Not One and the Same: How Personal Support Workers, Licensed Practical Nurses, and Registered Nurses Enact Interprofessional Collaboration in Long-Term Care

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Abstract

BACKGROUND & PURPOSE Personal support workers, licensed practical nurses, and registered nurses are the primary care providers in long-term care. Research reporting on how these professions collaborate in long-term is limited. Understanding how collaboration occurs in long-term care may support and improve the care of residents. The purpose of this paper is to describe how personal support workers, licensed practical nurses, and registered nurses enact interprofessional collaboration in long-term care.

RESEARCH DESIGN & METHODS A qualitative descriptive study using individual interviews with personal support workers, licensed practical nurses, and registered nurses working in long-term care (n = 13) was conducted. Data was categorized according to competencies from the Canadian Interprofessional Health Collaborative, National Interprofessional Competency Framework and then themes were identified to describe how collaboration is enacted.

FINDINGS Analysis revealed that collaboration occurs according to five competencies (interprofessional communication, collaborative leadership, role clarification, team functioning, and patient-centred care). Four themes are presented: chain of command communication, leadership based on resident condition, (mis)understanding of roles, and respect within team functioning. These themes are presented because they are organizational aspects of collaboration as opposed to individual attributes and are, therefore, more helpful for those charged with supporting or improving collaboration within an organization.

CONCLUSION Personal support workers, licensed practical nurses, and registered nurses naturally enact interprofessional collaboration is a manner that closely aligns with the Canadian Interprofessional Health Collaborative, National Interprofessional Competency Framework. Strategies to support and improve collaboration in long-term care should align with these competencies and take into account the nuances between personal support workers, licensed practical nurses, and registered nurses.

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Implications for Interprofessional Practice

- Personal support workers, registered practical nurses, and registered nurses enact interprofessional collaboration in long-term care according to chain of command communication, leadership based on resident condition, (mis)understanding of roles, respect within team functioning, and internalized patient-centred care
- Strategies to support interprofessional collaboration in long-term care should incorporate the ways in which healthcare workers naturally collaborate
- Interprofessional collaborative frameworks such as The Canadian Interprofessional Health Collaborative, National Interprofessional Competency Framework are useful for informing strategies aimed at supporting interprofessional collaboration in long-term care

Introduction

Interprofessional collaboration, hereafter referred to as collaboration, occurs when clinicians from different professions develop relationships and work in partnership with each other and clients to provide care and services (Canadian Interprofessional Health Collaborative, 2010; Schot et al., 2020). Collaboration contributes to positive organizational and patient outcomes (Reeves et al., 2017; Seaton et al., 2020). Conversely, the absence of collaboration has been attributed to deficits in care (Bolt et al., 2019); thus, supporting collaboration has become a priority for stakeholders across multiple health sectors including long-term care. However, while researchers have explored collaboration in long-term care, they have largely overlooked how collaboration occurs amongst personal support workers (PSWs) [PSW is used to refer to unregulated personal support workers, care workers, home support workers, home care workers, personal carers, nursing aides, nursing care assistants, psychiatric aide, and resident care aide] (Berta et al., 2013), licensed practical nurses (LPNs), and registered nurses (RNs). A lack of research describing how these three professions collaborate represents a sizeable gap in the literature as they comprise the primary caregivers in long-term care. Specifically, efforts to support collaboration in long-term care and ultimately improve care is dependent upon an understanding of how PSWs, RPNs, and RNs work together. The purpose of this paper is to describe how PSWs, LPNs, and RNs enact interprofessional collaboration in long-term care.

Literature Review

The population aged 65 and over is increasing more than any other age group worldwide and life expectancy in industrialized countries is projected to continue to increase across multiple continents (National Institute of Health, 2016). The increasing complexity of an aging population has already resulted in an global demand for long-term care facilities to meet basic health needs (Gibbard, 2017), placing strain on workers and residents. Recently, the fragility of the long-term care system has been thrust into the spotlight worldwide by the current COVID-19 pandemic (Béland & Marier, 2020) prompting calls to re-imagine how long-term care services are designed and implemented for both residents and providers. A focus on understanding and ultimately supporting collaboration amongst workers who provide the majority of long-term care services is an important component of re-imagining and strengthening long-term care services worldwide.

The term *long-term care* refers to residential, nursing, or care homes were residents live and have access to 24-hour nursing care (Squires et al., 2019). The provision of long-term care is typically aimed at supporting functional capacity of a global aging population (Ikegami, 2019). While multiple professions such as dietetics, physicians, and therapists (e.g., recreational, physio, occupational) all contribute to care within long-term care, PSWs, LPNs, and RNs comprise the primary caregivers in long-term care and are the only professions who provide care over a 24-hour period (Stone, 2019).

