EXPLORING THE STRUCTURES AND PROCESSES NEEDED TO SUPPORT THE DEVELOPMENT OF COLLABORATION AMONGST PUBLIC HEALTH NURSES, FAMILY PRACTICE NURSES, AND NURSE PRACTITIONERS WHO WORK IN BREASTFEEDING SUPPORT AND PROMOTION

by

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ABSTRACT

Community health nurses, like all other health professionals, are being called to develop new clinical practices based on collaboration and are faced with the demands of working both interprofessionally and interorganizationally (D'Amour et al., 2008). In Capital Health, public health nurses (PHNs), family practice nurses (FPNs) and nurse practitioners (NPs) are all working in different aspects of breastfeeding support and promotion. However, there is no formal structure for collaboration of services, despite the strong desire of these nurses to work together to improve breastfeeding outcomes. The purpose of this study was to explore the roles of PHNs, FPNs and NPs who work in breastfeeding support and promotion in Capital Health and the structures and processes needed to support the development of collaboration amongst these groups of nurses.

Through the analysis of semi-structured focus group interviews and follow-up focus group interviews with a purposeful sample (n=10) of four PHNs, four FPNs and two NPs, four major themes and sub themes were identified that represented the nurses experience with collaboration between public health and primary care in breastfeeding support and promotion. The data generated revealed that participants had not experienced active collaboration, rather developing or potential collaboration (D'Amour et al., 2008). The first theme, *Establishing Interpersonal Relationships*, provided an overview of the precipitators and barriers to forming relationships and the outcomes of interpersonal relationships between public health and primary care nurses. The second major theme, *The Organizational Context: Structures and Processes in the Everyday Work Environment* outlines the impact of the organizational context of the nurses work environment on the development of collaboration. *Benefits of Collaboration* was the third theme identified in the study. Consistent with other studies on collaboration between primary care and public health nurses, the nurses interviewed believed that the development of collaboration in breastfeeding support and promotion would benefit health care professionals and the clients that they serviced. The last theme, *Development of New Practices Grounded in Collaboration*, described new initiatives or innovations that the participants explained were needed for the development of collaboration between PHNs, FPNs and NPs.

Implications for practice include organizational support for PHNs, FPNs and NPs to work to the full scope of their competencies and providing them with opportunities to meet and establish relationships to facilitate joint planning initiatives related to breastfeeding support and promotion. Additionally, exploration of flexible roles and funding structures as alternatives to fee-for-service should be explored in primary care organizations. The development of a communication infrastructure is necessary for future development of collaboration between public health and primary care in breastfeeding support and promotion. Future research is needed in this area with a broader, more diverse sample, exploring organizational structures needed to improve breastfeeding outcomes and optimize FPN and NP roles. PHNs, FPNs and NPs have the opportunity to impact the model of care for breastfeeding families in the Capital Health District of Nova Scotia, optimizing their capacity to address issues in practice and ensuring that breastfeeding support and promotion activities address the complex social factors that influence the breastfeeding experience.

LIST OF ABBREVIATIONS USED

BCC – Breastfeeding Committee for Canada

BPG – Best Practice Guideline

CCHN Standards – Canadian Community Health Nursing Standards of Practice

CHN – Community Health Nurse

CHNC – Community Health Nurses of Canada

CNA – Canadian Nurses Association

Capital Health – Capital Health District of Nova Scotia

CRNNS – College of Registered Nurses of Nova Scotia

DHA – District Health Authority

DOHW – Department of Health and Wellness

FPN – Family Practice Nurse

HPP – Health Promotion and Protection

ICNT – Integrated Community Nursing Team

PHAC – Public Health Agency of Canada

PHN – Public Health Nurse

NP – Nurse Practitioner

NSOHP – Nova Scotia Office of Health Promotion

RN – Registered Nurse

RNAO – Registered Nurses Association of Ontario

UK – United Kingdom

US – United States

WHO – World Health Organization

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CHAPTER I

INTRODUCTION

Statement of Problem

The problem that this study addressed is the limited collaboration between community health nurses (CHNs) involved in breastfeeding support and promotion in the Capital Health District of Nova Scotia (Capital Health). There are many other health care professionals who are involved in breastfeeding promotion and support in Capital Health, including physicians, midwives, nutritionists, dieticians, doulas, and lay/peer supporters. However, through my experience as a public health nurse (PHN) working in breastfeeding support and promotion I have found that in Capital Health the largest number of health care professionals offering breastfeeding support are CHNs. The CHNs who most commonly work with breastfeeding families in Capital Health are PHNs and primary care nurses; family practice nurses (FPNs) and nurse practitioners (NPs).

A scoping literature review of collaboration between primary care and public health by Martin-Misener et al. (2008) revealed that minimal research has been conducted in Canada on this topic. The research that has been conducted in Canada originated mainly in Ontario and has not addressed the issue of breastfeeding support and promotion. Amongst a variety of recommendations, the authors suggested that an area for future research in this area is the exploration of collaboration amongst the nurses who work in public health and primary care. The concept of collaboration between PHNs, FPNs, and NPs has not been studied, however, it is clear that overlap exists in the roles, responsibilities, and functions in public health and primary care practice (Ciliska, Ehrlich & DeGuzman, 2005).

Findings from a recent qualitative study of the role of primary health care NPs in Nova Scotia (NS) revealed the potential overlap in the role of PHNs, FPNs, and NPs in health promotion, well woman and child care, immunization, chronic disease management and community health (Martin-Misener, Reilly & Robinson Vollman, 2010). While significant attention has been given to the overlap between the NP and family practice physician, less consideration has been given to the overlap in scope of practice between NPs and other Registered Nurses (RNs), such as PHNs and FPNs. Therefore, there is a strong case for research in this area. This study explored the structures and processes required to support the development collaborative practice amongst public health and primary care nurses who work with breastfeeding families.

In this chapter, I begin by providing a definition of the terms public health, primary health care, primary care, collaboration, community health nursing, PHN, FPN and NP. I then discuss my personal location in the research. Following is a discussion of the background for this study, including the need for collaboration in the care of breastfeeding families and primary health care and community health nursing. Next, I discuss the guiding conceptual frameworks used in the study related to the evolving health promotion discourse and collaboration. I end with a statement of purpose and the significance of this research.

Definition of Terms

Public Health

The Public Health Agency of Canada (PHAC) defined public health as: "An organized activity of society to promote, protect, improve, and when necessary, restore the health of individuals, specified groups, or the entire population. It is a combination of

sciences, skills, and values that function through collective societal activities and involve programs, services, and institutions aimed at protecting and improving the health of all people. The term "public health" can describe a concept, a social institution, a set of scientific and professional disciplines and technologies, and a form of practice. It is a way of thinking, a set of disciplines, an institution of society, and a manner of practice. It has an increasing number and variety of specialized domains and demands of its practitioners an increasing array of skills and expertise" (2007, p.13).

Primary Health Care

The Declaration of Alma Ata defined Primary Health Care as,

> essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (WHO, 1978, p.2).

The primary health care approach consists of five basic principles including: accessibility, public participation, health promotion, appropriate technology and intersectoral cooperation (WHO).

The Pan American Health organization developed a renewed definition of primary health care in 2007 that was intended for all countries and emphasized the health system as a whole:

> A primary health care-based system is composed of a core set of functional and structural elements that guarantee universal coverage and access to services that are acceptable to the population and that are equity-enhancing. It provides comprehensive, integrated, and appropriate care over time, emphasizes prevention and promotion, and assures first contact care. Families and communities are its basis for planning and action. A primary health care-based health system requires a sound legal, institutional, and organizational foundation as well as adequate and sustainable human, financial and technological resources. It employs optimal management practices at all levels to achieve quality, efficiency, and effectiveness

and develops intersectoral actions to address other determinants of health and equity (Roses Periago, 2007, p.8).

Primary Care

Considered one of primary health care's core functions, primary care is considered the foundation of a health care system and is defined as: "the first point of entry to a health care system, the provider of person-focused care (not disease oriented) over time for all but the most uncommon conditions and the part of the system that integrates and co-ordinates care provided elsewhere or by others" (Starfield, 1998).

Collaboration

Collaboration is defined as an established relationship among various sectors or groups, formed to address an issue in a way that is more effective or sustainable than one sector acting alone (PHAC, 2007). Further, it is "an approach to community care built on the principles of partnership and maximizing participation in decision making. Collaboration includes shared identification of issues, capacities and strategies"(Community Health Nurses of Canada (CHNC), 2008, p. 16).

Himmelman (2002) described collaboration as a developmental continuum. He defined collaboration in relation to three other strategies for working together: networking, coordinating and cooperating. Each of these strategies build upon one another along a developmental continuum and each of the four may be appropriate under certain circumstances. Networking is the most informal of linkages and its primary focus is information exchange. It is characterized by requiring minimal time commitment, limited levels of trust and reluctance to share turf. Coordinating is defined as "exchanging information and altering activities for mutual benefit and to achieve a common purpose"

(n.p). More time commitment and higher levels of trust are required than with networking, however there is little or no access to each other's turf.

Cooperating is defined as "exchanging information, altering activities, sharing resources, and enhancing the capacity of another for mutual benefit and to achieve a common purpose" (Himmelman, 2002, n.p.). With cooperation, greater organizational time commitment is required and may involve written or legal agreements. High levels of trust and significant access to each other's turf are required. Collaboration is defined as, "exchanging information, altering activities, sharing resources and enhancing the capacity of another for mutual benefit and to achieve a common purpose" (n.p.). Collaboration requires sharing of resources, extensive time commitment, high levels of trust and extensive sharing of turf. The main difference between collaborating and cooperating is the "willingness of organizations (or individuals) to enhance each other's capacity for mutual benefit and common purpose" (n.p.).

Community Health Nursing

Community health nursing is an umbrella term for all nurses who work in community-based practice, which includes PHNs, FPNs, NPs, home health nurses, community mental health, and occupational health nursing (King, Harrison & Reutter, 1995). CHNC (2008) defined a CHN as a registered nurse (RN) whose specialty practice is promoting the health of individuals, families, communities and populations, and an environment that supports health. CHNs practice under many position titles and in diverse settings, including homes, schools, shelters, churches, community health centres and on the streets. For the purposes of this study on CHNs, the focus will be PHNs, FPNs and NPs.

Public Health Nurses

In Canada, "public health nurses are the single largest group of professionals in the public health workforce" (Naylor, 2003, p.130). A PHN is defined as "a community health nurse who combines knowledge from public health science, primary health care (including the determinants of health), nursing science, and social sciences" (CHNC, 2008 p. 8). PHNs focus on promoting, protecting and preserving the health of populations and work with individuals, families, groups and communities and integrate the knowledge obtained from these interactions into population health promotion practice (CHNC). They apply multiple strategies for intervention and can bridge the gaps between science, policy and people (Deikemper Smith Battle, & Drake, 1999; Quad Council, 2003). A PHN is a registered nurse who has a baccalaureate degree in nursing (CHNC).

Family Practice Nurses

FPNs "are integral members of the health care team providing primary health care to patients and families throughout the life cycle" (Capital Health, 2005, np). In NS, FPNs are nurses that are employed in physician's offices and community health clinics (Patsy Smith, personal communication April 2009). They carry out key functions that include advocating for patients in the health care system, health promotion, disease prevention and health education, telephone triage, clinical procedures, well baby care, and completion of health records (Nasmith, 2005). An FPN is an active practising registered nurse who holds a Bachelor of Nursing or a Diploma in Nursing with five years of nursing experience (Capital District Health Authority, 2007).

Nurse Practitioners

NPs are "registered nurses with additional educational preparation and experience who possess and demonstrate the competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals, and perform specific procedures within their legislated scope of practice" (Canadian Nurses Association (CNA), 2009c, p.1). They work with "individuals, communities and diverse populations across the continuum of care based on principles of primary health care" (CNA, p.1). In addition to the Standards for Nursing Practice (College of Registered Nurses of Nova Scotia (CRNNS), 2009a), NPs are required to meet the expanded standards and conditions outlined in the Standards of Practice for NPs (CRNNS, 2009b).

Primary health care NPs are members of a collaborative team who provide primary health care services such as health promotion, illness and injury prevention, acute episodic care, continuing care of chronic conditions, and education and advocacy across the lifespan (CRNNS, 2009a). Settings that employ primary health care NPs include community-based health settings, primary health care organizations or health agencies that provide primary health services (CRNNS).

Personal Location in Research

My interest in this topic area stems from my professional background. I am a PHN and International Board Certified Lactation Consultant with over eight years of front-line experience in Family Health. I have practiced as a PHN in both Ontario and NS, assisting breastfeeding families through home visiting, telephone support, community clinics, policy development and contributing to work that supports the Baby Friendly

Initiative, including the Integrated 10 Steps Practice Outcome Indicators for Hospitals and Community Health Services (Breastfeeding Committee for Canada (BCC), 2010).

Practicing in the area of family health has given me the opportunity to develop relationships with clients and other health care providers. This has enabled me to receive first hand information regarding the concerns of breastfeeding families as they navigate through the health care system. Clients have shared their frustrations with me regarding the receipt of inconsistent information and feeling unsupported as they struggle to continue to breastfeed. Breastfeeding families move from the hospital to their primary care provider to public health, often confused by the variance in the health messages that they are given. As a PHN, I am disheartened when I hear these reports and I have always struggled with how to deal with these concerns in a way that is supportive to clients and other health care providers.

My intrigue for the collaboration between primary care and public health nursing surfaced during my practicum experience for the Community Health Nursing and Primary Health Care course in the Master of Nursing program at Dalhousie University. As part of this practicum experience, I explored the role of the CHN in breastfeeding promotion (Lovett, 2007). I gathered information from nurses working in the areas of public health, home health, family practice (physician's offices) and community health centres. This assessment revealed that PHNs and FPNs (including nurses that work in physician's offices and community health centres) had the most responsibility in the care of breastfeeding families in community settings in Capital Health. The relationship between these two groups of CHNs, their practice with breastfeeding families and their

interactions with the individuals, communities, organizations and systems where they work became a topic of interest.

During my practicum experience, I completed group interviews with FPNs and PHNs (Lovett, 2007). During these interviews, I found that nurses working in family practice and public health do not assemble formally or on a regular basis, though they expressed an interest to do so. I also found that although FPNs and PHNs see the same clients and potentially address the same issues, the communication between them is minimal. A striking revelation during this experience was the amount of overlap between the services that are offered in primary care and public health, particularly related to interventions offered at the individual level. Another significant outcome was the energy created between FPNs and PHNs and the desire for future collaborative practice. The background work completed during this practicum experience laid the foundation for this thesis.

On a personal note, during the completion of this thesis, I welcomed my second child. Despite my confidence and knowledge in breastfeeding, I was faced with significant challenges. Each health care provider I encountered, although their intentions were good, provided me with different information. At times I began to doubt my knowledge and ability and became frustrated with the lack of consistent support. This experience confirmed the need and importance of research in my chosen topic area.

Background

The Need for Collaboration in the Care of Breastfeeding Families

Capital Health is the largest of nine District Health Authorities (DHAs) in NS. With a population of 395,000, Capital Health accounts for 40% of NS's population

(Province of Nova Scotia, 2010). Forty eight percent of all babies in NS are born in Capital Health, with a birth rate of over 4,000. In NS, the breastfeeding rate at hospital discharge in 2006 was 73%, which falls below the national average of 87.5% initiation (Reproductive Care Nova Scotia, 2006; Statistics Canada, 2009). Even more concerning, are reported breastfeeding duration rates in NS. The Province of NS (2007) reported that only 36.5% of women in NS breastfed their infants exclusively to four months, although Health Canada recommends that infants be breastfed exclusively for six months with continued breastfeeding to two years and beyond (Health Canada, 2004).

In a review of strategies that influence the initiation and duration of breastfeeding, Dennis (2002) revealed that health care professionals can be a negative source of support if their lack of knowledge results in inaccurate or inconsistent advice. Also noted, was that a major concern in the care of breastfeeding families is a lack of continuity of care and inconsistency of information among health care providers. A study of breastfeeding support for families revealed that strong inter and intra-professional relationships among health professionals that supported breastfeeding families were related to improved breastfeeding outcomes in the community (Hoddinott, Pill & Chalmers, 2007). This evidence supports the need for collaboration in the care of breastfeeding families and further exploration into the problem addressed by this study.

The breastfeeding experience is mediated by complex social factors such as socioeconomic status, age, race, ethnicity and social support (Ontario Public Health Association, 2007). Dennis (2002) reported that women least likely to breastfeed are those who are young, unsupported, employed full-time, have a low income, belong to an ethnic minority, decided to breastfeed during or late in pregnancy, have negative attitudes

toward breastfeeding, and have low confidence in their ability to breastfeed; this is consistent with findings in NS (Nova Scotia Office of Health Promotion (NSOHP), 2005).

Despite a wide range of programs and services offered to support breastfeeding families in Capital Health, many women are still choosing not to breastfeed, with lowest levels of breastfeeding in younger mothers, single mothers, and mothers with lower levels of education and income (NSOHP, 2005). These findings suggest that a more comprehensive approach is needed to address this health issue. CHNs must search for a more effective model of care for breastfeeding families that addresses the complex social factors that influence the breastfeeding experience.

Primary Health Care and Community Health Nursing

The Declaration of Alma Ata, produced by the WHO in 1978, introduced the concept of primary health care, calling for an approach to health based in social justice and aimed at addressing the main determinants of health and reducing inequities. As both a philosophy and model for the improvement of health care, primary health care has been accepted internationally as above all, the most effective way to address the health needs of communities around the world (CNA, 2003). Thirty years after the declaration of Alma-Ata, Canada, along with most other developed countries, is still struggling to make the transition to comprehensive primary health care (Martin, 2006).

RNs were seen as essential to the attainment of health for all when the WHO originally adopted the primary health care approach in 1978 (WHO 1988, as cited in CNA, 2003). The CNA developed its position on the primary health care approach based on the WHO's five basic principles from the original Alma Ata declaration (CNA, 2000). The CNA called nurses to apply the five principles of the primary health care approach in

direct care, education, research, administration or policy roles and to become involved in research, planning, implementation and evaluation in a variety of settings. In this position statement, the CNA recommends that nurses should actively seek to raise public awareness and should encourage, support, and advocate for services that provide up to date information. This includes educating professional colleagues about the benefits associated with collaborative service provision, identifying gaps in services and the development of necessary services.

CHNs have been involved in promoting primary health care since 1978 and their role in taking action on health inequities is now more important than ever (Smith, Van Kirk & Rahaman, 2012). In an effort to support community health nursing practice, the Canadian Community Health Nursing Standards of Practice (CCHN Standards) were developed in 2003 and revised in 2008 and 2011 by CHNC, with an expectation for all CHNs to know and use these standards when working in any of the areas of practice, education, administration or research (CHNC). Although the CCHN Standards are intended to be utilized by CHNs working in a variety of roles in many different settings, they have the most direct application in areas such as home health nursing and public health nursing (CHNC).

The seven CCHN Standards include health promotion; prevention and health protection; health maintenance, restoration and palliation; professional relationships, capacity building, access and equity; and professional responsibility and accountability. They are based on the key principles of primary health care as described by the WHO in 1978 (CHNC, 2011). The CCHN Standards encourage CHNs to think about health and health care through the principles of primary health care amongst other values and beliefs

such as empowerment, individual and community partnership, and multiple ways of knowing.

FPNs are involved in health promotion, immunization, prenatal and postnatal care and chronic disease management (CNA, 2009a). FPNs may utilize the CCHN Standards; however, the CNA is currently working with FPNs to develop tools and resources for their practice (CNA, 2009b). Nationally, the Canadian Family Practice Nurses Association became an emerging and associate nursing group of the CNA in 2008. This is a step towards developing a national certification program for family practice/primary health care nurses in Canada. Provincially, an interest group for FPNs in NS has been formed.

NPs have their own set of standards and competencies. The standards of practice for Nurse Practitioners include accountability, continuing competence, application of knowledge, skills and judgment, professional relationships and advocacy, professional leadership, and self-regulation (CRNNS, 2009b). As registered nurses with advanced skills and knowledge, the NP role includes assessment, promotion and management and disease prevention (CNA, 2010). NPs are expected to be competent in the areas of health assessment and diagnosis; health care management and therapeutic intervention; health promotion and prevention of illness, injury and complications; and professional role and responsibility.

Like the CCHN Standards, the Canadian Nurse Practitioner Core Competency Framework outlines health promotion as an important part of an NP's practice (CNA, 2010). The framework states that NPs must demonstrate competency in the implementation, monitoring and evaluation of health promotion and illness/injury

prevention programs. Recognition of the influence of the determinants of health affecting clients and supporting health protection interventions that promote healthy environments are behaviours that an NP must demonstrate. The framework also calls NPs to collaborate with clients, health care providers and other sectors to help communities obtain the services that they need to meet their health-care goals (CNA).

CHNs who are involved in breastfeeding support and promotion are in an ideal place to provide a service to individuals and communities based on the principles of primary health care. In their study of PHNs' perceptions of their role in fostering citizen participation, Aston, Meagher-Stewart, Edwards, and Young (2009) found that practice of PHNs in NS showed their commitment to primary health care and population-focused health. Many of the PHNs studied described the development of partnerships with other organizations who were working on similar initiatives. Although the contribution of PHNs to primary health care practice was evident in this study, this work is often unacknowledged and did not reach its full potential due to structural and funding constraints.

There is a need for PHNs, FPNs and NPs to examine and evaluate their practice with breastfeeding families and optimize the capacity of CHNs who work in breastfeeding support and promotion. The CCHN Standards (CHNC, 2011) can provide a framework for community health nursing practice, encouraging a shared philosophy of care that can facilitate collaboration amongst CHNs who support and promote breastfeeding. The Canadian Nurse Practitioner Core Competency Framework (CNA, 2010) encourages NPs to practice with a similar philosophy of care. Given that the breastfeeding rates in NS are less that optimal (Province of Nova Scotia, 2007), despite

efforts of public health and primary care nurses who support and promote breastfeeding, it is evident that the approach to the care of breastfeeding families in the community is in need of renewal.

Guiding Conceptual Frameworks

The Evolving Health Promotion Discourse: Socio-ecological Model for Health Promotion

Since the writings of Florence Nightingale, the concept of health has remained central in nursing (Young & Wharf Higgins, 2012). Highlighting the emerging health discourse is a key component to understanding the role of CHNs in breastfeeding promotion and collaboration amongst public health and primary care nurses, as the various conceptual and philosophical approaches to health have implications for community health nursing practice. A pan-Canadian survey of CHNs' continuing education needs emphasized the importance of this discussion, as CHNs reported needing more education on the theoretical concepts of health promotion and indicated a lack of clarity about them in practice (Schofield et al., 2009). In this section I will examine the emerging health discourse and its influence on the practice of public health and primary care nurses who work with breastfeeding families.

Labonte (1993) described the presence of three major approaches to health enhancement since the beginning of the twentieth century: biomedical, behavioural (lifestyle), and socio-environmental. These three approaches provide an effective way to organize the discussion on the emerging health discourse (Cohen, 2012). Despite their emergence at varying points in time, biomedical, behavioural (lifestyle), and socio-environmental approaches still exist in health care and community health nursing practice.

Not only do these approaches influence the way in which health issues are defined, they also influence the choice of strategies and actions for addressing health issues; it is important for CHNs to recognize how this influences their practice (Ontario Health Promotion Resource System, 2006).

The biomedical approach to health enhancement continues to dominate the discourse on health in Western society (Robertson, 1998). This approach is synonymous with preventative health care, focusing on preventing disease by addressing an individual's physiological risk factors (Cohen, 2012). Lindsey and Sheilds (1998) argued that CHN practice has traditionally relied predominantly on needs and/or prevention models of health promotion. This reliance has narrowed CHN practice into a single solution perspective, rather than one that embraces multiple strategies. With a focus on prediction and control, the biomedical approach may encourage CHNs to take on the role of the expert, identifying problems and formulating solutions for those in their care (Young & Wharf Higgins, 2012).

Over four decades ago, a competing discourse on health emerged. This alternative discourse focused on the promotion of health, rather than the treatment of illness. To this date, there is no singularly accepted definition of health promotion. The health promotion discourse was introduced to Canada in the mid-1970s in a publication entitled "A New Perspective on the Health of Canadians" (The Lalonde Report) written by Marc Lalonde (1974). The Lalonde Report is credited with shifting the focus of health from illness care to health care and advancing the field of health promotion as a science (Young & Wharf Higgins, 2012).

The Lalonde Report argued for a new approach to how we view the determinants of health and encouraged health care services to move away from increasing investment in services for the sick. Lalonde's health field concept argued that the premature morbidity and mortality that was occurring could be associated with four main categories of factors (or "health fields"); availability of health services, human biology, the environment and lifestyle. Cohen (2012) noted that although the framework developed by Lalonde placed equal weight on each of the four health fields, it was believed that the premature morbidity and mortality that was occurring during that time was due to individual behaviours and lifestyles that could be modified. For that reason, health promotion efforts became focused on interventions to encourage individuals to adopt healthy behaviours or lifestyles; the result was the behavioural or lifestyle approach to health promotion.

The behavioural/lifestyle approach to health promotion suggests that the main determinant of health is individual lifestyle or behaviour and health promotion efforts should focus on strategies that persuade individuals to adopt behaviours or lifestyles that promote optimal health and wellness (Cohen, 2012). Strategies that focus on changing behaviours/lifestyles include: health education, health communication, social marketing, behavioural modification and regulatory measures (laws, policies, regulations). Despite its widespread popularity with provincial and national governments, this approach is often labelled as 'victim blaming' and criticized for its failure to address the social, economic and political context in which health behaviours are formed and occur (Robertson, 1998). This type of approach hampers the ability of health promotion

interventions to reach vulnerable groups who are at the most risk (McLeroy, Bibeau, Steckler & Glanz, 1988).

Beginning in 1978, the socio-environmental approach to health became a global discussion when WHO released the "Alma Ata Declaration on Primary Health Care" (WHO, 1978). This was the emergence of an innovative approach to health promotion which emphasized the need for community participation and intersectoral collaboration to address the social and environmental determinants of a population's health. Alma Ata redefined our approach to health care, planting the seeds for a more social definition of health promotion (Cohen, 2012).

In 1986 this new approach to health promotion further evolved with two key events. First, Jake Epp released a document entitled "Achieving Health for All: Framework for Health Promotion (Epp, 1986). This report challenged the behavioural/lifestyle approach to health promotion, arguing that health promotion was more a societal responsibility than it was an individual responsibility. Epp identified that there were three leading health challenges facing Canadian citizens: reducing the health inequities of low versus high income groups; finding new and more effective ways of preventing the incidence of injuries, illnesses, chronic conditions and their resulting disabilities; and enhancing people's ability to cope and manage chronic conditions, disabilities and mental health problems.

In order to meet these challenges, the framework identifies the three mechanisms for health promotion. These mechanisms are: self-care, individual practices and decisions to preserve health; mutual aid, people working together to deal with their health concerns; and healthy environments, preserving and enhancing health through altering or adapting

social, economic or physical surroundings. Lastly, the framework identifies three main strategies for health promotion: fostering public participation, strengthening community health services, and coordinating healthy public policy. The Epp report (1986) stressed the importance of the application of multiple strategies and mechanisms for health promotion; focus on only one strategy or mechanism would be ineffective.

Later in 1986, the framework outlined in the Epp report was foundational in the development of the Ottawa Charter for Health Promotion (WHO, 1986). The Ottawa Charter is the basis the current, widely accepted meaning of health promotion, as defined in the Charter: "enabling people to increase control over, and improve, their health" (p.5). This document emphasized that the main focus of health promotion should be achieving equity in health and advocacy for health through a multi-sectoral coordinated approach. The Charter outlined prerequisites for health as peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. Without a secure foundation in these prerequisites, health improvement is not possible.

Five strategies for health promotion are proposed in the Ottawa Charter: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services. The Charter acknowledges that people are the main health resource and that the community is the essential voice in all matters pertaining to its health, living conditions and well-being (WHO, 1986). Through taking an empowerment and community development approach to health promotion, the publication of the Ottawa Charter is credited with transitioning health promotion practice from one that focused on the behavioral and medical determinants of health to a practice

that defined health determinants in psychological, social, environmental and political terms (Cohen, 2012).

McLeroy et al. (1988) proposed a socio-ecological model for health promotion that focused on both individual and socio-environmental factors as targets for health promotion activities. This model draws emphasis to the environmental causes of behaviour as a means to identify appropriate interventions and encourages a multi-level approach to health promotion strategies. Changes in the social environment will produce changes in individuals and individuals must be supported in any effort to produce environmental change.

A socio-ecological approach to health promotion not only looks at individual, intrapersonal factors, but also examines how factors such as interpersonal, institutional, community, and public policy affect health promotion behaviours (McLeroy et al., 1988). Programs that are informed by social ecology models consider individual behaviour change in the context of the social and cultural environment where it occurs (Goodman, 2000). In addition to individual knowledge, attitudes and beliefs, interventions that are informed by this perspective are directed at socio-environmental factors.

During the 1980s, the discourse on health promotion broadened from the reduction of health–related risk behaviours to discussion of other health determinants. The socio-environmental approach to health, acknowledges that health is the outcome of social, economical and environmental determinants. This outcome provides benefits or barriers to the health of individuals and communities (Ontario Health Promotion Resource System, 2006). Therefore, in order for CHNs to understand their current role in

health promotion, it is important for CHNs to have an understanding of health inequities and how they influence the overall health of populations.

The 1990s saw another shift in the health discourse to a discussion of population health. Like health promotion, population health means different things to different people. In 1994, a document entitled "Strategies for Population Health: Investing in the Health of Canadians", described population health as an approach to public policy which focused on strategies that addressed the entire range of health determinants, designed to affect the entire population, in a comprehensive and interrelated way (Health Canada, 1994). In this document, health determinants were identified as income and social status, social support networks, education, employment and working conditions, physical environments, biology and genetic endowment, personal health practices and coping skills and healthy child development.

The population health approach has been criticized for its dominant epidemiological lens, emphasis on economics and focus on population for analysis and change, rather than the public, community or society (Labonte, 1997). This approach differs from the socio-environmental approach to health promotion in its concern with gradients in health status across all socioeconomic levels, rather than focusing on disadvantaged or marginalized groups. Population health defines health in terms of epidemiological "sickness" indicators, rather than welcoming a broader definition of health. Additionally, there is a focus on identifying determinants of disease and death, rather than strategies for change that emphasize empowerment of individuals and communities (Cohen, 2012).

The Population Health Promotion Model (PHPM) was developed by Health Canada in 1996 in an attempt to bridge the gap between population health and the socio-environmental approach to health promotion through providing a model for change (Hamilton & Bhatti). The PHPM combined the action strategies for health promotion outlined in the Ottawa Charter with the health determinants outlined in "*Strategies for Population Health: Investing in the Health of Canadians*" and the various levels within society at which action can be taken (individual, family and friends, community, sector/system and society), adapted from communication theory. Through its explanation of the relationship between population health and health promotion, the PHPM shows that through action of the full range of health determinants by means of health promotion strategies, the population health approach can be implemented.

The PHPM emphasized the need for evidence-based decision making in the development of population health promotion activities and values research, experiential knowledge and evaluative studies as sources of evidence. The model can be used to identify specific actions on an issue or how actions can be formed into comprehensive range of actions on an emerging health issue. Co-operation amongst organizations working in a variety of sectors is encouraged with the use of the PHPM. The PHPM also demonstrated the need for additional indicators for success related to determinants of health, rather than focusing on mortality and morbidity (Hamilton & Bhatti, 1996).

In 2001, Health Canada further organized and consolidated current understandings of population health and health promotion in the Population Health Template (Health Canada, 2001). The template is a comprehensive tool that consists of two principal components; key elements necessary for implementation of a population

health approach and actions required for mobilization. The eight key elements outlined in the template are: focus on the health of populations, address the determinants of health and their interactions, base decisions in evidence, increase upstream investments, apply multiple strategies, collaborate across sectors and levels, employ mechanisms for public involvement and demonstrate accountability for health outcomes. Each key element has a set of required actions to guide the development and implementation of policies and programs that align with population health principles and concepts; actions may be taken by a variety of players. The template added gender and culture to the list of health determinants that were outlined in Strategies for Population Health: Investing in the Health of Canadians." The Population Health Template builds on advances in health promotion and population health and is a resource for all of those who are involved in work that strives to improve the health of populations.

The NS Department of Health Promotion and Protection published a document in 2002 entitled "*Healthy People, Healthy Communities: Using the Population Health Approach in Nova Scotia*." The purpose of this document was to provide an explanation for the population health approach in a Nova Scotian context and to inspire those involved in the work of promoting the well-being and quality of life of Nova Scotians to explore the population health approach. The document uses the key elements and health determinants from the Population Health Template to explain a more comprehensive approach to improving the health of Nova Scotians.

Although there are many examples of the population health approach in action in NS, there are also many challenges associated with implementing this approach. My experience as a PHN in Capital Health has found that the system is not designed to

support collaborative action across systems and levels as outlined in the Population Health Template (Health Canada, 2001) and the NS (2002) document. There is often resistance or a lack of capacity to move from an individual to a population based approach and programs are often labelled as using the population health method, when in reality they do not apply this approach.

Currently, there is a gap between knowledge and action in promoting population health. Meagher-Stewart, Edwards, Aston, and Young (2009) found that PHNs believed that their population-focused practice was being eroded due to the public health system's increasing focus on tasks and specialty practice. The authors concluded that PHNs conducted population-focused practice, however, they expressed a sense of frustration as they were not able to act fully on the worsening health determinants that they were observing in the communities where they worked, due to compromised time and resources.

Cohen (2006) suggested that a more critical approach to population health practice is needed. A critical approach involves consideration of the social and economic causes and consequences of health inequalities and searches for an equitable distribution of social and economic conditions in order to reduce health inequalities. Conceptual frameworks of population health such as the PHPM (Hamilton & Bhatti, 1996) and Population Health Template (Health Canada, 2001) provide a basis for a more critical approach to population health; however, they do not include strategies for integration into practice. More work is required to begin to integrate the strategies outlined in conceptual frameworks into practice.

Community health nursing breastfeeding promotion practice. Biomedical, behavioural and socio-environmental approaches to health promotion all have value in the support and promotion of breastfeeding and are all present in Capital Health. However, in my experience as a PHN working in the Healthy Beginnings Team at Capital Health I have found that biomedical or behavioural approaches are the driving force in the current program priorities related to breastfeeding support and promotion in Capital Health. Interventions for breastfeeding most often occur at the individual level, addressing the challenges that women must overcome.

Initiation and duration of breastfeeding are two measures that are most commonly used to evaluate the success of breastfeeding promotion activities. Strategies that address low initiation and duration rates that are grounded in a biomedical approach would focus on the treatment of individual breastfeeding problems. Two systematic reviews that focused on support for breastfeeding mothers reported that individual professional support and education was effective in prolonging breastfeeding initiation and duration (Britton, McCormick, Renfrew, Wade, King, 2009; Dyson, McCormick & Renfrew, 2008). However, further research is required to establish whether individual support is effective in extending breastfeeding duration in settings with low rates of breastfeeding initiation and duration, as is the case in NS (Britton et al.).

Table 1 is adapted from the Ontario Health Promotion Resource System (2006) and was modified to illustrate strategies for breastfeeding promotion. The table explains the course of action for breastfeeding promotion strategies through the application of Labonte's three different approaches to health enhancement. A biomedical approach to the issue of low breastfeeding initiation and duration rates would focus on physiological

problems that prevent individuals from initiating or continuing to breastfeed. The focus of strategies to deal with these issues would be individual support or counselling by health care professionals and would include medical treatment of these problems. While this approach to breastfeeding promotion may be effective in some populations, it should not be the only approach to practice.

Table 1.

Three Approaches to Breastfeeding Promotion

Health Model	Causes of Problem (low breastfeeding initiation and duration)	Principal Strategies to Address Problem
Biomedical	• Difficulties with latch • Sore nipples • Low milk supply • Thrush, mastitis	• Individual support/counselling by health care professionals • Treatment of problems • Drugs
Behavioural	• back to school/work early • personal breastfeeding experience • influence of family/friends • body image	• individual support/counselling by health care professionals • pre and postnatal health education • self help • social marketing campaigns
Socio-environmental	• income • education • age • geographic location • social isolation • lack of support for breastfeeding in public	• policy change • advocacy • community mobilization • self help

Healthy Eating Nova Scotia, a provincial healthy eating strategy, recognized breastfeeding as one of four priority action areas in an effort to address nutrition-related

health issues (NSOHP, 2005). This strategy, which shapes breastfeeding promotion activities in NS, outlines the province's key initiatives. These initiatives include health education in the pre and postnatal period, a provincial breastfeeding policy, social marketing and peer support initiatives. Although the strategy recognizes that support for breastfeeding must go beyond health care settings, it does not make any solid recommendations for how this will be achieved, nor does it begin to address the social, economic and political context of the issue.

As found in group interviews held with PHNs and FPNs during my Master of Nursing Community Health Nursing practicum in 2007 (Lovett, 2007), there is disconnect between public health and primary care in breastfeeding support and promotion. This disconnect may be related to the different approaches to breastfeeding promotion employed by public health and primary care. In my experience, primary care is often associated with a more biomedical approach, while public health tends to focus on behavioural or socio-environmental approaches to breastfeeding support and promotion. Different approaches to care could potentially result in clients receiving conflicting information and messages, resulting in confusion and leading to early cessation of breastfeeding.

Although other perspectives on health promotion have emerged, the behavioural/lifestyle approach has remained predominant in community health nursing practice (Cohen, 2012). Dating back to the writings of Florence Nightingale, CHNs have been educating individuals, families and communities on healthy lifestyles and behaviours. Cohen argued that the prevalence of the behavioural/lifestyle approach to community health nursing practice is due to the strong influence of concepts and models

from behavioural science on the nursing models used in education and practice. As a result, the CHN approach to health promotion has often been downstream or microscopic.

