AN EXPLORATION OF THE EXPERIENCES AND PERCEPTIONS OF HEALTH AND ALLIED HEALTH CARE STUDENTS REGARDING INTERPROFESSIONAL COLLABORATION AND EDUCATION IN A RURAL CLINICAL SETTING IN SOUTH AFRICA

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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly unless otherwise stated), that reproduction and publication thereof by StellenboschUniversity will not infringe any third party rights and that I have not previously in its entiretyor in part submitted it for obtaining any qualification.

Student: Anna Luttig Theunissen

Signed date: 25 February 2014

ABSTRACT

An exploration of the experiences and perceptions of health and allied health care students regarding interprofessional collaboration and education in a rural clinical setting in South Africa was conducted.

The specific objectives included:

- The identification of the health and allied health care students placed within the IPC and IPE context in the rural area.
- The description of the demographic placement situations and educational status of the health and allied health care students placed in the rural area.
- The exploration of the experiences of students regarding interprofessional collaboration within an interprofessional educational context in a rural healthcare setting in South Africa.
- The establishment of the perceptions of students regarding interprofessional education within the interprofessional education programme in a rural health care context in South Africa.

An explorative, descriptive research design with a qualitative approach was applied to explore and describe the experiences and perceptions of health and allied health care students regarding interprofessional collaboration and education in a rural clinical setting in South Africa.

The research aim was to explore the experiences and perceptions of health and allied health care students regarding interprofessional collaboration and education during their clinical placement in a rural health care context in South Africa.

Interdisciplinary rotation schedules hampered the researcher's ability to determine an absolute number of the accessible population at any one time. An estimated population (N=31) over a six week period included the following disciplines: Physiotherapy (n=7), Speech and Hearing Therapy (n=14), Nursing (n=6) and Medicine (n=4). The student numbers varied from day to day as the various disciplines rotated at different times. The number of students representing a specific discipline at any given time was not constant. The inclusion and exclusion criteria were set to ensure optimal clinical experience in the field, to ensure that valid data was obtained. The ultimate accessible research sample consisted of all (N=8) of the purposefully selected final year undergraduate health and allied

health care students. The respondents were purposefully selected due to the wealth of information that they shared regarding the topic. The total number of voluntary participants was (n=7). The focus group interviews were attended by the departments of Physiotherapy (n=2), Speech and Hearing Therapy (n=2), Nursing (n=2) and Medicine (n=1). The totals applied to both the pilot interview, as well as the formal study group, however the participants differed. The pilot interview included students who had attended the clinical rural placement during 2012 and the formal study participants were selected from the student groups who attended the clinical placement during 2013.

Ethical approval to conduct the study was obtained from the Health Research Ethical Committee at Stellenbosch University. Consent was obtained from participants to conduct the interviews and permission was obtained from respondents to use a tape recorder to record the interviews.

An interview guide was used to pose the questions, with specific prompts to facilitate the exploration of information. The interview guide was adjusted following the pilot interview, to ensure optimal data collection.

Data obtained was analysed and the following main themes were derived from the study: *Organisation; Perceptions and experiences related to interprofessional team structures prior to and following interprofessional collaboration (IPC) and interprofessional education (IPE); Team cohesion (IPC and IPE) at Avian Park*; and lastly, *Advantages of practices within the Re-engineering of PHC*.The data was analised according to the five steps as explained by Terre Blanche, Durrheim and Painter (2006:322-325).Challenges such as the preconceived barriers to collaboration and the organisational aspects related to rotation were identified; however all the participants indicated that they had benefited greatly from the experience of learning and working together.

Recommendations or suggestions were made by the researcher to further improve IPC within IPE in a multi-cultural student group and society.

In conclusion, the experiences and perceptions were very positive and valuable information was obtained which may serve as the foundation for much needed future research within the South African context.

Key words: interprofessional collaboration; interprofessional education; health and allied health care students

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OPSOMMING

'n Verkennende ondersoek van die ondervindinge en persepsies van studente in gesondheidsorg en verwanteberoepe ten opsigte van interprofessionele samewerking en onderrig in 'n landelike kliniese area in Suid Afrika is onderneem.

Die spesifieke doelstellings het die volgende ingesluit:

- Die identifisering van die studente in gesondheidsorg en verwante beroepe, soos geplaas binne die interprofessionele samewerking en interprofessionele onderrig konteks in 'n landelike gebied
- Die beskrywing van die demografiese plasingsituasie en die onderrigstatus van die studente in gesondheidsorg en verwante beroepe, soos geplaas in die landelike area
- Die ondersoekvan die ondervindinge ten opsigte van interprofessionele samewerkingskonteks binne landelike gesondheidsorg in Suid-Afrika
- Die bepaling van die persepsies van studente ten opsigte van die interprofessionele onderrig binne die interprofessionele onderrigprogram in 'n landelike kliniese area in Suid-Afrika.

'n Uitgebreide, beskrywende ondersoekontwerp is toegepas met 'n kwalitatiewe benadering om ondersoek in te stel, asook om die ondervindinge en persepsies van studente in gesondheidsorg en verwante gesondheidsberoepe ten opsigte van interprofessionele samewerking en interprofessionele onderrig te beskryf.