Collaboration in long-term care settings can be challenging due to the mix of clinicians and associated arrays of responsibilities, training, and scopes of practice (Cranley et al., 2020). For example, while RNs' scope of practice is wider than LPNs' due in part to greater education requirements, both RNs and LPNs draw from the same knowledge-base and focus on more clinical skills compared to PSWs (Squires et al., 2019). Further, RNs and LPNs are charged with coordinating care (Montayre & Montayre, 2017), whereas PSWs provide the majority of direct-care (Berta et al., 2013; Chamberlain et al., 2019; Squires et al., 2019). Despite being more hands-on, some have suggested that PSWs are in the shadows of healthcare and are largely invisible to researchers, patients, and the public (Hewko et al., 2015). Notwithstanding nuances and distinctions, the complementary nature of PSW, LPN, and RN work demands a high level of collaboration.

However, researchers have largely overlooked collaboration between PSWs, LPNs, RNs and have instead focused on other professions (Fleischmann et al., 2017; Hurlock-Chorostecki et al., 2015; McAiney et al., 2017). For example, researchers have explored collaboration in long-term care in relation to nurse practitioners and physicians (McAiney et al., 2017), nurse practitioners and other healthcare professionals (Hurlock-Chorostecki et al., 2015), RNs and physicians (Fleischmann et al., 2017; Müller et al., 2018), as well as long-term care staff in general related to heart failure (Boscart et al., 2017) and palliative care (Kaasalainen et al., 2017). When researchers have examined collaboration within nursing in long-term care, they have focused on collaboration between regulated and unregulated workers as opposed to distinguishing between PSWs, LPNs, and RNs. For example, Heckman et al. (2016) recently examined the role of unregulated workers in the management of heart failure management within long-term care. They focused on how unregulated workers perceived their role in collaboration and concluded that unregulated workers faced multiple challenges when contributing to collaboration. The distinction between regulated and unregulated workers is an important consideration; however, given that the primary workforce in LTC consists of three unique professions, we argue that examining collaboration across professions as opposed to regulatory status offers a more holistic and influential perspective on collaboration.

The need for long-term care is expected to increase dramatically worldwide and overwhelmingly researchers have suggested that collaboration within long-term is an area for improvement (Cranley et al., 2020), yet we could find no research that examined collaboration amongst PSW, LPNs, and RNs. Given they are the primary caregivers in long-term care and provide care around the clock, this represents an important gap in the literature. Therefore, the aim of this study was to use an existing framework to describe how PSWs, LPNs, and RNs enact collaboration in long-term care.

Study Framework: Canadian Interprofessional Health Collaborative, National Interprofessional Competency Framework

The Canadian Interprofessional Health Collaborative, National Interprofessional Competency Framework comprises a set of six competencies that outline the knowledge, skills, and behaviors necessary for collaboration: role clarification, conflict resolution, leadership, team functioning, communication, and client centred care—with the two latter competencies being foundational to the other four (Canadian Interprofessional Health Collaborative, 2010). Brief descriptions of how we conceptualized the six concepts in the Canadian Interprofessional Health Collaborative, National Interprofessional Competency Framework are found in Table 1. For a more thorough description of each compentency please see the Canadian Interprofessional Health Collaboraitve (2010) document.

The competencies are situated along continuums of contextual issues, clinical complexity, and quality improvement (Canadian Interprofessional Health Collaborative, 2010). The framework has informed research in acute care (Hepp et al., 2015) and nursing education (Williams et al., 2020). In our research, we used the framework in a manner similar to Hepp et al. (2015) to categorize data prior to extracting themes (Crabtree & Miller, 1999; Hsieh & Shannon, 2005).

Competency	Conceptualization
Client Centred Care	Clinicians incorporate client input when providing care
Collaborative Leadership	Clinicians consider shared decision making and leadership principles when working in a team.
Interprofessional Communication	Clinicians communicate with clinicians from other professions in a collaborative and responsive manner.
Interprofessional Conflict Resolution	Clinicians constructively address conflicts as they happen.
Role Clarification	Clinicians understand their own role(s) and the role(s) of their colleagues from other professions
Team Functioning	Clinicians consider team dynamics and principles when working in a team.

Table 1. *Conceptualizations of Competencies in The Canadian Interprofessional Health Collaborative, National Interprofessional Competency Framework*

Methods

In this study we used a qualitative descriptive design (Sandelowski, 2010). This design is appropriate to answer our research question as qualitative descriptive approaches are a form of research commonly used in health care whereby qualitative data collected from informants (i.e., PSWs, LPNs, RNs) is analyzed to better understand a phenomenon of interest (collaboration in long-term care) (Kim et al., 2017). The National Interprofessional Competency Framework (Canadian Interprofessional Health Collaborative, 2010) informed our research and the Consolidated Criteria for Reporting Qualitative Research (Tong et al., 2007) guided reporting.

