5.2.4   Interprofessional team member relationship recommendations

The following needs to be done in order to create a space where the various HPs from the various health professions can regularly engage in dialogue and build relationships across the professions:

- Invest in IPT training and IPE as a means to help build relationships garnering the help of organisations such as AfrIPEN, who are advocates for the advancement of IPT and collaboration through IPE within the African health context (Darlow et al.,2010).

5.3   Research Limitations

As with any research, there are always limitations that should be acknowledged when looking at the research process retrospectively. In the research the following limitations were found:

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- ▪ The sample size was not representative of the total population of HPs and the various professions for the reasons described in Chapter three (page 44) which may have limited the representativeness of the findings.

- ▪ The research topic is context-based thus the results have limited in general in other health facilities.

- ▪ Since the research setting has demanding operational requirements HPs were limited in terms of time to contribute to the focus group setting, therefore, perhaps altering the data collection methods for any future studies on IPTW should take this factor into consideration in the method research design and methodology.

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APPENDICES

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Exploring the perceptions of IPT
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Appendix A: Research Facility Ethics Approval

Western Cape Government
Health

HOSPITAL
REFERENCE: **Research Projects**
ENQUIRIES: **Dr GG Marinus**
TELEPHONE:**021 938 5752**

Ethics Reference: BM/16/5/24

TITLE: **Exploring the perceptions of interprofessional teamwork and the barriers and facilitators thereof in, in-patient management at a tertiary hospital.**

Dear Ms N Arends

PERMISION TO CONDUCT YOUR RESEARCH AT TYGERBERG HOSPITAL.

1. In accordance with the Provincial Research Policy and Tygerberg Hospital Notice No 40/2009, permission is hereby granted for you to conduct the above-mentioned research here at Tygerberg Hospital.

2. Please note with regards to some concerns were raised by HOD's of specific disciplines [see attached] with regard to the impact of the proposed research activity. It is expected that the researcher consider some concerns and comments with regard to the methodology, due to mainly work load of staff and other logistics.

3. Researchers, in accessing Provincial health facilities, are expressing consent to provide the Department with an electronic copy of the final feedback within six months of completion of research. This can be submitted to the Provincial Research Co-Ordinator (Health.Research@westerncape.gov.za).

DR GG MARINUS
MANAGER: MEDICAL SERVICES [RESEARCH CO-ORDINATOR]

DR D ERASMUS
CHIEF EXECUTIVE OFFICER
Date: 4 May 2017

Administration Building, Francie van Zilj Avenue, Parow, 7500   Private Bag X3, Tygerberg, 7505
tel: +27 21 938-6267   fax: +27 21 938-4890   www.capegateway.go.v.za

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Ethics Reference: BM/16/5/24

TITLE: Exploring the perceptions of interprofessional teamwork and the barriers and facilitators thereof in, in-patient management at a tertiary hospital.

BY   _____

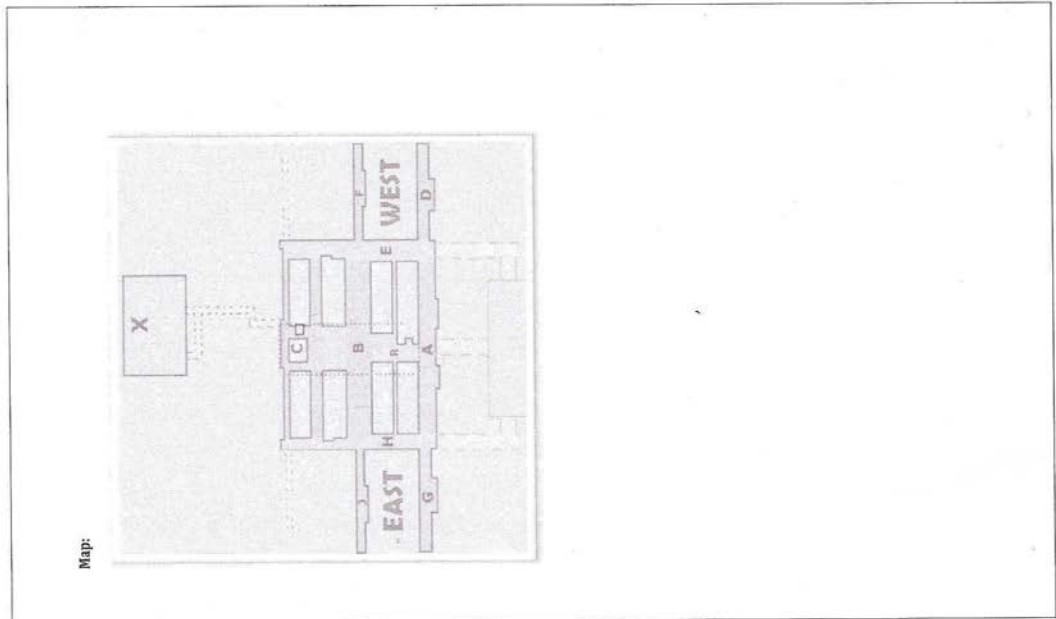An authorized representative of Tygerberg Hospital

