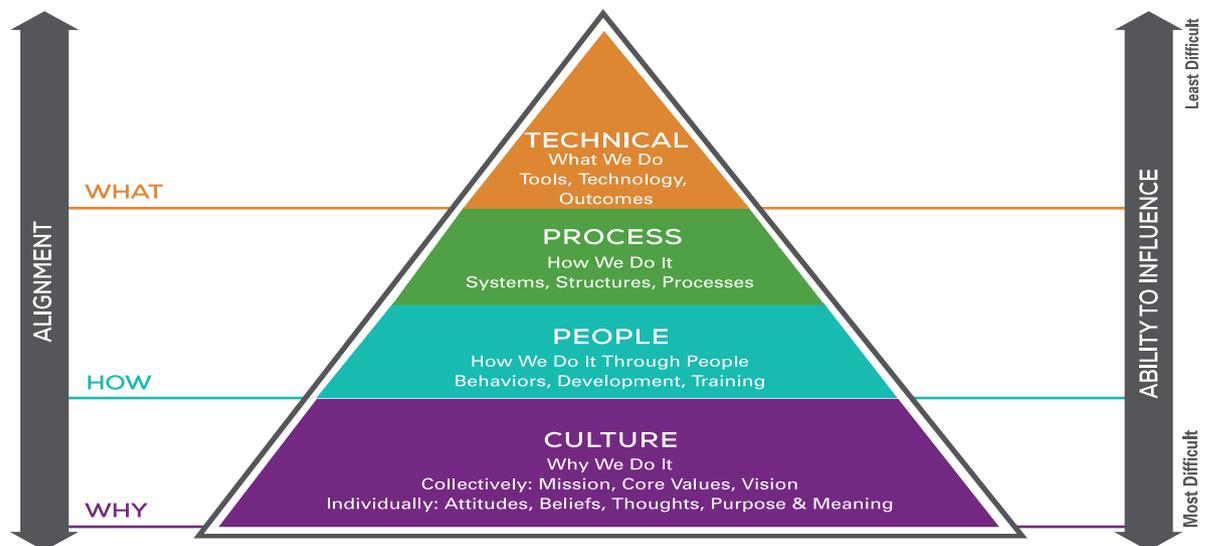


# Interprofessional Practice: *Just a Trend or Worthy Investment?*

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This article discusses the vital leadership role of the chief nursing officer (CNO) in building a dynamic professional practice environment across a hospital or system that ensures excellence in nursing practice within the context of a high-functioning interprofessional team. The CNO's ability to articulate the value of such an investment and demonstrate the expertise required to lead the effort is essential to garnering organizational support for such a major practice and culture change. This article describes the use of Edgar Schein's organizational culture model as a framework for making this foundational practice and cultural transformation successful.



**Figure 1.** The Change Pyramid  
Adapted from Schein and Schein,<sup>4</sup> © Trinity Health (Used with permission).

**B**ased on numerous experiences as a nurse executive, it is clear that deliberate and focused conversations with nurses about their practice were foundational to my understanding of the issues, challenges, and concerns they had related to their practice and practice environment. Seeking to understand, questions included asking them to describe what they do for patients and what difference they make. Too often, responses included, “I do assessments, give medications, and do treatments that the physician orders” or “I implement what is ordered for the patient and keep them safe from falls or other things that could harm them.” In conversations with advanced practice nurses, these pro-

viders often described themselves in terms that sound like the medical model of diagnosis and treatment with an extra dash of education for the patient and family thrown in. Some advanced practice nurses seemed to barely remember that they are, indeed, nurses. Each of these nurses work within a team made up of professionals from many different disciplines along with assistive roles. These conversations inevitably raised deep concerns about how nurses communicate the unique value of nursing with their colleagues on the interprofessional team. If nurses cannot articulate what nursing uniquely contributes to the team, then how can they fully function as team members and contribute collectively to patient