Setting, Sampling, and Recruitment

We conducted this study within two public long-term care facilities in a large urban centre in Ontario, Canada. Combined, the facilities consisted of 21 units with approximately 700 long-term care beds. Personal support workers, LPNs, and RNs who worked full- or part-time for at least a year in long-term care were eligible to participate. Using convenience sampling (Polit & Beck, 2017), we sought to recruit a diverse (e.g., employment status, gender, length of experience, etc.) combination of PSW, LPNs, and RNs. After Research Ethics Board and organizational approvals, we collaborated with administration at the long-term care facilities to recruit our sample. Recruitment involved members of the research team attending meetings and individual units to inform potential participants of the study. Additionally, administration staff distributed posters and information letters throughout the facilities. Potential participants contacted the research team directly if interested. Participants were offered a $15 gift-card for coffee shop. We enrolled 13 participants (see Table 2 for Demographics). Our initial target sample size was 12-20 participants. However, recruitment was challenging given the staff-shortages in long-term care during our study (Ontario Health Coalition, 2020). Nonetheless, we identified redundancy in responses during interviews, thus, suggesting we approached an adequate sample size (Polit & Beck, 2017). Further, similar research exploring collaboration in rural hospitals from the perspectives of multiple disciplines reported a comparable sample size (Morris & Matthews, 2014).

Profession	Sample Size	Years of Experience (Years)
PSW	6	4-17
LPN	4	1-23
RN	3	3-37

Table 2. *Participant Demographics*

Data Collection

We conducted open-ended semi-structured individual interviews with PSWs, LPNs, and RNs outside of working hours and at a private location at their place of work. Interviews were conducted by a PhD researcher trained in qualitative interviewing (Author 1) or an assistant who was trained in qualitative interviewing and

working under supervision (Author 2). Both interviewers were male, registered nurses, and knowledgeable in collaboration and the framework competencies. Aside from one interviewee, participants were unknown to the interviewers prior to the study. We developed an interview protocol using the National Interprofessional Competency Framework (Canadian Interprofessional Health Collaborative, 2010) and aligned with the long-term care context (Table 3). Topics included experiences with collaboration in general and, more specifically, role clarification, client-centred care, team functioning, collaborative leadership, communication, and conflict resolution. Questions were adapted to reflect the profession of the interviewee. Data were collected over a year starting in spring 2018. Data collection ended prior to the COVID-19 pandemic. All interviews were 45-60 minutes in duration and audio-recorded for verbatim transcription by a professional transcriptionist. Transcripts were not returned to participants. No participants refused to participate after signing consent forms, nobody was present during data collection other than participants and interviewers, and there were not repeat interviews. Fieldnotes were not compiled.

Introductory Questions	Tell me about your general experiences collaborating or working together with other professions such as (RN, LPN, PSW as appropriate). How do you think your colleagues view collaboration? How do you feel the organization values and supports collaboration?
Role Clarification	How do the roles of PSWs, LPNs, and RNs fit together to provide patient care? Is there overlap in roles? How do other team members understand your role in providing care?
Client Centred Care	Please describe how you (or the care team collectively) seek out information from the patient and/or family when providing care? If you had information you wanted to share with the patient/family, how would you go about doing so?
Team Functioning	During an average shift, please describe how the RNs, LPNs, and PSWs function as a team? How do you know when the RNs, LPNs, and PSWs have established a healthy working relationship?
Leadership	Leadership in a care team can change depending on the type of task that is required or situation that is faced. Please describe a scenario where you (or your profession) took on a leadership role when providing care?
Communication	When does most communication about patient care occur between RNs, LPNs, and PSWs occur? If you had information about a patient to share with other professions (specifically, RNs, LPNs, or PSWs), how would you go about doing so?
Conflict Resolution	Conflicts occur in most areas of health care. Please describe some common situations where conflict has occurred? How have conflicts been resolved in your care teams?
Closing Questions	Is there anything that you didn't get a chance to say related to interprofessional collaboration between RNs, LPNs, and PSWs?

Table 3. *Summary of Interview Guide*

Data Analysis

Transcripts were imported to Nivo12™. We used a hybrid approach to coding and thematic analysis involving both deductive and inductive coding (Fereday & Muir-Cochrane, 2006). First, we developed a codebook informed by the National Interprofessional Competency Framework (Canadian Interprofessional Health Collaborative, 2010). We used the codebook to categorize data deductively by matching it with the in-depth descriptions of the competencies of our framework (Crabtree & Miller, 1999). At this stage we were guided but not constricted by the categories and were open to creating new categories. A similar approach using the same framework was used by Hepp et al. (2105) to study collaboration in acute care. Once data was categorized, we

identified themes and patterns across categories (Crabtree & Miller, 1999). Our analysis was guided by the work of several authors (Crabtree & Miller, 1999; Fereday & Muir-Cochrane, 2006; Hepp et al., 2015). Participants did not provide feedback on the findings.

Study Rigour and Trustworthiness

Rigour was established using methods outlined by Feredy et al. (2006) and Crabtree et al. (1999). The deductive categorization was conducted using a-priori descriptions of each competency. This provides a trail of evidence for study credibility (Fereday & Muir-Cochrane, 2006). Two authors were involved in data analysis and discussed initial deductive categorizing and subsequent inductive theme generation throughout. A third author reviewed all data, categorization, and themes. We compiled analysis notes within Nivo12™ throughout the process.