Depending on their role within their organization, PHNs, FPNs and NPs may have a predominant focus on the care of the individual in breastfeeding support and promotion. However, with an increased focus on the individual, CHNs may lose important aspects of their practice. Butterfield (1997) offered a critique of community health nursing practice utilizing McKinlay's (1979, as cited in Butterfield) well known "upstream-downstream" analogy. The author suggested that traditional nursing practice is dominated by a downstream or microscopic approach, where the focus of assessment and interventions are at the individual level. Depending on their role within their organization, CHNs may need to adopt a more upstream, macroscopic approach to breastfeeding promotion and support. In this approach, efforts focus on the modifying precursors for poor health such as economic, political and environmental factors. Practice that over emphasizes a microscopic perspective prevents CHNs from working to alter social conditions and empowering clients to do so.

The Canadian Community Health Nursing Standards of Practice (CCHN Standards) encourage CHNs to adopt a macroscopic approach in their practice, identifying the socio-environmental approach to health promotion as the basis for CHN practice (CHNC, 2011). Integration of the CCHN Standards into practice settings would assist CHNs to build upon and evaluate their current practice with breastfeeding families. In the table in Appendix A, I map the CCHN Standards against a socio-ecological framework (McLeroy et al., 1988) to inform breastfeeding promotion. I considered existing and recommended breastfeeding support and promotion activities, how they fit

with the CCHN Standards (CHNC, 2008) and at which level of intervention would be most suitable for each activity. Multiple forms of evidence informed this framework for practice, including my practice, a review of research and key documents (BCC, 2010 & 2002; Health Canada, 2004; Izaak Walton Killam Health Centre (IWK) & Public Health Services, Capital District, 2010; Nova Scotia Department of Health Promotion and Protection, 2006; NSOHP, 2005; WHO, 1981), and theoretical literature (Hamilton & Bhatti, 1996; McLeroy et al., 1988).

For example, by looking at the CCHN Standard of Building Relationships (CHNC, 2008) with a socio-ecological lens, the CHN develops strategies for breastfeeding promotion at the individual (relationships with breastfeeding women), interpersonal (relationships with other health care providers), organizational (partnering with local hospitals), community (community health boards, tenants associations, parent advisory committees, etc.) and policy level (advocating for enhanced breastfeeding education for health care professionals). Combined with a socio-ecological framework, I contend that the CCHN Standards can provide direction for CHNs to choose multiple levels of interventions for breastfeeding promotion practice. The framework for practice, as presented in Appendix A, could help CHNs describe their practice and identify areas of strength, areas of repetition between primary care and public health and gaps in service.

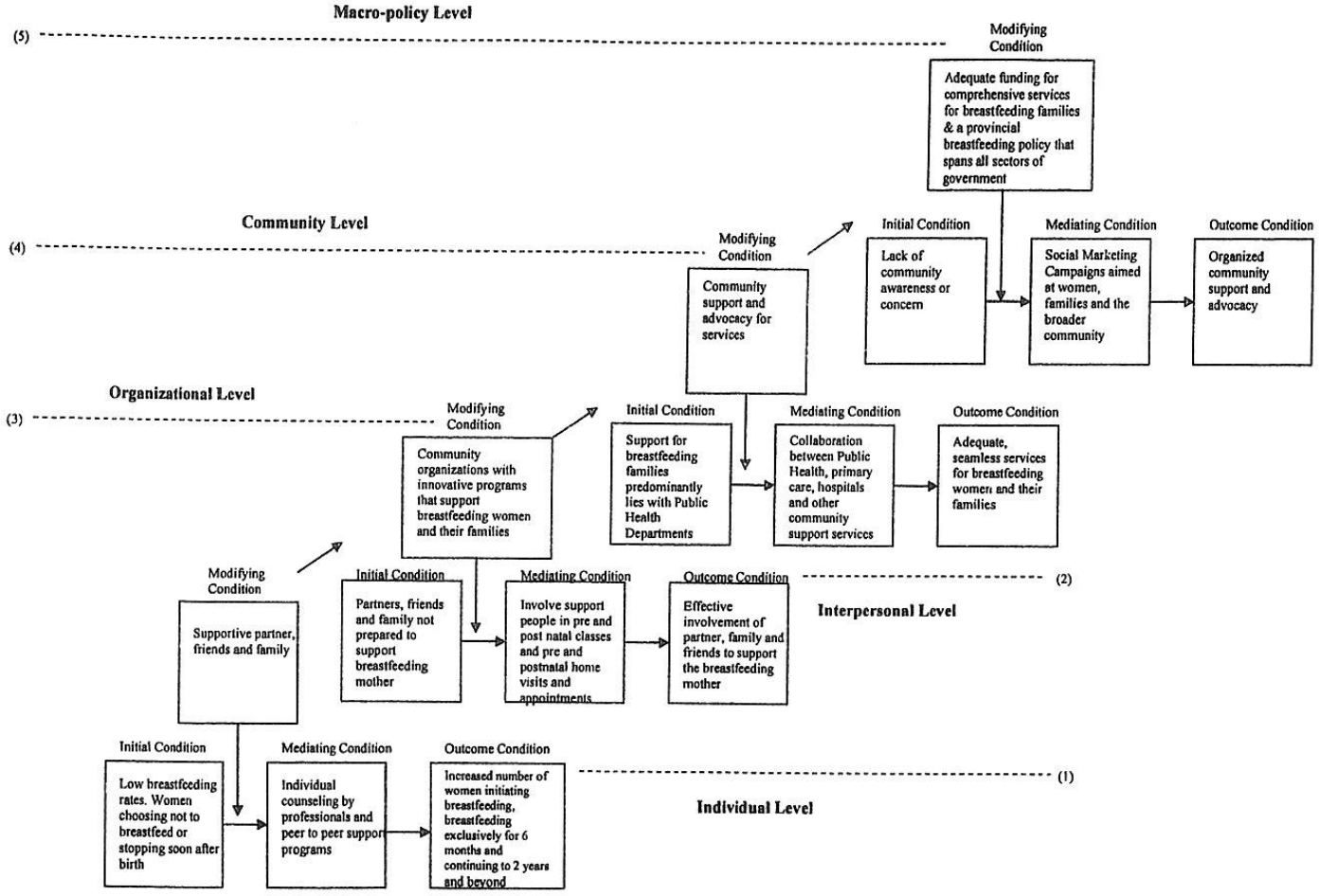
The community health nursing role in the protection, promotion, and support of breastfeeding would be enhanced through application of a socio-ecological approach to health promotion. An intervention strategy for low initiation and duration of breastfeeding as informed by social ecology principles is represented in Figure 1 (p.31) (adapted from Goodman, 2000). Goodman proposed a program implementation model

based on social ecology principles that demonstrates how program components occur across five levels; individual, interpersonal, organizational, community and macro-policy. The interventions in this model occur across social levels, are linked across levels in a logical manner. The model exemplifies how the socially complex issue of breastfeeding requires multiple interventions that are executed simultaneously and sequentially and illustrates how social ecology principles can assist CHNs in the development of intervention strategies for breastfeeding promotion (Goodman).

A population health approach is also useful when examining breastfeeding initiatives, as it encourages a multi level approach (Hamilton & Bhatti, 1996; Health Canada, 2001). Using a population health framework, the CHN can facilitate planned change at the individual, community and population level by identifying the level of intervention needed and which determinants of health require action or change to promote health, and utilizing a wide range of comprehensive strategies to address health-related issues (CHNC, 2011; Hamilton & Bhatti). For example, acting on the health determinant of education, at the sector level, using the strategy of creating a supportive environment, a CHN can participate in a School Board working group that is looking at developing child care and a breastfeeding lounge so that young mothers can complete their education while still continuing to breastfeed their infant (Cohen, 2008; Hamilton & Bhatti).

Although PHNs, FPNs and NPs are currently involved in a wide range of breastfeeding promotion activities in Capital Health, their practice has a predominantly individual focus and little is known about the effectiveness of their interventions.

Figure 1: Intervention strategy for low initiation and duration of breastfeeding informed by social ecology principles (adapted from Goodman, 2000).



Clearly, there is a need for CHNs involved in breastfeeding promotion to come together in an effort to coordinate care and enhance their practice to include a multi-level approach to their health promotion strategies. An understanding of each other's roles and the theoretical principles and frameworks that inform health promotion practice would assist CHNs in planning intervention strategies for breastfeeding promotion. CHNs, informed by principles of social ecology and population health promotion can provide leadership in establishing innovative models of practice.

Collaborative Practice

Within the context of the current health care system in Canada, much emphasis is being placed on the need for health care professionals to develop new clinical practices based on collaboration. Health care professionals are faced with the demands of working both interprofessionally and interorganizationally between different types of primary, secondary and tertiary care institutions (D'Amour, Goulet, Labadie, San Martin-Rodriguez & Pineault, 2008). The concept of collaboration and collaborative practice is significant to community health nursing. The CCHN Standards identified collaborative practice as a key aspect of community health nursing practice (CHNC, 2011). The CCHN Standards state that,

> Community health nurses connect with others to establish, build and nurture professional relationships. These relationships promote maximum participation and self determination of the individual, family, group, community or population. (p. 16).

The CCHN Standards also indicate that by working collaboratively with individuals, communities and other partners, the community health nurse identifies needs, strengths and available resources and evaluates the effectiveness of collaborative practice.

Hennemam et al. (1995) defined the attributes of collaboration as a joint venture, cooperative endeavour, willing participation, shared planning and decision making, team approach, contribution of expertise, shared responsibility, non-hierarchical relationships and shared power based on knowledge and expertise versus role or title. Keys to collaboration are respect and trust for oneself and others. In order to build a relationship to the level where collaboration can occur, patience, nurturance and time are required. Being secure in their own professional roles as well as understanding the roles and scopes of one another is important in the development of collaborative practice amongst PHNs, FPNs and NPs (Registered Nurses' Association of Ontario (RNAO), 2006).

D'Amour et al. (2008) suggested a model and typology of collaboration between professionals in healthcare organizations. The model focuses on relationships between individuals, the interaction between the relationships and the organizational dimensions but also takes issues of structure into account. The authors suggested the use of four dimensions; two relational and two organizational, operationalized through 10 indicators, to analyze collaborative processes. The first relational dimension outlined by D'Amour et al. is shared goals and vision and the other relational dimension is internalization, characterized by mutual acquaintanceship and trust between professionals. Formalization and governance are the two organizational dimensions.

D'Amour et al. (2008) also proposed a threefold typology of collaboration that takes into account the extent to which collaboration is actualized through consideration of the ten indicators and four dimensions of their model of collaboration. The highest level of collaboration is active collaboration, where partners have successfully established stable collaboration that can be sustained, despite any barriers and uncertainties in the

healthcare system. Developing collaboration is collaboration that is not yet imbedded in the cultures of the partner organizations and is still subject to re-evaluation, depending on internal or environmental factors. Lastly, potential collaboration refers to collaboration that does not yet exist or has been prevented by differences that are irreconcilable and the system cannot move forward and the implementation of satisfactory forms of collaboration cannot be realized.

San Martin-Rodriguez, D'Amour and Ferrada-Videla (2005) offered an evolving framework that identified three determinants of successful collaboration in health care teams. They identified these determinants as: systemic determinants (conditions outside the organization in the environment where collaboration takes place) organizational determinants (conditions within the organization), and interactional determinants (interpersonal relationships amongst team members). The authors explored the main characteristics of the three determinants and their influence on interprofessional collaboration through a review of empirical studies and conceptual work. The results are intended to provide a guide for professionals, managers and decision-makers who are cultivating interprofessional collaboration.

In their review of theoretical and empirical studies, San Martin-Rodriguez et al. (2005) found that systemic determinants included social factors, such as equality between professionals, that impact how collaborative practice may develop. Cultural values and the professional and educational system are other systemic determinants of interprofessional collaborative practice. The structure of an organization, the organization's philosophy, administrative support, team resources; such as time to interact and spaces to meet, and coordination and communication mechanisms; for

example the availability of standards, policies and interprofessional protocols, standardized documentation and meetings involving all team professionals, are organizational determinants of collaboration. Interactional determinants are elements of the interpersonal relationships that exist amongst the various members of the team, including their willingness to collaborate, trust, communication skills and mutual respect.

The work of D'Amour et al. (2008) and San Martin-Rodriguez et al. (2005) is incorporated in the Best Practice Guidelines (BPGs) for Collaborative Practice Among Nursing Teams developed by the RNAO (2006). These BPGs summarize factors contributing to collaborative practice amongst nursing teams at the individual/team, organizational and external/system level. The guidelines were developed to assist nurses at all levels to enhance positive outcomes for clients, nurses and the organization. At the individual/team level, a key recommendation is for nurses to develop knowledge about the values and behaviours that support collaboration as well as the impact of collaborative practice on client outcomes. For organizations, an organizational culture and specific strategies that support and encourage collaboration such as the physical space or technology that enables people to come together and supporting a culture where participative decision making is promoted are recommended. Recommendations at the external/system level include ensuring sustainable financial resources to support collaborative practice, supporting research that explores the impact of collaborative practice on nurse and client outcomes, education that values and promotes a culture of collaboration and for provincial and national nursing professional/regulatory bodies to work collectively to help assist members to increase knowledge of their own and their colleagues roles in the health system.

Purpose

This study explored the roles of PHNs, FPNs and NPs who work in breastfeeding support and promotion in Capital Health and the structures and processes needed to support the development of collaboration amongst these groups of nurses. This exploration was guided by a socio-ecological model for health promotion within a primary health care perspective and the frameworks for collaboration proposed by D'Amour et al. (2008) and San Martin-Rodriguez et al. (2005).

Significance of the Research

I have experienced that in Capital Health, the same clients are shared between primary care and public health from the prenatal period forward, yet there is no formal structure of collaboration of services, despite the strong desire of the nurses to work together for the benefit of the community. In light of the current socio-political environment, consideration is required for how public health and primary care can work together, rather than duplicate services; as seen in the one to one care of breastfeeding women. This concern was highlighted in a recent report on the health system in NS (Corpus Sanchez, 2007). To enhance cost effectiveness, the report recommended that areas of duplication between public health and primary care be resolved.

Exploring the structures and processes needed to support collaboration amongst PHNs, FPNs and NPs would have implications on the immediate practice situation, the specialty of community health nursing and the larger systems where practice occurs. The most significant impact that this research would have on breastfeeding support and promotion would be an understanding of how to facilitate collaborative practice amongst PHNs, FPNs and NPs. As a result, clients would have the potential to receive more

seamless care as they move between care providers in the community. Clients might also receive more consistent, evidence-based information that enhances their breastfeeding experience. In addition, this research could also lead to enhanced collaboration in areas other than breastfeeding support and promotion. Findings from this study may be of interest to those involved in paving the future of primary health care in NS.

For community health nursing, research on this issue could mean that nurses practicing in this area could have an increased awareness and understanding of the values, knowledge and beliefs that underpin their practice. The specialty of community health nursing, as well as its role in breastfeeding support and promotion could be enhanced, as CHNs would be coming together to connect as a community to strengthen their collective voice and contribute to improved health outcomes. Larger system implications could include the presence of community health nursing at various decision making tables, increased demands on the education system to prepare CHNs for practice in accordance with standards and competencies for community health nursing and public health, and community health nursing leadership in the development of a collaborative, multi level approach to breastfeeding promotion.

CHAPTER II

OVERVIEW OF CURRENT KNOWLEDGE

This chapter provides an understanding of the current state of knowledge related to collaboration amongst PHNs, FPNs and NPs. I begin with a discussion of the available evidence on (1) Collaboration Between Primary Care and Public Health through a discussion of two key documents. My literature review will build upon the findings of these reviews through further discussion of (2) Collaboration Among Public Health and Primary Care Nurses, (3) The Structures and Processes of Public Health Nurse, Family Practice Nurse, and Nurse Practitioner Practice, and (4) Collaboration in Breastfeeding Promotion and Support.

Collaboration Between Public Health and Primary Care

Two Canadian documents, "Public Health and Primary Care: Challenges and Strategies for Collaboration" (Ciliska et al., 2005) and "A Scoping Literature Review of Collaboration between Primary Care and Public Health" (Martin-Misener et al., 2008) provide an overview of the current knowledge of the structures and processes related to collaboration amongst public health and primary care. In a report prepared for the Ontario Capacity Review Committee, Ciliska et al. focused on "voluntary collaborative initiatives" revealed in the literature and key informant interviews conducted by the authors in Ontario. The authors reviewed collaborative initiatives that have occurred or could occur in the existing Ontario health care system. This is a system where the organizational structures of public health and primary care are independent from one another, but people in these two health care sectors work together. Although the authors

found examples where primary care and public health come together in a community collaboration, they concluded that there is significant overlap in roles, responsibilities and functions between these two sectors.

Ciliska et al. (2005) found that most examples in the literature of collaboration between public health and primary care involved only nurses and physicians; they identified this as a limitation of the literature. The authors described their findings using three categories; (1) primary care functions that take place in public health settings, (2) public health functions occurring in primary care settings, and (3) public health and primary care practitioners working together in a different setting. Some examples of primary care activities that took place within public health were sexual health clinics, pre and postnatal NP programs, and well baby clinics. In primary care settings, public health functions such as case finding, injury prevention, immunization and screening occurred. Heart Health coalitions, a TB clinic at a hospital, a smoking cessation clinic and a breastfeeding clinic within a hospital, were examples of public health and primary care professionals working together in a community collaboration that took place outside of both areas.

From their literature review and key informant interviews, Ciliska et al. (2005) found recurrent themes in the examples of public health and primary care collaboration. Challenges of working together included communication; different practice cultures; government policy and funding mechanisms; and professional and system integration. Potential strategies to deal with these challenges at the provincial level included coordination and priority setting group with provincial-level players from primary care and public health, creating a shared health information system, flexible funding, and

interdisciplinary education. Possible approaches identified at the local level were the development of a steering committee to consider local health needs and priorities, joint planning initiatives, flexible funding, encouraging NPs and PHNs to practice to their full scope, development of a common set of values and enabling students to experience collaboration.

Martin-Misener et al. (2008) completed a scoping literature review intended to determine current knowledge of the structures required to build successful collaborations between public health and primary care, outcomes of collaborations between public health and primary care, and markers of successful collaboration between public health and primary care. The evolving framework by San Martin-Rodriguez et al. (2008), which identifies three determinants of collaboration; systemic, organizational and interactional, was used to guide the review. The authors focused on collaboration between public health and primary care internationally. They did not describe the health care systems in detail; rather, they sought to gain an understanding of the collaboration that occurred between public health and primary care as reported in the various papers.

The majority of papers on primary care and public health collaboration reviewed by Martin-Misener et al. (2008) originated in the United Kingdom (UK) (n=44) and the United States (US) (n=38). Although many Canadian papers were reviewed (n=18), the majority originated in Ontario (n=11) and none in NS. The most common biomedical issues addressed by collaborations were communicable disease control and immunization. Smoking cessation, screening and other preventative activities were the most common behavioural issues addressed, while the most common socio-environmental health issues were poverty community development and disaster response

planning. Access to health care for underserved or vulnerable populations was also addressed. Although mothers and babies were amongst the target groups included, breastfeeding was not identified as an issue addressed by collaborations.

Major barriers to collaboration at the systemic level were summarized as policy, funding, power and control issues, and information infrastructure (Martin-Misener et al. 2008). Fee-for-service physician payment models, the power of hospital care over primary health care at a systems level and the lack of an integrated surveillance system were highlighted. Facilitators for collaboration at a systems level were government involvement and fit, funding and education, and training. While alternative payment plans other than fee-for-service were seen as enablers to collaboration with physicians, opportunity to bill for services was an enabling factor for the involvement of NPs in primary care and public health collaboration.

At the organizational level, lack of common agenda, resource limitations, and a lack of knowledge and skills were identified as barriers to collaboration (Martin-Misener et al., 2008). The primary care focus on short term results and individuals compared to public health's focus on populations and suboptimal use of the existing workforce, including PHNs not working to their full scope of practice, were barriers to collaboration at the organizational level. Leadership management and accountability issues, geographic proximity of partners and protocol tool and information sharing were identified as facilitators for collaboration at the organizational level (Martin-Misener et al.).

Role clarity, shared purpose, philosophy and identity, developing and maintaining good relationships, effective communication and decision making strategies were facilitators to collaboration at an interactional level (Martin-Misener et al.2008). Barriers

to collaboration at the interactional level included attitudes and beliefs and relationship challenges. Poor rapport among various community nursing roles and an inadequate understanding of each other's roles negatively influenced the ability to collaborate.

The review identified many positive outcomes of primary care and public health collaboration, benefiting the health care system, health professionals and the health of individuals and populations (Martin-Misener et al., 2008). Although some risks and costs to collaboration exist, the authors concluded that the benefits to collaboration warrant additional implementation in Canada. This review was based mostly on descriptive accounts, therefore the authors call for future primary research studies on this topic. Included in their recommendations for future research is the exploration of the collaboration amongst primary care and public health nurses.

In summary, it is evident that although there is discussion of primary care and public health collaboration in the literature, there is a paucity of research of public health and primary care collaboration in the Canadian context. Moreover, there are no publications on primary care and public health collaborations in NS. The majority of the literature that discussed voluntary collaborations, such as the type of collaboration that would take place within the current context of the NS health system, focused on collaborations amongst nurses and physicians. The literature on collaboration amongst nurses was lacking. Collaboration in breastfeeding promotion was not addressed in the literature, emphasizing the need for research in this area.

Collaboration Among Public Health and Primary Care Nurses

The Best Practice Guidelines (BPGs) for Collaborative Practice among Nursing Teams developed by the RNAO (2006) summarized factors contributing to collaborative

practice amongst nursing teams at the individual/team, organizational and external/system level. Unlike the conceptual frameworks offered by D'Amour et al. (2008) and San Martin-Rodriguez et al.(2005) that concentrate on interprofessional and interorganizational collaboration, these BPGs focus on how nurses can influence the workplace environment by utilizing communication, leadership skills, and knowledge of teamwork to make a better future for our clients and colleagues. They provide recommendations to assist nurses, nursing leaders, other health professionals and senior management teams to improve outcomes for patients/clients, nurses and organizations through collaborative practice. The guidelines are based on the best available evidence and where evidence was not available, expert opinion was sought. Similar to San Martin-Rodriguez et al., the BPGs summarized recommendations into three categories: individual/team, organizational and external/systems.

Dion (2004) suggested that in order to help practitioners move forward, there needs to be greater integration and collaboration among care providers in the community. The author stated that a truly public health-centred approach to the care of the community would involve collaboration between all nurses working in a community. As public health work threads through many community based practices, breastfeeding promotion being one example, collaboration with other agencies would contribute to seamless care across the continuum of services. CHNs can be leaders to direct the initiative towards collaborative working; individuals and communities can only benefit from a more coordinated approach to care.

A literature search was conducted on collaboration among public health and primary care nurses. A search of PubMed and CINAHL, going back to 2000 for English,

research articles, using “primary care” or “primary health care” and “public health” and “nurse/nurses/nursing” as search terms was completed. The reference lists of key articles were also searched for relevant references; articles published prior to 2000 were included in the review due to the lack of research evidence available on the topic under study. The articles were then screened to determine if they reported on collaboration amongst public health and primary care nurses. Most of the articles related to collaboration amongst nurses and physicians and looked at initiatives within one sector, rather than between sectors. The majority of the articles were descriptive accounts of collaborative initiatives, rather than research studies. None of the articles discussed collaboration amongst PHNs, FPNs and NPs or looked at collaboration in breastfeeding promotion and support. This section is a summary of the available research articles related to collaboration among public health and primary care nurses.

Two articles focused on collaboration amongst CHNs in infectious disease control (Keeling, 2009; Mayo, White, Oates & Franklin, 1996). Mayo et al. provided a descriptive account of collaboration amongst homeless clinic NPs, PHNs and university nursing faculty and students in response to an increased incidence of tuberculosis in a homeless shelter in a US city. These groups of nurses worked together to provide mass screenings, case identification and treatment, policy development and implementation, health education and establish methods of communication between the shelter, clinic and health department. Each practitioner had defined roles in this initiative and the result of the collaborative effort was a reduction of tuberculosis infection and disease in the homeless shelter.

Research by Keeling (2009) utilized a social history framework and traditional historical methods to describe and analyse the nurses' role in responding to the influenza pandemic in New York City in 1918. Keeling argued that nursing leadership, the work of nurses on the front lines and collaboration amongst nursing organizations and social agencies was essential to New York City's response to the pandemic. Nursing leaders working in the city during this crisis formed an Emergency Council and organized a city-wide response, calling all organizations that employed nurses to release them for work in the pandemic. Together with the New York City Health Department, the Emergency Council coordinated nursing activities throughout the city and pooled resources of hundreds of agencies to eliminate duplication of services and offer the quickest and best possible service to the sick.

Two studies examined collaboration among nurses working in the community on issues related to mental health (Skybo & Polivka, 2006; Davies, Howells, & Jenkins, 2003). American researchers, Skybo and Polivka, completed a review of literature and online resources focusing on children's exposure to violence. They proposed a collaborative model for assessing, preventing and intervening with children exposed to violence to be utilized by public health, psychiatric and primary care nurses. The authors identified that primary and secondary prevention strategies can be implemented on a community or individual level. PHNs addressed this issue at a community level with health promotion programs; including conflict resolution, advocacy and antiviolence programs. While psychiatric and primary care nurses utilized a psychosocial approach to intervene on an individual level, with crisis intervention, counselling, and behavioural/environmental changes.

Skybo and Polivka (2006) found overlap in public health and the psychosocial approach and recommended a collaborative approach that could be implemented by public health, psychiatric, and primary care nurses. The collaborative approach involved primary and secondary prevention strategies such as anticipatory guidance and screening which can be implemented at either the community or individual level. The authors suggested that all nurses could implement primary and secondary prevention strategies, focusing on strategies that pertain to their practice while being aware of the other prevention strategies that are being addressed by other nurses.

One UK study explored a project developed by health visitors (RNs with a public health focused role), and community mental health nurses aimed to improve the early detection and treatment of postnatal depression (Davies, Howells, & Jenkins, 2003). The health visitors and community mental health nurses recognized that the rate of detection of postnatal depression in their practice area was below the minimum level. The nurses collaborated to implement an intervention which consisted of an enhanced screening program using the Edinburgh Postnatal Depression Scale and improved communication and referral processes amongst professionals. As a result, early detection of postnatal depression was enhanced, resulting in effective treatment for the majority of women. The knowledge and skill required to deliver the intervention was developed through effective collaboration amongst health visitors and community mental health nurses.

Tear (2001) reported on a qualitative study that used focus groups to explore the views of health visitors, district nurses, school nurses, and children's community nurses about a children's community nursing service. The research was in response to issues regarding inconsistencies in community children's services in the UK. The article

focused on the theme of professional relationships that arose from the focus groups. Four homogenous focus groups of health visitors, school nurses, district nurses and children's community nurses were used to gather data (Tear).

Tear (2001) found that the context of each service (health visitors, school nurses and district nurses) influenced their expectation of the children's community nurses, therefore affecting the relationship that they had. As a result, the collaborations that occurred were based on how each professional group viewed the community nursing service. The children's community nurses viewed themselves as collaborators and saw value in working with the other professionals in the community, while the other professionals saw that the children's community nurses role overlapped with their own or was useful because it filled a gap in the services that their agency was offering. The study emphasized a need to establish a model of best practice for communication between services.

Several studies reported on the concept of nursing teams or integrated community nursing teams (ICNTs) (Cook, Gerrish, & Clarke, 2001; Gerrish, 1999; Headland, Crown & Pringle, 2000; Wiles & Robinson, 1994; Woodhouse, 2005). Four studies from the UK explored ICNTs (Cook et al; Gerish; Headland et al.; Wiles & Robinson). Integrated nursing teams were introduced in the UK as a way for nursing services to become more responsive to the needs of general practice populations. This way of working can lead to more effective team work and better communication (Headland et al.) The intention of ICNTs was to encourage nurses working in the community (district nurses, health visitors, practice nurses and others) to work in collaboration, as these groups of nurses are traditionally separated by both employer status and professional boundaries. Traditional

structures of middle management were put aside so that nursing teams could take a greater responsibility in managing day to day practice (Gerish).

Cook et al (2001) and Gerrish (1999) both reported on the findings of a qualitative evaluation study examining six integrated nursing teams in north of England. The aim of the study was to evaluate the implementation of integrated nursing teams into one Primary Care Trust in the UK. The study applied a pluralistic evaluation approach, completing in-depth individual interviews with various stakeholders; team coordinators, team facilitators, senior trust managers, General Practitioners (GPs) and practice managers, and focus groups with team members.

Gerish (1999) reported on the findings of individual interviews held with various stakeholders including integrated nursing team coordinators, GPs and practice managers and focus groups held with members of the nursing teams. A framework for evaluating the success of ICNTs was developed. This framework included five meanings of success that were identified by stakeholders: team working, effective communication, an orientation towards the general practice, changes in working practices, and responsiveness to change. The success of the ICNTs was evaluated based on these five criteria.

Support from peer groups was seen as a valuable aspect of team working (Gerish, 1999). However, resolving conflict related to tensions between individual personalities was highlighted as a difficulty experienced by many of the teams. Although arranging meetings when all team members could attend was often a challenge, each team evaluated reported improvements in both formal and informal communication between team members. The need for the development of common objectives was stressed.

Another benefit to team working was strengthening nursing contribution to the practice. Prior to working in teams, nurses had little prior knowledge of each other's roles and there was frequent duplication of services and overlap between team members. Overall, the author found that integrated nursing teams were successful, based on the criteria for success outlined by stakeholders.

Cooke et al. (2001) focused on the decision-making process in nursing teams. The authors found that opportunities for different ways of making decisions were created in the development of nursing teams. Although the authors reported some challenges associated with decision making in teams, particularly the difficulty that GPs had accepting a redistribution of power within the ICNT, they mostly found that decision making capacity was improved with the introduction of ICNTs. There was enhanced support for decision making, enhanced communication resulting in better information transaction and timeliness of decision making due closer geographical proximity, improved decision making capacity due to the of professional knowledge amongst team members, and greater autonomy in decision making. All of these enhancements ultimately led to improved client care through a more proactive and client led style of care management.

An earlier study by Wiles and Robinson (1994) utilized semi structured interviews to evaluate the success of teamwork in primary care in one family health services authority in England. The study examined the views and experiences of teamwork of practice nurses, health visitors, district nurses and midwives in 20 practices during a period of change in the organization of primary health care services. Six topics emerged as important; team identity, leadership, access to GPs, philosophies and care,

understanding of team members' roles and responsibilities and disagreement concerning roles and responsibilities. The majority of nurses interviewed felt that they were a member of a team and identified the GP as being the leader of that team. Other data collected revealed the extent to which nurses, midwives and health visitors felt integrated into the team. Health visitors and midwives emerged as feeling least integrated into the team, while, practice nurses did not appear poorly integrated. The author related these differences to recent changes and developments in the organization of primary care and the nursing profession in Britain; some groups were strengthened by these changes, whereas others were weakened.

Headland et al. (2000) reported on the development of an ICNT in a rural location in England. The team consisted of district nurses, registered general nurses, nursing auxillary, health visitors, midwives and school nurses. The authors did not use a particular research methodology, rather, provided a description of the stages of development of an ICNT. Six stages in the development of an ICNT were described in the study.

In the first stage, questionnaires were completed by nurses to identify professional qualifications, skills and interests among the team, as well as to establish the different views on ICNTs held by team members. Next, regular team meetings were introduced and caseloads were analyzed, areas of work and role overlap defined and caseloads were then amalgamated. Nurses were given the opportunity to raise issues throughout the process and contribute/participate in planning. Lastly, at the end of the implementation, the team was re-audited using the same questionnaire completed in the first stage of the development of the team. Findings were that team members had a greater appreciation for

each other's roles, there was a consensus on the definition of 'integrated nursing' and the perceived benefits to team working had become a reality.

A descriptive Australian study utilized a qualitative, non experimental, grounded theory approach to identify the interactions of nursing teams in a shared care model and to determine how shared care is evident in their practice (Woodhouse, 2005). In a shared care model, health provider's work together with common goals and objectives related to client care; it applies when patient care is shared between individuals or teams that are part of separate organizations. Four themes emerged from the study; a lack of understanding of each teams' roles; difficulties in communication of information; the importance of setting shared goals in care planning; and the need for collaboration to ensure clarity in case coordination.

Three papers looked at the concept of Nursing Centers or Nurse Managed Health Centers (Clarke & Mass, 1998; Ferrari & Rideout, 2005; Peck Lundeen, 1999). Using nursing models of health, professional nurses in nursing centres "diagnose and treat human responses to actual and potential health problems and promote health and optimal functioning among target populations and communities" (Peck Lundeen, p 17). Clarke and Mass discussed the only Canadian example of collaboration among nurses working in the community in the literature. The authors reported how the principles of collaboration and empowerment were actualized or suppressed within a nurse-managed centre in Comox, British Columbia, and how clients, nurses, and the community were impacted. The centre offered professional nursing services including health education, health promotion and direct care to individuals and groups. Collaboration and

empowerment were core concepts of the Nursing Centre and the clinic operated under principles of primary health care.

Antecedents for collaboration included an organizational philosophy which encouraged nurses to explore new ways to work in collaboration with clients and partners, the nurses own personal values and beliefs that supported a collaborative approach and a willingness of some health care providers (mental health workers, alternative care providers and school counsellors) to contribute expertise and enter into shared planning and decision-making that was supported by a collaborative approach (Clarke & Mass, 1998). There was a reluctance of some professionals, PHNs and physicians to collaborate with the centre, due to an initial lack of awareness of the functions of the centre; there was some concern that the Centre would potentially take funding away from other community nursing services.

Outcomes of the Nursing Centre included better health outcomes for clients and nurse satisfaction (Clarke & Mass, 1998). Within this Centre, nurses were responsible for their own practice, accountable to clients, authorized to outline their scope of practice, and were not under the supervision of another discipline. Under these conditions, nurses were able to effectively meet the needs of their client population, which included individuals, families and groups. Nurses were able to actualize the principles of primary health care, integrating concepts of collaboration and empowerment into their practice, and ultimately contributing to health care reform (Clarke & Mass).

A descriptive study reported on nurse sensitive outcomes, using the Nursing Minimum Data Set, related to services provided through the Lundeen Community Nursing Center model in a vulnerable urban community in the US (Peck Lundeen, 1999).

The Center used a community partnership approach to health promotion and is guided by organizational principles such as a holistic theoretical framework; continuous community assessment; collegial interdisciplinary relationships; community wide programming; computerized health-focused documentation of client issues and provider interventions; and integration of health care professional's education, clinical and health services research and policy activities. The Center embraced the entire community as the focus of service delivery, seeking to enhance access to health promotion and prevention services for all and emphasizes reducing the disparity in health indicators for vulnerable populations (Peck Lundeen).

Members of the Nursing Center team included RNs, advance practice nurses with expertise in a variety of specialty areas, and a variety of other professionals including mental health professionals, social workers, teachers, police officers, spiritual leaders and others (Peck Lundeen, 1999). The greatest challenge to the development and maintenance of these multiple relationships has been the constant need for role clarification and attention to communication patterns and styles. To overcome these challenges, the Center invests a significant amount of time and energy into the development of group communication skills. The data collected from the Center demonstrated that its model supports nursing practice that is orientated toward the promotion of health rather than the treatment of illness.

Ferrari and Rideout (2005) discussed the collaboration of public health nursing and primary care nursing in the development of a nurse-managed family health centre located in Philadelphia, US. The article is a descriptive account of the roles of PHNs and primary care nurses and preventative health services in communities, the developmental

process of PHN and primary care practice in a community, and lessons learned from the development of a nurse-managed health center that was grounded in the collaboration of PHN and NP practice. PHNs "paved the road into the community, assessed the specific needs of the community, and established a level of trust that is unmatched" (Ferrari & Rideout, p. 777). The PHNs were the trusted members of the community and were the reason that many clients came to the Centre for care, the NPs provided the primary care services in the clinic. The result of the collaboration of PHNs and NPs was a nurse-managed health centre that worked with the community to provide the care that they required an address needs identified by the community.

In summary, the research literature on collaboration among public health and primary care nurses is sparse, particularly in the Canadian context. The majority of papers originated in the US and UK and were mainly descriptive accounts of collaborative initiatives. Accounts of collaboration amongst CHNs in the literature discuss situations where there is support at systemic and organizational levels to facilitate collaboration; such as the ICNTs in the UK or the examples of Nursing Centers/Nurse-Managed Health Centers in Canada and the US. When the system/organization supports collaboration the main challenges are seen at the individual level; these include communication and role clarification. When collaboration amongst CHNs takes place, benefits include a reduction in duplication of services, enhanced communication, greater autonomy in decision making, and improved decision making capacity. Collaborative working amongst CHNs results in working to full scope of practice and actualizes the role of CHNs in health promotion and implementing principles of primary health care.

Communication between individuals and organizations is enhanced and ultimately, there are improved client outcomes.

The Structures and Processes of Public Health Nurse, Family Practice Nurse and Nurse Practitioner Practice

Within a complex system, healthcare professionals are required to collaborate amongst themselves in the development of new clinical practices (D'Amour et al., 2008). There is a need for a better understanding of collaborative processes amongst healthcare professionals and the tools needed to support this collaboration. San Martin-Rodriguez et al. (2005) offered an evolving framework that identified three determinants of successful collaboration: systemic determinants (conditions outside the organization in the environment where collaboration takes place) organizational determinants (conditions within the organization), and interactional determinants (interpersonal relationships amongst team members). This framework will be used to guide the discussion of the current knowledge of the structures and processes of PHN, FPN and NP practice.

Determinants of Collaboration

Systemic determinants. San Martin-Rodriguez et al. (2005) described systemic determinants of collaboration as elements that are outside the organization. RNs in NS are governed by the Registered Nurses Act (2006). All RNs, regardless of their practice focus or setting are responsible to uphold the fundamental knowledge and expectations that are intrinsic to the basic practice of nursing (CHNC, 2011). In NS, PHNs, FPNs and NPs are accountable to Standards of Practice, as defined by the CRNNS (2004). These standards include: accountability; continuing competence; application of knowledge, skills and judgement; professional relationships and advocacy; professional leadership;

self regulation. In addition to the standards outlined by the CRNNS, NPs are accountable to Standards of Practice for Nurse Practitioners (CRNNS, 2009b).