NAME ___Dr DS Erasmus_____

TITLE ___CEO_____

DATE ___4 May 2017_____

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Appendix B: Focus Group Reminder Letter and Card

Map:

Focus Group One Confirmation Letter

June 2017

Dear Health Professional,

Thank you for your willingness to participate in the focus group. As discussed per telephone, the researcher is interested in hearing about your perceptions of interprofessional teamwork in the hospital including the barriers and facilitators that you experience in working in interprofessional teams.

You will be in a focus group with approximately 8 other health professionals from a number of different health professions. Please note your responses will be kept anonymous. Since the focus group occurs around lunch time, you may bring your lunch light refreshments will also be served.

The focus you will be attending is as follows:

Focus Group 1	
Date:	08 June 2017
Time:	12:15 - 13:45
Venue:	A Ground –East Side, Room 81b *(map attached)*

There is a little reminder card attached with all the relevant information. If you are unsure about the location there is a map attached. There will be red arrows to direct you from the main entry points, the room where focus group will take will be clearly marked. If you still have trouble finding the venue or unable to attend please call Nicci 078 318 1399.

The researcher looks forward to meeting you and listening to your contribution.

Yours in Health

Ms N. Arends
UWC School of Public Health Student: 2748855

E-mail: nearphysiotherapy@gmail.com

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and the barriers and facilitators thereof in, in-patient management at a tertiary hospital.

Save the date

FOCUS GROUP 2

DATE: 12 JUNE 2017
TIME: 12:14
LOCATION: A GROUND EAST, ROOM 81B

Exploring the perceptions of interprofessional teamwork and the barriers and facilitators thereof in, in-patient management at a tertiary hospital.

Thank you in advance for your participation.
Your input is of significant value.

Should you have any questions etc. the researcher can be contacted as follows:

Ms Nicole Arends
Mobile   078 318 1399
E-mail   neaphysiotherapy@gmail.com

UNIVERSITY of the
WESTERN CAPE

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Ms. N.Arends (274885)

Exploring the perceptions of IPT
and the barriers and facilitators thereof in, in-patient management at a tertiary hospital.

Appendix C: University Ethical Clearance

OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

UNIVERSITY of the
WESTERN CAPE

Private Bag X17, Bellville 7535
South Africa
T: +27 21 959 2988/2948
F: +27 21 959 3170
E: research-ethics@uwc.ac.za
www.uwc.ac.za

06 December 2016

Ms N Arends
School of Public Health
Faculty of Community and Health Sciences
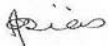
Ethics Reference Number: BM/16/5/24

Project Title: Exploring the perceptions of interprofessional teamwork and the barriers and facilitators thereof in, in-patient management at a tertiary hospital.

Approval Period: 24 November 2016 – 24 November 2017

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval. Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

PROVISIONAL REC NUMBER -130416-050

FROM HOPE TO ACTION THROUGH KNOWLEDGE.

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Ms. N.Arends (274885)

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Appendix D: Focus Group Information Sheet

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 xxxx, Fax: +27 21-959 xxxx
E-mail: nicolearends@uwc.ac.za

INFORMATION SHEET

Project Title: Exploring the perceptions of interprofessional teamwork and the barriers and facilitators thereof in, in-patient management at a tertiary hospital.

What is this study about?

This is a research project being conducted by Nicole Arends at the University of the Western Cape. We are inviting you to participate in this research project because of a teamwork approach to providing healthcare which has been receiving widening acclaim known as Interprofessional Teamwork. The acclaim has grown because evidence suggests that is has universal benefits for patients, health professionals, health facilities and health systems at large. Thus the research aims to collect baseline information on your perception of interprofessional teamwork and what barriers and facilitators you experiences in teamwork as health professionals working in a tertiary institution. The purpose of the research is to provide a basis for future research that is aimed at strengthening interprofessional teams in the healthcare system.

What will I be asked to do if I agree to participate?

You will be asked to participate in a focus group discussion which will be approximately 2 hours with the inclusion of a short break where refreshments will be served. The researcher will ask you and the rest of the focus group questions about your perceptions of interprofessional teamwork in your capacity as a health professional and about the barriers or facilitators you experience. You are encouraged to be as transparent as possible during the discussion.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution however since data will be collected in a focus group discussion the extent to which your identity will remain confidential is dependent on the participants in the focus group. A digital audio recording of the session will be made therefore, in the event of names being mentioned in the audio the transcriber will replace the name with an alias. It is a requirement audio recordings will be stored on 3 password-protected external storage devices, where only the researcher and those who are involved in transcribing and analysis of the data will be given access. The external storage devices will be kept in a locked storage compartment. A requirement for the research project is that data be kept for 5 years before it can be disposed of therefore thus, data will be manually disposed off the storage devices in 2022.