Ethics

Institutional Research Ethics Board approval was obtained from the university (#156 17-18) and participating sites (#2018004) as required. Prior to signing consent forms, participants were provided time to review written information outlining the study, discuss the study with the interviewee, and ask questions pertaining to the study.

Findings

We found evidence that PSWs, LPNs, and RNs enact collaboration in long-term care according to five of the six competencies (Canadian Interprofessional Health Collaborative, 2010). We found minimal data from interviewees that fit within the *conflict resolution* category. Aside from this, data aligned well with existing categories and no new categories were needed. From the competencies, we identified seven themes (Figure 1) and in this paper we present four of them: chain of command communication, leadership based on resident condition, (mis)understanding of roles, and respect within team functioning. We focus on these four themes due to space limitations and because they relate to organizational aspects of care as opposed to individual aspects. We take this approach to potentially inform initiatives aimed at supporting collaboration from an organizational perspective. In the interest of space and due to the individual focus, we do not report on data related to the client centered care competency. Notwithstanding, PSWs, LPNs, and RNs overwhelmingly reported the desire to provide client centred care. It was not evident in our research, however, the specific ways in which clinicians engage in client centred care.

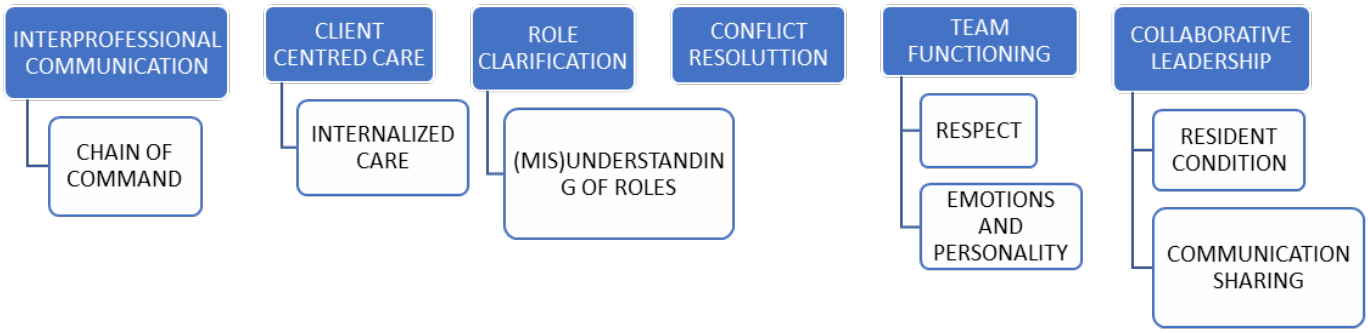

Figure 1. *The categories and themes from data analysis*

Chain of Command Communication

According to Canadian Interprofessional Health Collaborative, interprofessional communication occurs through verbal and non-verbal means and involves aspects of respect and transparency (Canadian Interprofessional Health Collaborative, 2010). During interviews, many of the participants discussed verbal aspects of interprofessional communication with they have experienced with their colleagues. Clinicians from all three professions discussed a clear chain of command for how information flowed between each of them. Such communication was established by the profession and it seems important to maintain such an order. Several different PSWs spoke about the chain of command in communication: "If I noticed something

with a resident, I could talk to the LPN, we could even go to the RN, we're all very good that way where you can talk to anybody" (PSW3), and "As a PSW, I don't think about that. I just think, oh– this is new information—I have to go the nurse. Everything is towards the nurse" (PSW9). A linear chain of command was prominent in answers from all professions. An LPN commented:

> "I would say to the RN, so-and-so is not feeling well. The PSW came to me this morning and I monitored her. She's still not feeling well. I think we've got to get hold of the nurse practitioner and doctor today." (LPN1)

The same LPN elaborated on the clear chain of command of communication between LPNs and RN:

> "You could go over their head but then it would really make for hard times. They wouldn't like that. I've had to do that a few times in my time. It wasn't very nice. So, you try not to do that" (LPN1)

The above quote illustrates how PSWs will bring information forward to LPNs who will then decide if they need to bring information forward to an RN—who then may decide to bring that information forward to other professions. A PSW elaborated and identified that, despite this clear chain of command, the sharing of information between professions generally occurs well and in a respectful manner:

> "The nurse is still the boss, right, but they're the only one on the team. We're a team, so even though we still report to each other, we're respecting each other and we're giving each other the information. The rest of the team can know and they can follow through." (PSW9)

An RN reiterated the notion of respect and how it influences communication: "You know, so you want to include them (PSWs) as a team member, you want make sure there's lots of communication and you're always open so they come to you and feel comfortable asking you." (RN4). The above quotes highlight the routinized chain of command and how following it contributes to, and is influenced by, positive respective relationships. The Canadian Interprofessional Health Collaborative identifies the importance of trust and respect to effective interprofessional communication and interviewees reported that communication orders exist within a culture of respect (Canadian Interprofessional Health Collaborative, 2010).