PHNs, FPNs and NPs are all guided by The Code of Ethics for Registered Nurses (CNA, 2008); this is the foundation for Canadian nurses' ethical practice. The CNA Code of Ethics identifies seven primary nursing values: providing safe, compassionate, competent and ethical care; promoting health and well-being; promoting and respecting informed decision-making; preserving dignity; maintaining privacy and confidentiality; promoting justice; being accountable. The responsibilities outlined under each of the primary nursing values apply to all interactions with individuals, families, groups, communities, populations and society, and also with students, colleagues and other health care professionals.

The CNA Code of Ethics (2008) also outlines the individual and collective efforts that nurses should endeavour to eliminate social inequities. Nurses are called to utilize the principles of primary health care, promote health, advocate for programs and services that address the determinants of health, work to improve the quality of life for people who are part of vulnerable groups, and advocate for accessible, universal and comprehensive health care services. In addition to the ethical responsibilities that nurses have in their professional relationships, the Code calls nurses to act on the broad societal issues that affect health and well-being. The CRNNS Standards (2004) and CNA Code of Ethics lay the foundation for collaborative practice amongst these groups of nurses.

The CCHN Standards expand on the generic nursing practice expectations outlined in the CRNNS Standards and look at the practice principles and variations associated with community health nursing practice (CHNC, 2011). The CCHN Standards

define the scope and depth of community health nursing practice, support on-going development of CHNs, promote community health nursing as a specialty, serve as a foundation to the development of certification of community health nursing as a specialty, and inspire excellence in and commitment to community health nursing practice (CHNC). All CHNs are expected to know and use the CCHN Standards and they are basic practice expectations after two years of practice. Although the Standards apply to all CHNs, they may be utilized more by PHNs and FPNs, as NPs have their own set of Standards and Competencies (CRNNS, 2009a; 2009b).

Standards of practice for NPs include accountability; continuing competence; application of knowledge, skills and judgement; professional relationships and advocacy; professional leadership; and self regulation (CRNNS, 2009b). These Standards reflect the legislative scope of practice for NPs. The Standards are a companion document to the Nurse Practitioner Competencies (CRNNS, 2009a). The Nurse Practitioner Competencies are categorized into four domains: health promotion and illness prevention, management of health (individual and family), advocacy and community development and professional leadership.

In addition to the RN Act (2006), CRNNS Standards (2004), CNA Code of Ethics (2008) and CCHN Standards (CHNC, 2011), PHNs are responsible for maintaining competency based on two sets of competencies. First, the Core Competencies for Public Health in Canada (Core Competencies), apply to many disciplines within public health, including PHNs (PHAC, 2007). They are the essential skills, knowledge and attitudes necessary for the broad practice of public health in Canada. The purpose of the Core Competencies is to strengthen the public health workforce by building individual and

organizational capacity and supporting learning strategies to prepare staff for excellence (PHAC).

Secondly, the Public Health Nursing Discipline Specific Competencies identify the unique knowledge and skills specific to public health nursing practice that was not captured in the Core Competencies (CHNC, 2009). There are eight discipline specific competencies: public health and nursing sciences; assessment and analysis; policy and program planning; implementation and evaluation; partnerships collaboration and advocacy, diversity and inclusiveness; communication; leadership; professional responsibility and accountability. These competencies are intended to guide nursing curriculum, professional development and public health nursing evaluation and feedback.

The fourth edition of Public Health – Community Health Nursing Practice in Canada, Roles and Activities was released in 2010 (Canadian Public Health Association (CPHA), 2010). This document is a companion document to the CCHN Standards of Practice (CHNC, 2011), Core Competencies for Public Health in Canada (PHAC, 2007), and Public Health Nursing Discipline Specific Competencies (CHNC, 2009). The document describes the practice of public health/community health nursing practice in Canada and focuses on five essential functions: public health; health promotion; disease and injury prevention; health protection; health surveillance; population health assessment; and emergency preparedness and response. The practice of public health/community health nursing is further clarified in this document and working collaboratively in consultation with the community, nursing and other colleagues is recognized as a key tenet in this practice.

The education system is a main determinant of collaborative practice, as this is where future health care professionals learn the value of collaboration. In Canada, current entry to practice for a RN is a baccalaureate degree in nursing. According to CHNC (2011), a PHN is a baccalaureate degree prepared RN. Although it is not a requirement for practice, many PHNs working in Capital District have completed graduate level education.

Current guidelines for FPNs in Capital Health indicate that an FPN requires a baccalaureate degree in nursing or a diploma with 5 years of relevant nursing experience. The highest level of education for the majority of FPNs in NS is a diploma (Todd, Howlett, MacKay & Lawson, 2007). Education varies across Canada for NPs, although there is growing consensus that the appropriate educational preparation is at the graduate level (CNA, 2009c). A recent survey of the practice patterns of NPs in NS revealed that of the 28 practicing NPs who responded, approximately half were prepared at the graduate level and the remainder had a diploma or baccalaureate education (Martin-Misener et al., 2010).

PHNs are part of the publicly-funded public health system in NS. Provincially, an external review of the publicly-funded public health system in NS was completed in 2005. In this review, the need to strengthen and develop the public health workforce in NS was identified and recommendations for workforce development were made (Moloughney, 2006). However, investment in public health nursing was not recognized in the review's strategies. This omission, whether deliberate or accidental, affirms the invisibility and loss of viability of PHNs in NS as identified by Meagher-Stewart, Aston, Edwards, Smith, Woodford, and Young (2004).

According to Meagher-Stewart et al. (2004), professional autonomy is one of the key values that PHNs value in their practice. A barrier to maintaining professional autonomy is the constant challenges that PHNs face as they are pulled in many directions simultaneously. Between obligations to their employer, professional body, clients and many community partners, PHNs are increasingly faced with conflicting loyalties and obligations. These findings suggest that the struggle of PHNs in NS is a result of the many systemic barriers erected in their practice environments.

Meagher-Stewart et al., (2007) reported on management's perspective on Canadian public health nurses' primary health care practice, as revealed in face-to-face interviews with public health management across NS and a review of public policy documents. The authors found that managers were able to recount many examples of PHNs utilizing their skills in population health and collaborative practice and they felt that PHNs made a difference in the health of the community. However, with the limited manpower in public health, PHNs found themselves in decreased contact with the community, due to increased demands on their time and multiple obligations, resulting in decreased visibility and satisfaction of the PHN workforce.

Optimal utilization of PHNs is an important issue in the public health system. Meagher-Stewart et al. (2010) reported on a qualitative study which utilized appreciative inquiry to gain insight into the organizational attributes that support PHNs to work effectively. The study revealed that there is a strong role for government- and system-level action to support PHNs to practice to their full scope of competencies. Government/system attributes which optimized PHN practice included sufficient, flexible and stable public health funding, political advocacy for public health at the government

level, and coordination across regions and nationally including shared infrastructure and resources.

FPNs and NPs are a part of the primary care system, which is ideally the point of access to health care (Ferrari & Rideout, 2005). Optimization of the role of the FPN and NP is also important in the context of our current health care system. The primary care environment is often associated with micro level interventions that deal with the provision of essential care to individuals with health problems, and is often biomedical in focus (Smith et al., 2008). The predominant focus of the primary care system on short term results may put constraints on the ability of nurses working in this setting to work to the full breadth and depth of their scope of practice, as outlined in the CCHN Standards and the Nurse Practitioner Competencies.

A qualitative study of FPNs in NS conducted by Todd et al. (2007) revealed that FPNs are often underutilized in the primary care system. They often perform non-nursing tasks such as billing, filing, booking appointments and tests, cleaning exam rooms, ordering supplies, restocking, and sterilizing equipment. Challenges that hinder FPNs ability to practice to their full scope include concerns related to infrastructure, education and remuneration (Todd et al.). Additionally, many FPNs are underpaid, often work with little or no job security and are frustrated that the NS provincial medical insurance plan does not allow them to bill for basic nursing services.

Integration of NPs into the Canadian health-care system has also faced challenges. In the past, the NP role was not sustained due to lack of funding and other barriers (Haines, 1993; Spitzer, 1984). The Registered Nurses Act of 2001 and revised Act of 2006 legally sanctioned the NP, including title protection; the first NPs were licensed in

NS in 2002 (Martin-Misener et al., 2010a, Martin Misener et al., 2010b). In order to practice, NPs require a collaborative practice relationship with one or more physicians (CRNNS, 2009c). CRNNS approved collaborative practice agreements are no longer required and have been seen as a barrier to implementation of the NP role in NS (Martin-Misener et al. 2010a). The number of NP positions in NS has increased gradually since 2002, predominantly through provincial government funding (Martin-Misener et al. 2010b). Compared to PHNs and FPNs, NPs have received immense support from education, regulatory bodies and governments both in NS and across Canada to establish and develop their role (Canadian Nurse Practitioner Initiative, 2006)

Organizational determinants. The structure of an organization has a strong influence on the development of collaborative practice (San Martin-Rodriguez et al., 2005). Organizational attributes such as its structure, philosophy, communication and coordination mechanisms have an impact on collaborative practice. Organizational structures that are flexible and support the importance of team work and shared decision-making are more favourable for collaborative practice.

The development of family practice nursing in Capital Health is a new initiative. In Capital Health, FPNs work mostly in physician offices. One of the key challenges is that most FPNs work in fee-for-service environments (Patsy Smith, FPN, Hatchet Lake Medical Centre, personal communication, April 2009). In this environment, nurses' ability to work in partnership with other health care professionals may be limited, as a fee-for-service model does not allow time for collaborative activities. Many FPNs feel isolated in their practice and have limited networking opportunities with their peers

(Todd et al., 2007). They also find it challenging to fulfill continuing education needs as it is difficult to take time away from practice to attend educational sessions (Todd et al.).

A smaller number of FPNs who work in Capital Health work in community health centres that have an alternative or salary-based fee schedule (Patsy Smith, FPN, Hatchet Lake Medical Centre, personal communication, April 2009). Nurses who work in this environment are in a better position to partner with other health care professionals, as their organizational structure is more supportive of collaborative practice. For example, the North End Community Health Centre, which employs NPs and RNs, has an organizational values statement "We are committed, in all we do, to uphold the values of…collaboration and partnership" (North End Community Health Centre, 2011). Collaboration is inherent in the organization, thus supporting its employees to engage in relationships with other health care professionals.

A 2010 survey of 28 practicing NPs in NS revealed that most NPs were employed either in a community health centre or family practice office (Martin Misener et al., 2010b). The NPs surveyed reported a high level of satisfaction in their collaborative relationships with physicians (Martin Misener et al.). The majority reported receiving organizational support for continuing education. The majority of NP's time was spent on direct patient care, however, the majority also reported performing community development activities. Although there is a high level of satisfaction amongst NPs in NS, barriers such as funding issues, scope of practice restrictions and resistance to role implementation persist (Martin Misener et al.).

In Capital Health, PHNs are employed by Public Health Services, Capital District Health Authority. "Public health uses a population health philosophy in its practice and

works collaboratively with many partners" (Capital District Health Authority, 2009). Public health also values partnerships amongst sectors. Despite an organizational value that supports collaborative practice, Meagher-Stewart et al. (2004) found that many nurses reported that public health had become a task orientated rather than a population focused practice; this was perpetuated by documentation structures that did not capture collaborative activities, increased specialization and working in silos. This has also been my experience as a PHN working in the Healthy Beginnings Team at Capital Health. PHNs are consumed with fulfilling mandatory program demands focused on individual services for breastfeeding women and struggle to keep up their collaborative practice and community connections. In my experience, PHNs are frustrated, as they feel unsupported by their organization to meet the growing needs of their communities.

In their study regarding the organizational attributes that assure optimal utilization of PHNs, Meagher-Stewart et al. (2010) identified three organizational characteristics that supported optimal nursing practice and outcomes. These included a clear organizational vision, mission and goals for public health that were understood throughout the organization, an organizational culture of innovation at both the management and frontline levels and effective leadership that demonstrated respect, trust and support for PHNs working to optimal level of competency. Additionally, the authors reported a strong association between management practices and optimal PHN practice. Eight management practices that supported PHN practice included: effective program planning, promoting and valuing public health nursing practice, supporting autonomous practice, commitment to learning and professional development, effective human resources planning, supporting public health partnerships and community development,

fostering effective communication and healthy workplace policies. Knowledgeable organizational advocates, such as managers and directors, are required to support effective public health nursing practice.

Interactional determinants. Willingness to collaborate, mutual trust, respect and communication are components of interpersonal relationships amongst team members that determine successful collaboration (San Martin-Rodriguez et al., 2005). Although organizations may be influential in supporting collaboration, it is a process that occurs between individuals; therefore the persons involved ultimately decide whether or not collaboration will take place (Henneman et al., 1995). Other key attributes associated with enhanced collaborative practice are accepting accountability, being motivated to work as a team member, commitment and enthusiasm (RNAO, 2006).

Nurses function as social beings and value the positive impact that quality relationships have on client outcomes and role satisfaction (RNAO, 2006). Outlined in CCHN Standard 4, "Professional Relationships", "Community health nurses connect with others to establish, build and nurture professional relationships. These relationships promote maximum participation and self determination of the individual, family, group, community or population*"* (CHNC, 2011, p.16).

These relationships are built on the principles of connecting and caring; a core value in community health nursing practice. Collaboration and relationship building are imbedded in the CCHN Standards, and thus are professional expectations for all CHNs.

A survey of 41 FPNs in NS indicated that next to family physicians, FPNs collaborate with PHNs most often (Todd et al., 2007). Additionally, the majority of FPNs surveyed agreed that collaboration improves continuity of care, alleviates the workload of

family physicians, increases patient and health professional satisfaction, is cost effective, and contributes to holistic care (Todd). NPs also reported collaborating with public health through referrals and that they felt that the health team members with whom they regularly worked (which included public health) understood their NP role (Martin Misener et al., 2010b)

As found in group interviews held with public health and FPNs during my Master of Nursing Community Health Nursing practicum in 2007, nurses working in public health and primary care in Capital Health present a willingness to work together, which is one of the primary determinants of enhanced collaboration (San Martin-Rodriguez et al., 2005). From my experience as a PHN working in the Healthy Beginnings Team in Public Health Services at Capital Health, it is evident that a mutual understanding of the roles of FPN and NPs is lacking in this District. Through the development of a greater understanding of each other's roles amongst PHNs, FPNs and NPs, other determinants of successful collaboration such as mutual respect, sharing and trust are improved upon (San Martin-Rodriguez et al., 2005).

In summary, while there are some shared standards amongst PHNs, FPNs, and NPs such as the RN Act (2006), CRNNS Standards for Registered Nurses (2003), and the CNA Code of Ethics (2008), there are many differences in the structures and processes of PHN, FPN and NP practice. The PHN role in the publicly-funded health care system focuses on promoting, protecting and preserving the health of populations (CHNC, 2011). PHNs work with individuals, families, groups and communities and integrate the knowledge obtained from these interactions into population health promotion practice

(CHNC). FPNs and NPs work in primary care settings where the main focus is on the health of individuals and groups and interventions aimed at these levels.

PHNs, FPNs and NPs have all faced challenges at the systemic, organizational and interactional level that could result in turf protection and mistrust, thus influencing their motivation and/or ability to collaborate. Although both public health and primary care highly value collaboration and report that collaboration exists, because public health and primary care are separate entities in NS, collaboration is typically by way of referral between practitioners, rather than at the systemic or organizational level.

Collaboration in Breastfeeding Promotion and Support

Several systematic reviews have evaluated breastfeeding promotion and support interventions (Britton, McCormick, Renfrew, Wade & King, 2009; Chung, Raman, Trikalinos, Lau & Ip, 2008; de Oliveira, Camacho & Tedstone, 2001; Dyson, McCormick & Renfrew, 2008; Fairbank, O'Meara, Renfrew, Woolridge, Snowden and Lister-Sharp, 2000; Guise, Palda, Westhoff, Chan, Helfand & Lieu, 2003; Hannula, Kaunonen & Tarkka, 2007; Protheroe, Dyson, Renfrew, Bull, & Mulvhill, 2003; Renfrew, Sbiby, D'Souza, Wallace, Dyson, & McCormick, 2004). Although these reviews did not look specifically at collaboration amongst public health and primary care nursing, they did include interventions that take place in public health and primary care settings.

In a recent review completed for the Cochrane Collaboration, Britton et al. (2009) looked at whether providing support for breastfeeding mothers, either from professionals, or from trained lay people, or both, would help mothers to continue to breastfeed. Thirty four studies from 14 countries, which included close to 30,000 women, were included in this review. The review found that additional professional support, in addition to standard

care, was effective in prolonging exclusive breastfeeding. Lay support was found to be effective in increasing exclusive and any breastfeeding. Combined lay and professional support was effective in assisting mothers to continue breastfeeding, especially within the first two months postpartum. Strategies that rely mainly on face-to-face support rather than telephone contact are more effective; however, there is not yet any evidence to suggest that breastfeeding is increased through routine prenatal contact. The authors caution that their attempts to outline the most useful components of support strategies should be treated with caution, as the studies reviewed were inconsistent in the reporting of the timing of their outcome assessments. Future research is required to identify the aspects of support that are the most effective.

Dyson et al. (2008) published a systematic review that evaluated the effectiveness of interventions for promoting the initiation of breastfeeding; 11 trials were included in the review. The authors found that among low-income women in the US, where baseline breastfeeding rates are typically low, health education and peer support interventions are likely to result in some improvements to initiation rates. A needs-based, one-to-one, informal session delivered by a trained professional or peer counselor in the antenatal and perinatal period is the intervention that is most likely to increase initiation rates amongst low-income women. In contexts where formula feeding promotion packages are distributed widely, offering breastfeeding promotion packages is an inappropriate use of resources. The authors suggest that there is a need for future research in this area.

In an earlier systematic review, Fairbank et al. (2000) evaluated the existing evidence to identify which promotion programs were effective at increasing initiation of breastfeeding. Fifty-nine studies (14 randomized control trials (RCTs), 16 non-RCTs and

29 before and after studies) were reviewed in this systematic review and the authors found that three types of interventions have been shown to be useful in the promotion of breastfeeding in developed countries. Among women from different income groups and some ethnic minorities, informal, small group health education sessions delivered in the prenatal period are effective in improving breastfeeding initiation rates. For women on low incomes, one to one health education can increase breastfeeding initiation and pre and postnatal peer support programs have been shown to increase both initiation and duration of breastfeeding. The authors found that packages of interventions including a peer support program and/or a media campaign in combination with changes to the structure of the health sector and/or health education activities were effective at increasing initiation and in many cases duration of breastfeeding.

Three reviews examined the effect of primary care-based interventions in breastfeeding promotion (Chung et al., 2008; de Oliveira et al., 2001; Guise et al., 2003). Two of the studies found that prenatal breastfeeding education was an effective strategy to improve breastfeeding initiation and duration (de Oliveira et al.; Guise et al.). Further, a later systematic review completed by Hannula et al. (2008), which focused on any breastfeeding support interventions prenatally, in hospital and postpartum, found that in order for prenatal breastfeeding education to be effective, group education needed to be interactive. Guise et al., found that antepartum education sessions offered by lactation specialists or nurses that reviewed benefits of breastfeeding, principles of lactation, myths, common problems, solutions and skills increased breastfeeding initiation and short term duration (up to three months). A significant impact on long term duration (up to six months) was not found. In contrast, Chung et al. (2008) found that interventions

with both prenatal and postnatal components increased breastfeeding duration when combined with usual care, whereas prenatal or postnatal interventions alone did not.

Home visits to support breastfeeding in the pre or postnatal period were effective in extending breastfeeding duration (de Oliveira et al., 2001). Interventions that included a component of lay support were significantly more effective than usual care in improving rates of short-term breastfeeding (Chung et al., 2008). In-person or telephone support alone significantly increased short and long term breastfeeding duration, but did not increase breastfeeding initiation. A combination of education and support was more effective than support alone, however not as effective as education alone. There are insufficient data to determine the effectiveness of peer counselor programs, written materials and discharge packets on breastfeeding initiation and duration intervention (Guise et al., 2003). Interventions that were not effective in improving breastfeeding initiation and duration included isolated distribution of written materials, strategies that included no face-to-face interaction; such as interventions based on telephone support alone, and small scale interventions limited to a short time during pregnancy (Guise et al.; de Oliveira et al.).

Two evidence briefings, syntheses of the most current evidence available, focused on the effectiveness of public health interventions to promote breastfeeding (Protheroe et al., 2003; Renfrew et al., 2005). These reviews are summarized in an 'evidence into practice' briefing on the promotion of breastfeeding initiation and duration (Dyson, Renfrew, McFadden, McCormick, Herbert & Thomas, 2005). The authors summarized the findings from four systematic reviews in combination with the experiential knowledge of practitioners, commissioners, managers and researchers. The authors

concluded that the evidence base and consultative feedback demonstrated the effectiveness of neighborhood interventions, where a single intervention comprised of several different components was delivered to the same population. This type of intervention not only increased breastfeeding rates, but also increased efficiency by reducing duplication through improved multisectoral practice.

The briefing by Dyson et al. (2005) outlined several evidence-based actions towards increasing breastfeeding rates in the UK. Implementing the UNICEF Baby Friendly Initiative in maternity and community centres, provision of education and support programs, changes to policy and practice within community and hospital settings, peer or volunteer telephone support, continuous support to women in high risk groups (support from one professional), continuation of postnatal support for breastfeeding for one year for high risk mothers, and media aimed at adolescent attitudes towards breastfeeding are amongst these recommendations. The authors found that several of these actions shared key attributes including; collaboration amongst practitioner groups that encourages effective communication and role clarity, delivery of a package of interventions versus a single intervention, and an integrated and multi-sectoral approach.

In a critique of the evidence identified in a systematic review of interventions to promote and support breastfeeding, Renfrew et al. (2004), concluded that there is a lack of well-designed research in this area. Although ample studies have been completed, most of the studies are methodologically flawed and no studies of policy interventions or community interventions were identified. Little information regarding the process of implementation, organizational structures and cultural contexts is often provided in studies related to effective breastfeeding interventions (Fairbank et al., 2000; Guise et al.,

2003; Protheroe et al., 2003; Renfrew et al., 2004). This lack of information makes it difficult to understand why some interventions are successful where others are not. The evidence base to enable women to continue to breastfeed must be strengthened to incorporate rigorous evaluations of breastfeeding policies and practices.

One study specifically addressed a collaborative effort in breastfeeding support. A Scottish controlled intervention study which used principles from action research methodology found that a breastfeeding coaching intervention was more effective in improving breastfeeding rates in areas where several local health professionals worked together to implement the program (Hoddinott, Pill & Chalmers, 2007). The program involved health professional-facilitated breastfeeding groups for pregnant women and breastfeeding mothers and/or a group lay member as a one to one coach. Qualitative data on process and attitudes of health professionals (health visitors and midwives) implementing the intervention was collected and this was supported with data from women receiving the intervention. The authors found that in areas where the facilitation of the breastfeeding group was shared or rotated amongst midwives and health visitors, breastfeeding rates improved. Strong inter and intra-professional relationships were also related to improved breastfeeding outcomes. Collaboration improved recruitment and promotion of the groups, changed professional orientation towards breastfeeding and empowered the health professionals involved. These findings have implications for this study, as they suggest the importance of collaborative working amongst health professionals as a way of increasing incidence of breastfeeding.

In summary, several studies have looked at both primary care and public health interventions that contribute to improving breastfeeding outcomes; however, the

heterogeneity and methodological flaws of research in breastfeeding promotion makes it difficult to ascertain which interventions are most effective. A consistent finding across the literature is that multi-faceted, multi-level interventions that span the prenatal and postnatal period or a combination of health promotion strategies are more effective than single-level, isolated efforts. Additionally, when professionals work together to support breastfeeding families, breastfeeding rates improve. Actions that contribute to improving breastfeeding outcomes share key the key attribute of collaboration amongst practitioner groups that encourages effective communication and role clarity. These findings emphasize the need for CHNs to collaborate in the care of breastfeeding families and lay the groundwork for discussion regarding of how CHNs can work together on this issue.

Summary

In this Chapter, I have discussed collaboration between public health and primary care, collaboration among public health and primary care nurses, the structures and processes of PHN, FPN and NP practice, and collaboration in breastfeeding support. The majority of examples of primary care and public health collaborations in the literature are taken from the US and UK and the majority of Canadian examples are from Ontario, with no examples from NS. Breastfeeding is not a health issue that was focused on in any of the literature, although mothers and babies were a frequent target of collaborations.

The literature reviewed on collaboration among public health and primary care nurses revealed mostly descriptive accounts of collaboration, with most studies originating in the US and UK. No studies were found that looked specifically at collaboration amongst PHNs, FPNs and NPs or at collaboration in breastfeeding promotion. However, where systemic and organizational support existed, benefits of

collaboration included a reduction in duplication of services, improved client outcomes, enhanced communication, CHNs working to their full scope, greater autonomy in decision making, and improved decision making capacity. Obstacles were associated with issues at the individual level such as communication and role clarity.

There are many differences in the structures and processes of PHNs, FPNs and NPs. While the PHN role focuses on promoting, protecting and preserving the health of populations, FPNs' and NPs' main focus is on the health of individuals and groups and interventions aimed at these levels. Public health and primary care are separate entities in NS and collaboration that does exist is on an individual basis typically by way of referral between practitioners. The CHNs themselves are facilitators to collaboration; however, segregation at the systemic and organizational level leads to challenges at the individual level such as lack of communication and role clarity.

When professionals work together to support breastfeeding, it is believed that breastfeeding outcomes improve. Although several studies have looked at both primary care and public health interventions that contribute to improving breastfeeding outcomes, the quality of research in breastfeeding promotion makes it difficult to establish which interventions are most effective. However, a consistent finding across the literature is that multi-faceted, multi-level interventions that span the prenatal and postnatal period or a combination of health promotion strategies are more effective than single-level, isolated efforts.

There is a paucity of research that looks at collaboration among public health and primary care nursing in the context of the Canadian, and more specifically, the NS health care system. There is an awareness of the overlap between public health and primary care,

however, it is not well understood how PHNs, FPNs and NPs could collaborate. As the role of the FPN and NP are relatively new in NS and the role of the PHN is evolving in the context of systemic and organizational changes in public health, the time is right to explore how these groups of CHNs can work together. The findings of this literature review support the need for research in this area.

Chapter III

METHODOLOGY AND METHOD

In this chapter, I begin with a description of the methodology selected. Following is a description of the method used in the study that included the study setting, procedures for the selection of participants, data collection procedures, and data analysis. Lastly, I discuss how trustworthiness was established and describe ethical considerations for this study.

Qualitative Methodology

The concept of collaboration between PHNs, FPNs and NPs in Canada has not been studied; however it is clear that overlap exists in the roles, responsibilities and functions amongst primary care and public health (Ciliska et al., 2005). The aim of this study was to develop an in-depth understanding and rich description of the structures and processes required to support the development of collaboration amongst PHNs, FPNs and NPs. To achieve this, a qualitative approach was used to allow discovery of this phenomenon through the use of multiple ways of understanding (Speziale & Carpenter, 2007).

Qualitative methodology is grounded in the constructivist paradigm. The aim of inquiry in this paradigm is understanding or reconstruction (Guba & Lincoln, 2005). Control is shared between the inquirer and the participants who take an active role in recommending questions of interest for inquiry (Guba & Lincoln). Reality or validity "are derived from community consensus regarding what is "real" what is useful, and what has meaning" (Guba & Lincoln, p. 197). I chose to use a qualitative approach in this

research, because, I value the rich meanings in people's lived experience. Little is known about how PHNs, FPNs and NPs collaborate. I believe that in order to understand how these groups of nurses can work together more effectively, a more complete picture of this complex experience needs to be developed. This can be achieved through listening to the participants' descriptions of their experiences; as qualitative methodology permits.

To capture the complexity of the human experience, there are a variety of qualitative approaches that can direct the collection of data (Polit & Beck, 2004; Speziale & Carpenter, 2007). Speziale and Carpenter emphasized that it is essential for the researcher to have thorough comprehension of the philosophical underpinnings of the chosen research approach. Qualitative researchers highlight six major tenets in their studies: a belief in multiple perspectives, a dedication to identifying a method to understanding that supports the phenomenon being studied, a commitment to the subject's point of view, belief in a method of inquiry that limits disruption of the natural context of the phenomena being studied, acknowledged contribution of the researcher to the research process, and the reporting of findings in a method that is rich with participant stories (Speziale & Carpenter). Researchers using a qualitative approach address questions regarding a particular phenomenon by uncovering the most suitable approach to answer the research question. Therefore, this discovery brings the researcher to the method, rather than the method guiding the discovery.

In qualitative or naturalistic inquiry, the researcher begins with a particular focus in mind, but has no objection to shifting their focus as new information makes it appropriate to do so (Lincoln & Guba, 1985). Rather than approaching the study "knowing what is not known", the naturalist assumes the stance of "not knowing what is

not known". In this form of inquiry, the human is the instrument and anyone partaking in this type of inquiry will have acquired and continue to develop the skills required to operate as an effective instrument.

There are many approaches to qualitative research. For this study, I chose a qualitative descriptive approach (Neergaard, Olesen, Anderson & Sondergaard, 2009; Sandelowski, 2010; Sandelowski, 2000). Qualitative descriptive studies are the least "theoretical" of the various qualitative approaches and therefore researchers using this approach are not burdened by a commitment to a specific theoretical or philosophical perspective as in grounded theory or phenomenological approaches (Sandelowski, 2000). However, this does not mean that qualitative descriptive studies are not influenced by theory (Sandelowski, 2010). "Every word is theory; the very way researchers talk about their subject matters reflects their leanings, regardless of whether they present these inclinations as such or even recognize them" (Sandelowski, 2010, p.79). Qualitative descriptive studies generally draw from the basic beliefs of naturalistic inquiry.

Qualitative Description

A qualitative descriptive design allows for a thorough explanation of the nurses' experience of collaboration between primary care and public health. Qualitative descriptive studies enable the researcher to provide "a comprehensive summary of an event in everyday terms of those events", without theory laden, philosophical commitments (Sandelowski, 2000, p.336). This is an appropriate method when straight descriptions of phenomena are desired. Addressing the proposed research question with a qualitative descriptive design will provide a straightforward, practical answer, relevant to the practitioners and decision makers in primary care and public health.

Sandelowski (2000) described basic qualitative description as "a method that researchers can claim unashamedly without resorting to methodological acrobatics" (p. 335). She viewed qualitative description as a distinct category for qualitative research that is less interpretive than interpretive descriptive studies (Thorne, Kirkham & MacDonald-Emes, 1997), as they allow the researchers to stay close to their data with minimal interpretation and low influence descriptions. Qualitative descriptive studies do not require the researcher to transform their data into an abstract or conceptual format, which fits with the interpretive descriptive approach (Thorne et al.). Findings produced in qualitative descriptive studies are closer to the data as reported or "data-near" (Sandelowski, 2010, p.78). However, as with all qualitative research, qualitative descriptive studies require the researcher to move somewhere from their data; researchers must "make something of their data" (Sandelowski 2010, p.79).

Qualitative descriptive studies aim to present a phenomenon as naturally as possible and are based on the theoretical orientation of naturalistic inquiry (Sandelowski, 2000). "The goal is to stay close to the surface of data while capturing all the elements of that experience, and the inherent scientific rigor is a reflection of a researcher's ability to achieve that goal" (Milne & Oberle, 2005, p. 413). In naturalistic inquiry, there is an emphasis on understanding the human experience as it is lived and studies result in rich, in-depth findings that uncover many aspects of a complex phenomenon. Naturalistic studies generate findings that are reflective of the realities of study participants (Polit & Beck, 2004). Qualitative descriptive designs may integrate hues, tones and textures from other qualitative approaches such as phenomenology, grounded theory, ethnographic or

narrative studies. Shadings from larger paradigms such as feminism may also be present in studies using a qualitative descriptive design.

Study Setting

As previously stated, this study took place in Capital Health, the largest of nine District Health Authorities (DHAs) in NS, Canada. With a population of 395,000, Capital Health accounts for 40% of NS's population (Province of Nova Scotia, 2010). The average family income in Capital Health is $77,052, which is almost $11,000 higher per year than the average family income in NS (Province of Nova Scotia).

There are 19 government Departments in NS. At the commencement of the study, the NS Department of Health (NSDOH) and Department of Health Promotion and Protection (HPP) had the principal responsibility for health (Meagher-Stewart, Martin-Misener & Valaitis, 2009). In January 2011, the NSDOH and HPP merged to become the Department of Health and Wellness (DOHW) (Province of NS, 2011). The hope of this merger is to streamline health operations in NS, aiming to integrate preventative and treatment services, thus improving health care to Nova Scotians (Province of NS). The DOHW and public health service areas in nine DHAs make up the publically-funded public health system. The DHAs are responsible for supporting 37 community health boards; seven of which are in Capital Health (DHA 9) (Meagher-Stewart et al.). The Community Health Boards are the eyes, ears and voices of the community and work with the DHAs to support health care planning and delivery (Capital Health, 2010).

Capital Health includes urban, suburban, rural and semi-rural communities. The seven Community Health Boards in Capital Health include: Chebucto West, Cobequid, Dartmouth, Eastern Shore-Musquodoboit, Halifax Peninsula, South Eastern, and West

Hants.. There are over 420 physicians providing care for families in Capital Health (Capital Health, 2010). In addition to medical centres and physicians offices, there are two Community Health Centres, the North End Community Health Centre and the Duffus Health Centre. These centres are built on collaborative models of care amongst a variety of primary care professionals including RNs, NPs, GPs, social workers, dieticians, and mental health professionals.

Participant Selection

A purposeful sampling technique was used in this study (Patton, 2002). Purposeful samples are convenient, cost-effective and are appropriate in qualitative research (Polit & Beck, 2004). Purposeful sampling selects study subjects based on their knowledge of a phenomenon for the purpose of sharing that knowledge (Speziale & Carpenter, 2007). The goal of purposeful sampling is to select subjects who are information-rich, from whom the researcher can learn a great deal about the issues of most importance to the purpose of the study (Patton).

This study explored the structures and processes required to support the development of collaborative practice amongst public health and primary care nurses who work with breastfeeding families. The sample for this study consisted of PHNs, FPNs and NPs practicing in Capital Health, as these are the nurses who are working in primary care and public health in Capital Health.

The PHNs selected were nurses involved with the delivery of the Healthy Beginnings Program in Public Health Services at Capital Health, as they are the nurses who most often work with breastfeeding families. The FPNs and NPs were nurses who worked in physician's offices, medical centres or community health centres that self-

identified as providing support to breastfeeding families through responding to the invitation to participate (Appendix C and D).

Public health and primary care nurses who worked with breastfeeding families, were employed full or part-time, practiced in Capital Health, and had at least two years of experience in community health were included in the study. I selected nurses with two years of experience, because the CCHN Standards state that this is the period of time that occurs before a CHN is practicing to the full scope of the Standards (CHNC, 2011). At the time that the study took place, there were approximately 35 PHNs working in the Healthy Beginnings Program in Public Health Services at Capital Health, 34 FPNs (Corrine Hodder Malloy, personal communication, 2010) and six NPs who worked with breastfeeding families in Capital Health.

To recognize the diverse communities and practice situations in Capital Health, I applied a maximum variation sampling strategy (Patton, 2002). This strategy is useful when the researcher seeks to capture and describe the central themes that are common across a tremendous amount of variation (Patton). As there are seven CHB areas in Capital Health, it was not be feasible to have participants who represented each CHB area in Capital Health, given the small sample size in this study. Therefore, I used maximum variation purposeful sampling to select PHNs, FPNs and NPs that practice in the urban, suburban, and rural/semi-rural areas to ensure that the diversity of Capital Health's communities and practice settings were represented. As the researcher, I identified that there are differences in practice between rural/semi-rural areas and urban and suburban areas. I held one focus group with participants who practiced in rural/semi rural settings and one focus group with participants who practiced in urban and suburban settings.

Participants were recruited using a variety of techniques. As all of the potential PHN participants were known to the researcher, all PHNs who qualified for the study were given an equal chance to participate. An invitation to participate in the study (Appendix B) was given to all Healthy Beginnings Program PHNs who were eligible to participate; as well, the invitation was displayed at Public Health Services, Capital Health. The invitation was also submitted to the Public Health Weekly Newsletter and disseminated by email through public health managers. To recruit FPNs, an invitation (Appendix C) was posted on the Family Practice Nurses Association of Nova Scotia website and sent out through the Association's listserv. Additionally, a follow-up email was sent one week later through the Association's listserv. As there are only six NPs in Capital Health, an invitation (Appendix D) was mailed to each NP with a follow up telephone call one week after mailing (contact information for NPs is public information and is available on the CRNNS website). In addition, an invitation was posted on the Nurse Practitioners' Association of Nova Scotia website.

Participants who volunteered for the study were then selected using random purposeful sampling (Patton, 2002), applying maximum variation sampling to ensure representation of urban, suburban, rural/semi-rural practice settings. Maximum variation sampling allows the researcher to choose a wide variation on dimensions of interest, such as, in this case, location of practice. Volunteer participants for an urban/suburban focus group and a rural/semi-rural focus group were randomly drawn from a hat to eliminate researcher bias in the selection of participants.

Participants

A total of 10 participants engaged in the focus groups and one individual follow-up interview conducted in this study; PHNs (n=4), FPNs (n=4) and NPs (n=2). Focus Group One included participants (n=5) who identified themselves as working in an urban/suburban community. Participants for this group included PHNs (n=2), FPNs (n=2) and NP (n=1), with the NP attending only the follow-up focus group. One PHN was only able to attend the initial focus group; however, an individual follow-up interview took place to gain her input on emergent themes. Focus Group Two (n=5) included participants who identified themselves as working in rural/semi rural communities. Participants for this group included PHNs (n=2), FPNs (n=2) and an NP (n=1). All participants attended both focus groups, the NP connected to the group via teleconference.