What are the risks of this research?

There may be some risk from participating in the focus group as the research involves human interaction. Talking about ones self or others may carry potential risk. Since the discussion may become intense and social or psychological stress may be triggered you will be referred to a counsellor for appropriate intervention. If any other adverse effects should occur during or as a result of the research you will also be promptly referred to an appropriate professional for intervention.

What are the benefits of this research?

This research is not specifically designed to help you personally however your contribution to the body of research is invaluable to the researcher to do the groundwork for the basis of introducing the interprofessional teamwork approach into the South African health system. The researcher hopes that, in the future the interpretation of the results of the focus groups may be used to strengthen interprofessional teamwork in patient management practices, strengthen the approach to clinical service delivery and ultimately the health system.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may decline consent or withdraw your participation from the study at any time without consequence regardless if you have given consent.

What if I have questions?

This research is being conducted by Nicole Arends a student at the University of the Western Cape's School of Public Health. If you have any questions about the research study itself, please contact

Ms. N.Arends (274885)

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Appendix D: Focus Group Information Sheet (continued)

Nicole Arends at:

Contact: 078 3181 399

Address: 6 Lingfield Crescent, Wetton

E-mail: neaphysiotherapy@gmail.com

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you may have experienced related to the study, please contact:

Prof Helen Schneider   **Prof José Frantz**

School of Public Health   Dean of the Faculty of Community and
                                    Health Science

Head of Department   University of the Western Cape

University of the Western Cape   Private

Private Bag X17   Bag X17

Bellville 7535   Bellville 7535

soph-comm@uwc.ac.za   chs-deansoffice@uwc.ac.za

This research has been approved by the University of the Western Cape's Research Ethics Committee. Reference Number: BM/16/5/24

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office

New Arts Building,

C-Block, Top Floor, Room 28

University of the Western Cape

Private Bag X17

Bellville 7535

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Appendix E: Focus Group Confidentiality Binding Form

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21/959 2809, Fax: 27 21/959 3872
E-mail: soph-comm@uwc.ac.za

Focus Group Confidentiality Binding Form

Title of Research Project: Exploring the perceptions of interprofessional teamwork and the barriers and facilitators thereof in, in-patient management at a tertiary hospital.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone by the researchers. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. I understand that confidentiality is dependent on participants' in the Focus Group Discussion maintaining confidentiality.

I hereby agree to uphold the confidentiality of the discussions in the focus group by not disclosing the identity of other participants or any aspects of their contributions to members outside of the group.

Participant's name......................................

Participant's signature...................................

Date.........................

Researcher: Nicole Arends

Contact: 078 3181399

E-mail: neaphysiotherapy@gmail.com

Contact Person	Professor Helen Schneider	Professor José Frantz
Department	School of Public Health, Head of Department	Dean of the Faculty of Community and Health Sciences
Address		University of the Western Cape Private Bag X17 Bellville 7535
E-mail	soph-comm@uwc.ac.za	chs-deansoffice@uwc.ac.za

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office

New Arts Building,

C-Block, Top Floor, Room 28

University of the Western Cape

Private Bag X17

Bellville 7535

Ms. N.Arends (274885)

Exploring the perceptions of IPT
and the barriers and facilitators thereof in, in-patient management at a tertiary hospital.
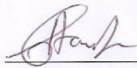
Appendix F: Demographic Data Questionnaire

Focus Group - Demographic Questionnaire

Gender	
Age	
Current Profession	
Rank (if applicable)	
Number of years working since obtaining your last qualification?	
Number of years of service working at Tygerberg Hospital?	
How many years of experience do you have working as health professional in healthcare?	
Do you work in a set health care team?	

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and the barriers and facilitators thereof in, in-patient management at a tertiary hospital.
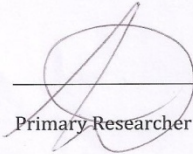
Appendix G: Declaration of confidentiality

DECLARATION OF CONFIDENTIALITY

I _C. ARENDS_, have agreed to assist Ms N. Arends with analysing data collected for the following research project: *"exploring the perceptions of interprofessional teamwork and the barriers and facilitators thereof in, in-patient management at a tertiary hospital"*. It was explained to me by Ms Arends why the data analysed should remain confidential and therefore adhere to this request.

_____   10 / 07 / 2017

External co-coder signature   Date

_____   10 / 07 / 2017

Primary Researcher   Date