Collaborative Leadership Based on Client Condition

Collaborative leadership involves shared accountability and decision making for actions and is determined by a given situation (Canadian Interprofessional Health Collaborative, 2010). From our interviews, we identified two themes: (1) collaborative leadership based on client condition and (2) communication sharing during leadership. The theme related to communication overlapped with communication chain of command, thus, we focus on client condition in this section. Indications from interviewees suggested that collaborative leadership is largely dependent upon changing client conditions. Changes in a resident's condition was often met with changes in leadership. For example, an RN commented:

> Well, the PSWs are more physical care. If they see an open area or wound, we encourage them to report to the LPNs. If the LPN isn't sure what to do about it, then they'll forward it to us….and we have to do the assessment. But, essentially, they deal with the physical care and if there's any issues or problems they bring those forward. (RN4)

These "issues" or "problems" constitute clients' changing conditions. From the above quote, it appears that as the condition changes, the care or decisions required may go beyond a particular scope of practice, thus, necessitate collaboration and shifting of leadership. This theme occurred within the interviews with all professions. An LPN explained how a client's change in condition necessitated sharing decisions-making:

> So right away the PSW came to me and said I know her. And this is a new unit I'm on. She's not right. So, there's just something about her. I don't know what it is. So, then I went to the RN and then the NP and we all sat around and we talked about it. (LPN4)

It is apparent in the above quote how "knowing the client" plays a role in determining if a condition requires a shift in leadership or decision making. With increasing staff-to-client ratios, and worker shortages, knowledge of particular clients becomes is becoming more challenging—and this compounds challenges with shifting leadership. An RN discussed leadership:

> It's almost like the RN is the supervisor or the floor lead. So, the LPNs are more the unit lead, but sometimes they can't always do that or if something's (is) out of their comfort zone, then the RNs will step in and help out. So, then we (RNs) take over the role of being the leader, but most times we don't know people well enough because of our patient load. (RN5)

Not knowing clients can affect care decisions beyond one particular profession, especially when a client condition changes. A PSW stated: "You look to your registered staff as in your RN to make the decision as to what we're doing." (PSW3). Shared decision making as collaborative leadership is especially important in situations where conditions change given the collective decision-making processes occurring in long-term care. An LPN discussed how decisions are made by input from other professions: "I rely heavily rely on my PSWs. If there isn't any change at all, if the resident is declining or even like baths or feeding…I rely to them and I respect what they could input." (LPN8).

(Mis)understanding of Roles

Role clarification refers to clinicians understanding their own role and the roles of others (Canadian Interprofessional Health Collaborative, 2010). In our study, role clarification challenges related to RNs, LPNs, and PSWs were prominent. A theme we identified was a lack of understanding of each other's roles. Although this theme applied to all professions, the role of the RN as misunderstood by the LPNs and PSWs was most prominent.

A lack of understanding of the RN role was related to the nature of RN work—specifically that RN work in long-term care is not usually conducted on one particular unit but is instead spread throughout multiple units or floors. As a result, the work of the RN is not visible to all workers which can lead to misunderstanding about their roles. An RN commented:

> A lot of LPNs and PSWs have issues with the RNs because they don't understand. They just think we come onto the unit, tell them to do this, or come in with our clipboards and then leave. But we'll spend a lot of our time on one particular unit…so, if someone's extremely ill…that's where we're spending our time…but, the other LPNs or the other staff don't – they don't know that. (RN5)

The importance of visible work was also raised by LPNs. When the nature of the RNs work caused them to spend time on one unit, the clarity of their role on the other units was negatively impacted. An LPN stated:

> They see that the RN shows up, asks a few questions, and leaves... I think RNs get a bad rap because they can't be there all the time. They used to do the wounds and they used to this and they used to that. Well, they don't need to do it anymore. (LPN6)

In long-term care, the expanding scope of the LPNs and the shifting role of the RNs to a more supervisory role has resulted in more invisible work for the RN. When viewed through the Canadian Interprofessional Health Collaborative, National Interprofessional Competency Framework (Canadian Interprofessional Health Collaborative, 2010), role clarification has diminished and, as an RN pointed out, this has created challenges:

"When you don't really truly understand what the other person has to do, there's always this (negative) thing going on" (RN12). In the above quote, the thing being referred to is a difficulty in effectively collaborating with each other. However, unclear roles were not only associated with the role of RNs. Several workers also reported that the role of the LPN is poorly understood and frequently assumed to be related only to administering medications or performing assessments. An LPN commented:

> [an RN] had absolutely no idea what our job was now because she said, "you're not just on the med cart." You have 50 million people coming at you all the time. You're literally running the dining room. You're doing this. You're doing that. And she's like, "I thought you guys did meds." (LPN6)