All participants in Focus Group One were female. They described their primary work setting as either CDHA Public Health Services (n=2), Physician's Office (n=1), Family Medicine Centre (n=1) or a federal health facility (n=1). Participants identified their highest level of educational preparation as master's degree in nursing (n=2), baccalaureate degree in nursing (n=2), and diploma in nursing (n=1). Four participants worked full-time and one participant worked part time. Participants reported a range of eight to 35 years experience as an RN, with an average of 24 years. There was a range of four to 25 years in their current role, averaging 11 years, and a range of 6-20 years supporting breastfeeding families, with an average of 14 years.

Focus Group Two also included all female participants. Participants described their primary work settings as either CDHA Public Health Services (n=2) or Physician's Office (n=3). Their highest level of education was reported as master's degree in nursing

(n=2) and baccalaureate degree in nursing (n=3). All participants (n=5) worked full time. The years of experience as an RN ranged from 8-26 years, averaging 18 years. There was a range of 3 to 10 years in their current role, with an average of seven years, and a range of between 6 and 24 years supporting breastfeeding families, averaging 12 years.

In summary, it was apparent that this sample was an experienced and highly educated group of nurses. Their average experience as RNs was 18-24 years, with an average of 12-14 years supporting breastfeeding. Fifty percent of the participants held a baccalaureate degree in nursing and 40 % had a masters degree in nursing. Ninety percent of the participants worked full time.

Many of the participants were known to the researcher. This made it easy to establish rapport, however, it also made it difficult at times, as participants may not have expressed themselves thoroughly and honestly. As the researcher, I had to reinforce that I was not testing participants; that I was genuinely curious in what they had to say. In addition, at times I had to probe participants to expand upon their responses, perhaps because they knew that I worked in breastfeeding support and promotion. In Focus Group One (urban/suburban), all participants were known to me, the researcher, other than the NP. Most of the participants were familiar with one another and had working relationships. This put participants at ease with one another. All participants worked in the Halifax Regional Municipality.

In contrast, all of the participants in Focus Group Two (rural/semi rural) did not have previous relationships with one another or with the researcher. The PHNs knew each other; however did not work together on a regular basis. The FPNs worked in the same clinic together, the NP, who joined via teleconference, was familiar with one of the

FPNs but did not work in the same clinic. Despite their unfamiliarity with one another, conversation flowed well amongst them. Other than the two FPNs, all participants worked in different communities.

Data Collection

The naturalistic inquirer tends to use techniques that will allow the target phenomenon to present itself as if it were not under study (Speziale & Carpenter, 2007). In qualitative descriptive studies, data collection is typically aimed towards discovering the who, what, when, and where of events or experience. Minimally to moderately-structured open-ended individual and/or focus group interviews are a desired data collection technique for the chosen methodology (Sandelowski, 2000).

Focus group interviews were used for data collection in this study. Focus groups were appropriate in this study as the researcher was seeking a range of ideas or feelings, attempting to understand differences in perspectives between groups of people, and to uncover various factors that influence behaviour, opinions or motivation (Krueger & Casey, 2000). Focus groups were chosen versus individual interviews, as the researcher hoped that ideas would emerge from bringing PHNs, FPNs and NPs together in a group. "A group possesses the capacity to become more than the sum of its parts, to exhibit a synergy that individuals alone don't possess" (Krueger & Casey, p.24).

A focus group is "a semi-structured group session, moderated by a group leader, held in an informal setting, with the purpose of collecting information on a designated topic" (Carey, 1994, p. 226). Some advantages of focus groups are that they are flexible, stimulating, cumulative, elaborative, assistive in information recall, and capable of

producing rich data (Speziale & Carpenter, 2007). Focus groups are also efficient in that they obtain the viewpoints of many subjects in a short time (Polit & Beck, 2004).

There are some disadvantages to focus groups. Certain people are uncomfortable expressing their views in a group situation and there is possible concern that the group culture could inhibit individual expression, resulting in "group think" (Polit & Beck, 2004). However, Kid and Parshall (2000) reported that focus groups have shown to be comparable to individual interviews in terms of the quality and quantity of ideas generated.

Had I chosen homogeneous focus groups versus heterogeneous focus groups for this study, the dialogue may have unfolded differently. While heterogeneous focus groups enabled PHNs, FPNs, NPs to share and learn from one another, it may have also been a hindrance. Although PHNs are involved in population focused interventions, they did not speak of these activities frequently. Given the individual focus of FPN and NP practice, PHNs may have focused their answers on individual level interventions in breastfeeding support and promotion to compare with FPNs and NPs. If I had used homogeneous focus groups, I may have been able to probe PHNs to discuss their population focused practice in more detail, however, this would have been at the expense of the rich conversation and learning that occurred when the three groups of nurses were brought together in the focus groups.

In the past, it was thought that focus groups should involve 10-12 participants; however, this large number is impracticable, especially with complex topics (Krueger, 1994). Smaller groups of five to seven participants are more workable, provide opportunity for individuals to talk and are much easier to set up and manage (Krueger).

Groups that are too small may be dominated by only one or two individuals, whereas larger groups make it difficult to encourage participation from all members (Stewart & Shamdasani, 1990). Focus group sessions typically last between 90 and 120 minutes. As I am a novice researcher, this study used two focus groups, with five participants in each. One focus group included participants who worked in rural/semi-rural communities and the other included participants who work in urban and suburban communities. Each focus group met twice with the researcher. The initial focus groups lasted approximately 90 minutes each and the follow up focus groups also lasted 90 minutes.

Focus groups are guided by an interviewer, often referred to as the moderator. Moderators guide the discussion using a written set of topics or questions to be covered during the interview (Polit & Beck, 2004). As the moderator in the study, I observed and listened to eventually analyze the discussion and draw meaning (Krueger & Casey, 2000). To ensure that the group discussion goes smoothly, moderators should be well trained in group dynamics and interview skills (Stewart & Shamdasani, 1990).

As the moderator, I was cognoscente of my actions and interactions during the group session. This was difficult to do during Focus Group One, as I was becoming comfortable with the process and flow of the research questions. I displayed an attitude of curiosity while avoiding gestures or responses that are indicative of agreement or disagreement (Krueger, 1998). As well I paused, probed, and listened. Pausing gave participants time to consider others participant's responses and to reflect on the question. Probes were used frequently in the beginning of the interview to elicit clear responses and decreased as the session progressed. Moderators must also listen and decide when a question is answered completely (Krueger). After listening to the recordings of the first

focus groups, I identified areas for improvement such as pausing and applying this to subsequent focus groups. Overall, I felt more confident in my role with the follow-up focus groups, as I had gained experience and had established a rapport with participants.

Focus group success can be dependent on the moderator's skill in facilitating group interaction and dealing with group dynamics. As a researcher and practitioner, I have some previous experience with focus groups. I facilitated two focus groups with PHNs and FPNs during my Master of Nursing Community Health Nursing practicum in 2007. I have also been a participant in focus groups on numerous occasions. Additionally, as a PHN, I have extensive experience with group facilitation through prenatal classes, support groups for new mothers and various other education sessions.

Groupthink is a process that transpires when dominant members of a group have major influence or control over the verbal expression of other group members (Speziale & Carpenter, 2007). The moderator must be aware of strategies to overcome groupthink such as reminding participants of the valuing of different points of view or directly asking the group if there are any different thoughts or opinions to add (Krueger, 1998). In addition to the researcher, a graduated Master of Nursing student assisted in recording contextual aspects of the focus group sessions. This individual was briefed on the interview questions and structure by the researcher.

The focus groups used semi-structured, open-ended interview questions that invoked conversation, utilized language that was familiar to participants, were easy to comprehend, open-ended, straightforward, and included clear direction. Five types of questions were utilized in the focus group interviews: opening; introductory; transition; key and ending questions. (Krueger & Casey, 2000). An Interview Guide (Appendix F)

was developed to ensure that all questions were covered with each participant. In addition, a Demographic Profile was collected for each participant (Appendix G).

The researcher performed focus group interviews in a quiet setting, free from distractions, that was familiar to the participants under study. The site was either within Capital Health offices or Dalhousie University. The setting was a neutral one that was comfortable, not intimidating, accessible and easy to find (Polit & Beck, 2004). Refreshments were also provided to participants.

The focus group interviews were digitally recorded and transcribed verbatim, by a transcriber selected by the researcher, as soon as possible after the focus group sessions. Participants were invited to a follow-up focus group following the initial focus group interview, to provide any feedback to the researcher and elaborate on emergent themes. The follow-up for Focus Group One was held six weeks after the initial focus group and the follow-up for Focus Group Two was held 11 weeks after the initial focus group, due to scheduling conflicts. Participants were not excluded if they were only able to attend one of the focus groups. One NP participant only attended the follow-up focus group and one PHN participant was unable to attend the follow-up focus group due to illness. An individual interview was completed with this participant to discuss emergent themes from the first focus group and to give her the opportunity to elaborate. This interview was held 14 weeks after the initial focus group.

A reflective journal was used by the researcher throughout the research process. The purpose of the reflective journal was to clarify any potential biases that the researcher had through reflection on observations, interpretations and experiences during

the research process. The observations, interpretations and experiences contained in the journal were used by the researcher during data analysis.

Data Analysis

"Data analysis can be described as the heart of qualitative inquiry" (Speziale & Carpenter, 2007, p.52). The data analysis in qualitative inquiry requires openness to possibilities and entails listening intently to narrative and while maintaining a high level of integrity, sharing a description and understanding of what has been said (Speziale & Carpenter). The analysis strategy of choice in qualitative descriptive studies is qualitative content analysis (Sandelowski, 2000). A content analysis of qualitative data includes an analysis of themes and patterns that emerge among the themes (Polit & Beck, 2004). As the goal of qualitative descriptive studies is a comprehensive description of a phenomenon or events in everyday language, researchers using this method stay away from penetrating their data in any interpretive depth (Sandelowski).

In qualitative content analysis, transcribed data is broken down into smaller units, coded or named according to their content and/or concepts they represent, and then coded data is categorized or grouped based on like concepts (Braun & Clarke, 2006; Miles & Huberman, 1996). Collection and analysis of data is simultaneous, as treatment of data is continuously modified by the researcher to accommodate new data and new insights regarding data (Sandelowski, 2000). Although researchers may begin analysis with predetermined coding systems, during content analysis coding systems may be modified or completely discarded for a new system to ensure best fit to the data (Sandelowski).

Transcribed focus group interview data were analysed for themes without interpreting or re-presenting the data in any other terms, but how it was reported by the

participants (Sandelowski, 2000). Braun and Clarke (2006) describe thematic analysis as "a method for identifying, analysing and reporting patterns (themes) within the data" that "minimally organizes and describes your data set in (rich) detail" (p.79). The authors identified six phases of thematic analysis: familiarizing yourself with your data, generating initial codes, searching for themes, defining and naming themes, and producing the report.

As the researcher, I immersed myself in the data by actively reading and re-reading the transcripts several times, while noting initial codes and patterns in the data (Braun & Clarke, 2006). The initial patterns that I was seeing in the data were presented to the participants in follow-up focus groups. During the follow-up focus groups, participants had the opportunity to review and comment on the preliminary emerging themes. Additionally, I sought further clarification and elaboration on interview questions.

Next, the interview transcripts from the initial and follow-up focus groups were coded using NVivo 9 software (QSR International, 2011). NVivo9 is a software program intended for qualitative analysis that assists the researcher in making sense of unstructured information. The program does not do the thinking for you; rather it provides a workspace that helps the researcher work through data (QSR International). The process of coding involves meaningfully dissecting transcribed data, while keeping relations between the parts intact (Miles & Huberman, 1994). Codes are described as "tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study" (Miles & Huberman, p.56).

As the goal of qualitative description methodology is straight descriptions of phenomena, I coded for as many potential themes/patterns as possible and kept relevant

surrounding data to the code, so to not lose the context of the code (Braun & Clarke, 2006). Codes were determined after I familiarized myself with the data, using the interview questions as an 'a priori' guide. I identified codes and then matched them to data extracts that demonstrated that code (Braun & Clarke). Data were coded and then collated together within each code (Braun & Clarke).

Once the data were coded and collated using NVivo 9 (QSR International, 2011), I used the software's auto coding function to draw out data from PHNs, FPNs and NPs. This function allowed me as the researcher to classify coded focus group data by participants. I examined the codes that appeared most frequently for significance. I used this process to ensure that one participant's voice was not over-represented in the data and that the code was important to both primary care and public health.

Next, I sorted the codes into pattern codes or potential themes and collated the relevant coded data extracts within the identified themes (Braun & Clarke, 2006). Lincoln and Guba (1985) state that the phase of categorizing data involves bringing together initial codes or categories that relate to the same content, devising rules that describe category properties and providing internal consistency for the category set. Using constant comparison, I analysed codes to see how they may or may not fit together to create an overarching theme (Braun and Clarke). At the end of the phase of searching for themes, I had a collection of possible themes and subthemes and all data were coded in relation to these themes (Braun & Clarke). A thematic map was used to illustrate relationships between codes, themes and different levels of themes (main themes and subthemes).

I was in constant consultation with my thesis supervisor during each step of this process. Original transcripts and coded data were reviewed by both the researcher and my supervisor and several meetings were held to discuss the evolving thematic structure. Once I was satisfied with my thematic map, I further refined each theme and subtheme and generated clearer definitions and names for each theme (Braun & Clarke, 2006). Themes and subthemes were first confirmed with the researcher's thesis supervisor and then presented to the entire thesis committee.

Ensuring Trustworthiness

The qualitative researcher must consider how to "persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to…" (Lincoln & Guba, 1985, p.290). Lincoln and Guba described four concepts to be considered when examining trustworthiness in qualitative research. The concepts, credibility; dependability, confirmability, and transferability will be applied to ensure trustworthiness in this study.

Credibility

In qualitative research, credibility is defined as confidence in the truth and interpretations of the data generated (Lincoln & Guba, 1985). According to Lincoln and Guba, credibility is an overriding goal of qualitative research and activities that increase the probability that credible findings will be produced contribute to the credibility of findings. There are two aspects to credibility, first the study should be conducted in a way that enhances believability of the findings and secondly, the researcher must take steps to demonstrate credibility to consumers.

Triangulation is one way that the researcher can enhance credibility, as multiple references are used to derive conclusions as to what constitutes truth (Lincoln & Guba, 1985). Investigator triangulation involves using two or more researchers to analyze and interpret data, as to reduce the possibility of a biased interpretation (Lincoln & Guba). In this study, my thesis advisor and I reviewed the data collected.

Two other techniques were used to enhance credibility. I used peer debriefing sessions to review and explore various aspects of the inquiry with members of my thesis committee (Lincoln & Guba, 1985). Member checking was used to establish credibility of the data (Lincoln & Guba). Follow-up focus groups and one individual interview were used to enable participants to further review the data and contribute to the process of identifying emerging themes.

Patton (2002) discussed researcher credibility as another aspect of credibility. The qualifications, experiences and reflexivity of the researcher are essential to establishing certainty in the data. As a RN and an International Board Certified Lactation Consultant with over ten years of experience working in public health with breastfeeding women, and a mother of two children, my personal and professional experience bring credibility to my ability as a researcher in this study. Through my experience as a PHN and a woman accessing breastfeeding supports in Capital Health, I have acquired a thorough knowledge base and I am able to view the research topic through the lens of a professional as well as a client.

Dependability

Once a qualitative researcher has demonstrated the credibility of findings, the dependability of the results must be considered. Dependability refers to the stability of

the data over time and conditions (Lincoln & Guba, 1985). Dependability is promoted by ease of data replication and review of the data by external researchers (Speziale & Carpenter, 2007). Providing an audit trail of detailed description of data analysis activities and including sufficient raw data, makes it possible for the study to be replicated by future researchers.

Confirmability

Confirmability refers to the objectivity or neutrality of the data and the potential for two or more independent people to arrive at similar conclusions about the accuracy, relevance, or meaning of the data (Lincoln & Guba, 1985). This study utilized qualitative description methodology, which enables the researcher to provide "a comprehensive summary of an event in everyday terms of those events", without theory laden, philosophical commitments (Sandelowski, 2000, p.336). This study provides a straight description of the structures and process required to support the development of collaboration amongst PHNs, FPNs and NPs, therefore the data remained neutral, easing the ability for external users to draw their own truth from the data.

Transferability

According to Lincoln and Guba (1985), transferability is the extent to which the research findings are applicable to other settings, populations and contexts. To ensure transferability of study findings, it is the responsibility of the researcher to provide adequate descriptive data in the research report so the user is able to evaluate the applicability of data to other settings (Lincoln & Guba). As qualitative descriptive studies do not require the researcher to transform their data into an abstract or conceptual format, this will facilitate transferability. In this study, transferability was ensured through

providing a detailed account of the research process and including sufficient raw data to allow the consumer to ascertain transferability.

Ethical Considerations

Speziale and Carpenter (2007) acknowledged that because it is impossible to fully anticipate what sensitive issues may occur in the emergent process of qualitative inquiry, researchers need to be prepared for unexpected concerns. Permission to conduct this study was gained through the Capital Health Research Ethics Review Board.

Informed consent is necessary in any research involving human participants (Speziale & Carpenter, 2007). A consent form describing the purpose and nature of the research being conducted was presented to each of the participants for review. Information outlined in the letter and was reviewed with each of the participants prior to the signing of consent to ensure that they were fully informed. Participants were informed of their right to withdraw from the research study at any time. A signature of the participant was required and a copy of the consent form was given to the participant for his or her personal records.

The researcher attempted to assure confidentiality at each stage of the study. The consent form assured participants that their names would not be used in the reporting of results or during the writing of reports or articles for publication. Pseudonyms were used in the writing of this thesis report. Study participants were asked not to share interview data outside of the focus group sessions. In addition, the MN student who assisted the researcher as a recorder and the transcriber were required to sign a confidentiality agreement (Appendix H and I).

All information was stored in a locked filing cabinet in the researcher's office throughout the study. Digital interview data was stored on a password protected computer in a locked briefcase until completion of the study. Original files were deleted from the recording device after they were transferred to the researcher's computer. After a seven year archiving period, as per Capital Health policy, all digital recordings and electronic files will be removed from the researcher's hard drive using WipeDrive software. Paper documents will be shredded using Capital Health's confidential shredding.

The benefits of this study outweighed the risks. The subject matter that was discussed may have potentially evoked feelings of frustration with the current state of practice with breastfeeding families. However, the experience may have enlightened participants on future collaborative relationships and connected them with practitioners that they may have had previous working relationships with. The researcher did not attempt to counsel participants.

CHAPTER IV

FINDINGS AND INTERPRETATIONS

Introduction

The purpose of this chapter is to present the findings and interpretations in this qualitative descriptive study "Exploring the Structures and Processes Needed to Support the Development of Collaboration Amongst Public Health Nurses, Family Practice Nurses, and Nurse Practitioners who Work in Breastfeeding Support and Promotion." A qualitative descriptive design was used to explore and understand the nurses' experience of collaboration between primary care and public health. Data were collected in focus group interviews, using a semi-structured interview guide. A qualitative descriptive design allowed me as the researcher to provide a thorough explanation of the nurses' experience of collaboration between primary care and public health by providing "a comprehensive summary of an event in everyday terms of those events", without theory laden, philosophical commitments (Sandelowski, 2000, p.336).

With reference to Himmelman's (2002) definition of collaboration and D'Amour et al.'s (2008) typology of collaboration, as outlined in Chapter I, the participants in this study most frequently described activities that can be considered networking or coordinating along the developmental continuum of collaboration and classified as potential or developing collaboration. Participants discussed situations where information was exchanged, and trust was absent or forming. They also described few opportunities to meet or participate in joint activities with nurses outside of their organizations. In this chapter, I describe the study participants' perceptions of the structures and processes

needed to support the development of active collaboration amongst public health and primary care nurses who promote and support breastfeeding.

This chapter begins with a discussion of the roles and responsibilities of PHNs, FPNs and NPs. The four major themes are discussed that emerged during the analysis of the focus group interviews: (a) *Establishing Interpersonal Relationships*, (b) *The Organizational Context – Structures and Processes in the Every Day Work Environment*, (c) *Benefits of Collaboration*, and (d) *Development of New Practices Grounded in Collaboration*. Pseudonyms are used for the participants in the presentation of their narrative accounts.

Roles and Responsibilities

Participants were asked to describe their roles and responsibilities in the care of breastfeeding families, including what a typical and atypical day would look like supporting and promoting breastfeeding. In this study, the "clients" that the participants most reported that they supported ranged from individuals (PHNs, FPNs and NPs), to groups (FPNs and PHNs), communities (FPNs, PHNs) and populations (PHNs). Primary care nurses described supporting a wide variety of clients from many backgrounds and socioeconomic classes. Two of the PHNs worked in a pre and postnatal program that was targeted to families who were determined to be "*vulnerable*" according to a screening tool and various assessment tools that measure parent-child interaction. The other two PHNs in the study worked in a universal pre and postnatal program available to all families. Roles and responsibilities, as reported by study participants, are grouped into the following categories: (a) *Prenatal Support*; (b) *Postnatal Support*; (c) *Mentoring, Preceptoring and Education;* and (d) *Community- Based Practice*, *Policy*, and *Advocacy*.

Prenatal Support

All participants described a role in supporting breastfeeding during the prenatal period. NPs and FPNs typically described their role in primary care as talking about breastfeeding with individual clients, while the PHNs interviewed in the focus group discussed their role as offering group education to clients about breastfeeding through prenatal classes. One FPN, Andrea, discussed a group approach to prenatal care that is being initiated in the clinic where she works,

> *And in our group, we are now starting... Because we have the 3 teams and physicians who are doing obstetrical care. So we're going to try and set up a model of group education so that we can meet. Even though the patients are still going through prenatal. It's not to replace any of the prenatal visits or anything like that but it's just to give them the support when they are going through the pregnancy and then support... After they have the baby, they'll come back in a group. And that's what our model is....*

PHNs, FPNs and NPs saw their role in the prenatal period as helping individual mothers make an informed decision about how to feed their baby through discussing the benefits of breastfeeding and answering mothers' questions. One NP, Wendy, stated,

> *I see my role as discussing the benefits of breastfeeding in pregnancy visits, and getting a sense if the mom feels that's something that she wants to do and what she perceives the benefits as and what type of support she has for that experience.*

Postnatal Support

During the postnatal period, both public health and primary care nurses reported offering individual support to women; the major differences were the location and intensity of the interactions. Primary care nurses typically interacted with clients in a clinic environment or over the telephone, for short periods of time on a recurring basis. Trudy (FPN) explained, "*We see them the first day to day 7 and then weekly or bi-weekly after that. And then at 2, 4, 6, 12 months and so on."* The interactions between PHNs and clients took place in the hospital prior to discharge, over the telephone, in homes, or other

community settings such as Family Resource Centres or community centres. They tended to spend longer with clients in a single interaction; however, their contact with clients did not always occur on a recurring basis, although they often had more than a single interaction with a client. Doris described,

> *And if they just have some questions, I can answer them over the phone. If they do need some assistance in terms of latching or, you know, just feel like a home visit would be maybe a better way to meet their needs then that is arranged usually that day or usually, you know, within a day or two. And so sometimes that just involves one visit. Other times it involves going back for several more visits in a few cases. And she may call back. The moms sometimes will call back with questions.*

PHNs described their role as completing a postpartum screening tool before hospital discharge, telephone contact post discharge, and home visiting for breastfeeding support where assistance is provided with the baby's position and latch. Rene (PHN) also discussed using texting as a way to offer support to clients in the postpartum period. Sally (PHN) described a typical interaction on a home visit with a mother during the postpartum period,

> *So walking in and, if it's feeding time, then offering a feeding assessment, a latch assessment, a weight check for the baby. And really kind of hands-off to be honest. Watching what she's doing and trying to talk her through that latch or talk her through that positioning. And then if that doesn't work, of course then you're... You're not even taking her hands away but just guiding her own hand on how to latch that baby. A lot of talking, a lot of positive reinforcement for my clients as well. Like, "This is great that you've made this decision. It's a great decision you've made for the health benefits, for financial benefits as well." And just reiterating all the benefits.*

FPNs and NPs most often described their role as supporting mothers and families with breastfeeding in the clinic environment. Andrea (FPN) mentioned that the flexibility of her role enabled her to make home visits to mothers; however this was not a typical occurrence. FPNs and NPs also discussed telephone support as part of their role in supporting mothers with breastfeeding during the postnatal period. Rita (FPN) described

her role in supporting breastfeeding postpartum as, *"... it's the hands-on care for the baby and the mom for me... But also I do answer a lot of phone calls as well." Or I [at] least give the Public Health number."* In addition to providing individual support to mothers in the home and over the telephone, PHNs also offer support to breastfeeding mothers in a group setting in the community.

Mentoring, Preceptoring, and Education

Both the PHNs and FPNs interviewed in the focus group spoke about a particular role within their organization related to breastfeeding support. PHNs and FPNs noted that they provide mentorship and preceptorship to other staff and students. One FPN, Andrea, discussed her role in mentoring medical students,

> *We have also the residents in the community program. And so we do mentor with the residents, and we stress about how important it is and helping them to get comfortable with the new moms and with prenatal and postnatals. So getting the residents really comfortable with it so that they are educating the parents as well.*

The four PHN participants discussed their role in providing education to other health care professionals and community agencies through education sessions and a breastfeeding education program. They also mentioned providing breastfeeding education to high school students in family studies classes, although this was not a typical daily activity.

Community-Based Practice, Policy Development, and Advocacy

Although all of the nurses described most of their time as being spent with individual or group interaction, some of the participants also spoke about other roles that they assumed in breastfeeding support and promotion. Rita (FPN) described community outreach as being a part of her role within the physician's office where she worked and having the time to attend community meetings and take part in community initiatives. Whereas, Wendy, an NP stated that although her role was intended to include community

development work, this work was neglected because of a high direct service focus to her job. *"There is. But it's become a bit of a shadow because of the...I guess the high clinical focus and patient needs right now."*

Lois and Trudy, two FPNs working in a fee-for-service Family Practice Clinic, voiced a desire to be involved in community initiatives and mentioned using their personal time to take part in such initiatives. Any activities outside of seeing patients in the clinic was described as being, *"...volunteer stuff at the end."*

The PHNs who were interviewed discussed roles related to policy development and advocacy, as well as initiatives within their community and beyond their organization related to breastfeeding support and promotion. Helen (PHN) discussed her involvement with population focused activities such as involvement in strategies related to the Baby Friendly Initiative (BFI) and a provincial education committee. She stated,

> *I am also a member of the BFI Breastfeeding Committee. And we are looking at the 10 steps of baby friendly initiative to look at what supports need to be in place to help these families. So most recently there was a policy that has been revised to make sure that it is current. And we're going through the various steps to see where we are as an organization. And also it's a joint policy between public health and the IWK Hospital. So we're trying to reach out to our different community partners to make sure that we're on as much as a same page as possible and working together so that it's more of a seamless transition from the mom's perspective.*

Additionally, she discussed,

> *I am working on a provincial education breastfeeding committee, and I'm one of the co-chairs with [Name]. And we're looking over the current terms of reference. And although a big part of the project is around educating healthcare professionals to meet the criteria for our baby-friendly initiative, it's kind of growing bigger and bigger.*

Doris (PHN) explained that although these types of initiatives were part of public health practice, this was not always the focus of her typical daily activities. She stated,

And the other promoting parts, we don't do that much. Like World Breastfeeding Week is just once a year. And the other Community of Practice stuff is just... It's ongoing but it's every once in a while, you're going to meetings or connecting with other community people.

As a significant amount of time was spent with individual contact with mothers, PHNs also discussed challenges in fulfilling other aspects of their role, Rene (PHN) stated, "*My role is still, I see it as very much putting out those fires day-to-day, and not really getting into the advocacy/policy change because there's no one else to do what I do."*

Thematic Findings

In the following section, I discuss the four major themes and sub themes that emerged from the analysis of the focus group interviews as described below.

1. Establishing Interpersonal Relationships
    a. Precipitators to Forming Interpersonal Relationships
        i. Motivation – passion for breastfeeding
        ii. Making a connection
        iii. Establishing trust and mutual respect

    b. Barriers to Developing Interpersonal Relationships
        i. Different approaches to care
        ii. Not knowing each other
        iii. Lack of role clarity
        iv. Poor relationships between PHNs and family physicians

    c. Outcomes of Effective Interpersonal Relationships
        i. Referrals
        ii. Networking and coordinating
        iii. Improved client outcomes and care
        iv. Improved knowledge and capacity building of health care professionals

2. The Organizational Context: Structures and Processes in the Everyday Work Environment
    a. Communication and Coordination
        i. Effective information exchange

ii. Ineffective communication mechanisms
iii. Resources to guide practice

b. Service Delivery Models
    i. Situated opportunities for innovation
        (i) flexible organizational structure
        (ii) fee-for-service environment
        (iii) administrative support and leadership
    ii. Generalist versus specialist practice

c. Location
    i. Physical space
    ii. Geographic Proximity to other Health Care Professionals

d. Resource Limitations
    i. Time
    ii. Limited access to breastfeeding education

3. Benefits of Collaboration

    a. Interprofessional Connectivity

    b. Improved Breastfeeding Outcomes

    c. Consistent Messages

4. Development of New Practices Grounded in Collaboration
    a. Common Understanding
        i. Shared goals, vision and location
        ii. Client- centred orientation

    b. Improving Relations Between Professionals
        i. Mutual acquaintanceship
        ii. Forming trust

    c. Creating an Environment for Collaboration
        i. Supportive organizational structure
        ii. Communication mechanisms

    d. Required Resources
        i. Funding
        ii. Physical space

iii. Human resources

Establishing Interpersonal Relationships

Interpersonal relationships were a significant theme related to collaboration between public health and primary care in breastfeeding promotion and support. In a scoping literature review of collaboration between public health and primary care, Martin-Misener et al. (2008) found that the quality of professional relationships between public health and primary care practitioners was an important facilitator for collaboration amongst the two sectors. The sub themes found in the thesis are; (a) *Precipitators to Forming Interpersonal Relationships*, (b) *Barriers to Developing Interpersonal Relationships*, and (c) *Outcomes of Interpersonal Relationships*.

Precipitators to Interpersonal Relationships

Precipitators to strong interpersonal relationships were: (i) *motivation – passion for breastfeeding*, (ii) *making a connection*, and (iii) *establishing trust and mutual respect*.

Motivation – passion for breastfeeding. Sharing a passion for breastfeeding emerged as common ground that led to the development of an interpersonal relationship. Sharing common goals and a common vision was found to be an important determinant in the development of collaborative relationships amongst professionals at the interactional level in the literature (Cohen & Bailey, 1997; Evans & Dion, 1991; Liedkta & Whitten, 1998). Conversely, the literature noted that a lack of common agenda or vision and dominating or competing agendas was found as a barrier to collaboration between public health and primary care (Dion, 2004; Hogg & Hanley, 2008).

The focus group participants revealed that a common passion for breastfeeding facilitated collaboration within and between organizations. Andrea (FPN) stated, *"I'm*

really lucky in our group, we [FPNs] collaborate really well because we have a very strong feeling about breastfeeding and support it." Sharing a known passion for breastfeeding with other nurses in the community also contributed to collaboration between PHNs and primary care nurses. Sally (PHN) stated,

> *And I've listened to her passionately speak about breastfeeding. And she's just been... As soon as I called [Name] Health Centre, there was no choice, they put me through to Rita. Because as soon as I said breastfeeding, it's like it went right through to Rita. So knowing that even within her organization, there's that trust as well.*

The importance of sharing a common passion about a topic as a factor contributing to collaboration is consistent with the literature that discusses communities of practice. A community of practice is defined as "groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis (Wenger, McDermontt & Snyder, 2002, p.4). Within communities of practice, members help each other solve problems through sharing of advice and information (Wenger et al.). This was evident when Doris (PHN) described trying to get a new initiative to support breastfeeding off the ground, she stated, "*Well, the motivation behind that particular one in terms of the breastfeeding centre would be to bring in people who are already converted and hopefully they're going to, you know, lend support, as well as mothers."*

Making a connection. Another important factor in establishing interpersonal relationships was making a connection with another RN or other health care professional. Participants described this process as "*reaching out*" or "*putting themselves out there*". In an attempt to form a relationship, they talked about attending meetings, making phone calls, sending letters or doing presentations. For professionals to build trusting

relationships, it is important that they get to know each other personally and professionally (D'Amour et al., 2008).

Trudy (FPN) explained,

> *Five years ago I went over and did a presentation at public health about the role of family practice nurses. And then we invited the three... One of them has since changed or maybe two. The three nurses to come out and actually meet with us at the clinic. So they came out one time. The plan was to have them come out again.*

Rita, another FPN, described her experience as,

> *With public health nurses, I established a relationship by going to the breastfeeding committee originally, is what I did, so I know the Public Health and a lot of other people in the breastfeeding community as well...I know a lot of doulas who I could call if I see patients who are looking for doulas. I can give numbers out for that. And somebody today asked about breast pumps. And I said, well, we just got the email about the [Place] having breast pumps. And I was chatting with her about the breast pumps. And that just came. We just got that the other day. So I think it's just being in the know. If you had asked me something about another, not breastfeeding but something else like COPD [chronic obstructive pulmonary disease], would I have that ability? Probably not. But this is where my interests lie so I know a lot more about this. And in the clinic itself, it's just you just build the rapport. You just get to know people just by being there and your experience in the clinic with the physicians and the new population as well.*

Although these FPNs took the initiative to connect with PHNs and other health care professionals involved in breastfeeding support, the PHNs and primary care nurses in the study agreed that it was public health's role to reach out and make connections. Trudy (FPN) stated, *"So I think it's going to have to be Public Health really like inviting themselves in - I'd like to come over and bring you guys lunch some day and tell you about the great programs..."* Similarly, Rene (PHN) suggested,

> *So what I'm sensing is that maybe we need to go back and really put ourselves out there to find out where the family practice nurses are and the nurse practitioners, and see what we can do to work together.*

Sally (PHN) also expressed, *"I think we're [public health] responsible for promoting the work that we do."*

Establishing trust and mutual respect. Participants believed that the most significant component to forming interpersonal relationships was establishing trust and mutual respect. This is consistent with theoretical and empirical studies of collaboration, as found in a review of determinants of successful collaboration completed by San Martin-Rodriguez et al. (2005) and in D'Amour et al.'s (2008) model and typology of collaboration between professionals in healthcare organizations. San Martin-Rodriguez et al. found that trust is a key element in the development of collaborative practice; trust is indispensable in the development of collaborative working relationships. D'Amour et al. stated trust reduces uncertainty and that professionals need to have trust in each other's competencies to be able to achieve collaboration. Established trust and respect was reported by participants in both focus groups as a facilitator to collaboration within primary care and public health organizations and between public health and primary care.

Henneman et al. (1995) found that building trust requires time, effort, patience and previous positive experiences; the focus group interviews were consistent with this finding. When discussing her relationship with public health, Andrea (FPN) stated, *"I think because my predecessor did such a good job liaising with Public Health, all we have to do is call and say it's so and so from [Name] and then we get a call right back."* Rita (FPN) also described a comparable situation, "*I have very good collaboration with Public Health because I've been in on very many meetings with them and that. I know the people in the community."*

San Martin-Rodriguez et al. (2005) stated that professionals tended to place more trust in other professionals who they considered to be more experienced and competent. This was evident in the interactions between public health and primary care. Rita (FPN) stated, *"I'll give the Public Health number out to them. Because whatever Public Health says, I'm agreeing with."* Similarly, Sally (PHN), stated,

> *...if I know they're going to the [Name] Health Centre, I'll drop your name and say, you know what, Rita knows her stuff. And I trust what Rita's telling you. So it's just kind of that collaboration. Yes, I'd say that's the one nurse in my community.*

Trust and mutual respect was also an important precipitator to collaboration within public health and primary care organizations. FPNs discussed how within their organizations, physicians would come to them with questions related to breastfeeding, as they were viewed as being knowledgeable on the topic. Trudy (FPN) stated,

> *I would say that the physician and I would... I mean he would support anything that... I probably have a lot more background than he would, having been the manager and done the 18 hour course and all that kind of stuff. So he tends to sort of look to me.*

Andrea (FPN) described a similar experience,

> *But the physicians come to us and say, "What would you recommend? What are you going to help..." You know, what will help them benefit more? And if they don't know, they ask us. So I think that's the collaboration piece because they do look on the nurses having had the training, having had the support. And maybe they look at the anatomy, I don't know.*

When discussing collaboration amongst nurses in public health, a PHN, Sally, stated,

> *I think within my own organization, I learn from my nurse colleagues. So I identify those with more experience than what I may have with breastfeeding and supporting women with breastfeeding. So there's some collaboration going on within the organization as well.*

Barriers to Developing Interpersonal Relationships

Participants identified barriers to developing collaborative interpersonal relationships: (i) *different approaches to care*; (ii) *not knowing each other*; (iii) *lack role clarity*; and (iv) *poor relationships between PHNs and family physicians*. Having different approaches to care was more of an issue for PHNs than FPNs and NPs. Some of the participants suggested that all health care professionals were not speaking the "*same language*" in relation to breastfeeding support and promotion. The importance of recognizing various interests and imbalance of power amongst different partners involved and the negotiations that occur as a result of these differences was noted in the literature (Corser, 1998; Henneman, 1995; Sullivan, 1998).