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outcomes? For teams to both contribute and draw intellectual capital from one another, team members must understand one another's practice and what elements of that practice are uniquely needed by the interprofessional team in assessing, implementing and evaluating the patient's plan of care. My experience with the Magnet Recognition Program<sup>1</sup> underpinned the belief that the development of a nursing professional practice model (PPM) can be a powerful and pivotal vehicle to accomplish clarity of thought and give guidance in daily practice about the value of the nurse's contribution to patient care within an interprofessional team. Magnet standards require active involvement of nurses in the development of the professional practice model with the participation inclusive of nurses across many clinical settings. With these principles in place, a key goal was to create a shared vision for nursing within an interprofessional framework and actively engage them in the process where the designing, development, and clarity about the practice of nursing resulted in a shift in their mental model, a key element necessary to accomplish significant organizational culture change.

### **ORGANIZATIONAL CHANGE AND THE DEVELOPMENT OF A PROFESSIONAL PRACTICE MODEL**

Nurse leaders know the challenges of moving a large group of nurses toward common thought and behavior.<sup>2</sup> Use of models in nursing has increased in part due to the desire to seek Magnet designation or simply adopt and use the standards as guides. Models help nurse leaders better understand the work at hand and offer a framework for construction of a tactical plan to accomplish the desired strategy. Achieving significant change in culture is a tall order, especially, when the change addresses the system of attitudes, beliefs, values, and behavioral norms of a group. It is more so when the desired outcome is culture change through creation of a shared product of shared learning.<sup>3</sup> For the purposes of this article, Schein's model of organizational culture<sup>4</sup> can be most instructive because it relates to the utility and value of using models to achieve strategic goals.

Schein describes the unique function of leadership as the management of culture. Leaders create new groups and organizational structures, define how work will be done, set motivation and reward structures in place, and define the values of the organization. Leaders also must manage the direction of the evolution of the culture. Schein argues that in organizational change, such as the purposeful evolution of a culture, it is critical that leaders focus on the need for specific behavior change. Structures and technologies must be designed to support the new behavior, as does redefining of processes. Moreover, behavior change will not become internalized and stabilized without new learning within those impacted. A key strategy is for the nurse executive to set the tone and make it

clear that the entire endeavor is a learning process. Through nurse leader facilitation, those impacted must have a reality based understanding of the change and the consequences related to the change which in turn can lead to new beliefs and values and cognitive redefinition. In other words, actually changing the mental model and the way people think about the organizational change is what will lead to the change becoming embedded and stable within the culture.

Unfortunately, many of the changes that take place within health care settings are enacted only at the level of technology and process. If we need to change an element of documentation, something that nurses do every day, the electronic medical record (EMR) is reprogrammed, a date for implementation set, the policy rewritten, and a memo distributed to the nursing staff. This process is repeated frequently, and leaders expect staff to accomplish the change. However, written communication may fail to communicate the reason for the change, or the EMR change in workflow may not be as seamless as anticipated. In failing to understand the purpose behind the change, nurses will act based on their current attitudes and beliefs about what is right or important, and develop a way to work around the EMR and workflow change. They will seek to do the right thing, using old attitudes, beliefs, and ways of thinking about documentation. The deeper work of altering the knowledge of the nurses is not addressed, perhaps to save time, effort, or cost. There is no facilitation of new thinking. Old beliefs and attitudes about EMRs are not attended to. This overly simplistic change plan will be unlikely to result in the desired change in behavior and may actually produce a greater degree of variation as well. What is missed in this planned change is the need to go deeper and address the additional levels of people/learning and cultural beliefs.

Schein describes in his model a hierarchy of building blocks that starts with the "why" and moves through the "how that includes people and processes" and ends with the "what," namely, the technical tools needed for enactment. This framework provides a valuable structure for how to proceed with the development of a professional practice model that supports strong collegial relationships and in inter-professional practice. The conversation starts with the culture "why we do it" and establishes a collective purpose and belief system. This phase must include clarification of the unique role of the nurse within an inter-professional practice approach such that a shared value of the work of nursing is achieved. The model then directs us to the people domain. Here, discussions as to how we can work together to achieve such a practice are conducted within a shared belief system focused on the "How." As nurse leaders contemplate leading an effort to change culture that includes clarifying the purpose of nursing work, it is essential that all 4 of Schein's domains of organizational culture change are addressed. Ownership

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of the product, a PPM, is more likely to occur through active engagement in all 4 stages of the framework. In addition, it is the learning experience that creates the opportunity for redefinition of old mental models of what a nurse is and does. If done well, the deeper and more challenging work of learning and changing the beliefs, values, and assumptions about the work of nurses can be accomplished early in the process, with plans to address technology/structure and process coming soon after. With new role clarity, nurses can return to their interprofessional team ready to articulate their unique work and contribute to the planning of patient care in new, more impactful ways.