Another RN reported an appreciation for the expanded role of the LPNs as they suggested that aspects could be missed due to the expanding nature of the LPNs responsibilities – primarily related to medication administration:

> It [medication administration] just consumes so much of their time and then they're expected to do assessments, they're expected to do evaluations of care plans and RAIs and all this other stuff…their jobs have become so task oriented that they – they find themselves struggling and

> feeling guilty not getting to the assessment part. (RN12)

Respect within Team Functioning

Team functioning refers to clinicians' ability to integrate the principles of team work and group processes when working in a team (Canadian Interprofessional Health Collaborative, 2010). It requires safe working relationships built upon respect. After categorizing data, we identified two themes related to team functioning: (1) emotions and personality; and (2) respect. We focus on respect as it represents an aspect of collaboration that can be supported by an organization—more so than individual aspects such as emotions or personalities.

Many participants commented on how aspects of respect influence collaboration. Earning respect was identified as an aspect of team functioning. Participants spoke about how assisting with physical care or tasks was an important approach to earning and offering respect. A PSWs commented: "when you have good LPNs, that aren't afraid to get their hands dirty, they deserve respect" (PSW3). A similar comment was also made by a second PSW: "As a PSW, my favourite LPNs were definitely the ones that weren't afraid to get their hands dirty." (PSW7). Both of these PSWs are referring to their colleagues "getting their hands dirty" with their work in a figurative sense showing a respect for PSWs' work. LPNs and RNs seemed to appreciate how assisting with PSW work could help garner respect:

> I think people in general have to learn appreciation for the other discipline, what they're doing. That appreciation will come down helping them out. When you're not busy, help them. It don't take much to say that, but it sure builds up a lot of – more trust between you. (RN12)

Assisting other professions with physical care or tasks that are not routine parts of one's scope of practice was reported as appreciated by workers from all professions. However, one LPN highlighted the unintentional negative outcomes that can occur when one spends time assisting others: "The PSWs love them because they're always in there, getting their hands dirty and then I'll come on shift afterwards and this hasn't been done and that hasn't been done" (LPN6). This quote sheds light on the cost of earning respect through assisting with tasks.

Related to assisting others, an LPN and RN both acknowledged the hierarchy between RNs, LPNs, and PSWs in long-term care. They identified the importance of trying to equalize the status of the three professions in a manner that would convey respect and support collaborative practice: "We talk about respect. There obviously has to be some sort of an order. However, I think that we need to level the ground a little bit that will create more cohesiveness and more team" (LPN13). "Hierarchy does play a role even though I try to break down those barriers by always saying, my role is not better than the PSWs, it's just different." (RN5). The notion that hierarchy be acknowledged and processes put in place to support respect across different and complementary roles aligns with Canadian Interprofessional Health Collaborative, National Interprofessional Competency Framework competency of team functioning (Canadian Interprofessional Health Collaborative, 2010). Specifically, the framework highlights how collaboration depends upon mutual respect among team members—and that consciously working to support respect is important. The above quotations suggest that by working to "level the ground" and "break down those barriers" the staff are explicitly focused on processes to support collaboration by attending to team functioning. Moreover, it illustrates how PSWs, LPNs, and RNs are working to enact collaboration in long-term care.

Discussion

Our research describes how PSWs, LPNs, and RNs enact collaboration in long-term care. Aside from conflict resolution, data fit with all competencies in our framework. From this, several themes were identified—four of which we reported above. Specifically, chains of command influence communication, changing resident conditions shift leadership, respect is garnered by assisting others, and enactment of collaboration occurs despite some professional roles being misunderstood when not immediately visible. Our findings align with those from existing research.

The National Interprofessional Competency Framework Applied to Long-Term Care

Hepp et al. (2015) reported that the Canadian Interprofessional Health Collaborative framework offered a useful conceptualization of how collaboration occurs in acute care. We found support for the framework cap-

turing collaboration in long-term care. Given the different contexts between acute care and long-term care, and calls to incorporate theoretical frameworks into collaboration research (Reeves, 2016), support for the utility of this framework to capture collaboration and guide research across diverse settings is promising.