Different approaches to care. Most of the participants discussed how health care professionals and organizations differ in their approach to breastfeeding support and promotion. These differences seemed to have an impact on forming interpersonal relationships. PHNs most often discussed issues with physician practices conflicting with their own practices. Doris (PHN), stated:

> *Sometimes all of the promotion and support that you give women, they go to the doctor and formula is recommended because of, you know, something that's probably within norm. It's kind of frustrating when the weight is not quite what, you know, you'd like to see but it's still very acceptable. So I find that that is a huge challenge that I run into a lot.*

Helen (PHN) also shared the same concern, she stated,

> *Probably one of the issues I struggle with is inconsistent messages, particularly if they're from a physician. And that's always challenging with how to deal with it because... Like an example would be around a time when they're being recommended to supplement when there's not necessarily a medical reason that that is needed at that point in time. So it's hard for moms because they are kind of wanting very hard to follow the physician's advice but something inside them is looking for a different answer. And then if I'm giving them a different angle to look at it, it puts them in an awkward position because now they have two professionals telling them two different things.*

One PHN also mentioned how these differences impact client care. When working with community partners, she discussed the difficulties that she encounters while trying to balance between ensuring that correct information is shared and building a collaborative relationship Sally stated,

> *It's tough because I see it affecting the client. And the client is then confused and says, "Well, this person told me that, and this person told me that, and this person told me that." So it's difficult if we're not all on the same page, coming from the same perspective. It would affect collaboration. And I guess it would be then whose role is it to educate the other people? You know, constantly if public health is coming at them, "Well, actually it's this, actually it's that," I don't know how you'd build a good relationship for collaboration in that sense. But you're accountable to provide them with the key messages and the correct key messages that are coming out at the same time. And doing so cautiously with some organizations.*

The FPNs and NPs less frequently discussed issues with physicians, as they all described having close working relationships physicians. However, they did reveal some differences in approach to care compared to physicians. Rita (FPN) stated,

> *And I think a lot of physicians look at outcomes. So for example, they would look at baby's weight. They don't look at anything else, only baby's weight. So the baby's weight isn't... So they're all hung up on numbers and looking at outcomes, not looking at the short term outcomes right now because my baby isn't gaining weight. So they want to gain that weight so they can say, yes, they went back to the birth weight in this many days. I've got to get it in this many days. And forget to look at the whole picture. They just need the outcome right now. And I think that's with not only breastfeeding but other things as well. You know, I think I'm just generalizing there but that's what they do and they don't look at the whole picture. I think that's what happens mainly.*

When discussing how her approach to breastfeeding support compared with the physician that she works with, Trudy (FPN) mentioned, *"I think he would be much quicker to supplement if I wasn't there, honestly."*

One FPN, Rita, discussed differences in approaches to care amongst FPNs. She stated,

> *Because I hate to say this because as a family practice nurse, we're all medical modelled. Especially working in a physician's office, medical model, medical model. It's that swing around which we're all trying to do, is the health promotion and looking at wellness. So I think that changes now. And I think that change is happening in CDHA as well, the change to the wellness model more than the medical sickness model, is what's happening.*

Similar to this study, Wilkes and Robinson (1994), also noted how primary care nursing roles and philosophical differences in approach to care created interpersonal barriers to collaboration.

Not knowing each other. Participants noted that not knowing who the other nurses are within the community was a significant relationship challenge that created a barrier to collaboration and this was common amongst PHNs and primary care nurses. This is consistent with the findings of Poulton (2000). The author found that poor rapport and among various types of community nursing roles was an interpersonal challenge and a barrier to collaboration between primary care and public health.

Participants had difficulty naming other nurses who worked in breastfeeding support and promotion in their community. When discussing making connections with other nurses in her community, Doris, a PHN, stated, "*Because I don't... I'm trying to think, I was just sitting here thinking my gosh, do I know someone else in family practice besides you? I'm not coming up with anything."* Wendy (NP), thought that communication was lacking between public health and family practice offices, mostly because practitioners did not know one another; she stated,

> *Well, I guess if I had a mom that was in my office and she was having trouble, I don't even think I could name the public health nurse who they would call. Maybe I might be able to in one part of my area, in the [Location] side, but probably not the [Locaiton] side, who she could call for support.*

Participants voiced a yearning to know who the other nurses are in their community so they could work more closely with them and provide better client care. Trudy (FPN) stated,

> *I want to have that personal connection with, you know, one or two or three public health nurses that I know I can call at any time and say, "Help! Help with this mom. Can you come see her?" You know, that sort of thing. And that's, I think, a challenge for us. But on the other side, I know the reality so I'm not... So it's not a criticism, it's just it would be really helpful to have that kind of support.*

Even though they had the desire to work with others, most participants believed that they would not even know who to call, *"And I wouldn't know specifically who to pick up the phone and refer to."*

Lack of role clarity. Participants described an insufficient understanding of the specific roles that other nurses had in their community. When discussing her knowledge of the roles of other nurses in her community who support breastfeeding Rita (FPN), stated,

> *But that would be very typical as well because I wouldn't know what other family practice nurses did because family practice nurses have very different roles and have very different positions in many places. So I know what [Name] does because I know [Name]. But some of those others working with different physicians have kind of different outlooks on nursing and the nursing profession and roles working with that. So I wouldn't not simply know what another family practice nurse does in another practice.*

Wendy (NP), thought that there needed to be a better understanding between public health and family practice offices, she stated,

> *And I guess I'm not even clear maybe on that person's role if they could even offer the support to that mom. I'm sure I'm not the only person in a family practice office that maybe doesn't understand what the roles are.*

When discussing her knowledge of FPN practice, Helen (PHN) expressed,

> *And I guess I probably didn't...or wrongly assumed that family practice nurses had more times to do full assessments. So was assuming if a client was going to*

> *their office and the nurse had helped them, then sometimes I, in my mind, assumed that that would look very similar to what I did. So therefore there's no sense for me to try and do anything. Or, you know, the mom probably got that same information and things. So it's interesting to know that that's not what happens.*

This lack of understanding of one another's roles was a barrier to developing collaborative interpersonal relationships with other nurses in the community.

Poor relationships between PHNs and family physicians. PHNs believed that they had poor relationships with physicians. PHNs voiced their difficulty in establishing relationships with physicians, due to the large number of physicians and the fact that many women travel outside of their community to access a physician, they found it difficult to get to know the physicians who are in their community. Helen, a PHN, stated,

> *I don't feel connected with the physician groups in my area. I mean I know the nurse who happens to work in the doctor's office that I physically go to. And that's just because we have the side chats about things. But you know, when I had asked her what she does with breastfeeding women if they're having issues or whatever, she sends them in to the [Name] Centre. So you know, they're driving 30 km when we have a local group and they might be able to call me and we could have done things differently.*

She also noted,

> *Also the other challenge is because I work on the outside of the city but it's not exactly rural, half the people will use local physicians and the other half come somewhere in the city. So you know, I've got some in [Location], some in [Location], some in [Location], some in [Location]. Oh-oh, it would be really hard to try and establish relationships with all of them because people are going outside their community in order to access services for various reasons. You know, they lived in the city. They were comfortable with the doctor so they're just staying with them despite moving.*

PHNs thought that their role was not understood by physicians, partially due to the public health agency not communicating their role outside of their organization. Although PHNs typically thought that it was public health's role to reach out to physicians, Sally (PHN) believed that physicians and FPNs could take some initiative in

contacting public health. Particularly in situations where PHN expertise related to breastfeeding was needed, *"For me, I'd like to see a more active role in a GP even calling the public health nurse themselves and taking initiative to learn more about the issue that the mom may be experiencing."* She thought that if physicians or FPNs made the effort to contact PHNs, valuing their role and expertise in breastfeeding support and promotion, then PHNs would feel more comfortable doing the same. *"And that way it may make us also feel comfortable to call a GP, to call a family practice nurse and have that conversation with them. Because right now, we work very much in isolation, I feel."*

Outcomes of Effective Interpersonal Relationships

Despite the difficulties reported by participants, most participants were able to identify examples of successful interpersonal relationships that resulted in positive outcomes. The outcomes of these relationships were: (i) *referrals*; (ii) *networking and coordinating*; (iii) *improved client outcomes and care*; and (iv) *improved knowledge and capacity building of health care professionals*. These findings are consistent with the markers of successful collaboration between public health and primary care as reported by Martin-Misener et al. (2008).

Referrals. Referral was the most significant outcome of established interpersonal relationships amongst PHNs, FPNs, and NPs, and was significant to both primary care nurses and PHNs. Participants discussed referring clients to other care providers or organizations whom they had existing relationships with. Sally stated, *"...if I know they're going to the [Name] Health Centre, I'll drop your name and say, you know what, Rita knows her stuff. And I trust what Rita's telling you. So it's just kind of that collaboration."* FPNs also discussed referring clients to public health. Andrea stated,

I will pick up the phone and call public health if I have a concern. Or if I need to have a check on a baby that I know that we're not going to get in to see that baby at a given time, I will call public health. I'll call and say, "Can you make a call or have you been in? And is there anything that I'm missing on this?"

Referrals occurred when participants had knowledge of other organizations or professionals and the services being offered and trusted in the support that they would be able to offer to clients. This happened in situations where clients required additional support; Rita, a FPN, stated,

I've often referred people to the [Name] Centre or [Name] for the Tuesday morning lactation consultant, or the public health nurse as well. That's something we do on the phone pretty regularly on the breastfeeding line, would be encouraging the moms to go to those places where the public health nurse is.

Similarly, Trudy (FPN) stated,

That's when I make my phone calls or I say, you know what, if you get some help, I think they can support you to make this a much more positive experience. So why don't you call them. They'll come into your home. They'll have lots of time to sit down with you and watch you feed your baby. And I think there's just a few minor adjustments – I don't know what they are. A few minor adjustments and you'll be much happier with your...

PHNs discussed referring to physicians for "medical issues" when clients required care that was outside of the scope of a PHN. Sally (PHN) stated,

I think if there were any medical issues, I'd consult with the GP. You know, any milk supply issues, certainly calling a GP and maybe providing them with information about different treatments for milk supply. Any medical issues like mastitis, consult with even the family practice nurse or the GP about, you know, appropriate treatment of mastitis. Those would be the main things that I think I'd consult for.

Networking and Coordinating. Networking and coordinating as a result of interpersonal relationships was more significant for primary care nurses than for PHNs. All of the primary care nurses interviewed worked as part of an interdisciplinary team, either with physicians only or physicians and other health care professionals. Strong

interpersonal relationships lead to networking or coordinating among nurses working in the same location, as well as with other health care professionals. Elizabeth, (NP), described her work setting,

> *It's a lovely place to work. It's very collaborative. And if you have questions, most people want to hear what they are and will help you find answers. So pharmacy, occupational, physio, physicians, specialists, other nurses. Terrific resources.*

She believed that this type of work environment created a *"spirit of inquiry"* where professionals were comfortable asking questions and learned from one another. She described a feeling of comradery, rather than competition or animosity.

Andrea (FPN) also described a similar experience in her work setting,

> *So I don't think I ever had any problems with the communication part of it or working with physicians. Mostly I find the physicians are very, very supportive of breastfeeding and they really push as much as they can... if they see any of the patients who are struggling in any way, they will get one of the nurses in [Name] to spend time. So they set the patient up for success.*

Rita (FPN), discussed coordinating within her organization and networking between her organization and public health. She stated,

> *Myself and the other family practice nurse see about 90% of the postpartum women and babies. And we do a lot of... We have a separate breastfeeding room. So if they're having breastfeeding problems, we do actually watch the moms and babies breastfeed. And we also at that time contact... If they're having any further problems, contacting Public Health for their support as well at the time. And liaising with the physicians in the office if they're having medical issues as in low milk production and stuff like that. But a lot of times the physicians are calling us to assist with the breastfeeding in the rooms.*

Most of the PHNs did not describe experiences like this; however, one PHN working in a rural community, frequently described strong interpersonal relationships and networking amongst the health care professionals in her community. She had established relationships with the FPN, physicians and other professionals in her community. Rene described her experience as,

> *So that's what I'm seeing, is that I have a collaborative practice with the [Name] Health Centre. And we have Dr. [name] and Dr. [name] that come out and do all the prenatals out there. So they know... It's really simple. If a client goes into Dr. [name]'s office and she doesn't have a family practice nurse, she goes, "Oh, Rene's going to be calling you anyway." Right? So they know.*

One PHN, Doris, thought that public health and primary care had better collaboration in the past, when they were part of a joint initiative. She stated,

> *Just going back in history a bit. When we used to have a volunteer breastfeeding support line, I felt a little more connected to family practice nurses because the nurses that took the beeper after hours, a number of them were family practice nurses. So you know, we did have a few education sessions actually that we conducted and connected with, you know, any of the volunteers. And so yes, I felt much more connected to them. But that's going back in history because that was quite a while ago.*

Improved client outcomes and care. Participants also discussed improved client outcomes and care as a result of interpersonal relationships. Sally, PHN, described helping clients acquire a family physician,

> *I think some of my clients are discharged with no family doctor on their referral. So that's when I may... especially the [Name] Clinic, I often will bump over to them and plead and beg for somebody to see one of my clients with no family physician.*

Consistent messages amongst health care professionals had a positive impact on client care. Rita stated, *"because the more people who are given those messages, these positive messages, the greater likelihood they're going to continuing breastfeeding"*. Sally, PHN, had a similar experience with consistent messages when working with a physician,

> *The client continued breastfeeding. The client was supported from both ends to continue on with breastfeeding. Because the physician just needed some reassurance that everything was normal. This was normal feeding issues, that I was involved, that there was a bit of a safety net for this baby.*

Improved knowledge and capacity building of health care professionals.

When participants had established interpersonal relationships with other health care professionals, they discussed information sharing that occurred. Improved knowledge and capacity building in health care professionals occurred as a result of this information sharing, Rita, FPN, stated, *"Because the majority of the new stuff I learn about breastfeeding is from Public Health. That's where my knowledge comes from."* Sally, a PHN, described her experience with physicians as,

> *Most cases have been positive, I'm happy to say. Most cases, the GPs have been very gracious and saying, "Oh, I didn't know that. Fax me that information and then we can go from there." And I've learned too that sometimes that's just words that are spoken over the telephone and then when I follow up with the mom, the GP – I say GP because it's normally with the GP – just follows routine practice of what they would normally do. And is either prescribing the same dose of the medication or is still weighing the baby every two days, which isn't necessary. Or still requesting that a public health nurse go in three times a week to weigh the baby.*

Summary

In this section I discussed the theme of *Establishing Interpersonal Relationships* and included the sub themes: (a) *Precipitators to Forming Interpersonal Relationships*, (b) *Barriers to Developing Interpersonal Relationships*, and (c) *Outcomes of Effective Interpersonal Relationships*. Three precipitators to *Establishing Interpersonal Relationships* were discussed; *motivation – passion for breastfeeding*, *making a connection*, and *establishing trust and mutual respect*. These components played a significant role in the development of the interpersonal relationships that participants described in their experiences. *Barriers to Developing Interpersonal Relationships* were also evident. Participants described their difficulties when they encountered other professionals who had *different approaches to care*; *not knowing other nurses*, *not*

understanding the role of other nurses in the community and *poor relationships between PHNs and family physicians.* These challenges put constraints on the development of interpersonal relationships. Many participants believed that they did not know or understand who the other nurses or health care professionals were in their community. When good interpersonal relationships did exist, participants described positive outcomes including; *referrals*, *networking or coordination*, *improved client outcomes and care*, and *improved knowledge and capacity building of health care professionals* involved.

The Organizational Context: Structures and Processes in the Everyday Work Environment

Studies reporting on effective breastfeeding interventions provide little information about the organizational structures and processes that support these interventions (Hoddinott, Pill & Hood, 2000). Therefore, it is challenging to comprehend why some interventions fail and others succeed. When discussing collaboration, it is important to note that collaboration does not just take place between individuals, it takes place within the context of a larger organizational setting and occurs between organizations (D'Amour & Oandasan, 2005).

Organizational Context: Structures and Processes in the Everyday Work Environment was the second major theme related to developing collaboration between public health and primary care related to breastfeeding promotion and support. The organizational context of the work environments of nurses who were interviewed in the focus groups was heterogeneous. Practice settings ranged from fee-for-service family practice offices, salaried family medicine practices, urban and rural public health offices, and a federal health facility. The influence of the organizational context on the

development of collaboration in breastfeeding support and promotion was a common theme amongst public health and primary care nurses. The sub themes of (a) *Communication and Coordination*, (b) *Service Delivery Models*, (c) *Location*, (d) and *Resource Limitations* will be discussed in the following section.

Communication and Coordination

Appropriate coordination and communication mechanisms are required in the development of collaborative practice (Evans, 1994). Important factors related to communication and coordination between PHNs, FPNs and NPs that were expressed during the focus group interviews included: (i) *effective information exchange*, (ii) *ineffective communication mechanisms*, and (iii) *resources to guide practice*.

Effective information exchange. D'Amour et al. (2008) stated that when professionals do not know their partners well, they utilize information systems to decrease uncertainties. Participants identified using a variety of strategies, both formal and informal, to exchange information about clients and services with nurses and other health care professionals including telephone calls, email, group discussions and committee meetings. Overall, participants thought that there was an absence of any formalized system or mechanisms for communication between primary care and public health organizations.

Interorganizational agreements, protocols, and information systems are examples of formalized tools for information exchange (D'Amour et al., 2008). In the absence of a formalized system, participants relied on established relationships that they had with other professionals within these organizations to allow for a rapid and completed exchange of information. This type of information exchange was mentioned more

frequently in Focus Group One where most of the participants had established interpersonal relationships with one another.

In Focus Group One, the FPN participants did not have any issues communicating with public health, as they had established interpersonal relationships with PHNs and were confident that they knew who to call and how to reach someone in public health if they needed to. Rita (FPN) stated,

> *I know I normally just call somebody in public health who I know, who I know is going to... And they'll call me back and I'll say, "Oh, I'm looking for this." And then I'll get through like that instead of going through any main switchboard. Normally I'll call somebody direct and leave a message. And then I get through pretty quite to who I wanted to talk to.*

Andrea (FPN) also thought that she could easily get in touch with a PHN if needed. *"Well, sometimes it's just picking up the phone and saying, you know, I have this problem. And on the other end they say, "Well, send her to me." So it's just as simple as that. It's just connecting."* Doris (PHN) discussed how she communicated with physicians, *"Oftentimes if we need to speak with a physician, we can usually get through. I mean sometimes we have to wait and sometimes we have to leave a message."*

Participants who had interpersonal relationships with professionals in other organizations did not believe that using a formalized tool for communication was necessary, as they were comfortable just picking up the phone and calling. Rita (FPN) stated,

> *No, I like calling. And I also ask, "Do you want me to call public health? I can call Public health and I can talk to public health about this if you want me to." And I know that public health, when they call me and say I've got this concern, I've talked to the mom and it's okay for me to disclose it to you. They always have that privacy thing...A lot of times you call and the mom is right there in the office as well...So I like the telephone.*

Rene (FPN) who had established a good relationship with a local health centre commented on how she exchanged information with her primary care colleagues, she stated, *"Like [Name] Health Centre doesn't call my office number. [Name] Health Centre calls my Blackberry and it comes up [Name] Health Centre."*

Some of the PHN participants discussed formal mechanisms for information exchange within their organization and between an acute care facility and their public health unit. Doris (PHN) described a liaison position that connected PHNs with hospital staff and then provided information back to public health services,

> *And other little part of what I do is I back up a liaison position in the hospital. So in that position, I would be seeing moms in their rooms but also connecting with the postpartum staff and seeing what issues the mother may have. Sometimes they're not always related to breastfeeding but when they do come up. You know, the physicians there also connect with us. And so we pass that information on through... You know, we fax the information to the Public health nurses in the offices.*

Sally (PHN) also described how the hospital and the liaison PHN sent information through to public health when mothers were discharged from hospital. *"My first interaction would be a paper interaction where I'd read information that was provided from the IWK about breastfeeding status, any issues, maybe any additional information from our liaison nurse."*

Rita and Andrea (FPNs) discussed the formalized structures that were established within their organization to facilitate information exchange between health care professionals. Both of these FPNs worked in a non-fee-for-service environment. Rita stated,

> *Every two weeks we meet with one of the physicians and all the collaborative care workers in the same clinic. So every other Wednesday, everybody meets together. And we talk about... We meet with normally one of the physicians about their patients, sort of their collective care with all the other collaborators. And then we*

talk about specific people. And we can bring anybody up in the meeting. And then two weeks later, we'll meet with another physician.

Andrea (FPN) also mentioned a formalized structure within her organization to assist in the exchange of information,

And in our group, we are now starting... Because we have the three teams and physicians who are doing obstetrical care. So we're going to try and set up a model of group education so that we can meet. Even though the patients are still going through prenatal. It's not to replace any of the prenatal visits or anything like that but it's just to give them the support when they are going through the pregnancy and then support... After they have the baby, they'll come back in a group. And that's what our model is....

Some participants discussed a more formalized structure of information exchange between public health and primary care in the form of a *"committee."* This was only mentioned in Focus Group One. Two PHNs and one FPN in Focus Group One referred to sitting on a committee that had joint membership between public health and primary care. The FPN that discussed being a part of this committee worked in a non-fee-for-service physician's office.

Ineffective communication mechanisms. Participants also discussed deficiencies and challenges within the current infrastructure for information exchange between primary care and public health. Additionally, they discussed how current formalized systems did not allow for suitable exchange of information between professionals and how they were insufficient and inappropriate. D'Amour et al. (2008) suggests that collaboration is influenced less by the existence of formalized communication tools and more by consensus among professionals regarding details and rules related to their use in practice settings.

Trudy (FPN) described the confusion associated with the privacy legislation in NS. In her experience, this confusion made it difficult to communicate with professionals

outside of the Family Practice office where she worked. She noted that there is a misunderstanding as to when professionals are permitted to share information with one another. She explained,

> *One of the other big challenges and barriers is this whole confidentiality and [Personal Information Protection and Electronic Documents Act] PIPEDA stuff, that we're not allowed to talk to each other. So I'll have mom in, and I'm worried that there's something... You know, we've had a couple of, you know, abuse situations that I've been really worried about. And I call public health and say, "Oh my god, they've got to be seeing this mom. There's got to be one of the enhanced home visiting people visiting." Sure enough. But they are not allowed to talk to me, and I'm not... Like we've got to get that sorted out so we know.*

Primary care participants thought that the current information infrastructure did not allow for timely exchange of information. In contrast with other areas of their practice like chronic disease management, primary care nurses discussed a sense of "*immediacy*" associated with information exchange related to breastfeeding support and promotion. Wendy (NP) stated,

> *There's also a sense of immediacy that needs to happen if breastfeeding is not going well. Especially, you know, if this is a very young infant and feeding is not going well with babe, mom's not going to be able to handle that for very long. If feeding doesn't go well for 24 hours or so, and when we can't organize or provide some support to that mom and babe then breastfeeding is probably going to stop.*

Trudy, an FPN working in a fee-for-service family practice, described the difficulties that she encountered while exchanging information with other health care professionals. She believed that the current way of communicating between public health and primary care, which in her practice was via telephone, was ineffective. She stated,

> *... but one of the issues for me particularly because I'm not there full-time is that it's really hard to get a hold of somebody to talk to. Like if I want to problem-solve, you know, around something that's going on with the mom who sitting in front of me... Or I say, "Okay, you go home. I'm going to try to get a hold of someone, and I'll call you this afternoon and let you know what I find out." It's really, really difficult to make that human connection with anybody else in the health system. It's a big challenge.*

Rita (FPN) discussed how she believed that *"faxing"* a referral, which was the method traditionally used in primary care settings, was not appropriate in the care of breastfeeding women, because of the nature of the information being exchanged. Rita stated,

> *I think the other resources, if it was another... If we were sending somebody to an Emerg who needs to be seen soon then we call Emerg up and say we've got this patient coming. So it's more of these more emergent kind of issues. Which breastfeeding many times is why we would call public health, we want them to be seen in a short period of time. If you were sending somebody for osteoarthritis in their knee who isn't going to be seen for 6 months anyway then you send a fax. So it's all that kind of needs-based.*

Sally (PHN) discussed the information that she received upon a mother's discharge from hospital. She thought that this information was unclear. She stated,

> *I think the information we have is quite vague. So what type of supplementation occurred? Were IV fluids used? Was formula used? Was expressed breast milk used to supplement? I think more specific information about that. I'd also like, you know, to know sometimes if any devices are being used. Is a breast pump in action? Are nipple shields being used? Sometimes we don't know about that. Has Domperidone been prescribed? Because some patients are coming out already on Domperidone and that's not written anywhere for me. So knowing that information in advance could prep me for the phone call, I think. Yes.*

Trudy (FPN) explained how mothers are sent home with "*sheets from the hospital*" to give to their primary care provider, however, these sheets are often misplaced or forgotten by mothers. She commented,

> *But a lot of my moms don't bring them. Anyway, one did yesterday and I was thrilled. But that's it, that's all you get. And I know from working in the hospital, there were feeding plans made and there were all kinds of interventions...one of the moms came home pumping exclusively. And I'm like I've got nothing...I don't know what they did with her in there. You know? And so you just want... But I've asked for that and the answer I've gotten has been, "Well, you know what, the physicians don't want to see that stuff." Well, you know what, there's nurses now and we do. And that's what nurses are like. We like information. We care about that stuff. So start sending out... If there's physicians that don't want it, they can shred it or put it in the chart or whatever. But there's enough nurses out there*

> *now that want more information on our patients. So we're happy to have whatever we get our little hands on that will help us provide good care.*

Helen (PHN) stated that there had been some discussion within public health services as to how they could better communicate with primary care, mainly physicians. She talked about a communication tool that would be faxed to physicians to communicate that public health was involved with a client. She thought that this method of communication would be quite time consuming, given the number of births in the District. Helen stated,

> *It's just when you think of 5,000 babies a year, and you've got to do 5,000 of these, it gets a bit overwhelming. And will there be support for someone to be faxing these sheets off as opposed to added onto my workload of non-nursing functions to then do.*

Resources to guide practice. Evidence-based toolkits and decision making support tools have been described in the literature as facilitators for collaboration between public health and primary care (Huston et al., 2006; Larson et al., 2006; Wedel, 2007). The RNAO developed Breastfeeding Best Practice Guidelines for Nursing to provide the resources that are necessary to support evidence-based nursing practice in breastfeeding (2003; 2007). These guidelines were not mentioned as a tool used by the participants. However, the FPN participants interviewed did mention other practice guidelines that they used in practice, such as "*diabetes care*", as their education program is very "*guidelines based*".

Participants believed that there is an absence of such supports in their practice and because, of this relied on resources such as professional websites, information lines, pamphlets, books, and provincial resources, such as Loving Care and Breastfeeding Basics (Nova Scotia Department of Health and Wellness, 2011; Parent Health Education

Resource Working Group, 2011). Rene (PHN) stated,

> *So I pretty much go with our Breastfeeding Basics book...Our practice is based on that. Jack Newman, a resource around... I mean if the mom is having issues around sore nipples or whatever then I use that as a resource. But I keep it pretty simple.*

Sally (PHN) discussed how she used an information line to get information to help support the clients that she worked with,

> *For me, I utilize Motherisk quite a bit. So a lot of my clients have questions, like the alcohol question – When can I have a few drinks? And it may not mean that I'm calling Motherisk but I'm utilizing their resources. And for some clients, they may be on lots of different types of medications. So I'll be referring to Motherisk because they have questions that they feel weren't answered from the hospital staff. And we can talk to Motherisk in that sense. And I consult Motherisk too because there is use of narcotics in my population, marijuana in my population. So I'll consult with them as well so that moms can hear that information from the experts.*

As the resources mentioned throughout the focus group interviews were not professional protocols or tools, participants referred their clients to these same resources for information. Andrea (FPN) described her use of websites for breastfeeding information,

> *I love the Jack Newman site and the Kelly Mom site. I find that really good. And it's a great site to refer the moms to because then they can get on there and they can watch the videos of how to do it and changes that they can do for it.*

Service Delivery Models

For collaboration to develop amongst professionals, a favourable organizational setting is required (San Martin-Rodriguez et al., 2005). The focus group participants described structures of Service Delivery Models in their organization that were both facilitators and barriers to the development of collaboration in breastfeeding support and promotion. In this study, the researcher defined Service Delivery Models as approaches to client care taken by primary care and public health organizations. Examples include:

fee-for service, alternative funding, generalist practice and specialist practice. The factors related to Service Delivery Models that were identified by the participants in the focus groups were (i) *Situated opportunities for innovation*, and (ii) *Generalist versus specialist practice*.

Situated opportunities for innovation. As the development of collaboration leads to new activities and often changes in clinical practices (D'Amour et al., 2008), the structure of service delivery within the organizations where the participants were employed provided either provided opportunities for the development of such innovations or prevented them from getting off the ground. The participants discussed how factors such as (i*) flexible organizational structure*, (ii) *fee-for-service environment*, and (iii) *administrative support and leadership* influenced the development of collaborative practice.

Flexible organizational structure. During the focus group interviews, it was evident that participants working within a flexible structure had autonomy to adapt their practice to meet the need of their clients. The teamwork and shared decision-making that are found in decentralized and flexible structures fosters collaborative practice (Evans, 1994; Feifer, Nocella, DeArtola, Rowden & Morrison, 2003). This was evident from the participant's responses. Elizabeth (NP) remarked, "*So being able to kind of adjust your schedule to fit your style I think has been very helpful for me there. You know, I feel listened to*."

Helen (PHN) explained that even though all PHNs working in her program have the same job description, day to day activities may vary, depending on the population. She described,

Although Rene [PHN] and I do the exact same...we have the exact same job title and we work for the same organization, because we're in different areas, what our day-to-day stuff looks like is quite different because the communities are different. And so sometimes, you know, the ability is there to partner with whomever if there's a need that's identified in the community and it fits in with what our mandate is around looking at determinants of health and things like that that would be supported.

Flexibility in health professional roles to meet priority health needs in the community is a strategy for dealing with the challenges associated with collaboration between public health and primary care (Ciliska et al., 2005). Rita (FPN) discussed how flexible rather than restrictive scheduling allowed her to provide better support to her clients. She explained,

Supposedly I have half an hour. It depends on who comes to the office. But we're all flexible. You know, you spend more time with one person and the next person knows you can spend more time with them. You know, even they waited a little longer. You know that you're not rushing anybody. I think that's the flexibility. A lot of patients when you see them over and over again, they know that if even if you're a little behind, they still know you're going to spend the time with them. I don't think that's problematic. And a lot of times we can... I work with a few physicians where can just kind of, "Well, you do this while I do that." We kind of back each other up and things like that.

Fee-for-service environment. FPNs and NPs discussed challenges associated with the scheduling practices of working in a fee-for-service environment. "*Time*" was an issue that arose frequently. Although many of the participants were able to find creative ways to do their work within restrictive schedules, they frequently commented about how this way of working may not be optimal for supporting and promoting breastfeeding. Elizabeth (NP) remarked,

You've got someone booked every 10 minutes. So I've got a number. I can put it on the chart. I'm being responsible...You're squeezed for time so you don't have time to go hunting for the whole picture the way you might if you had a half an hour appointment. So I think sometimes that fee-for-service model really sets up this friction in a relationship actually, or dissatisfaction anyway.

Andrea (FPN) also point out,

> *In the 5 minute doctor's office visit out in the community, you know, a lot of the patients don't get in and out... They're in and out of there so fast that there's no possible way that they've talked to them about breastfeeding and the benefits and what it can do for the child and all that.*

Another FPN participant, Lois, who worked in a fee-for-service organization, revealed that although she had a positive working relationship with the physician that she worked with, she felt "*pressured*" to get clients out the door quickly. She stated, "

> *It's kind of hard because I almost feel pressured for time even if the physician should support whatever I want to do. And she's supportive of breastfeeding. But I still feel that I'm pressured to get the mom in and out.*

Wedel (2007) submits that alternative payment plans other than fee-for-service billing allowed for more flexibility in primary care practices. The author explains that in alternative payment plan practices, physicians are able to divide tasks amongst their team, thus allowing them to provide services with a greater focus on community based care and more complex patients. Although two of the fee-for-service primary care nurses in the study described offering services based in their community, this facet of their role was done outside of regular work hours.

Although the primary care nurses working in fee-for-service organizations had limitations to their time with clients due to appointment scheduling, they had flexibility within this structure and also had the ability to follow-up with clients. Wendy (NP) remarked,

> *I tend to see my well baby visits for half an hour. So that does sometimes give me the opportunity. But if they've come in because it's not a scheduled well baby visit but mom's having trouble because she thinks she has a blocked duct or something is going on, then that would be a quick 10 or 15 minute visit. Or sometimes it's a returning a phone call to a mom and trying to troubleshoot over the phone.*

Trudy (FPN) also agreed, stating,

> *But one of the things that you can do is see them for that 10 or 15 minutes, try to do what you can, connect them up with resources, but have them come back in a couple of days or have them come back in a week... And that's one of the beauties of the kind of practice we work in, is we can have them come back multiple times and, you know, do a lot of reassurance through, you know, just going through the checklist of poops and pees and weighing them, and, you know, that kind of thing.*

Administrative support and leadership. According to Kilduff, McKeowan and Crowther (1998), administrative support is required for the development of collaboration. D'Amour et al. (2008) also emphasizes the importance of leadership in the development of interprofessional an interorganizational collaboration. D'Amour professes that leadership could either be exercised by managers mandated to do so or by professionals who take the initiative on their own.

Meagher-Stewart et al. (2010) concluded from their study of *Organizational Attributes that Assure Optimal Utilization of Public Health Nurses*, that effective public health organizations foster a culture of innovation at the management and frontline level and the organization's leadership respects, trusts and supports PHNs to work to their optimal level of competencies. The PHNs in the study explained that they thought that their nursing expertise was not recognized by management and this was a barrier to the development of innovative practices that supported collaboration. Moreover, Meagher-Stewart et al. reported that promoting and valuing public health nursing practice and supporting autonomous practice were effective management practices that supported optimal public health nursing practice in the literature. Doris (PHN) described how leaders within her organization did not value the experience and knowledge that she gained from working with families. She stated,

> *And I think sometimes being able to really sort of help the powers to be to fully understand. Because it's not that you want to take away from peer support, it's not that you want to take away from hospital or anybody, it's just to me, it's a void.*

> *And I think that's something that's maybe as hard to communicate. Because in public health, I do believe in the other things. I definitely believe in the broader education and in empowering people as opposed to always doing for them. I definitely believe in that. However, I have been seeing moms for a very long time and I think there is a period of time that they do have needs. And I think that we shouldn't turn our back to that, just to say, well, okay, we need to just continue to promote or we just need to empower other members of the community to... Because nurses do have a certain amount of expertise. And it doesn't mean other people can't learn it. I just think that, you know, there are some situations where babies could be dehydrated or babies aren't gaining well. And you know, having a nurse with some kind of nursing background I think is important. It doesn't mean you can't teach the family or teach other support people but I think that I needs to be there with the experience and knowledge. So I just think that sometimes the powers to be maybe don't fully understand that need.*

The same concerns were shared by PHNs in a qualitative study public health nursing in NS (Meagher-Stewart et al., 2005). The authors found that several PHNs did not believe that management respected them for their expertise and they did not have sufficient opportunity to provide input into program planning.

Rene (PHN) shared the same concerns as Doris (PHN). She believed that it was a challenge to embark on new initiatives with community partners because it was difficult to know what would be supported by management. She remarked,

> *But the question comes back from our management, is, well, how are you deciding should you do a cholesterol clinic or what are the key issues? How are they being determined because they're already not... We don't have that in research...Or that information. Instead of sometimes you just have to do it. See who comes and figure that out. So around breastfeeding, if I'm at a table of community practice and then the physicians all know that, and somebody comes in for physio and she's breastfeeding and she's having difficulty all of a sudden, she knows where to be connected to.*

PHNs have an important role in building trusting, respectful partnerships within their communities (CHNC, 2011). However, it is necessary for organizations to allot time for PHNs to develop these partnerships (Meagher-Stewart et al., 2010). Helen (PHN)

stated how she did not think that developing collaborative relationships was a priority within her organization. She explained,

> *And with time maybe goes priorities and setting up what are the priorities. Because if it [collaboration] was seen as important in the overall organization then there wouldn't be questions if you were making time to do that and you didn't have time for other things. But if it's not seen as a priority throughout the whole structure, that doesn't always count when you're looking at productivity and what's your workload and what have you been doing?*

The primary care nurses in the focus group interviews worked most closely with physicians. The FPNs described the physicians that they worked with as being supportive of practice innovations. This support appeared to be important to the FPNs interviewed in the focus groups. Andrea (FPN) stated,

> *But I think the one nice thing is that it's also physician driven. The physicians really want it to happen as well. So it's not a fact that you're going in and trying to talk the physicians into encouraging the new mothers to breastfeed. They're laying the foundation as well as you are as a nurse. So that makes a difference.*

The primary care nurses had the support within their organizations to be proactive in their day to day practice. Trudy (FPN) mentioned,

> *We're lucky in family practice because we don't really have many rules. So if we have to do the right... If that's the right thing to do for that mom today, that's what we do. It doesn't matter what the rules are because there really aren't any. It's just go to where they are and help them where they are today, whatever that looks like.*

Generalist versus specialist practice. Depending on their organizational setting and role, the nurses in the focus group interviews reported that they required varying levels of practice knowledge and expertise in breastfeeding support and promotion to perform their jobs. The PHNs in the study worked specialised practice and as such focused on prenatal and postpartum women and their families. While the primary care nurses worked in a generalist role.

PHNs explained that they needed expertise in the area of breastfeeding support and promotion, while the primary care nurses believed that they did not need the same level of expertise as a PHN in this area. However, as Trudy explained, they "*need to be able to access an expert*". She stated,

> *So would it make sense for me to become more specialized in breastfeeding? It's probably not where I need to be spending a lot of my energy. [Name] on the other hand or [name] out in [Location], they do tons of prenatal.*

In a literature synthesis report on the challenges and strategies for collaboration between public health and primary care, Ciliska et al. (2005) found that differences in practice cultures between primary care and public health was a challenge to working together. They stated that the move of public health practitioners from a generalist to a specialist role "*conflicts with the generalist needs of primary care*" (p.15). Meagher-Stewart et al. (2005) also reported that increased specialization was a challenge to PHN professional practice. In their interviews with public health nurses, they found that most PHNs felt that a generalist practice had the greatest benefits, as this gave them the opportunity to have a better understanding of the community.