Nurse leaders are teachers that look for teachable moments and willing learners. Over the years, my experience tells me that when a PPM is developed and applied consistently, it is a gift because it provides tools for further cultural evolution within the entire organization. When nurses clarify their practice and develop a PPM, they establish powerful language that is created as a shared product through shared learning. The new language and PPM are tools that the nurse leader can use for reinforcement of the work of nursing among nurses and for facilitating an understanding and support for nursing with other members of the interprofessional team at many levels. The PPM provides a framework upon which to hang other work, such as rewriting job descriptions, redesigning performance review systems, developing research studies, and creating career advancement programs. In the case of health system formation, nurses working together under a common PPM can serve as role models of the integration possible within a system.

### **CASE STUDY—AN INVESTMENT IN LEARNING**

Learning is an ongoing process, and my past experiences have helped me examine my nurse executive practice in real time and learn new ways to improve my role as a nurse leader. My leadership was put to the test when I took up the challenge to bring together a number of hospitals across the system with the goal of increasing effectiveness and efficiency that would result in positive outcomes for the patients and the organization. The hospitals varied from critical access hospitals to an academic medical center (AMC). Ambulatory practices and clinics were spread across a wide geographical area. A large number of advanced practice nurses were employed by the system, but these nurses voiced concerns that they did not feel a part of the nursing enterprise, something that dismayed some, but not all, of these highly educated nurses. Nurses often expressed difficulty in articulating the unique work of nurses within their interprofessional teams. The challenge was clear: we needed to bring together nurses across multiple hospitals, from every part of the continuum and the community, new graduates, skilled direct care nurses and advanced practice nurses, and

develop a clear model of nursing that would be meaningful to all.

Guided by Schein's model, we created an opportunity for nurses and nurse leaders from all levels within the health system and from all member hospitals within the system to participate in a shared learning experience. During this experience, nurses explored the essential building blocks of a PPM and recognized the value of using a role and standards-based approach to the role of the nurse.<sup>5</sup> The 80 participating nurses then participated in a large session designed to accomplish the development of the health system's nursing PPM.

As the nurse executive responsible for moving the work forward, my approach was built on transparency and open and honest feedback within a safe environment. It was hoped that this approach would ensure that the nurses did not feel coerced or pressured into accepting the new PPM. This was a possibility given that the AMC and clinics were much larger than all the smaller hospitals combined. It would be relatively easy for nurses from one of these organizations to feel dominated by the AMC nurses or feel their input into model design did not carry much weight. The nurses from the smaller hospitals were invited to be part of the shared learning, contribute to the creation of the PPM, and then choose whether their organization would adopt the new model. By the end of the PPM development process, each of the nurses from the smaller organizations readily chose to adopt the new model they had helped create on behalf of their home organizations. The process generated a palpable sense of camaraderie among the participants across all the settings.

The AMC had developed and used a previous PPM. It was important that the former PPM and the work that had gone into its development was honored. It was acknowledged that the former PPM was developed only by the acute care nurses and did not resonate with the ambulatory or advanced practice nurses. After an evaluation with input from the AMC nurses, the nurses involved in the design session chose to voice appreciation for the former model, and then set it aside in favor of development of a totally new model that would be meaningful to all nurses throughout the system.

During the design session, nurses expressed both their shared learning about the professional role of the nurse and the barriers they perceived would be obstacles to clear thinking and excellent nursing practice within an interprofessional team. This sharing was key to the engagement of these nurses in the PPM development. They needed to be heard in order for them to begin the cognitive restructuring and develop new mental models of their role. Discussions included times they didn't feel able to contribute to the interprofessional plan of care, or when they felt hindered in meeting their professional standards of practice. Once able to air these concerns, these nurses fully engaged in the design of the PPM.