Our research was the first to apply the Canadian Interprofessional Health Collaborative, National Interprofessional Competency Framework to long-term care (Canadian Interprofessional Health Collaborative, 2010). While our findings lend support to the framework aligning with long-term care and further validate the appropriateness of this framework across several settings, our data did not algin with conflict resolution as described in the framework. The Canadian Interprofessional Health Collaborative identifies conflict resolution as the process of actively engaging self and others to address disagreements as they arise (Canadian Interprofessional Health Collaborative, 2010). Conflict between professions can be a positive influence especially if addressed in a healthy way (Thistlethwaite & Jackson, 2014). Unfortunately, conflict (alongside power and hierarchy) can have negative consequence for collaboration (Paradis & Whitehead, 2015, 2018). In our research we elicited data on conflict resolution from interviewees—we asked questions about conflict. However, we did not obtain sufficient data to develop themes or make substantive claims about how conflict resolution contributes to collaboration between PSWS, LPNs, and RNs, in long-term care. This should not be interpreted as evidence of a lack of conflict resolution in the context of collaboration in long-term care. There is no reason to assume conflict does not exist between PSWs, LPNs, and RNs—we know it does (Lankshear et al., 2016). Instead, our findings can potentially be explained in two ways. First, it is possible that, compared to the other five competencies, interviewees were hesitant to discuss conflict in the context of collaboration due to social desirably response bias. Conflict is generally viewed as negative and social desirably response bias can lead to respondents overestimating the positives of an experience (Bergen & Labonté, 2020). Therefore, it may have seemed counteractive to discuss conflict (a negative) in the context of collaboration (a positive). This also speaks to how participants may have conceptualized concepts from our framework differently than we intended. Second, there may be a lack of awareness of conflict resolution strategies amongst participants when in fact, conflict resolution is occurring more broadly than discussed. When Hepp et al. (2015) used the same framework to study collaboration in acute care, they also reported little data being generated related to conflict resolution and attributed it lack of awareness. It is possible a similar instance occurred in our research. Further research is need in this area.

Roles and Communication

Our themes align with, and in some cases extend, existing literature. Researchers have reported that role ambiguity is common amongst workers in long-term care and that ambiguity can contribute to misunderstanding of roles (McCloskey et al., 2015). In the professions we studied, RNs have the broadest scope of practice resulting in them often taking on a supervisory or delegatory role—which can result in less time in a direct-care role (Montayre & Montayre, 2017). We found that time away from direct care caused challenges for collaboration in long-term care. For example, RNs may not understand the roles of others (McCloskey et al., 2015) which could lead to delegation of inappropriate tasks. Delegatory situations where RNs become less visible and more distant from physical care can result in others misunderstanding the role of the RN as was reported in our research. However, the need for RNs to spend time in these indirect aspects of care is what sets them apart from the other professions and adds a complementary element to the team (McCloskey et al., 2015; Montayre & Montayre, 2017). Therefore, the ways in which collaboration is enacted in long-term care can precipitate a tension between visible roles which, in turn, could be detrimental to interprofessional collaboration.

Elements of communication in long-term care have also been discussed in existing research. The communication "chain of command" related to collaboration in long-term care has was first coined by researchers examining communication patterns between medical and nursing staff in long-term care (Colón-Emeric et al., 2006). Colón-Emeric and colleagues reported a clear yet thin chain of command between direct-care (i.e., nursing) and medical staff (Colón-Emeric et al., 2006). They found this style of interprofessional communication hindered resident care because it prevented effective problem-solving (Colón-Emeric et al., 2006). Recently, other researchers used the term "communication trajectories" to refer to similar findings related to collaboration in long-term care and reported communication trajectories were problematic in the care of residents with congestive heart failure (Boscart et al.,

2017). Specifically, they found that when communication patterns departed from hierarchical "trajectories" or "chains of command", communication between professions who do not normally interact improved role understanding and team functioning (Boscart et al., 2017).

We found the chain of communication to be a normative aspect of care that all professions acknowledged. Participants reported it would be unexpected, or even disrespectful, if they differed from this approach. Interestingly, it was not mentioned that these communication channels could be hindering problem-solving or team functioning as has been suggested in the literature. It is possible that clinicians have not considered alternatives to communication or how existing processes could be improved upon. Therefore, it may be fruitful to consider disrupting these chains of communication and encouraging more diverse communication amongst PSWs, LPNs, and RNs (Boscart et al., 2017).

In the study reported here, we used a conceptualization from the Canadian Interprofessional Health Collaborative (2010) that is common in the interprofessional collaboration literature. Specifically, we viewed communication as the transfer of information While principles of communication (e.g., active listening, respect) may impact the transfer of information, we stopped short of examining the reciprocal relationships between communication and context – specifically, how individuals co-create context and communication patterns (Eisenberg, 2008). Communication patterns happen over time and eventually clinicians view them as static and unchangeable; thus, the context in which they exist becomes an unquestioned reality (Eisenberg, 2008). This can result in perpetuation of hierarchies and communication frameworks. However, in actuality, context can be altered by adjusting communication patterns. Therefore, moving beyond conceptualizing communication as the transfer of information and considering how social structures (e.g., hierarchy, professional culture) both create and are created by communication may be a useful line of inquiry and practice for those interested in contributing to improved interprofessional collaboration. Eisenberg (2008) offers both a theoretical and practical discussion of this idea.

Hierarchy in Collaboration

Hierarchy is a significant influence on collaboration (Paradis & Whitehead, 2018). Hierarchical location in healthcare is determined by a clinician's profession and supported by such things as specialized degrees and regulatory licensure (Brooks et al., 2020)—attributes that differ across PSWS, LPNs, and RNs. While efforts to flatten healthcare hierarchies are common, a hierarchal landscape continues to exert influence on collaboration (Paradis et al., 2017). Our findings support hierarchical influence on collaboration.