Doris (PHN) recalled when she did a "*different type of public health nursing*", "*generic nursing*". She believed that practicing in this way provided more opportunities for the development of collaboration because she worked with a variety of age groups in many settings, addressing many health issues. She commented,

> *And certainly at one time when I did a different type of public health nursing, we did breastfeeding kind of things in schools... Oh, when I did generic nursing. When I did a combination of school, public health nursing and postpartum follow-up. Yes, we did everything. And opportunities that you could pick up on in a situation like that.*

According to Larson et al. (2006), public health can play an important role in

assisting primary care organizations to adopt best practice. One PHN, Rene, reflected upon how PHNs who work in specialized practice could be of support to FPNs who work in a generalist role to increase their knowledge of breastfeeding support and promotion. She stated,

> *Like she'll get the prenatal mom here and there, maybe 25. At one time, she might have 25 clients and she might not have another prenatal client for another few months. So do you know what I mean? Like it's a hit or miss. Because she's dealing with chronic disease. She's dealing with all the other health issues. So I think what's brought up tonight is it's really encouraging to know that we need to maybe partner and share our expertise a little bit more intentionally but not expect it to be done unless I say I'm going to come work with you for 4 hours next Friday morning and I'm just going to run around with you, and whenever we have a chance, we'll talk a little bit about breastfeeding.*

Location

The public health and primary nurses considered location to be an important factor in the development of collaboration between primary care and public health. Factors associated with location were (a) *Physical space* and (b) *Geographic proximity to other health care professionals*.

Physical space. The space available to practitioners to work in could be a facilitator or a barrier to the development of collaboration. A key condition to successful collaborative practice is the availability of spaces to meet (San Martin-Rodriguez et al., 2005). Elizabeth (NP) explained how the physical characteristics of her office space was a draw for clients and other professionals that she worked with to come in and see her and it enabled her feel valued. She stated,

> *I don't have a basement office. You know, I've got the General's view in my office. It's this huge window looking out on the harbour. I get morning sun. And people walk into my office and just go, "Wow," and go right over to the window. I think sort of it's a climate of feeling listened to.*

Rita (FPN) thought that having a room in the physician's office where she worked

was important for her work in breastfeeding support and promotion, as it provided a comfortable space for women to breastfeed. She explained, *"Another resource we have, we have a breastfeeding room so we can actually watch moms breastfeeding if they're having problems as well."* Conversely, another FPN, Andrea, did not have this resource readily available to her and this was an issue. She stated,

> *Comfort zone for the patients. Not having a waiting room allocated or a space in the waiting room for them to breastfeed. Because so many of the mothers feel that they'd be very uncomfortable breastfeeding in our large waiting room. We have a room set aside but sometimes that room is in use.*

Rene (PHN) explained how she offered a drop-in program for breastfeeding support at a health centre in her community. Although this space was not "*the greatest*" she was able to adapt and continued to offer the program in the health centre because she believed that it was an opportunity to develop a relationship with them. She remarked,

> *And it's hard to do those adjustments when you're in this kind of a chair in a physician's office. So that's what I find, is that my relationship with [name] at the family practice, is she knows when I'm coming and she knows I do a drop-in there. And it's not the greatest. It's a room like this. We're in a boardroom. And you know, it's not a very comfortable room but you know what, you have to make due. So you roll up jackets and try to get the baby at the level of the breast. So what I do is when I see a mom in a drop-in, it's usually on a Friday afternoon when nobody else can see her. And then you arrange a visit the following week.*

Geographic proximity to other health care professionals. Physical proximity is viewed as helpful in the development of collaboration; however, it is not a guarantor of success (Williams et al., 1999). When team members worked in close geographic proximity, outcomes included improved communication, information exchange, and trust (Cook et al., 2001; Hurst et al., 2002; Xyrichis & Lowton, 2008).

The focus group participants described the benefits of sharing premises with other professionals were evident for development of intraorganizational collaboration. Rita

(FPN) worked in a shared location with other professionals including RNs, physicians, a social worker and a physiotherapist. Working in close proximity to other professionals allowed for opportunities to exchange knowledge and information. She stated,

> *I think I mentioned some of corridor collaboration. Just walking down the corridor, I've got a problem with the back, and they'll grab the physio and they'll just walk to where I'm at, "Yes, I've got 5 minutes. I'll just zip in." All that corridor collaboration is huge where I work.*

Sally (PHN) had similar ideas about working in public health, *"And within our own [team], I mean I think we network pretty good. We're either upstairs or around the corner from each other, and we usually network pretty well for supporting moms."*

Co-location of public health and primary care organizations and team members was noted as an important facilitator of collaboration in the literature (Hurst et al., 2002; Oros et al., 2001). According to Wiles and Robinson (1994), when team members have separate buildings or bases, this can result in less integration which may limit team functioning. None of the participants described working in co-location with public health or primary care, although this is something that they would like to see in the future. The idea of co-location was more significant to PHNs. However, one FPN expressed her desire to work in co-location with PHNs.

Helen (PHN) described how her office was 30 kilometres from the community that she serviced; this limited her opportunities for developing collaboration. She explained,

> *I mean my office is...30 km away from my community. So I have to drive 30 km every morning just to get my assignment, despite having been given a laptop and a Blackberry, in order to turn around if there's a mom, call them and then drive back. Right?*

This was also Sally's (PHN) experience. She expressed concern that public health

was not taking opportunities to work more closely with primary care in her community,

> *Because right now, we work very much in isolation, I feel. Yes. It would be nice to have a bit of a presence as well at the new...like in [Name]. What's that place called? We were there for a meeting. The [Name] Centre. Right now I'm seeing Family Resource staff at that centre. I'm seeing a model of care that they're trying to do with prenatal and having all their prenatal appointments booked on Wednesday afternoons. But I'm not seeing a presence of public health there. And because that's, you know, a large part of our job, it would have been ideal to have included us maybe in some of the talks. We may not even have to be there but just include some advice on, you know, this is... Even talking to them as facilitators. You know, how do I best protect, promote and support breastfeeding? What would you guys recommend?*

Trudy (FPN) also saw the benefits in working in closer proximity to PHNs. She remarked,

> *However, in a perfect world if Helen was down the hallway from me, because that's where her office was 2 mornings a week, and she said, "Trudy, come quick. I just want to show you a neat case. You know, something that you'll learn from." Like honestly, that's probably how we'll learn the best, is actually... Or, "Helen, come quick. Just tell me what I'm doing wrong here."...And then you could share what you did with the mom after, and I could go, "Oh! Well, I could have done that." Do you know what I mean?*

Rene (FPN), on the other hand worked in a "*rural*" office that was based closer to the community that she serviced. She described more positive experiences working with the primary care practitioners in her community. She believed that she had the relationship with primary care that her other colleagues in public health were longing for,

> *And we sit around a table at public health and say but that's what nurses working in [Name] want. That's what I have. I have the ability to call. If [name] has a question, she gets the admin to call me from [Name]. Bring this up. I'm short this. I need this. The next time you're in, bring that. Physicians call me all the time.*

Rene also described plans for public health and primary care to move into the same building as primary care in her community,

> *Within the next few months, we're going to be moving into a new site. And that's going to be with the physician's office that has a family practice nurse. The [Name] office is moving to enhance our connect with them and improve hopefully*

some of the prenatal education that folks are getting

Resource Limitations

Martin-Misener et al. (2008) reported that a finding in their scoping literature review was that the most common barrier to collaboration between public health and primary care is limited resources. The major limitations reported by the focus group participants were: (a) *Time and (b) Limited access to breastfeeding education.*

Time. Lack of time was a barrier to the development of collaboration for both primary care nurses and PHNs. The PHNs found that their day-to-day work often kept them busy with a focus on individual contact with breastfeeding mothers, "*putting out fires*" and as such, they often did not have the opportunity to work on breastfeeding initiatives and the community and population levels. Helen reflected,

> *Some things, it's just related to the time. You know, if you're so busy doing one-on-one care with your clients, there's not a lot of time at the end of the day to look at bigger picture, broader planning, community development and all those other things that we know are important. But if you've got moms calling on the phone because they're needing you to come and help them at the time, that's who gets the first priority at the time, is someone who's currently in crisis or has needs. And everything else ends up on the back burner. So even though it's not necessarily less important, it gets less time put on it because it's not urgent at that particular moment. And then we either forget about it until something reminds us that we should go back.*

A nurse working in public health focuses on promoting, protecting and preserving the health of populations (Battle Haugh & Mildon, 2008). Population-based interventions in public health should consider all levels of practice; community, systems and individual/family (Keller, Strohschein, Lia-Hoagberg, & Schaffer, M., 2004)). PHNs participate in population based practice through responding to community priority and need, establishing caring relationships at the community, family, and systems level, collaborating with community resources (Keller, Strochschein & Schaffer, 2011). PHN

practice is grounded in values of social justice; embraces the connectedness of mind, body, soul, spirit and environmental aspects of health; and promotes health through strategies driven by epidemiological evidence (Keller et al., 2011). Although the PHNs interviewed had the desire to work in this way, the PHNs in the study did not believe that they were able to practise at the community and population level on a regular basis. Doris (PHN) reported,

> *And the other promoting parts, we don't do that much. Like World Breastfeeding Week is just once a year. And the other Community of Practice stuff is just... It's ongoing but it's every once in a while, you're going to meetings or connecting with other community people.*

The development of collaboration takes time (Himmelman, 2002). The primary care nurses working in fee-for-service practices reported having limited time to perform activities beyond the individual care of clients during their work day. Lois (FPN) remarked, *"If it's on the evening or on weekends, great."* They could not take the time away from their day-to-day practice to connect with other professionals in their community. Activities outside of seeing clients in the family practice needed to be done outside of clinic hours. Therefore, the development of collaboration with public health was a challenge. Trudy (FPN) commented,

> *... we have like 10 minutes, we woof down a sandwich and get back to work. So you know, taking an hour to meet with a group is a challenge for us. But I think, you know, it's important and we need to start, you know, investing some energy in that direction.*

Limited access to breastfeeding education. Undergraduate programs that train healthcare professionals do not provide adequate preparation in the skills needed for breastfeeding support and promotion (Register et al., 2000). There is strong support for the view that where on the job training has not been provided, there is a general lack in

knowledge and skills amongst health care professionals who support breastfeeding women (Cattaneo & Buzetti, 2001; Ekstrom, Widstrom & Nissen, 2005; Hall Moran, Bramwell, Dykes & Dinwoodie, 2000; Khory et al., 2002; Rea, Venacio, Martines & Savage, 1999; Valdes et al., 1995; Westphal et al., 1995).

Both FPNs and NPs in this study identified that limited access to appropriate breastfeeding education was an issue. Despite supporting breastfeeding women on a regular basis, the majority of primary care nurses in this study stated that they had not received any breastfeeding education in their current role. Wendy (NP) stated, *"My last any sort of education session related to breastfeeding would have been when I did my nurse practitioner program in 2006."* Rita (FPN) also explained,

> *Because typically a family practice nurse, they could have been hired from any area. They could have been working med surg all their lives. And the chance of them ever having hands-on breastfeeding is probably zero... So I think we don't have the training in breastfeeding. And we have had recently... At our last conference, like we had a conference, we did have public health in talking about breastfeeding. The people from [Name] came in. But that's really one of the few places we would have seen breastfeeding education.*

Interdisciplinary continuing education is identified as a strategy to address challenges with public health and primary care collaboration (Ciliska et al., 2005). Although a breastfeeding education program, "*Making a Difference*" is available to all health care professionals working in Capital District, this program is not accessible to all. Four out of the six primary care nurses in this study had not heard of the program. The Making a Difference course requires professionals to take three consecutive days away from their practice, which was viewed as not realistic for most, particularly for nurses working in fee-for-service practice. The primary care nurses in the study also stated that this type of program would not be realistic for physicians; "*Because they can't afford to*

take 3 days out of their practice". Wendy (FPN) remarked, "*Three days isn't going to happen*"

Summary

The theme of: *Organizational Context: Structures and Processes in the Everyday Work Environment* was discussed along with the sub themes of (a) *Communication and Coordination*, (b) *Service Delivery Models*, (c) *Location*, and (d) *Resource Limitations*.

In the sub-theme of *Communication and Coordination,* focus group participants described how they exchanged information with other organizations through a variety of strategies. They reported using both formal and informal mechanisms to exchange information about clients and services with nurses and other health care professional. These mechanisms included: telephone calls, email, group discussions and committee meetings. In general participants noted that there was an absence of formalized systems or mechanisms for communication between primary care and public health organizations. Because of this deficiency, they relied on established relationships that they had with other professionals within these organizations to exchange information.

Although the participants in the study revealed that they utilized some formalized structures for communication and coordination in their practice, they believed that these structures insufficient. Overall participants thought that the information exchange between primary care and public health was poor. They believed that there was an absence of formalized tools for decision making, such as best practice guidelines. Because of this, they relied on resources such as professional websites, information lines, pamphlets, books, and provincial resources such as Loving Care and Breastfeeding Basics to guide their practice.

Service Delivery Models within the organizations where the participants were employed provided either opportunities for the development of practice innovations to support the development of collaboration or prevented them from getting new initiatives off the ground. In this sub-theme, the participants discussed how a flexible organizational structure, a fee-for-service environment, and administrative support and leadership influenced the development of collaborative practice. The practices of the PHNs, FPNs and NPs differed in that the PHNs worked in a specialised practice that focused on prenatal and postpartum women and their families, FPNs and NPs worked in a generalist practise. Ciliska et al. (2005) reported that this is a challenge associated with collaboration between these two sectors in the literature (Ciliska et al., 2005).

The physical space where participants worked and their geographic proximity to other health care professionals were identified as important structures in the nurses every day work environment that supported collaboration. A warm, welcoming environment and co-location or shared spaces were noted as facilitators to the development of collaboration. Lack of time and inadequate access to breastfeeding education activities were discussed as barriers to the development of collaboration for PHNs, FPNs and NPs.

Benefits of Collaboration

The third theme that developed from the focus interviews was "*Benefits of Collaboration*." Primary Care and public health nurses saw advantages to working collaboratively across sectors. Consistent with the literature regarding collaboration between public health and primary care nurses, most of the outcomes of collaboration reported by the focus group participants were positive (Clarke & Mass, 1998; Cook et al., 2001; Davies et al., 2003; Ferrari & Rideout, 2005; Gerrish, 1999; Headland et al., 2000;

Keeling, 2009; Mayo et al., 1996; Peck Lundeen, 1999; Skybo & Polivka, 2006; Wiles & Robinson, 1994; Woodhouse, 2005). There is a paucity of literature that discussed the benefits of collaboration in breastfeeding support and promotion.

Only one participant saw any potential risks or harms to the development of collaboration. Helen (PHN) commented,

> *And I guess the other coming out of this is there's always, and I'll throw it on the table, the territorial issues. Right? And so how much do we share without the concern of losing our territory? So that always came up. So meaning that if all of the family practice nurses and all the nurse practitioners become experts in breastfeeding will that mean the end of public health needing to support breastfeeding?*

These thoughts were not voiced by other participants. The FPNs in the focus group responded to Helen's remarks reassuring her that because FPNs worked in a generalist practice, they would never become or need to become as specialized in breastfeeding as a PHN. Trudy responded, *"And we're not territorial. There's enough work to share.* Helen's concerns were similar to findings by McDonald, Langford and Boldero (1997). This UK study found that the development of collaboration amongst nurses working in the community led to anxiety related to the skills mix and training requirements for nurses.

Helen's concern could also be grounded in the current situation in public health in NS. 2011 saw the release of the new *Nova Scotia Public Health Standards 2011-2016* (DOHW, 2011). These Standards establish the expectations for public health at the local and provincial level and are the result of recommendations from a 2006 report, *The Renewal of Public Health in Nova Scotia: Building a Public Health System to Meet the Needs of Nova Scotians* (NSDOH). The emphasis in the Standards is a shift from an

emphasis on individuals to populations. This has created uncertainty for the future of the PHN role in breastfeeding support and promotion.

When asked about risks or harms associated with collaboration, one participant, Rita (FPN) joked, *"Apart from having to have these focus groups?"* Although this comment may have been made in jest, one risk of collaboration that is reported in the literature is the fear that professionals will have less time with clients, as more time is needed to work with other professionals. Himmelman (2002), reported that collaborating involves extensive time commitments and lack of time was reported as an issue by focus group participants.

As focus group participants more often discussed the benefits of collaboration, the following section will focus on such. The subthemes of *Benefits of Collaboration* are: (a) *Interprofessional Connectivity*, (b) *Improved Breastfeeding Outcomes* and (c) *Consistent Messages*.

Interprofessional Connectivity

The focus group participants discussed positive outcomes for health care professionals as a result of collaboration. Collaboration provides opportunities for individuals and organizations to connect and coordinate, giving opportunities for discussion and adjustments to practice (D'Amour et al., 2008). For the participants in the focus groups, this connectivity lead to engagement of healthcare professionals, transfer of information, and improved understanding of each other's roles.

Rita (FPN) stated, "*The more people you engage, the better success you'll have".* The involvement of multiple partners is often associated with inconsistent messages in breastfeeding support and promotion (Nelson, 2007). However, participants in the focus

groups thought the opposite. They believed that having the opportunity to work with multiple partners was a benefit to collaboration. Andrea (FPN) expressed, "*And so I really think that the more people you engage in it, and the more people you get to change the ideas around it, the more success you're going to have for breastfeeding."*

Increased use of evidence in practice is discussed as a positive outcome of collaboration amongst healthcare professionals in the literature (Hurst et al., 2002). The participants in this study identified that improved knowledge about breastfeeding as a benefit of collaboration. Andrea (FPN) noted, "*Plus, we're learning because we get...we share the knowledge with one other...It definitely makes a big difference. So that we can learn something to take back to the patient and to the mom. It's important."*

Increasing their knowledge about other services in the community was also a benefit to collaboration that was identified by the participants in the focus group interviews. As illustrated by Rita (FPN),

> *And my big thing is knowing what's in the community. I mean referring people out in the community is my big thing. I need to know where I can send somebody if they're having problems, where they can go.*

Additionally, learning about resources was described by one participant, Sally (PHN), as an outcome of attending the focus group. She stated,

> *I think learning about different resources. Like I picked up on some resources that have been mentioned here today. You know, learning what's going on in the practices and what may be changing in practice. Just keeping up with what we're collectively doing.*

Improved Breastfeeding Outcomes

Given the complex social factors such as socioeconomic status, age, race, ethnicity and social support that mediate the breastfeeding experience (Ontario Public Health Association, 2007), it would be difficult to attribute collaboration alone to

improvements in breastfeeding outcomes, such as rates of initiation, duration, and exclusivity of breastfeeding. However, focus group participants believed that having health care professionals work together in collaboration would result in more seamless services, thus impacting positively on breastfeeding outcomes; "*100% breastfeeding rates*".

Participants in both focus groups agreed that the greatest benefit to collaboration would be for the client. Doris (PHN) commented,

> *I think one of the long term benefits, like the broader benefit is just when we collaborate, we're hopefully improving health, physical health and emotional health of the moms and the babies as well. If we're all giving the same messages, there's trust with our clients and our patients. And you know, ultimately we're improving the physical health of everybody.*

In a mixed methods study that looked at chronic disease management, findings suggested that management of chronic disease was superior in organizations where professionals collaborated with one another (Russell et al., 2009). One study that specifically addressed a collaborative effort in breastfeeding support, found that a breastfeeding coaching intervention was more effective in improving breastfeeding rates in areas where several local health professionals worked together to implement the program (Hoddinott, Pill & Chalmers, 2007).

Sally (PHN) described an experience where cooperating with a physician in the care of a breastfeeding mother helped the mother reach her breastfeeding goals. She stated,

> *The client continued breastfeeding. The client was supported from both ends to continue on with breastfeeding. Because the physician just needed some reassurance that everything was normal. This was normal feeding issues, that I was involved, that there was a bit of a safety net for this baby.*

Consistent Messages

The third benefit that focus group participants identified as a result of collaboration was consistent messages. Despite persistent maternal complaints related to the inconsistencies in professional breastfeeding support, there is a paucity of research that explores the aetiology of this issue (Nelson, 2007). A variety of factors have been shown to influence the behaviour of health care professionals related to breastfeeding, including knowledge, attitudes, and personal and professional breastfeeding experiences.

A high level of breastfeeding knowledge has been associated with increased consistency and favourable professional practices (Valdes et al., 1995). Breastfeeding education programs have been successful in increasing health care professionals' knowledge regarding breastfeeding. However, findings are conflicting related to the impact of education programs in changing attitudes (Downie, Juliff & Rakic, 2001; Ekstrom, Widstrom, & Nissen, 2005; Hillenbrand & Larson, 2002; Khoury et al., 2002; Martens, 2000; Siddell et al., 2003; Simmons, 2002). The personal and professional experiences that health care professionals have with breastfeeding can significantly influence how they behave professionally (Hellings & Howe, 2000; Patton et al., 1996; Simmons, 2002, Tennant,Wallace, & Law, 2006; West & Topping, 2000).

Focus group participants emphasized that collaboration would help professionals "*get on the same page.*" Doris (PHN) explained,

> *I think it really is helpful when you are saying the same thing. When the mother hears the same thing from...different people that she passes through in the early weeks of... Well, late and during pregnancy as well as in early postpartum. Because it's just so frustrating to her if she's told one thing by one nurse and then something completely different by another health professional. It's very frustrating for her. And if she is feeling a moment of weakness, there's some way to give her that excuse to not continue. And also helping the mother to understand*

that if she says that she's getting different messages, you know, supporting her in the sense that, you know, sometimes there are 2 right ways to do something.

Similar findings were reported by Nelson (2007) in a qualitative study of nurses' experiences of inconsistent professional breastfeeding support. A major theme identified by the author was "*what works for one does not work for all*" (p.34). The nurses in Nelson's study described the frustration that mothers experienced associated with the process of several professionals suggesting alternative breastfeeding, positions, techniques and patterns. Although the professionals in Nelson's study were only attempting to find what worked for a particular mother, even the process of suggesting a different breastfeeding positions was seen as inconsistent by mothers. The finding of this study suggests that there are many dimensions that influence the phenomena of inconsistent professional breastfeeding support.

As a result of receiving consistent messages, focus group participants thought that mothers would feel more supported and empowered. Lois (FPN) explained, "*...then the moms would feel more comfortable and have more trust in the health care system."* Rene (PHN) agreed, "*Exactly. What I was going to say is it's so empowering for a family if they say to me, "Well, I was seen and [name] said this," and I'm like, oh my gosh, I know [name]. She's wonderful."*

Summary

This section discussed the third theme, *Benefits of Collaboration*, as described by the participants during the focus group interviews. The section began with a brief discussion of the risks or harms associated with the development of collaboration between public health and primary care in breastfeeding support and promotion. Next, three subthemes related to Benefits *of Collaboration* were discussed; (a)

Interprofessional Connectivity, (b) *Improved Breastfeeding Outcomes* and (c) *Consistent Messages.*

Development of New Practices Grounded in Collaboration

Initial review of the data collected during Focus Groups One and Two revealed that overall, participants believed that they were not working in a health care system where public health and primary care functioned in active collaboration with one another. During the follow-up focus groups, the researcher provided participants with the following definition of collaboration:

> *Collaboration is defined as an established relationship among various sectors or groups, formed to address an issue in a way that is more effective or sustainable than one sector acting alone (PHAC, 2007). Further, it is "an approach to community care built on the principles of partnership and maximizing participation in decision making. Collaboration includes shared identification of issues, capacities and strategies"(Community Health Nurses of Canada (CHNC), 2008, p. 16).*

The development of collaboration leads to new activities and the development and implementation of new innovations (D'Amour, 2008). Given that the data from the initial focus groups revealed that collaboration in breastfeeding support and promotion was not occurring, participants were asked to imagine what collaboration would or could look like in breastfeeding support and promotion in Capital Health and what structures and processes would be needed to support this collaboration. Their responses revealed five subthemes that will be discussed in the following section. The subthemes were; (a) *Common Understanding*, (b) *Improving Relations Between Professionals*, (c) *Creating an Environment for Collaboration*, (d) *Required Resources*. Indicators of collaboration according to D'Amour et al.'s (2008) typology of collaboration are used to guide the discussion.

Common Understanding

Facilitators to the development of collaboration between public health and primary care nurses who support and promote breastfeeding were described as (i) *Shared goals and vision and location* (ii) *client centred orientation*. Focus group participants discussed the idea of a centralized place or space that offered support to breastfeeding mothers, something that does not currently exist in Capital Health.

Shared goals, vision, and location. A lack of common agenda is discussed as a barrier to collaboration between public health and primary care in the literature (Dion, 2004; Hogg & Hanley, 2008). D'Amour et al. (2008) also noted that "*identifying and sharing common goals is an essential point of departure for a collaborative undertaking*" (p.5). Participants in this study voiced how important it is for everyone involved to "*be on the same page*". The idea of a "*Centre of Excellence*" for breastfeeding was discussed during Focus Group One. Elizabeth (NP) remarked, "*So if there was a Centre of Excellence for Breastfeeding somewhere, it would be very exciting in my imagination.*"

Elizabeth (NP) believed that having a place such as a "*Centre of Excellence*", where everyone who worked there shared the same passion for breastfeeding would create an environment free from interpersonal barriers to the development of collaboration. She explained,

> *So if it's a Centre of Excellence that values individuals and hires people that truly have a passion for working with families and young moms, that enthusiasm kind of transcends some of the I want her desk because it's closer to the window kind of thinking. I think if it's a happy place to work, it's delightful. And you know, there's that kind of real sense of up – "I work at the breastfeeding clinic centre of excellence."*

Having a common place, with a common philosophy would lessen confusion about where to go for breastfeeding support in Capital District, thus promoting a more

patient centred approach to breastfeeding support and promotion. Education that supported these shared goals/ vision was also important to focus group participants. Rita (FPN) stated,

> *I think you need a physical building or place, and you need the policy behind it so that everybody is on the same page and the reason why we are here and what we're doing, and make it BFI [Baby Friendly Initiative] certified*.

Helen (PHN) also described,

> *A place where if you ask anybody, prenatally or you ask a grandmother, and you say, if your granddaughter just had a baby and where would you go for help, everybody knows. It's not a secret. Everyone in HRM could say, "Well, if it's straightforward, she goes to X. And if she's having any extra and she needs that little bit extra support, she goes to Y," and it's a common place.*

A common understanding was also thought to contribute to consistent messaging and information for clients. Helen (PHN) explained that the goal should not be complicated, "*So when I think about that collaboration, it should be a very simple message to help support all moms*" This would help create an environment where clients felt supported in their individual decisions. Lois (FPN) remarked,

> *...if everybody had the same information, was on the same page, you know. You know, breastfeeding obviously is best, there's all these benefits. But if you can't breastfeed for this reason, this reason and this reason, don't feel bad, it's okay, you're not a bad mom.*

Client- centred orientation. Focusing on the client rather than the agendas of organizations or professionals is a facilitator to the development of collaboration (D'Amour et al., 2008). D'Amour et al. reported that stakeholders are most likely to come together to collaborate if the goal is promoting care that is focused on the client's need. Having a client- centred orientation meant that a collaborative initiative or "*Centre of Excellence*" would be community based, mom and baby-friendly, and value flexibility and diversity.

Doris (PHN) described her vision as,

> *And I just think...especially something after hours. And I know a lot of our staff would be very happy to do something, you know, at least some evenings a week...the weekends and holidays too. To be there. Because you know, there are people that, you know, they don't necessarily want you visiting in their home or... we have a lot of different cultures and I find there are some cultures that don't really want you to come to their home. But they may come to a clinic. And clinic maybe isn't the right word. But some kind of a breastfeeding cafe, something where moms can go that's predictable because their days are very unpredictable. And so I'd like to see something like that here locally. And I think having a place where many different folks can actually share. You know, we can continue to learn from each other. But we're sort of spinning our wheels on that one. And I'd really like to see it.*

This was in contrast to the structure that she currently worked in. She believed that this way of working would be more centred on the needs of the client and more supportive of breastfeeding in the community.

"*I think you should go with a plan and then you change the plan, and you go with the flow."* stated Rita (FPN). Andrea (FPN) also discussed how flexibility was important to meet the needs of new mothers. She explained,

> *But I think that there is an element of you can have all the places in the world but in that first month of having a new baby, trying to get out of your bedroom or out of your pyjamas or just get out of your own space to go to anything like this is not always feasible for some of the mothers. Because really they feel just so overwhelmed with everything that is coming at them. And I know my daughter was speaking about a friend of hers, and she said that she's just had such a horrible transition from being a no mother to a single mother. And she said she's had no support whatsoever. But she's also been so tired, she couldn't even leave to go out. So she really depended on the occasional visit of somebody who would come in from public health. So I think it's bridging that gap of, you know, maybe having multiple people going in at different times just to assist.*

Elizabeth (NP) emphasized the need for a collaborative initiative to be reflective of the community that is being serviced. She expressed,

> *And they have to be visible in this place. It's not just lip service. You want the staff to reflect the community. You know, have grandmothers and volunteers and nurses that are the face of the different cultures that you're working with. And*

maybe the outreach piece of it is the initial interface, and then you work from there.

Oros et al. (2001) suggest that when servicing culturally diverse populations, cultural competence and sensitivity are important values in collaborative initiatives. They also suggest that core services such as primary care, health promotion, and community outreach that can be delivered through nurse-managed centres in the community are essential services that are needed to achieve better population health outcomes.

Improving Relations Between Professionals

Participants in the focus groups discussed the importance of professionals getting to know each other both personally and professionally as a facilitator to collaboration. This was seen an important step in developing trusting relationships amongst professionals, which was also noted to be important by participants. The main factors associated with *Improving Relations Between Professionals* that were discussed during the focus group interviews were: (i) *mutual acquaintanceship* and (ii) *forming trust*.

Mutual acquaintanceship. According to the CCHN Standards (CHNC, 2011) establishing, building and nurturing professional relationships is a major expectation of community health nurses. Despite the barriers that participants had described previously in establishing interpersonal relationships, they recognized that relationship building between professionals was a precursor to collaboration. This view is consistent with Shaw, Ashcroft and Petchey (2006) who, concluding from their qualitative study that investigated the barriers and opportunities for developing sustainable relationships between public health and primary care in the UK, that the existence of previous positive relationships between public health and primary care facilitates the development of collaboration. During the focus group interviews, participants stressed the importance of

professionals going through the process of getting to know each other in the development of collaboration. They suggested a "*meet and greet*", "*tea party*" or just getting into "*the same room*" as strategies. Elizabeth (NP) suggested,

> *That might start off as some kind of, I don't know, something as informal as a tea party or even like a committee meeting of some kind. And then once I have sort of a face to a name, I have some go to people that I've seen sort of face-to-face, I'm more likely to access them either by phone or email or again in person. But if I haven't had that initial contact, I'm more reluctant to just dial somebody up or email them. So for me that's often how it starts.*

In the follow-up focus groups, there was more of an understanding between the public health and primary care nurses interviewed regarding the differences in their roles and the structure of their practice. This prompted discussion regarding how these two groups could start to develop collaboration in breastfeeding support and promotion. Trudy (FPN) commented, "*I know you guys have time restrictions too but we've [public health and primary care providers] got to be in the same room.*" Recognizing these differences, Rene (PHN) added,

> *But I think because I know how the family practice nurse works, if I didn't go to her, she's not coming to me. So we need in public health, if we're going to sit around the table and talk about when to collaborate and when to reach out and get to know our community, then we need to go... There's 35 of them. So you get an email list. Which I'm thinking [Name] may already have an email list. And you get the email list and you send out an email. And you send out from public health and you say these are the nurses that are working in this area. And start like that. Because everybody checks email. And you may have a minute to check email in your work, I'm not sure. Right? I know there might be 5 or 10 minutes down time where you get onto a computer. But just to start those quick conversations. But I think... I have no idea where public health is going in the future. I have no clue. But right now, if we're still doing what we're doing then we need to reach out to the family practice nurses and collaborate with them if we're trying to do some breastfeeding initiative. Because they're not going to come to us.*

The educational system has been identified as one of the main determinants of interprofessional collaborative practice in the literature, as education influences the

collaborative values of future health professionals (San Martin-Rodriguez et al., 2005). The importance of a "*common piece of education*" was noted by participants as being a key element in the development of collaboration in breastfeeding support and promotion. Trudy (FPN) remarked, *"I would say that we are really missing the boat there as a community of healthcare providers looking after these moms in that we don't ever do education together."*

This education was not only targeted to RNs, but to all professionals. It was thought that "*common piece of education*" would help to create a common understanding of each other's roles, therefore positively impacting client care. Doris (PHN) explained,

> *Like it's not just do an education piece and everybody kind of ticks off that they've been through it but do some follow-up. And I think one of the best ways to help people determine for themselves if they in fact have... You know, if they're helping to achieve the outcomes that are desired. It would be through like stories of mothers. So if a mom got a certain type of help one place and then she went somewhere else and another group, and it was totally opposite. You know, like that would be important for those involved to be able to say, well, okay, you know, let's look at what was helpful or how is another way that we can help this mom? Because insistent messages are very confusing. So that whole attitude of humbleness. That, you know, maybe I could have done something differently. And that it's okay because we're, no matter how long you've been in the business, you're still learning, right.*

Forming trust. Trusting other professionals' knowledge and skills to support breastfeeding emerged during the focus group interviews as an important factor in the development of collaboration. According to Henneman et al. (1995), the absence of trust presents an impossible barrier to overcome in the development of collaboration. These authors also suggest that effort, patience, and previous positive experiences are required to build trust.

PHNs were viewed as having an expertise in breastfeeding promotion and support and participants agreed that it is public's health role to reach out to primary care. Sally

stated, *"Because I think we're [public health] responsible for promoting the work that we do."* While the PHN expertise in breastfeeding was recognized by the primary care nurses interviewed, it was apparent that there was still a critical element missing in the relationship between PHNs, FPNs and NPs. Knowing a name or a face was viewed as an important factor in the development of collaboration. From the focus group interviews, it was evident that although there was some connect between public health and primary care organizations, it was insufficient to establish a trusting relationship between PHNs, FPNs and NPs. Trudy expressed, *"It's like I'm going to send you to just an anonymous person. It's not the same as sending them to someone that you trust."*

Participants discussed the development of new initiatives that would create a more trusting environment between public health and primary care, as currently, the two systems functioned in "*isolation*" the majority of the time. Having public health and primary care nurses working in close proximity with one another was discussed during both focus groups. This was expressed as a way for these groups of nurses to learn from one another, share and communicate. Trudy (FPN) commented,

> *However, in a perfect world if Helen was down the hallway from me, because that's where her office was 2 mornings a week, and she said, "Trudy, come quick. I just want to show you a neat case. You know, something that you'll learn from." Like honestly, that's probably how we'll learn the best, is actually... Or, "Helen, come quick. Just tell me what I'm doing wrong here."*

Elizabeth (NP) thought that a Centre of Excellence for breastfeeding would create the environment for professionals to get to know each other through communication and sharing, enabling them to feel comfortable negotiating their various contributions. When discussing how professionals would work together in a perfect collaborative relationship, she remarked, "*I think if you have a Centre of Excellence, some of that is letting people*

discover that for themselves. I mean you sit around the table like this and you negotiate and offer what is your expertise to that." Andrea (FPN) added,

> *So it's really drawing on what people can bring to it. That you can't just sort of set out a formula and expect people to fit into it because people are not going to come all on the same page.*

Focus group participants were able to envision how these two groups of nurses could work effectively with one another, if their environment allowed for them to work more closely.

Creating an Environment for Collaboration

Many participants discussed working collaboratively on interdisciplinary teams within their own organizations. Although there was discussion of cooperating or referring to colleagues outside of their organizations, descriptions of collaboration between public health and primary care organizations in breastfeeding support and promotion was not evident during the focus group interviews. During the follow-up focus groups, participants articulated what environmental factors would work to facilitate collaboration, these included: (i) a *supportive organizational structure* and (ii) *communication mechanisms*.

Supportive Organizational structure. During the focus group interviews, it was evident that there was some confusion related to roles of various professionals and services or resources available for breastfeeding support and promotion in Capital District. Confusion between professionals can only lead to uncertainty in clients. A major concern in the care of breastfeeding families is a lack of continuity of care and inconsistency of information among health care providers (Dennis, 2002). Having a central structure or authority to support breastfeeding in the District was discussed during

Focus Group One, the idea of a "*one stop shop*", "*one door*", "*Centre of Excellence*" was discussed as an answer to an identified lack in continuity of care in breastfeeding support and promotion. Sally (PHN) stated,

> *And I know at Capital Health and provincially, we've said it should be a one stop shop, one door for all services. That's the easiest way for a patient, a client, whatever you're calling them to access services and to get truly holistic care from different healthcare providers.*

Rather than developing a completely new organizational structure, participants in Focus Group Two discussed how improvements could be made to current structures and how the development of collaboration between public health and primary care could take place within existing structures. Participants in Focus Group Two discussed the current state of the health system in Capital District and broader level systemic initiatives that could be useful in moving collaboration between public health and primary care forward in Capital District. Trudy (FPN) remarked,

> *So maybe it's primary health care, let's say, at the [Health Sciences Centre] that needs to, and in conjunction with [Name]'s group at the IWK, that need to be getting together and saying, okay, where are the communities of practice or whatever we want to call them, and let's get those...all of those that are involved in that community practice together and find a mechanism to do that, to discuss whatever. It could be breastfeeding, it could be other health issues.*

Mack, Brantley and Bell (2007) concluded from their report on the development of a community health system in the Southern United States that an absence of knowledge and skills related to state level laws and policies and mechanisms to provide health care was a barrier to collaboration between public health and primary care. The authors reported that a misunderstanding of the functioning of various systems caused conflict between organizations.