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In the end, the new PPM was a rather simple model that addressed the professional role and clear focus on the patient, family, or community. Last, the model described nurses as united across the system in service of the persons that they served.

The design of the PPM was done in a way that addressed 2 of Schein's domains, those of the people/learning and the culture. After the design of the model and its adoption by all the hospitals and services across the system, the hard work of dealing with change on the technical/structural and process levels needed to start. The model needed to be presented to the many system nurses who had not been a part of the design of the PPM. This was accomplished through the leadership of a number of the nurses who had participated in the design session. They were able to present the visual model and share not only the meaning of the PPM, but also their experience in identifying the elements of the model that were meaningful to them personally, and how this new language could transform the way nurses across the system worked with each other and with the interprofessional team.

The PPM also began to be wired into the many processes of the health system, such as job descriptions, career pathways, coaching, peer review, and performance reviews. The language of the PPM became the language of nursing everywhere. It was deemed of particular importance to present to nursing students in a local college to help students who were ready to graduate and their faculty begin to understand the model and incorporate the language into the academic process.

## LESSONS LEARNED

As a nurse executive, the value of using a PPM became evident when I talked with senior leaders about creating and disseminating a common model for system nurses. I found it relatively easy to articulate the value of nursing in contributing the goals of creating a unified system of affiliated organizations, which made it easier to garner support from other system leaders for this work. The organization had goals of creating a health system, unifying nursing practice across the continuum, and developing consistency in care processes. The creation of a PPM for nursing would help to advance each of these organizational goals. The executive leaders were later surprised to learn how powerful common language across the system was to advancing system-ness, and how that language helped facilitate adoption and spread of various patient care practices and outcome improvements. As it turned out, because the system's nurses worked under a common PPM, using language they all understood, nurses were often the first to embrace opportunities to improve care or integrate best practices at all sites. Nurses were positioned to bring improvements in care to their inter-professional care teams and be powerful agents for change.

I also relearned an important lesson, namely, that developing positive working relationship is essential when knocking down walls that serve as barriers to change. In this case the nurses who participated in PPM development knew one another on at least 1 level—the level of the PPM and the messages about nursing practice that it conveyed. Because nurses had gained a clearer understanding of their professional role, they were able to communicate their contributions to the interprofessional team in new and more meaningful ways. There were a number of stories of nurses that indicated that nurses had moved from a passive role in daily interprofessional rounds to an engaged and contributing role. This shift energized the entire team and brought out greater engagement from other members of the interprofessional team. In this respect, the nurses of this health system became a catalyst for promoting better inter professional team collaboration and system integration. So yes, supporting interprofessional practice was worth the investment.

From time to time, I have heard from nurse leaders, “Why do we need to have a pictorial depiction of our PPM?” The process of developing a new PPM, uniting the nurses of a brand-new health system, showed me that a visual model of a PPM has powerful meaning to nurses. The nurses involved in the development of the model spent considerable time verbalizing which words they wanted to use and what figures, colors, and positioning of words would best describe their thinking. At the end of the creation of the visual depiction, the nurses from the member organizations then embraced using the same graphic across all organizations, without change, and adding their organization's name to the system name. In retrospect, I wish we had conducted a study to understand the powerful meaning of the experience to the individual nurses as well as the meaning of the PPM. It certainly meant more to the nurses than I ever would have expected.

## SUMMARY

Nurses need to have clear mental models about what they uniquely contribute to the interprofessional teams within which they practice. PPM development is one powerful way to bring that clarity; however, in order to accomplish the desired change in attitude, belief, values, and behaviors, the process must use a robust model that addresses the need for change in the knowledge, thinking, and mental models of the nurses within the organization or system. PPM development and implementation takes organizational commitment and cannot be fully accomplished without the nurse executive leading this robust cultural change. The investment of the nurse executive's time and social capital will yield significant and sometimes unexpected organizational and patient care rewards.

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