The authors of the Canadian Interprofessional Health Collaborative (2010) National Interprofessional Competency Framework identify the importance of trust and respect to interprofessional communication. However, the framework depicts the care team's collaboration and communication as being relatively equal. Such a conceptualization is not the case for nurses and PSWs working in long-term care. Instead, interprofessional communication occurs in a more linear or prescribed order with the LPN acting as the liaison or link between PSWs and RNs. In this configuration, the LPN is located between the two other professions and is frequently required to assess and act on information being shared. A PSW described how an LPN fits in: "I think as an LPN, I think you're probably the one's with the widest eyes, because you're right in the middle" (PSW4). Being in the middle is difficult for a profession that participants in our study identified as primarily task oriented. It was viewed as a positive by PSWs when LPNs undertook tasks that involved "getting their hands dirty". Although not mentioned by the LPNS, helping with "dirty" tasks could be an intentional attempt to assist with work that is regarded as lower-status (Wolf, 2014). In this regard, the LPNs could be working to mitigate the hierarchical status differences between their own profession and that of the PSWs. Such an attempt could contribute to improved collaboration. For example, researchers have recently suggested that collaborative leadership can be supported if clinicians at different hierarchical positions consciously work to foster shared decision making amongst the team and that this work begins long before the decision making stage (Fox & Comeau-Vallée, 2020).

The chains of communication in our research started with PSWs and extended to LPNs and RNs who may or may not pass the information along to each other or other profession. If the information is not passed along, then PSWs are "left in the dark" about the plan of care and their role can be inaccurately perceived by colleagues, residents, and families. (Heckman et al., 2016) As such, professional hierarchy can limit communication and lead to role confusion, thus, negatively impacting collaboration.

Implications for Future Research

Our findings highlight three areas for future research. First, we focused on PSWs, LPNs, and RNs. However, there are other professions involved in long-term care such as nurse practitioners, physicians, social workers, and recreational therapists. Interprofessional collaboration involves all professions and, therefore, future research could explore how an expanded perspective of collaboration occurs in long-term care. Second, we found that communication occurred across a chain of command. Future research could examine how communication tools facilitate or hinder the enactment of collaboration in long-term care such as charts, medical records (electronic or paper), and messaging systems could be useful. Third, as previously mentioned, participants did not report much data on conflict despite being asked about it. Future research should explore in more detail how conflict occurs across professions in long-term care and, most importantly, ways that clinicians work to engage in conflict resolution.

Limitations

There are four limitations of this research. First, challenging recruitment resulted in a relatively low sample size. Staff recruitment challenges in long-term care research are well documented (Lam et al., 2018) and although we attained our target sample size, recruitment was challenging. Second, interviewing only PSW, LPN, and RN clinical staff captured a clinical perspective and overlooked the perspective of managers and administrators. Administrative staff are important members of the team in long-term care. Employees may have different perceptions of collaboration depending on their role in the organization, with administration and managerial staff having higher or more positive perceptions than direct care staff (Forbes-Thompson et al., 2006). Third, this study was carried out in two long-term care facilities in one urban area. As such, it is probable our sample does not represent long-term care more widely. Finally, how we conceptualized aspects from our framework may not have matched how clinicians conceptualized them. For example, while we viewed collaborative leadership as relating to shared decision making and leadership principles, most participants provided answers that suggested they viewed collaborative leadership as authoritarian.

Conclusion

Personal support workers, LPNs, and RNs provide the majority of care in long-term care (Stone, 2019). Our findings illustrate how PSWs, LPNs, and RNs enact collaboration according to the Canadian Interprofessional Health Collaborative, National Interprofessional Competency Framework (Canadian Interprofessional Health Collaborative, 2010). Designing measures to support and improve collaboration in long-term care has been identified as a priority for decision-makers and stakeholders (Cranley et al., 2020). Consideration of our results could assist with these endeavors. First, designing supports for collaboration in long-term care that acknowledge and incorporate a clear chain of command may be useful. This could involve interprofessional education related strategies to support information bi-directionally across PSW, LPNs, and RNs. Second, educational support across all professions (including LPNs and PSWS) in developing leadership capabilities would acknowledge how leadership responsibilities shift depending on client conditions. Third, initiatives aimed at highlighting and appreciating roles, especially those that are less visible, may assist in a better understanding of how various scopes of practice and roles are complementary within a long-term care team. Finally, acknowledging how existing hierarchies and the structures that maintain them impact aspects of collaboration could inform strategies aimed at supporting or improving collaboration in long-term care. Collectively, we refer to the work of others to frame our suggestions as "ingredients" that could contribute to improving relationships, and thus care, within long-term care (Baines & Armstrong, 2015). We recognize that in a highly complex, regulated and, policy-driven environment such as long-term care these suggestions are not easily implemented. However, the Canadian Interprofessional Health Collaborative (Canadian Interprofessional Health Collaborative, 2010) offers a useful framework for informing initiatives aimed at strengthening collaboration in long-term care.

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