Participants discussed "*Community Health Teams*" that had recently formed in two communities in Capital District. They described the teams as being, focused on "*chronic disease management.*"Although they identified the potential for this type of structure to support the development of collaboration between public health and primary care in breastfeeding support and promotion, they noted that nurses are not part of these teams. Helen (PHN) stated,

> *And if you look at the primary care teams... the [Name] and the [Name] one, to my understanding, there's no nurses on their teams. So again, these are being held up as the new prototype models that are being tried out there. Which is interesting to see. Which is why you're getting so many questions too.*

Sally (PHN) explained why she believed that PHNs were not a part of this initiative in her community. She discussed,

> *I mean with public health, we seem to have a history of being very slow and going through hierarchy of leadership within our organization. For me personally, my assumption is that we just...we missed the boat as an organization. And not necessarily frontline staff but perhaps managers who were present at that table didn't recognize the importance of that collaborative relationship. That's an assumption.*

Rene (PHN) described her experience in her community. She was unsure of her role on a primary health care team that was forming and thought that public health needed to define their role within initiatives such as this one that are forming in communities. She remarked,

> *But then public health needs to define their role in a community of practice. And that's what I'm trying to pull out of them right now, is we're starting to build one on the [Location]. So it's primary health-led.*

According to Henneman (1995) organizational structures that are "*flat*" versus "*hierarchical*" and where professionals were supported to act autonomously, facilitates collaboration. Leadership was an important factor identified by focus group participants

when discussing the development of a new collaborative initiative to support and promote breastfeeding in Capital District. Doris stated, *"Because you know, in order to make some change, you would have to have support to do it."*

There was confusion among the PHNs in the focus groups as to what the role of the frontline PHN could be in the development of collaboration with primary care. Sally (PHN) stated,

> *It could be the recognition that... I mean certainly from a leadership perspective in this organization, collaboration, we talk about how important it is but we don't see our leaders collaborating with others. So how are we as frontline staff to have any role models in our leaders if we're not seeing the collaboration at that level?*

In Meagher-Stewart et al.'s (2010) qualitative study of organizational attributes that assure optimal utilization of PHNs, the authors discussed management practices associated with optimal PHN practice. Effective program planning; promoting and valuing PHN practice; and supporting autonomous practice were three management practices that were identified. It was evident that in order for PHNs to move forward with the development of collaboration with primary care, management practices that are more supportive of optimal PHN practice are required.

Leadership in collaboration can take on a variety of forms and can be emergent or a designated position (D'Amour et al., 2008). Leaders may be managers or others who take the initiative themselves (D'Amour). The focus group participants identified leadership qualities that would support the development of collaboration in breastfeeding support and promotion. Participants suggested that the leader of such an initiative would be a passionate supporter of breastfeeding, have skill and expertise in breastfeeding, vision, be community oriented, and respected by community members. Elizabeth (NP) explained,

> *I think you appoint somebody as the chair of the Centre of Excellence that works with a committee. But it's helpful to have some direction from the helm. Who appoints that person? Well, maybe the coalition puts forward some names. Maybe the Department of Health. But you really want someone that has a passion for this, who really believes in that kind of a vision.*

Rene (PHN) discussed the notion of a "*breastfeeding champion*". In her experience, having a champion to lead an initiative within an organization determined its success. She stated,

> *So if you had a champion, a breastfeeding champion in Capital Health... if that was their piece and that's all that they were responsible for, it might be a little different. And I think about [Name]. He's project manager for primary health care. And his job is to get these primary health care teams up and running and established in communities so that they can improve some of the health outcomes of things that just aren't improving. So with breastfeeding, it's so out there because it isn't directly impacting the health. It is directly impacting but it's not acute. So you're not...So maybe in my perfect collaborative world, there would be a champion. There would be the [Name] of the breastfeeding world...You know, someone that is the driving force of this.*

Sally (PHN) described how a formal leader may not be necessary to facilitate the development of collaboration, however, believed that there may be multiple people required to take on leadership positions. She mentioned,

> *So even if there are identified mentors or kind of lead people within each healthcare organization. It doesn't have to be... I don't have to know everybody but just who to contact about this question for follow-up for a client that I'm seeing that I know somebody else is also following. Just so we can collaborate and be all on the same page about things.*

D'Amour et al. (2008) submits that in some circumstances, leadership may be shared amongst different partners in the development of collaboration.

Rita (FPN) and Andrea (FPN) stated the importance of a community development approach and mobilizing members of the community as leaders. Andrea discussed a successful initiative in one community. She described,

> *Well, if you looked at what's happened in the [Location] in their co-op there, they have really made a significant difference. It would be very similar to something like that if you really wanted to expand on it. And I mean they took people who had a passion for gardening and then for housing and all these different things and they moved it into one almost like a coalition. And that's where it has gone from. And it didn't have to be one assigned person. It was whoever had that passion that they brought into it. And it really has to be driven by passion, I think, something like that. But I mean driven by passion with lots of money in hand.*

Rita (FPN) explained the significance of having an initiative led by the community. She noted,

> *I think what you're going to do is you're going to have a stronger workforce if it's somebody who you know already and is established in the community...So it may not be a nurse. It may be just somebody who the breastfeeding community has known for a long time. They've know their strives towards breastfeeding...For example, I know it's totally off the subject but the police officer who's from that community, the First Nations, how he's got his police office there and he's established all these community centres. He's such a really strong leader there.*

Communication mechanisms. Communication is a critical antecedent to collaboration (Hennemen et al., 1995). Effective communication leads to the development of trust and mutual respect between professionals (D'Amour et al., 2008). During the focus group interviews, participants recognized that there was an absence of formalized tools available to facilitate communication between public health and primary care in their work with breastfeeding mothers. Participants were able to identify tools that they used for communication in other areas of their practice, such as chronic disease management, and were able to make suggestions as to which tools would be most useful in breastfeeding support and promotion activities.

Tools that facilitate the development of collaboration that have been identified in the literature include; standards, policies, professional protocols, standardized documentation tools, sessions, forums or formal meetings involving all team professionals (San Martin-Rodriguez et al., 2005). Breastfeeding occurs across a

continuum of care and a breastfeeding woman has many points of contact with the health care system along her breastfeeding experience. One aspect of communication that was discussed during the focus group interviews was a tool to communicate with clients as well as the various professionals involved in her support. It was evident that there are many resources available and many professional involved in breastfeeding support and promotion activities. These resources are not familiar to all clients or all professionals.

A strategy as simple as a "resource booklet" was important to primary care nurses and was seen as something that would help in the development of collaboration, as well as assist mothers to navigate through the health care system during their breastfeeding experience. Rita (FPN) discussed,

> *I was just thinking too, like the development of a resource booklet so that we all know what sort of expertise could be offered to moms and a name to that. So like a resource kind of list. I mean that would be sort of part of a coalition or a part of the committee anyway but formalizing it a little bit.*

Lois (FPN) explained that given the time constraints in the fee-for-service practice where she worked, it was important to have information easily accessible. She remarked,

> *And I liked...the[idea of a] contact list...That you could send out to like Trudy and I saying this is the list of public health nurses, the list of services that you can offer moms. I mean when I'm in the office and I've got a mom that's stressed out and tired and whatnot, I don't have the time to go rooting through all my papers. If I had something, a quick reference guide or something, I could say, "Okay, look, this is where you live, this is who you call".*

A patient passport was another strategy discussed during Focus Group One. This was an initiative that had been considered in the past. Doris (PHN) explained,

> *There was discussion of a patient passport which I think would be... A patient passport, that the patient actually carries something, you know, with her when she's coming to see the physician or the public health nurse. So everybody puts some information in there. I mean that's just one little piece of communication. But I don't know what's ever happened to that*

Rita (FPN) added,

> *And the whole idea of a patient passport would be for me to complete it, not for somebody else to complete it. It's my passport...So you would go and you'd see a physician, and you'd go and write down what your physician informed you, and they would be completing the passport. You know what I mean? Like a health journal.*

Rita discussed that although this passport did not move forward in maternal-child health, her organization was using a similar tool for chronic disease management. She described,

> *And first of all, they meet with one of the nurses to help complete it originally...So all the medical conditions, all the medications, will assist in writing all those down. And there's little different slots...there's a place where you go and see your physician, why you went to see your physician. What happened at your physician's appointment and what's going to happen? What I have to do, what they have to do. And it's not only... It's not actually physicians, it's health professionals. So then you would take it to the physiotherapist or you'd take it to the cardiologist or you'd take it to OT and places like that. So it would travel with you wherever you went. And it has all the immunizations in it as well. It has your height and weight. There's a spot for diabetes, keeping up your diabetes care. It's one of the chronic conditions we focused on first of all. And then we're going to expand it to other ones. What else is there? Blood work, vital stats and all that kind of stuff. And also if you're female, at what age you should start getting pap smears, how often you should get them. Like at the age of 30, do this. The age of 40, more annual exams you do at age 50...*

Participants thought that a similar resource would be useful in the care of breastfeeding women.

Participants in Focus Group Two thought that the development of a formalized system for communication between public health and primary care was more important than the participants in Focus Group One. The participants in Focus Group Two less often identified established relationships with their primary care or public health colleagues. Currently, a shared electronic system for communication does not exist between public health and primary care; they each have their own information infrastructure. For PHNs, their system is only accessible in a CDHA building and

because most of their work is done outside of these buildings, inputting and accessing information is a challenge. Helen (PHN) noted,

> *And they have an electronic system where some of it gets put into an electronic system. I have a brother who works in IT. He said you can put programs in place that people...that you can access outside your organization that's secure, if the will was there to do that kind of stuff.*

Participants in Focus Group Two thought that a formalized referral system, similar to what they use with other professionals would be a step towards improving communication between primary care and public health. Trudy (FPN) believed that she could use her existing system that was effective for other types of referrals for a breastfeeding mom, rather than creating a new system. She stated,

> *So we could just do one of those general sick note letters on Nightingale and just put – Please see re: breastfeeding support – and send to public health. And that would be very quick. And it's on the patient's record. You know.*

Given the time constraints of her practice in a fee-for-service physician's office, Trudy (FPN) believed that this would be more efficient for her than using a telephone referral system, whereas, FPN participants in Focus Group One preferred to use a phone call to refer a client to public health. This emphasizes the point made by D'Amour et al. (2008), suggesting that it is not only the communication tool that is important, but how professionals negotiate their use.

Participants also suggested that clinical practice guidelines that are used by all professionals involved in breastfeeding support and promotion was an important way to facilitate collaboration. The Health Healthy Babies, Healthy Families: Postpartum and Postnatal Guidelines were developed by a committee of health professionals from acute care, primary care and public health (NSDOH, 2001). They were created to ensure that all health professionals could provide optimal care after birth and to help to facilitate a

smoother transition from hospital to home. It was intended that an implementation plan for these guidelines be carried out at the local level. Focus group participants revealed that these guidelines are not familiar to all health professionals. Trudy (FPN) explained,

> *And the postnatal guidelines that are now old, right, they're 2004, 2003... Those aren't well distributed. We give them to the family practice nurses when they...in their training. But I mean in the guidelines, it tells you exactly what you should be doing at... You know, the depression screen and, you know, when to... It's all in there, what should be done when. I don't think those are well...circulated well. Because clinical practice guidelines is what we use. We don't have any... There are no policies. There's no such thing as policies in family practice. There's nothing written anywhere in a binder. So we really rely on best practice guidelines or clinical practice guidelines. And those are not really... I brought it up in a meeting with the Department of Health the other day, and they all looked at me like I had, you know, rocks in my head. And I said, "No, it's a green book. You know?" Nobody knew. Right? But we need to get... There needs to be some guidelines to...There needs to be some guidelines around care. Like the introducing solids at 2 months, where are the guidelines? Because there are guidelines around that and they should be well documented. So in terms of infrastructure, that would be really helpful because then we're following guidelines. And we're really good at following guidelines. But they're not well publicized.*

Having the document in place was not sufficient to support collaborative practice, there needs to be discussion amongst professionals as to how the guidelines will be used in practice and how responsibilities will be shared between sectors. Guideline 2.8 states, "*A standardized breastfeeding/feeding assessment tool should be developed/identified and used by all providers and in all settings/contacts (i.e. hospital, phone, home)*" (NSDOH, 2001). Through the participants' responses during the focus group interviews, it was evident that this guideline had not been implemented in Capital District.

Required Resources

As mentioned earlier in the Chapter, resource limitations were noted as a barrier to primary care and public health collaboration during the focus group interviews. This is also consistent with the literature (Martin-Misener et al., 2008). Thus, it was not

surprising that participants recognized that resources such as (i) funding, (ii) physical space, and (iii) human resources would be needed to facilitate the development of future collaboration between public health and primary care.

Funding. "*Stability of funding*" was recognized to be important by focus group participants. Ciliska et al. (2005) concluded from their literature review of primary care and public health collaborations and key informant interviews that provincial support for funding for collaboration and initiatives carried out between public health and primary care as an important facilitator to collaboration. "*It should be funded by the Department of Health*," stated Rita (FPN).

Participants agreed that a "fee-for-service" funding structure would not facilitate future development of collaboration between public health and primary care. Elizabeth (NP) remarked, "*So that model can't be fee-for-service".* Alternative fee structures other than fee-for-service have been noted as facilitators to collaboration (Wedel, 2007). The primary care nurses interviewed who worked in a fee-for-service environment; any time that was not spent directly working with clients in their clinic was "*volunteer*". Trudy expressed,

> *You know, for us, for most of us, the majority of us working out in family practices, we wouldn't get paid for a day to go learn about such and such. So if you take a day to go do something, you're out a day's pay. Right? So a lot of it is really around funding.*

Although the research literature does not comment on the impact of fee-for-service structures on breastfeeding outcomes, one Canadian study reported that chronic disease management was superior in alternatively funded community health centres versus other models of primary care (Russell et al., 2009). Health professionals in community health

centres were able to achieve high-quality care by spending more time with clients and collaborating with other professions (Russell et al.)

Physical space. When discussing the development of a collaborative initiative to support breastfeeding, participants recognized, "*we need some place where moms can go."* Participants in Focus Group One identified that space was lacking for professionals to offer breastfeeding support in the community. In recent years, there has been more emphasis placed on social support for mothers (peers, partner, other family members), as this has been associated with successful breastfeeding outcomes (Hoddinott et al., 2000; Khory et al., 2005). Although participants identified offering support in homes and community spaces that is shared with other organization, the participants longed for a welcoming space for breastfeeding women.

Participants discussed the importance of a facility that is accessible to mothers. The physical layout and characteristics of the space were key factors to participants. Elizabeth (NP) remarked, "*It has to have a lot of good natural light in it. So higher ceilings and good light. These basement caves for pregnant women, those have to go".* Rita (FPN) added,

> *You want it in a facility like the Captain Spry where there's the pool there, there's the exercise room. So then you're there and you've got some... Maybe you have these child minding facilities. You can go into the library. You can go to your meeting for the other kids. You know, you want it somewhere where there's other things as well. So then you're going to meet... And there's the area where you can go have coffee and chat. There's informal education as well at the same time.*

Doris (PHN) agreed,

> *A physical layout so that moms who came, they could actually sit and have their own informal conversations but also for those who would like to have privacy. Or maybe it's just we need a good chair or some pillows or whatever. To have that as well. Because you know, lots of people do need the one-to-one help. But a physical layout so that moms could support each other...And probably some*

classroom space in there too. And some kind of exam offices. Like so there's a private place where the nurses can examine and do their thing in privately.

Having a dedicated space for breastfeeding would indicate that breastfeeding support and promotion was valued.

Human resources. As breastfeeding takes place across a continuum, many practitioners are involved in breastfeeding support and promotion activities. Focus group participants identified multiple partners that would need to be involved in the development of collaboration in breastfeeding support and promotion, in addition to primary care and public health nurses. These included physicians, midwives, nutritionists, doulas, acute care staff, family resource centres, La Leche League, chiropractors, massage therapists, occupational therapists, physiotherapists and politicians.

In addition to professionals, participants identified the importance of community involvement of mothers and their supports (grandmothers, fathers, etc.). Involving clients in decisions and provision of care has been identified as vital to future initiatives moving towards primary health reform (Butler-Jones, 2004). Those that have the greatest interest in the outcomes of programs and health decisions are those who are affected by them (Butler-Jones).

Summary

In this section, I discussed future initiatives that focus group participants wanted to see in the development of collaboration in breastfeeding support and promotion. As participants identified that there was little opportunity for collaboration between public health and primary care within the current health system in Capital District, they were given the opportunity to identify how they would work differently to support the development of collaboration. The sub-themes discussed were; (a) *Common*

Understanding, (b) *Relations Between Professionals* (c) *Creating an Environment for Collaboration*, and (d) *Resources Required*.

Two factors related to developing a common understanding were discussed, shared goals, vision and location and client-centred orientation. Participants believed that each of these factors would need to be put into place if collaboration was going to be developed between primary care and public health. Mutual acquaintanceship and trust were identified as key components to improving relations between professionals. Without taking the time to develop these relationship components, participants believed that collaboration would not be possible.

Creating an environment for collaboration involved developing a supportive organizational structure that supported professionals to enter into collaborative partnerships through effective leadership. A repertoire of communication mechanisms was another key environmental component. Participants thought that standardized and effective communication mechanisms would need to be developed if collaboration was going to be actualized. Lastly, the importance of appropriate resources to facilitate the development of collaboration, including funding, physical space, and staff were discussed.

Summary

In this Chapter I discussed the major themes that were revealed when PHNs, FPNs and NPs discussed their experiences with collaboration related to their practice in breastfeeding support and promotion. "Community health nurses connect with others to establish, build and nurture professional relationships" (CHNC, 2011, p. 16). For this reason, it was not surprising that the first major theme identified during this study was *Establishing Interpersonal Relationships*. This theme provided an overview of the

precipitators and barriers to forming relationships and the outcomes of interpersonal relationships between public health and primary care nurses.

The second major theme identified during the focus group interviews was *The Organizational Context: Structures and Processes in the Everyday Work Environment*. This them discussed the impact of the organizational context of the nurses work environment on the development with collaboration. Participants in the study discussed how factors such as communication and coordination, service delivery models, location and resource limitations effected the development of collaborative initiatives between primary care and public health. The impact of the organizational context on the development of collaboration in breastfeeding support and promotion is consistent with findings in the literature (D'Amour & Oandasan, 2005).

Benefits of Collaboration was the third theme identified in the study. Consistent with other studies on collaboration between primary care and public health nurses, the nurses interviewed believed that the development of collaboration in breastfeeding support and promotion would benefit health care professionals and the clients that they serviced.

The last theme, *Development of New Practices Grounded in Collaboration*, described new initiatives or innovations that the participants explained were needed for the development of collaboration between PHNs, FPNs and NPs. Participants articulated the structures and processes that they believed were required to develop collaboration in breastfeeding support and promotion which were consistent with D'Amour's (2008) indicators of collaboration. A more in-depth look at the research conclusions and

implications for practice, research, education, and policy related to the themes is presented in Chapter V.

CHAPTER V

CONCLUSION AND IMPLICATIONS

Research Conclusions

CHNs are RNs who practice in diverse settings in the community, such as homes, schools, shelters, churches, community health centres and on the streets (CHNC, 2011). Their practice promotes the health of individuals, families, communities and populations; and an environment that supports health (CHNC). Although there are many practitioners that support and promote breastfeeding in the community, this study focused on CHNs. The CHNs who are most often involved in breastfeeding support and promotion are PHNs, FPNs and NPs.

The aim of this qualitative descriptive study was to explore and understand the PHN, FPN and NP experience of collaboration between primary care and public health. This study explored the roles of PHNs, FPNs and NPs who work in breastfeeding support and promotion in Capital Health and the structures and processes needed to support the development of collaboration amongst these groups of nurses. Data were collected in focus group interviews, using a semi-structured interview guide. Thematic analysis was used to examine the data from transcribed focus group interviews into the following account of their experiences (Braun & Clarke, 2006).

Although PHNs, FPNs and NPs all work with clients (individuals, families, communities and populations) to support and promote breastfeeding, research was not found in which the concept of collaboration was explored these groups of nurses. Significant attention has been given in the literature to the overlap between the NP and the family practice physician and the relationship between the RN and the physician. It

has been suggested that there is a potential overlap in the role of PHNs, FPNs and NPs in health promotion, well woman and child care, immunization, chronic disease management and community health (Martin-Misener et al., 2010).

The breastfeeding experience is mediated by various complex and intermingled factors such as socioeconomic status, age, race, ethnicity and social support (Ontario Public Health Association, 2007). Lower rates of breastfeeding in NS are found in younger, single mother with lower levels of education and income (NSOHP, 2005). Despite a wide range of programs and services offered to support breastfeeding families, there has been little impact on local breastfeeding rates (PHAC, 2009; Reproductive Care Nova Scotia, 2006; Statistics Canada, 2009). PHNs, FPNs and NPs have the opportunity to impact the model of care for breastfeeding families in Capital District, optimizing their capacity to address issues in practice and ensuring that breastfeeding support and promotion activities address the complex social factors that influence the breastfeeding experience.

CHNs "lead in the integration of comprehensive and multiple health promotion approaches that build the capacity of clients" (CHNC, 2010, p. 1). The evolution of health promotion has been influenced by several key documents and reports including: The Lalonde Report (1974), the Alma Ata Declaration on Primary Health Care (WHO, 1978), Achieving Health for All: Framework for Health Promotion (Epp, 1986), the Ottawa Charter for Health Promotion (WHO, 1986), the socio-ecological model for health promotion (McLeroy, 1988). Health promotion discourse shifted over the years from a focus on lifestyles and the reduction of risk-related behaviours a socio-environmental approach which acknowledged that health is the outcome of social,

economical and environmental determinants (Ontario Health Promotion Resource System, 2006).

In the 1990s, the health discourse shifted to a discussion of population health. Due to the dominant epidemiological lens of the population health approach, which has been criticized by some (Labonte, 1997), attempts have been made to bridge the gap between population health and the socio-environmental approach to health promotion. The PHPM (Hamilton & Bhatti, 1996) and the Population Health Template (Health Canada, 2001) connected the concepts of population health, taking into account the need to focus on the health of populations, address the determinants of health, use evidence in practice, apply upstream thinking, utilize multiple strategies for intervention, collaborate across sectors and levels, increase public participation and evaluate based on health outcomes.

The current discourse in public health in NS emphasizes a shift from an emphasis on individuals to populations, as stated in the new *Nova Scotia Public Health Standards 2011-2016* (Nova Scotia Department of Health and Wellness, 2011). This has created uncertainty among PHNs for the future of the PHN role in breastfeeding support and promotion. Keller et al. (2004) emphasized that population-based interventions in public health should consider all levels of practice; community, systems, and individual/family. The present socio-political environment within health services in NS calls for consideration as to how public health and primary care can work together, rather than duplicate services, as highlighted in a recent report on the health system in NS (Corpus Sanchez, 2007). These factors support the need for this current study.

In this study the PHNs, FPNs and NPs working in breastfeeding support and promotion were involved in the care of various clients from individuals (for PHNs, FPNs

and NPs), to groups (for FPNs and PHNs), communities (for FPNs, PHNs) and populations (for PHNs). PHNs, FPNs and NPs were all involved in prenatal and postnatal support for breastfeeding mothers. Depending on their role within their organizations, PHNs, FPNs and NPs focused on different levels of interventions. Both public health and primary care nurses are involved in the individual care of breastfeeding women, the major differences were the location and intensity of the interactions. PHNs typically interacted with breastfeeding women for longer periods of time, not always on a recurring basis, in their homes or community settings. While FPNs and NPs had briefer interactions in clinic settings, but most often their contact with clients took place during multiple episodic contacts. In this study, interventions at the community and population level are typically the role of PHNs. However, they, like PHNs in other studies, often experienced constraints in their every day work environment that thwart their ability to work to the full scope of their competencies (Meagher-Stewart et al., 2005; 2010).

CHNs, like all other health professionals, are being called to develop new clinical practices based on collaboration and are faced with the demands of working both interprofessionally and interorganizationally (D'Amour et al., 2008). In Capital Health, PHNs, FPNs and NPs are all working in different aspects of breastfeeding support and promotion. However, there is no formal structure for collaboration of services, despite the strong desire of these nurses to work together to improve breastfeeding outcomes. By working collaboratively in breastfeeding support and promotion, PHNs, FPNs and NPs could work together to improve breastfeeding outcomes, acting on the determinants of health, using of evidence and multiple strategies for interventions.

Crowell (2011) described health care organizations as complex adaptive systems. "Complex adaptive systems are nonlinear interactive systems that can learn and adapt to changing environments. They are composed of many diverse and independent agents, all in relationship; cooperating, collaborating, competing and connecting" (Crowell, p.34). The importance of relationships in establishing and developing collaboration between public health and primary care in breastfeeding support and promotion was evident in the data generated in focus group interviews with PHNs, FPNs and NPs. Bringing these nurses together to discuss experiences and opportunities for collaboration demonstrated how new behaviours, ideas, patterns and structures can emerge from relationships (Crowell).

According to D'Amour et al.'s (2008) model and typology of collaboration, the data generated during the focus group interviews revealed that PHNs', FPNs', and NPs' experience with collaboration in breastfeeding support and promotion could be classified as developing or potential collaboration. In accordance with developing or potential collaboration, participants discussed an absence of shared goals, few opportunities to meet, lack of trust or forming trust, absence of a central body, and incomplete information exchange. Participants did not describe experiences with active collaboration between public health and primary care in breastfeeding support and promotion.

Through the analysis of the focus group interviews with PHNs, FPNs and NPs, four major themes were identified during the exploration the structures and processes required to support the development collaborative practice amongst these nurses: (a) *Establishing Interpersonal Relationships*; (b) *The Organizational Context: Structures and*

Processes in the Everyday Work Environment; (c) *Benefits of Collaboration*; and (d) *Development of New Practices Grounded in Collaboration*.

Establishing Interpersonal Relationships

Examining the experiences of PHNs, FPNs and NPs of working with other nurses and health care professionals in the community helped to gain an understanding of the precipitators to forming relationships with other professionals who are involved in breastfeeding support and promotion. Participants in the study were more likely to form interpersonal relationships with another professional if they believed that they shared their enthusiasm for supporting and promoting breastfeeding. This is consistent with literature that discussed collaboration amongst professionals. Literature that discusses communities of practice, "groups of people who share a concern, set of problems, or passion about a topic" (Wenger et al., 2002, p.4), suggests that passion about a topic is a key factor contributing to groups of professionals coming together to solve problems, share advice and information (Wenger et al.).

Participants in the study detailed examples of relationships that they had formed with other RNs or health care professionals. Instances where they had formed relationships with colleagues in primary care and public health had resulted from an effort that participants described as reaching out or putting themselves out there. It was apparent that for relationships to form someone needed to take the initiative; participants agreed that it is the role of PHNs to reach out and make connections with primary care. PHNs were viewed to hold expertise in breastfeeding support and promotion by FPNs and PHNs, participants concurred that PHNs needed to promote their role and their work in breastfeeding support and promotion to create an understanding amongst public health

and primary care. This finding was suggested in Meagher-Stewart et al.'s (2005) earlier study of PHN's primary health care practice in NS. The PHNs in this previous study also called for a better understanding of their work in health promotion.

Establishing trust and mutual respect was the most significant component to forming interpersonal relationships between public health and primary care as described by the focus group participants and consistent with the literature on determinants of successful collaboration (D'Amour et al. 2008; San Martin-Rodriguez et al., 2005). Participants placed more trust in other professionals who they considered to be experienced and competent in their knowledge of breastfeeding. This was also evident within organizations and this trust was attributed to positive relationships between physicians and RNs in primary care settings.

Several barriers to developing interpersonal relationships emerged during the focus group interviews. Different approaches to care, not knowing each other, lack of role clarity and poor relationships between PHNs and family physicians all impeded the development of interpersonal relationships amongst professionals in public health and primary care. PHNs frequently discussed issues with physician practices conflicting with their own practice. These discrepancies were believed to negatively impact client care and breastfeeding outcomes. Although FPNs described better working relationships with physicians, they did articulate how approaches to care can differ between RNs and physicians in family practice settings due to philosophical differences in practices. Given the importance credited to establishing positive relationships with physicians by the focus group participants, one limitation to this study was that physicians were not included in the focus groups.

Focus group participants experienced successful interpersonal relationships, despite the barriers that were reported during the study. When compared to the literature, the relationships described by participants were not examples of collaboration, rather networking or coordinating and would be placed along the continuum of collaboration as potential or developing collaboration (Himmelman, 2002; D'Amour et al., 2008). The most significant outcome of established interpersonal relationships that was discussed during the focus groups was referral. The likelihood of referring a client to another provider or organization was greater if professionals knew each other and trusted in one another. Having knowledge of other professionals' roles also prevented inappropriate referrals.

Networking and coordinating was another positive outcome of interpersonal relationships. The participants most often described activities that occurred within their own organizations, rather than between public health and primary care, other than the case of one PHN who worked in a rural community and in close proximity to other professionals involved in breastfeeding support and promotion. The FPNs and NPs interviewed all worked in organizations where various professionals worked alongside each other, most often, nurses and physicians. PHNs were not involved in models of service delivery as described by the FPNs; in fact, they described being left out of care teams that were forming in communities.

Improved client outcomes and care and improved knowledge and capacity building of health care professionals were also positive results of established interpersonal relationships. Having relationships with other professionals gave participants the opportunity to share and learn from one another, thus impacting the care

provided to clients. As a result, clients experienced better care and consistency of information. Despite difficulties encountered while establishing relationships with other professionals and organizations, participants in the focus groups spoke enthusiastically and passionately about the possibility of working more with one another. Although it was evident that opportunities for PHNs, FPNs and NPs to work together collaboratively were few, there is a strong desire for these nurses to further develop collaboration in breastfeeding support and promotion.

Organizational Context: Structures and Processes in the Everyday Work Environment

This theme highlighted the impact of the organizational context of PHN's, FPN's and NP's work environment on the development of collaboration between public health and primary care in breastfeeding support and promotion. Participants described several factors related to their organizational settings that negatively influenced the degree to which they could develop collaborative relationships.

D'Amour et al. (2008) suggested that information systems could help to decrease uncertainties amongst professionals when they did not know each other well and that formalized tools such as interorganizational agreements, protocols and information systems can be helpful in the development of collaboration. Participants identified that such systems or formalized tools are not available for their work in breastfeeding support and promotion. Primary care participants who thought that they had well established relationships with their public health colleagues did not see the benefit in developing communication tools, however, those who did not believe that they had strong relationships believed that a more formalized communication system was needed.

FPNs and NPs were accustomed to making referrals in other areas of their practice, such as chronic disease management; however, they believed that the nature of their work with breastfeeding women did not lend itself to the traditional mechanisms that they used for referral. Their work with breastfeeding women required them to have immediate contact with someone, such as a PHN, who could provide the mother with the help that she needed. PHNs recognized a need for better communication with primary care, however, given the large number of primary care practices in the District, were overwhelmed with the breadth of the issue. Also noted, was the lack of guidelines for practice in breastfeeding support and promotion, resulting in the use of websites, pamphlets, books and information lines to guide practice.

Focus group participants worked in a variety of settings with different models of service delivery and described characteristics that helped or impeded the development of collaboration between public health and primary care in breastfeeding support and promotion. Participants who worked in a flexible organizational structure believed that they had autonomy to adapt their practice to meet the needs of their clients. Flexibility in the roles of health professional roles has been identified in previous literature as a strategy for dealing with the challenges associated with collaboration between public health and primary care (Ciliska et al., 2005).

The restrictive scheduling parameters associated with the fee-for-service environment were noted as a barrier to the development of collaboration in breastfeeding support and promotion. Participants revealed that in a fee-for-service environment, time spent on interventions beyond service delivery to individuals was done outside of paid work hours. Formal or informal leadership could thwart or promote the development of

collaborative initiatives in breastfeeding promotion and support. PHNs reported having difficulty embarking on new initiatives, because it was difficult to know what would be supported by leadership within their organization. Despite working in a flexible organizational structure where their role was supposed to involve multiple levels of intervention in breastfeeding support promotion, the PHNs interviewed found that the time needed to build trusting and respectful partnerships within their communities was not a priority within their organizational structure; this was also identified in a previous literature (Meagher-Stewart et al., 2010). Although FPNs often felt constrained within the organizational structure of primary care, it was evident that they had support within their organizations to be proactive in their day to day practice.

The PHNs interviewed worked in specialized practice, while the FPNs and NPs worked in a generalist role. This difference in practice cultures has been associated with challenges in the development of collaboration between public health and primary care (Ciliska et al., 2005). Increased specialisation in PHN practice and loss of geographic areas for practice has been noted in the literature as a barrier to PHNs primary health care practice, as nurses experienced a diminished presence in the community (Meagher-Stewart et al., 2005).

Location was another key factor that influenced the development of collaboration between public health and primary care in breastfeeding support and promotion. Having physical space that was conducive to working with others was important to the development of collaboration. Spaces to meet with other health care professionals or to provide programs and services were reported to impact the development of collaboration by the participants in the focus group interviews.

Consistent with literature (Cook et al., 2001; Hurst et al., 2002; Xychris & Lowton, 2008), working in close geographic proximity to other health care professionals was viewed as a facilitator to the development of collaboration. The PHNs, FPNs and NPs in the study did not work in co-location with one another, although this was mentioned as something that they would like to see in the future, and for some participants, was seen vital to the development of collaboration between public health and primary care.

Another identified barrier to the development of collaboration within organizational structures during the focus group interviews was resource limitations. The development of collaboration required resource investment (Himmelman, 2002). For PHNs, FPNs, and NPs, time was a significant factor that impacted their ability to develop collaborative relationships. Even when organizational roles and responsibilities involved forming partnerships with other organizations, participants believed that contacts that they had with individual mothers consumed the majority of the time spent in breastfeeding support and promotion.

Access to breastfeeding education was another resource that was important in the development of collaboration in breastfeeding support and promotion. Although an education program for health care professionals was available in the District, the structure of the program was not suitable for those working in a fee-for-service environment. Primary care nurses did not believe that they had sufficient education in the area of breastfeeding for their role; they thought that public health could support them on this issue.

Benefits of Collaboration

The third theme that emerged from the data in the focus group interviews discussed the advantages to the development of collaboration between PHNs, FPNs and NPs who worked in breastfeeding support and promotion. Participants believed that the benefits of collaboration outweighed any potential risks or harms that may be associated with the development of collaboration between public health and primary care. Not surprising, there was slight trepidation amongst the participants related to the fear of time commitment involved with collaboration and uncertainty as to the impact that it may have on the PHN role in breastfeeding support and promotion.

Overall, participants in the focus groups saw many benefits in the development of collaboration between public health and primary care in breastfeeding support and promotion. Having the occasion to connect with other professionals was viewed as a positive outcome to the development of collaboration by the focus group participants. Increased connection with other healthcare professionals meant the opportunity to increase health care professional engagement in breastfeeding support and promotion activities. Participants believe that this involvement would bring about change in the area of breastfeeding support and promotion.

Connectivity between health care professionals was also viewed as a way to transfer information about breastfeeding and the various resources available to support breastfeeding women in the District. Practice is constantly evolving; participants believed that working with other health care professionals who are involved in breastfeeding promotion would increase their capacity to support clients in their daily work by helping them to keep their knowledge current. One participant identified an outcome of the focus

group interviews was having the opportunity to connect and share, thus improving her knowledge of resources available in the community.

Participants also believed that the development of collaboration in breastfeeding support and promotion would contribute to improved breastfeeding outcomes in the community. Although it is difficult to directly link collaboration to breastfeeding outcomes, participants believed that collaboration would enhance the support available to mothers and families in the District, thus contributing to improved breastfeeding rates. Hoddinott, Pill and Chalmers (2007) studied the impact of a breastfeeding coaching intervention in various communities. They found that breastfeeding rates were better in areas where several local health professionals worked together to implement the program,

The finding that consistent messages were seen as a benefit to collaboration by focus group participants was not surprising. This is a common concern in the care of breastfeeding women and was one of the catalysts for this study. The aetiology of this issue is unknown (Nelson, 2007); however, what is clear is that there are a variety of factors that influence the behaviour of health care professionals related to breastfeeding including: knowledge, attitudes, personal and professional experience (Nelson). The development of collaboration between public health and primary care was believed to be one strategy to improve the consistency of information provided by health care professionals to breastfeeding women.

Development of New Practices Grounded in Collaboration

The development of collaboration leads to new activities and the development and implementation of new innovations (D'Amour et al., 2008). During the focus group interviews, it was apparent that collaboration, as defined in Chapter I, was not present

between public health and primary care in breastfeeding support and promotion in Capital Health. Although PHNs, FPNs and NPs provided examples of working together, their relationship had qualities of networking or coordinating, rather than collaboration and developing or potential collaboration versus active collaboration (D'Amour et al.; Himmelman, 2002). However, when participants were asked to describe what collaborative practice in breastfeeding support and promotion would look like in Capital Health, they had an abundance of ideas of the structures and processes required for public health and primary care to work more effectively together. There was a strong desire amongst the PHNs, FPNs and NPs interviewed to re-examine their practice in breastfeeding support and promotion and to work collaboratively to contribute to improved breastfeeding outcomes in the community.

The current health system in Capital Health does not integrate public health and primary care. Although working in the same communities and with the same clients, there is little opportunity for PHNs, FPNs and NPs to collaborate in breastfeeding support and promotion, or other issues that they face in their practice. Participants in the study agreed that key components to the development of collaboration were currently missing from practice in breastfeeding support and promotion such as; shared goals, vision, and location. As noted in the literature about collaboration between public health and primary care, lack of a common agenda is a barrier to collaboration (Dion, 2004; Hogg & Hanley, 2008). Many of the participants preferred public health and primary care to work under the same roof, particularly those who did not have previous relationships with public health or primary care colleagues, as they believed that this would contribute to a common understanding.

Participants also believed that a focus on the needs of the client was important to the development of collaboration. Having flexibility to respond to client needs was an important factor that participants thought would facilitate the development of collaboration in breastfeeding support and promotion. The nurses thought that community involvement in the development of new initiatives to support breastfeeding was important. This reflects the principles of primary health care that are an important foundation to CHN practice.

Improving relationships between professionals was viewed as a crucial factor in further development of collaboration in breastfeeding support and promotion in Capital Health. Participants believed that professionals involved in breastfeeding support and promotion in the District needed opportunities to get to know each other both personally and professionally.

The impact of positive relationships with other health care professionals was evident during the course of the study. Although some of the participants in the study had previous relationships with one another, it was evident that they did not have a clear understanding of each other's roles in breastfeeding support and promotion. During the follow-up focus groups, participants exhibited a greater understanding of one another's roles and the discussion was one of negotiation. Participants recognized that PHNs, FPNs and NPs had different roles in breastfeeding support and promotion and they began to discuss how these nurses could work more effectively together to develop collaboration.

Having the opportunity to get to know one another and each other's roles helped to build the trust that was needed for PHNs, FPNs and NPs to work more effectively together. FPNs acknowledged PHN expertise in breastfeeding and envisioned how if

working in closer proximity to one another, PHNs could help to build capacity in FPNs to strengthen their practice with breastfeeding women. Participants believed that if public health and primary care worked in an environment that provided the opportunity for them to work more closely, their practice in breastfeeding support and promotion would be more effective.

Although many of the participants were employed in organizations where they worked alongside other health care professionals such as physicians, dieticians, social workers and physiotherapists, descriptions of collaboration between public health and primary care did not emerge during the focus group interviews. Participants believed that changes would need to be made to current organizational structures for the development of collaboration between PHNs, FPNs and NPs in breastfeeding support and promotion to occur. Some participants believed that this would require a completely new organizational structure and setting, a Centre of Excellence, while others thought that existing structures, such as the newly formed Community Health Teams, in some areas in the District would be structures that could potentially support the development of collaboration in breastfeeding support and promotion. A barrier noted was that nurses had not been included as a part of the community health team structure.

Supportive leadership, formal or informal, was also believed to be an important factor that would contribute to future collaboration between public health and primary care. Consistent with the literature on collaboration (Henneman, 1995), participants believed that horizontal versus hierarchical leadership supported innovative practice that was needed to develop collaboration. Without leadership support, participants thought that it would be difficult to make changes to practice. Meagher-Stewart (2010) also

reported in an earlier study that effective program planning, promoting and valuing PHN practice, and supporting autonomous practice were management practices necessary to support optimal PHN practice. Future development of collaboration in breastfeeding support and promotion would require PHNs to work to their full level of competency.

Participants in the study recognized that communication between public health and primary care organizations needed further attention. Therefore, it was not surprising that participants acknowledged that the development of a formalized tool for communication between primary care and public health would be necessary for collaboration to develop between these two organizational structures. Patient passports, resource booklets and a formalized referral system were suggested as possible structures that would support the development of collaboration. Additionally, the development of practice guidelines for breastfeeding that could be shared between public health and primary care was also proposed as a structure that would contribute to strengthening working relationships between public health and primary care in breastfeeding support and promotion.

For collaboration to continue to develop between PHNs, FPNs and NPs, participants believed that resources such as funding, physical space and human resources would need to be considered. Resource limitations were noted by participants as barriers to collaboration and also supported in the literature (Martin-Misener et al., 2008). Participants recognized that a fee-for-service structure is not ideal for the development of collaboration. The FPNs and NPs who worked in a fee-for-service environment reported that the majority of their time was spent in the clinic working with individual clients. In a

flexible organizational structure, health care professionals can spend more time with clients and collaborating with other professionals (Russell et al., 2009).

A physical space located in the community where women could access breastfeeding support was important to many of the participants in the study. A warm, welcoming, accessible space in the community where women could go for support with breastfeeding if needed was a vision that was described; this did not currently exist in Capital Health. Having a dedicated space for breastfeeding would indicate that this practice was supported and valued in the community. Focus group participants thought that the involvement of partners, in addition to PHNs, FPNs and NPs would be necessary to support the development of collaboration in breastfeeding support and promotion. This recognized that breastfeeding support and promotion takes place across the continuum of care, involving multiple levels of intervention. Breastfeeding support and promotion activities extend beyond public health and primary care.

Future Implications

All participants in this study were purposefully selected, which enabled rich information to be elicited in the focus group interviews. However, as the study included a small, but rich sample, findings should be interpreted with caution as transferability is limited due to the small sample and the heterogeneity of the nurses' practice settings. However, transferability was assured in this study because the focus group interviews provided detailed descriptions of the participants' experiences. The researcher and the participants recognized that there are many other lay and professional supporters involved in breastfeeding support and promotion. These implications relate to PHN, FPN and NP practice, as they were the individuals who took part in the study. Additionally,

the subjective nature of this inquiry suggests that another researcher may have interpreted the data differently.

PHNs, FPNs and NPs all dedicate time and effort into the support and promotion of breastfeeding, yet active collaboration amongst these nurses was not evident in this study (D'Amour et al., 2008). An examination of PHN, FPN and NPs' experiences with the development in breastfeeding support and promotion revealed the aforementioned research conclusions. Although there are some similarities in their roles and responsibilities in breastfeeding support and promotion, there are differences in the type of support, where and when it is offered, and the level of intervention. Establishing interpersonal relationships was an important factor in the development of collaboration. Their organizational environment shapes the work that they do and can positively or negatively impact their ability to take part in collaborative initiatives. PHNs, FPNs and NPs believed that the benefits of collaboration outweigh any potential risks.

As demonstrated in this study, when practitioners are given the opportunity to meet one another and understand each other's roles, they are able to identify strategies to overcome barriers associated with the development of collaboration and recommend new structures and processes that are required for the development of collaboration in breastfeeding support and promotion (Crowell, 2011). The results of this study provide numerous implications for public health and primary care nursing practice, implications for future research, education, and policy. These implications were generated by the participants during the focus group interviews and co-constructed with my analysis of their responses.

Implications for Practice

CHNs are called to work with various professionals and organizations to address the needs of the community. "Collaboration includes shared identification of issues, capacities and strategies" (CHNC, 2008, p. 16). First and foremost, PHNs, FPNs and NPs need the opportunity to meet one another and to get to know each other both personally and professionally. Establishing interpersonal relationships set the stage for the development of trust and mutual respect, which are both key factors in the development of collaboration.

Once relationships have been established, joint planning initiatives related to breastfeeding support and promotion between PHNs, FPNs and NPs, including community members should occur. This would help to create partnership, a common understanding and initiatives that are responsive to community need. Development of a common set of goals and values and vision for breastfeeding support and promotion, as well as a plan to evaluate collaborative initiatives should occur. Nurses need the opportunity to meet on an ongoing basis, as practice recommendations and community need changes over time.

A framework for practice, similar to the one presented in Appendix A, could assist CHNs work to their full scope of practice, using the CCHN Standards (CHNC, 2011) and the socio-ecological approach (McLeroy et al., 1998) applied to breastfeeding support and promotion. Through the identification of activities at the individual, interpersonal, organizational, community and policy levels of intervention, CHNs could apply a multi-level, coordinated approach to breastfeeding support and promotion. For example, a multi-level approach to promoting extended duration of breastfeeding could

involve supporting mothers during clinic visits at 12 and 18 months (FPNs and NPs), supporting workplace programs that support breastfeeding women (PHNs), establishing a surveillance system to track breastfeeding duration rates (PHNs), supporting activities related to the Baby Friendly Initiative (PHNs, FPNs, and NPs), promoting breastfeeding friendly spaces community (PHNs), and advocating for full implementation of the Provincial Breastfeeding Policy (PHNs). Employing a framework for breastfeeding support and promotion in Capital Health could help to create a common goal and understanding between public health and primary care nurses in the District.

Organizationally, flexibility in roles and funding are required to support joint initiatives between PHNs, FPNs and NPs. Alternatives to fee-for-service structures should be explored for FPNs and NPs working in family practices. In addition, PHNs, FPNs and NPs should be encouraged to work to the full scope of their competencies.

The development of a communication infrastructure is necessary for future development of collaboration. A standardized communication tool, such as a patient owned passport or health record, should be explored, with input from all parties who would be required to use the tool. Development of practice guidelines for breastfeeding support and promotion that are shared between public health, primary care and other professionals involved in breastfeeding support and promotion would also be beneficial.

Implications for Research

As this was a descriptive study with a small but rich sample size, future research could look at exploring this topic further with a broader sample. The topic of collaboration between public health and primary care is timely within the current financial constraints in the health system in NS and the renewal of the public health

system in the Province. Questions are being raised at the organizational and systems level as to how public health and primary care can coordinate rather than duplicate services (Corpus Sanchez, 2007). Additionally, there is uncertainty about the future role of PHNs in breastfeeding support and promotion and public health is being directed away from a focus on providing service to individuals (Nova Scotia Department of Health and Wellness, 2011).

As breastfeeding takes place across the continuum of care, many professional and lay supporters are involved in breastfeeding support and promotion at difference points along this continuum. Future studies should include all professionals who work in breastfeeding support and promotion, with an emphasis on including the physician voice, as currently, the predominant model in primary care in Capital Health is physician provided primary care. Physicians were identified as important factors in the development of collaboration in breastfeeding support and promotion and should be included in future research that looks at this issue.

Participants in the focus groups believed that the fee-for-service structure was a barrier to the development of collaboration. Further research needs to be undertaken to look at the impact of fee structure on the development of collaboration. Previous research looked at the impact the organizational context on PHN practice (Meagher-Stewart et al., 2010). Further attention needs to be given to the organizational structures that support FPNs and NPs to work to the full scope of their competencies related to breastfeeding support and promotion.

Several studies reported on various initiatives that impact breastfeeding outcomes (Britton et al., 2009; Chung et al., 2008; de Oliveira et al., 2001; Dyson et al., 2008;

Fairbank et al., 2000; Guise et al., 2003; Hannula et al., 2007; Protheroe et al., 2003; Renfrew et al.,2005). However, only one has looked at the impact of collaborative initiatives on breastfeeding outcomes (Hoddinot et al., 2007). Future research needs to look at the impact of collaboration on outcomes related to breastfeeding. Additionally, a better understanding of the organizational structures that are needed to support successful breastfeeding interventions is needed.

Implications for Education

Education lays the foundation for health care professionals' future practice. Students should have the experience to experience collaboration in undergraduate and graduate programs. The concepts that are the foundation for CHN practice are found in the Canadian Community Health Nursing Standards of Practice (CHNC, 2011). Although practitioners are not meant to be practicing to the full scope of these Standards until they have two years of practice experience (CHNC), it is important that future CHNs are well educated in the foundation of community health nursing practice and the underlying values of caring, principles of primary health care, multiple ways of knowing, individual and community partnerships, empowerment and social justice (CHNC). This understanding will facilitate future CHNs to optimize their role in breastfeeding support and promotion.

Focus group participants clearly stated the need for joint breastfeeding education initiatives between public health and primary care. Although a three day breastfeeding education program for health care professionals does exist in Capital Health, consideration must be made as to how to adapt the program to the fee-for-service practice environment. This program could be altered to accommodate fee-for-service primary care

through the development of shorter modules, based on education needs identified by primary care practitioners. In addition, telehealth sessions or online modules could be explored. PHNs are viewed as having expertise in breastfeeding support and promotion and can help to build capacity in FPNs and NPs who are supporting breastfeeding mothers in the community.

Implications for Policy

For active collaboration (D'Amour et al., 2008) to occur between public health and primary care in breastfeeding support and promotion, broader strategies would need to be implemented at the health system level in NS. San Martin-Rodriguez et al. (2005) described systemic determinants of collaboration as elements that are outside the organization.

The Model of Care Initiative in Nova Scotia (MOCINS) "is a joint initiative of the Department of Health & Wellness, District Health Authorities, and the IWK Health Centre" (Government of NS, 2011, n.p.). It is a collaborative care model that considers how health care services are organized and delivered. The initiative focuses on streamlined processes, faster access to information, and modern technology to support staff to provide the safest and best possible patient care (Government of NS). To date, the focus on this initiative in Capital Health has been in the acute care setting. Consideration should be made as to what this initiative means to public health and primary care and to nurses working in community settings, such as PHNs, FPNs and NPs.

Working to full scope of practice has been identified as an issue for PHNs, FPNs and NPs (Martin-Misener et al., 2010b; Meagher-Stewart et al., 2010; Todd et al., 2007) However, compared to PHNs and FPNs, NPs have received immense support from

education, regulatory bodies and governments both in NS and across Canada to establish and develop their role (Canadian Nurse Practitioner Initiative, 2006). Optimization of the role of PHNs, FPNs and NPs is an issue that requires attention from the NS provincial government, CRNNS, and professional associations such as CHNC, the Family Practice Nurses Association of Nova Scotia and the Nurse Practitioners Association of Nova Scotia.

Flexibility of funding is an important implication for health policy. Support for funding for collaboration and initiatives carried out between public health and primary care as an important facilitator to collaboration (Ciliska et al., 2005). Participants in the focus group interviews believed that the fee-for-service structure of primary care was a barrier to collaboration between public health and primary care. Provincial government support is needed to implement and evaluate new innovative, collaborative initiatives between public health and primary care in the area of breastfeeding support and promotion.

Final Reflections

The PHNs, FPNs and NPs in the study were asked to discuss their experiences with collaboration between public health and primary care related to their practice in breastfeeding support and promotion. The nurses in the study identified the importance of establishing interpersonal relationships in the development of collaboration. They also discussed the impact that the organizational context of their work environment had on the development of collaboration. Participants believed that the development of collaboration in breastfeeding support and promotion would benefit health care professionals and the clients that they serviced. When given the opportunity to describe new initiatives or

innovations that were needed for the development of collaboration between PHNs, FPNs and NPs, participants articulated the structures and processes that they believed were required to develop collaboration in breastfeeding support and promotion.

PHNs, FPNs and NPs in Capital Health have a strong desire to work collaboratively to support and promote breastfeeding in their communities. They have knowledge of their communities and the structures and processes that would support the development of collaboration. Prior to taking part in the focus group interviews, the majority of the nurses were not aware of each other's roles in breastfeeding support and promotion. From my experience working in the Healthy Beginnings program, I believe that there is a lack of role clarity amongst various nurses in the community. Given the opportunity to come together and be a part of joint initiatives, PHNs, FPNs and NPs could adapt their practice within their current organizational structure to facilitate the development of collaboration and contribute to improved breastfeeding outcomes.

I began to investigate the topic of this thesis because of my professional and personal experience with inconsistency of information and lack of communication between public health and primary care. Discovery of the role of the FPN during the course of the journey through my Master of Nursing program at Dalhousie University sparked a desire to further investigate how nurses working in public health and primary care could work together more effectively in breastfeeding support and promotion. In depth examination of literature related to health promotion, public health, primary care and collaboration has developed my knowledge of these topics, and enhanced my practice as a PHN. Moreover, the enthusiasm and passion that was exhibited by the PHNs, FPNs and NPs during this study has inspired me to continue to advocate for future

collaborative initiatives between public health and primary care in breastfeeding support and promotion.

Findings of this study will be disseminated at a local level through presentations to public health practitioners in Capital Health, the Annual Family Practice Nurses Association of Nova Scotia Education Day, and providing a summary of this study to the Nurse Practitioners Association of Nova Scotia. A summary will also be provided to study participants. To ensure broader circulation of the research findings, a research article will be submitted to at least one peer reviewed journal (Polit & Beck, 2004). Additionally, the researcher plans to deliver research findings in an oral presentation at a variety of venues including the 7th National Community Health Nurses Conference in Vancouver, the 2013 Canadian Association of Advanced Practice Nurses Conference in Halifax, and the Annual International Lactation Consultant Association Conference. Oral presentations will give the researcher an opportunity to have dialogue with other professionals on the research topic (Polit & Beck).

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APPENDIX A

Applying the Community Health Nursing Standards of Practice (CHNC, 2008) to Breastfeeding Promotion
Using an Ecological Model of Health Promotion (McLeroy, 1988) (Lovett, 2007)

CCHN Standard	Individual	Interpersonal	Organizational	Community	Policy
Promoting Health	- Home visits - Breastfeeding support line - Community breastfeeding clinics - Prenatal classes with information about breastfeeding threaded throughout - Breastfeeding messages in school curriculum; include puberty talks, discussion about child rearing, and whenever infant feeding is addressed - social marketing campaigns	- Involving family members, partners and support persons in all aspects of breastfeeding support - Peer to peer Breastfeeding support groups - Workplace programs that support breastfeeding women	- Baby Friendly initiative - Organizational breastfeeding policies - Employee breastfeeding policies - School curriculum designed with breastfeeding education messages rather than bottle feeding messages - Measuring breastfeeding outcomes - Application of a variety of data to inform programs offered to individuals, families and communities - Application of the Population Health Promotion Model to identify the level of intervention required, which determinants of health require action and which strategies are useful in addressing the promotion of breastfeeding - Health promotion strategies based on the Ottawa Charter for Health Promotion - Evaluate and modifies population health promotion programs related to breastfeeding	- Breastfeeding friendly spaces in the community - Social Marketing Campaigns - Asset based community assessment related to breastfeeding, assess community attitudes and beliefs related to breastfeeding to inform program strategies	- Provincial Breastfeeding Policy - Adequate funding for the development and sustainability of health promotion programs that support breastfeeding initiatives - Evaluation of programs - Goal of recreating the cultural norm for breastfeeding

CCHN Standard	Individual	Interpersonal	Organizational	Community	Policy
Building Individual/ community capacity	- Providing individuals with information about benefits of breastfeeding and risks of formula to facilitate making an informed decision - Individuals are supported to get through challenges, empowered with information - Assess individual goals related to infant feeding - Education of other health care providers and professionals outside of the health care sector to support breastfeeding (including physicians) - Training of peer volunteers for in-person and telephone support - Expert PHNs mentor novice staff	- Assess the breastfeeding mother's support system - Increase capacity of partner, family and friends to support the breastfeeding woman - Uses effective facilitation skills to support group development	- Community health assessments - Share developed resources with other health care providers, other health units - Partner with La Leche League and other community agencies - Work collaboratively with other agencies to identify needs, strengths and resources - Uses principles of community development in breastfeeding initiatives	- Community health board involvement in breastfeeding initiatives - Motivate community members to become involved in local breastfeeding initiatives - Encouraging communities to form breastfeeding coalitions - Assisting the community to marshal available resources to support taking action on issues that affect breastfeeding families - Assists the community in action to influence policy change - Facilitate World Breastfeeding Week Celebration in the Community	- Implementing population based strategies such as the Baby Friendly Initiative supported by all levels of government - Advocacy in support of individuals and communities who are not able to take action for themselves

CCHN Standard	Individual	Interpersonal	Organizational	Community	Policy
Building Relationships	- CHNs may have their own personal experience with breastfeeding (positive or negative), CHNs must recognize the potential impact that this may have on care of breastfeeding families - Building relationships with breastfeeding women through repeated contacts through home visits, telephone calls and community clinics - Links breastfeeding women with community resources - Maintains a therapeutic professional relationship with the breastfeeding mother and negotiates the end of the relationship when goals have been achieved	- Building supportive relationships with families - Involving families in feeding plans, discharging when family is ready - Building relationships between groups of nurses who support breastfeeding families (public health, family practice, hospital)	- Partner with community organizations that address the needs of vulnerable populations (immigrant settlement services, community services, Children's Aid, Canadian Prenatal Nutrition Program (CPNP)) - provide education to these organizations regarding the benefits of breastfeeding & supports available - Partner with local hospital to facilitate a smooth transition from hospital to the community (hospital liaison role) - Partner with local businesses to create breastfeeding friendly spaces	- Involve community papers to write positive articles on breastfeeding - Community is an active partner in identifying their own needs; partnership with community health boards, tenants associations, parent advisory committees, parent teacher associations, etc.	- Advocacy to College of Family Physicians to increase physician education for breastfeeding - Advocacy to BScN programmes to enhance breastfeeding education for students - Local, provincial and national breastfeeding coalitions involving members from multiple sectors

CCHN Standard	Individual	Interpersonal	Organizational	Community	Policy
Facilitating Access and Equity	- Educate women regarding their choice to access alternative health care options (doulas, midwives, naturopath/homeopath, LCs in private practice) - breastfeeding addresses issue of food security - Provincial enhanced home visiting program provides service to mothers who need extra support; increased duration of breastfeeding is an expected outcome of this program - Healthy Baby program, home visiting for high risk prenatal clients, these clients are less likely to breastfeed - Provides culturally sensitive care to breastfeeding women	- Prenatal classes that are inclusive and recognize the many variations of family structure - Offering services that include the breastfeeding woman's support network; evening and weekend programs are offered so that women can attend programs with support people who may be working during the day - Care is respectful of the family's diverse needs	- Offering services like community clinics and support groups for breastfeeding families, free of charge - development of a patient owned health record that follows them prenatal to 24 months; facilitates communication and continuity of care between providers - Mobilizing peer support networks for breastfeeding - Support to external programs like the volunteer Doula program and CPNP - Co-ordinates and facilitates access to services within health and other sectors	- Community members advocating to local MLAs if issues related to breastfeeding surface - Community members lobbying government for more supports for breastfeeding families in the community (funding for Doula program, peer support groups) - assessing community capacity to understand norms, values, beliefs, knowledge, resources and power structure	- Advocates for healthy public policy by participating in legislative and policy making activities that influence health determinants and access to services - Lobbying governments for midwifery legislation to ensure that families have a choice when selecting appropriate care providers - Advocating for government policies that support diversity in health care; eg. Health Canada document: Breastfeeding: A Multicultural Perspective - Promoting Nova Scotia Human Rights Commission statement on breastfeeding - Advocating for appropriate resource allocation to facilitate access to appropriate health care services for breastfeeding families

CCHN Standard	Individual	Interpersonal	Organizational	Community	Policy
Demonstrating Professional Responsibility and Accountability	- Seeking out learning opportunities to develop skills that will help support breastfeeding families - Refers to other professionals when needed - Reports suspected abuse or neglect - educates other professionals as needed	- Networks of community health nurses who support breastfeeding initiatives "communities of practice" - mentoring students and novice practitioners in	- Implementation of BPGs for Breastfeeding Support - BFI initiative for Community Settings - Development of organizational policies and protocols related to breastfeeding; education for all employees based on their interaction with breastfeeding families - resource development - development of guidelines for breastfeeding education of employees - supporting membership to CHNC, development of communities of practice and other supports that promote reflective practice and lifelong learning - Offering professional development experiences that enhances practice with breastfeeding families	- Mobilizing groups of community health nurses in advocacy efforts, eg. Community Health Nurses Association of Canada - Breastfeeding Position statements by the College of Registered Nurses and the Canadian Nurses Association	- Advocacy for enforcement of The International Code of Marketing of Breastmilk Substitutes in Canada - government support of BFI initiatives - Advocacy for social policies that support breastfeeding

APPENDIX B

INVITATION

Capital Health

Are you a Public Health Nurse who works in breastfeeding support and promotion?

You are invited to participate in a research study exploring collaboration among public health nurses, family practice nurses and nurse practitioners who work in breastfeeding support and promotion.

Each participant will be invited to participate in two 90 minute focus groups.

You will be financially compensated for your participation in the study.

If you are interested and want more information, please contact Tracy Lovett at 902-481-5925 or via email at tracy.lovett@cdha.nshealth.ca

Version 1
December 17, 2010

APPENDIX C

INVITATION

Capital Health

DALHOUSIE UNIVERSITY
Inspiring Minds

Are you a Family Practice Nurse who works in breastfeeding support and promotion?

You are invited to participate in a research study exploring collaboration among public health nurses, family practice nurses and nurse practitioners who work in breastfeeding support and promotion.

Each participant will be invited to participate in two 90 minute focus groups.

You will be financially compensated for your participation in the study.

If you are interested and want more information, please contact Tracy Lovett at 902-481-5925 or via email at tracy.lovett@cdha.nshealth.ca

Version 1
December 17, 2010

APPENDIX D

INVITATION

Capital Health

DALHOUSIE UNIVERSITY
Inspiring Minds

Are you a Nurse Practitioner who works in breastfeeding support and promotion?

You are invited to participate in a research study exploring collaboration among public health nurses, family practice nurses and nurse practitioners who work in breastfeeding support and promotion.

Each participant will be invited to participate in two 90 minute focus groups.

You will be financially compensated for your participation in the study.

If you are interested and want more information, please contact Tracy Lovett at 902-481-5925 or via email at tracy.lovett@cdha.nshealth.ca

Version 1
December 17, 2010

APPENDIX E

Capital Health

LETTER OF INFORMATION AND CONSENT FORM

STUDY TITLE: Exploring the Structures and Processes Needed to Support Collaboration amongst Public Health Nurses, Family Practice Nurses, and Nurse Practitioners who Work in Breastfeeding Support and Promotion

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PART A.

1. Introduction

You have been invited to take part in a research study. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

Please read this carefully. Take as much time as you like. If you like, take it home to think about for a while. Mark anything you don't understand, or want explained better. After you have read it, please ask questions about anything that is not clear.

The researcher will:

- Discuss the study with you
- Answer your questions
- Keep confidential any information which could identify you personally
- Be available during the study to deal with problems and answer questions

We do not know if taking part in this study will help you. You may feel better. On the other hand it might not help you at all. It might even make you feel worse. We cannot always predict these things. We will always give you the best possible care no matter what happens.

PART B.

EXPLAINING THE STUDY

2. Why Is This Study Being Done?

The purpose of this study is to explore the structures and processes needed to support collaboration amongst public health nurses, family practice nurses, and nurse practitioners who work in breastfeeding support and promotion. The intent of the study is to capture public health nurses', family practice nurses' and nurse practitioners' experiences as participants share their thoughts and understandings surrounding this topic. In Capital Health, the same clients are shared between primary care and public health from the prenatal period forward, yet there is no formal structure of collaboration of services. Knowledge of how public health nurses, family practice nurses, and nurse practitioners work together could lead to improved support of breastfeeding families and enhanced collaboration in areas other than breastfeeding support and promotion.

3. Why Am I Being Asked To Join This Study?

You are being asked to participate because of your role as a public health nurse, family practice nurse or nurse practitioner and your expertise regarding public health nurses', family practice nurses', or nurse practitioners' role in breastfeeding support and promotion.

4. How Long Will I Be In The Study?

You are being asked to take part in two face-to face 90 minute focus group interviews two to four weeks apart.

5. How Many People Will Take Part In This Study?

This study is taking place only in Nova Scotia. Approximately 35 public health nurses, 34 family practice nurses and six nurse practitioners are eligible to participate in Capital Health. Of these, four to six public health nurses, four to six family practice nurses and two to four nurse practitioners will be randomly selected from those who volunteer to participate in the study. There will be two focus groups with five to six participants in each focus group (maximum 12 participants in the study). Each focus group will contain two to three public health nurses, two to three family practice nurses and at least one nurse practitioner. One focus group will contain participants who practice in rural/semi rural settings and one focus group will have participants who practice in urban and suburban settings.

6. How Is The Study Being Done?

This study uses focus groups to gather opinions and experiences from participants. Your are being asked to participate in two face-to-face 90 minute audio-taped, focus group interviews. The focus groups will be conducted at a time and location that is convenient for you, either within Capital Health or Dalhousie University. There will be two focus groups with five to six participants taking part in each focus group. During the first focus group interview, you will be asked to respond to questions related to your perceptions and experiences as a public health nurse, family practice nurse, or nurse practitioner working in breastfeeding promotion. You will be invited to a follow-up focus group two to four weeks following the first focus group interview, to provide any feedback to the Principal Investigator and comment on the information that was collected. You will not be excluded if you are only able to attend one of the focus groups. Participants who are unable to attend the follow-up focus group will be mailed a summary of the ideas generated from the first focus groups to have the opportunity to elaborate.

7. What Will Happen If I Take Part In This Study?

If you want to take part in this study and sign this consent form, during the focus group interview you will be asked to provide answers to a series of questions developed by the Principal Investigator. There will be four to five other participants in the group, representing public health nurses, family practice nurses and nurse practitioners. The questions will require you to draw upon your professional experience as a public health nurse, family practice nurse or nurse practitioner. There is no right or wrong answer to the questions and you may decline to answer any of the questions. You will also be asked to complete a brief questionnaire that is intended to collect demographic information. Following the first focus group, you will be invited to return to a follow-up focus group where the Principal Investigator will review the information that was collected in the first focus group and you will be asked to comment on what is shared.

8. Are There Risks To The Study?

There are risks with this, or any study. To give you the most complete information available, we have listed some *possible* risks. We want to make sure that if you decide to try the study, you have had a chance to think about the risks carefully. Please be aware that there may be risks that we don't yet know about.

You may find the interviews and questionnaires you receive during the course of the study upsetting or distressing. You may not like all of the questions that you will be asked. You do not have to answer those questions you find too distressing. You may request that the interviewer turn off the tape recorder at any time. Aggregate data for the focus group interviews will be reported. If the researcher wishes to use any verbatim words or statements that you have made to illustrate a meaning or concept, you will have the opportunity to give or decline consent for its use.

There are no anticipated direct personal benefits from participation in this study. As you will have the opportunity to discuss you personal experiences and perceptions with a non-judgmental listener, you may gain increased knowledge about your role in breastfeeding support and promotion. Also, you may have the opportunity to establish new relationships with practitioners who you may otherwise not have the opportunity to meet. In addition, your participation may inform future understanding of how public health nurses, family practice nurses, and nurse practitioners can work in collaboration with one another. The data generated from your participation will also increase the visibility the important role of public health nurses, family practice nurses, and nurse practitioners in breastfeeding support promotion.

9. What Happens at the End of the Study?

At the end of the study, you will be mailed a summary report of the study.

10. What Are My Responsibilities?

As a study participant you will be expected to:

- Follow the directions of the Principal Investigator

11. Can I Be Taken Out Of The Study Without My Consent?

Yes. You may be taken out of the study at any time, if:

- There is new information that shows that being in this study is not in your best interests.
- The Capital Health Research Ethics Board or the Principal Investigator decides to stop the study.
- You do not follow the directions of the Principal Investigator.

You will be told about the reasons why you might need to be taken out of the study.

12. What About New Information?

It is possible (but unlikely) that new information may become available while you are in the study that might affect your health, welfare, or willingness to stay in the study. If this happens, you will be informed in a timely manner and will be asked whether you wish to continue taking part in the study or not.

13. Will It Cost Me Anything?

Compensation

You will not be paid to be in the study. You will be compensated $25.00 per focus group attended (maximum $50.00) to cover personal expenses that you may incur.

Research Related Injury

If you become ill or injured as a direct result of participating in this study, necessary medical treatment will be available at no additional cost to you. Your signature on this form only indicates that you have understood to your satisfaction the information regarding your participation in the study and agree to participate as a subject. In no way does this waive your legal rights nor release the Principal Investigator, the research staff, the study sponsor or involved institutions from their legal and professional responsibilities.

14. What About My Right To Privacy?

Protecting your privacy is an important part of this study. A copy of this consent will be put in your health record.

When you sign this consent form you give us permission to:

- Collect information from you
- Share information with the people conducting the study
- Share information with the people responsible for protecting your safety

Access to records

The members of the research team will see study records that identify you by name.

Other people may need to look at the study records that identify you by name. These might include:

- the CDHA Research Ethics Board and Research Quality Associate

Use of records.

The research team will collect and use only the information they need to complete the Study. This information will only be used for the purposes of this study.

This information will include:

- information from study interviews and questionnaires

Your name and contact information will be kept secure by the research team in Halifax, Nova Scotia. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study. Information collected for this study will kept as long as required by law. This could be 7 years or more.

If you decide to withdraw from the study, the information collected up to that time will continue to be used by the research team. It may not be removed.

After your part in this study ends, we may continue to review your health records. We may want to follow your progress and to check that the information we collected is correct.

Information collected and used by the research team will be stored by in a locked filing cabinet in the Principle Investigator's office in Capital Health. The Principle Investigator is the person responsible for keeping it secure.

15. WHAT IF I WANT TO QUIT THE STUDY?

If you chose to participate and later change your mind, you can say no and stop the research at any time. If you wish to withdraw your consent please inform the Principal Investigator. All data collected up to the date you withdraw your consent will remain in the study records, to be included in study related analyses. A decision to stop being in the study will not affect any work performance evaluations you may have.

17. Declaration Of Financial Interest

The Principal Investigator has no financial interests in conducting this research study.

18. What Are My Rights?

After you have signed this consent form you will be given a copy.

If you have any questions about your rights as a research participant, contact the **Patient Representative** at **(902) 473-2133**.

In the next part you will be asked if you agree (consent) to join this study. If the answer is "yes", you will need to sign the form.

PART C.

20. Consent Form Signature Page

I have reviewed all of the information in this consent form related to the study called:

Exploring the Structures and Processes Needed to Support Collaboration amongst Public Health Nurses, Family Practice Nurses, and Nurse Practitioners who Work in Breastfeeding Support and Promotion

I have been given the opportunity to discuss this study. All of my questions have been answered to my satisfaction.

This signature on this consent form means that I agree to take part in this study. I understand that I am free to withdraw at any time.

_____	_____	_____ / _____ / ____
Signature of Participant	Name (Printed)	Year Month Day*
_____	_____	_____ / _____ / ____
Witness to Participant's Signature	Name (Printed)	Year Month Day*
_____	_____	_____ / _____ / ____
Signature of Principal Investigator	Name (Printed)	Year Month Day*

Note: Please fill in the dates personally

You Will Be Given A Signed Copy Of This Consent Form

Thank you for your time and patience!

APPENDIX F

FOCUS GROUP INTERVIEW GUIDE

Public Health Nurse, Family Practice Nurse and Nurse Practitioner Focus Group

Introduction

Before we begin the focus group, I would like to thank all of you for agreeing to participate in the study and taking the time out of your work day to be here today. Your perceptions and experiences related to the structures and process needed to support collaboration amongst public health nurses, family practice nurses and nurse practitioners is important to understand how public health and primary care can work together in the support and promotion of breastfeeding. I have some questions to ask you about your experiences. Please be assured that there are no right or wrong answers. You may ask me questions at any time during the interview and you are free to refuse to answer any questions or stop the interview at any time. I ask that only one participant speaks at a time to allow everyone the opportunity to share their experiences.

1. What is your role and responsibility in breastfeeding support and promotion?

   Probes: What is your role with individual clients?
   How do you work with groups of clients?
   What is your role in your organization?
   What is your role in your community?
   What is your role in health promotion?
   How do you support policy development?
   Are you involved in advocacy?

2. What does your typical day look like supporting and promoting breastfeeding?

   Probes: What activities are you involved with most often? Why?
   Who would you meet with? Why?
   What are some of the issues that you face?

3. What things would be different on an atypical day supporting and promotion breastfeeding?

   Probes: What activities do you rarely take part in?
   What are issues that you face less often?

4. Who are the nurses working in your community who support and promote breastfeeding?

   Probe: What are their roles in breastfeeding support and promotion?

5. Give some examples of how you have collaborated with PHNs, FPNs, and NPs.

    Probes: What motivates people to work together?

6. What is your relationship like with your nurse colleagues in public health or primary care?

    Probe: How do you think that your approaches to breastfeeding support and promotion differ from the other nurses who are doing this work? How do these differences influence collaboration?

7. Give some examples of how you have collaborated with other health care professionals (e.g. midwives, doulas, physicians, nutritionists, etc).

    Probes: What motivates people to work together?

8. What are the structures or processes that exist to support collaboration with PHNs, FPNs or NPs in breastfeeding support and promotion?

    Probes: Leadership? Organizational culture? Shared vision or goals? Are there decision making tools such as policies and procedures? Referral systems? Liaison roles? Meetings? Joint education initiatives? Other opportunities?

9. What are some of the benefits to collaboration with PHNs, FPNs and NPs in breastfeeding support and promotion?

    Probes: What are the potential risks/harms to collaborating?

10. Are their initiatives related to breastfeeding support and promotion that you would like to see happen but are unable to carry out?

    Probes: What structures or processes do you feel should be in place to support these initiatives?

11. Is there something that you have learned new about your peers during this session?

APPENDIX G

DEMOGRAPHIC PROFILE

Public Health Nurses, Family Practice Nurses and Nurse Practitioners Demographic Profile

1. Which best describes you? (Check one)

- ☐ 1. Public health nurse
- ☐ 2. Family practice nurse
- ☐ 3. Nurse practitioner
- ☐ 4. Other, Please explain: _____

2. Educational Preparation (Check all that apply)

- ☐ 1. RN diploma
- ☐ 2. BN/BScN
- ☐ 3. Undergraduate degree other than BN/BScN. Please specify: _____
- ☐ 4. Master's Degree. Please specify: _____
- ☐ 5. Certification (e.g. CNA certification, IBCLC). Please specify: _____
- ☐ 6. Other. Please Specify: _____

3. What is your gender?

- ☐ 1. Female
- ☐ 2. Male

4. Work

- ☐ 1. Full-time
- ☐ 2. Part-time: Compliment worked (i.e. .8 FTE): _____

Number of years worked as a nurse: _____

Number of years in current role (PHN, FPN or NP): _____

Number of years supporting breastfeeding families: _____

5. Primary Work Setting

- ☐ 1. CDHA Public Health Services
- ☐ 2. Physician's Office
- ☐ 3. Nova Scotia Department of Health funded Community Health Centre
- ☐ 4. CDHA funded Family Medical Centre

Thank you!

APPENDIX H

Confidentiality Agreement for Recorder

Thesis Title: 'Exploring the structures and processes needed to support collaboration amongst public health nurses, family practice nurses and nurse practitioners who work in breastfeeding support and promotion'

Principal Investigator: Tracy Lovett

I _____ have agreed to keep the information obtained within the focus groups for the above research study confidential. I will not relate any segment of this information to another person, nor will I discuss the contents with anyone other than the researcher, for purposes of clarification for recording.

Recorder (print name)

_____

Recorder (signature)

_____

Date _____

Principal Investigator (signature)

_____

Date _____

APPENDIX I

Confidentiality Agreement for Transcriber

Thesis Title: 'Exploring the structures and processes needed to support collaboration amongst public health nurses, family practice nurses and nurse practitioners who work in breastfeeding support and promotion'

Principal Investigator: Tracy Lovett

I _____ have agreed to keep the information obtained within the tapes for the above research study confidential. I will not relate any segment of this information to another person, nor will I discuss the contents with anyone other than the researcher, for purposes of clarification for transcription.

Recorder (print name)

_____

Recorder (signature)

_____

Date _____

Principal Investigator (signature)

_____

Date _____