Interdissiplinêre rotasieskedules het die navorser se vermoë om die absolute aantal studente op een slag te bepaal, beïnvloed. Die beraamde populasie (n-31) binne 'n periode van ses weke het die volgende dissiplines ingesluit: Fisioterapie (n-7), Spraak- en gehoorterapie (n-7), Verpleegkunde (n-7) en Geneeskunde (n-4). Die studentegetalle was op 'n daaglikse basis verskillend, want die onderskeie dissiplines het op verskillende tye roteer Die aantal studente wat een spesifieke dissipline op 'n gegewe tyd verteenwoordig het, was nie konstant nie.

Om optimale kliniese ondervinding te verseker, is die insluitings- en uitsluitingskriteria van so 'n aarddat toepaslike en geloofwaardige data versamel kon word. Die uiteindelike navorsingstudiegroep (steekproefgrootte) het uit 8 deelnemers bestaan. Hierdie groep was doelbewus vanuit die finale jaar voorgraadse studentegroep van die gesondheidsorg- en verwante gesondheidsberoepegeïdentifiseer. Die studente is doelbewus gekies vanweë hul

kundigheid aangaande die onderwerp. Die totale aantal vrywillige deelnemers was sewe. Onderhoude van die fokusgroep is bygewoon deur studente van die volgende departmente: Fisioterapie (n-2), Spraak- en gehoorterapie (n-2), Verpleegkunde (n-2) en Geneeskunde (n-1). Hierdie totale is van toepassing op die loodstoetsing-onderhoud, asook die formele onderhoude maar die deelnemers het egter verskil. Die loodsonderhoud het die studente wat die landelike kliniek in 2012 bygewoon het, ingesluit. Die formele studiegroep het die studenteingesluitwatdie landelike kliniek in 2013 bygewoonhet.

Etiese goedkeuring vir die uitvoer van die studie, is deur die Gesondheidsnavorsing Etiesekomitee Stellenbosch Universiteit verleen. Toestemming van die deelnemers vir hul deelname aan die studie, asook toestemming vir die opname van die onderhoud op 'n klanktoestel is verleen.

'n Onderhoudsgids is gebruik die stel van vrae aan die deelnemers en spesieke frases wat aansporing van antwoorde kon fasiliteer,is gebruik sodat inligting ingesamel kon word. Die onderhoudsgids is aangepas metdie voltooiing van die loodstoetsing-onderhoud om optimale versameling van data te verseker.

Die versamelde data is geanaliseer en die volgende hooftemas is uitgelig, naamlik organisasie, persepsies en ondervindinge verwant aan interprofessionele spanstrukture voor en na aanleiding van interprofessionele onderrig (IPE); spankohesie in Avain Park en dan laastens, die voordele van die praktyke binne die herontwerp van primêre gesondheidsorg. Die data is geanaliseer na aanleiding van die vyf stappe soos uiteengesit deur Terre Blanche, Durrheim and Painter (2006:322-325). Uitdagings soos vooropgestelde idees teenoor interprofessionele samewerking, asook aspekte wat verband hou met rotasieskedules is geïdentifiseer, alhoewel al die deelnemers aangedui het dat hulle almal grootliks gebaat het deur die ondervinding om saam te leer en te werk.

Aanbevelings of voorstelle is gemaak deur die navorser vir die verdere verbetering van interpersoonlike samewerking en onderrig ten opsigte van die bevordering daarvan binne die multi-kulturele studentegroep en die gemeenskap.

Ter afsluiting, die ondervindinge en aannames was baie positief en waardevolle inligting was bekom wat behoort tekan dien as die grondslag van baie noodsaaklike toekomstige navorsing binne die Suid-Afrikaanse konteks.

Sleutelwoorde: interprofessionele samewerking; interprofessioneleonderrig; gesondheidsorg en verwante gesondheidsberoepe.

DEDICATION

I dedicate this work to:

God, without Him none of this would have been possible.

All who protect God's creatures.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CHW	Community Health Worker
CIPP	Centre for Interprofessional Practice
CTEG	Cape Town Equity Gauge
IPC	Interprofessional collaboration
IPE	Interprofessional education
IPEP	Interprofessional Education and Practice
IPL	Interprofessional learning
IPTMs	Interprofessional team members
PHC	Primary Health Care
PNs	Professional Nurses
TB	Tuberculosis
UNICEF	United Nations Children's Fund
US	University of Stellenbosch
WCCN	Western Cape College of Nursing
WHO	World Health Organization

CHAPTER 1: FOUNDATION OF THE STUDY

1.1   INTRODUCTION

The Department of Health (2010) identified shortcomings in the implementation of Primary Health Care (PHC) in South Africa. A new strategy was proposed to address these shortcomings as the absolute burden of disease remains an increasing problem.

This strategy will become known as the "Re-engineering of Primary Health Care". The Department of Health (2010) explained that the success of the aforementioned strategy would depend largely on competent health care workers, working together as a collaborating team. Interprofessional health teams invited in this study are from the faculties of Medicine, Nursing, Physiotherapy, Occupational Therapy and Speech and Hearing.

1.2   SIGNIFICANCE OF THE PROBLEM

Burns and Grove (1995:722) explain significance of a problem as: *a part of a research problem that indicates the importance of the problem to health care professionals and to the health of individuals, families and communities.*

Health care in South Africa is currently not achieving its envisaged results due to shortcomings. Sanders and Chopra (2006: 74) argue that: "the infant mortality rate per 1000 live births is still more than four times higher among Blacks when compared to Whites". Furthermore, they state that there is a great difference in life expectancy; that of Blacks being eighteen years lower than that of Whites. An alternative strategy is in place, to be implemented to achieve the following main outputs to:

1) increase life expectancy
2) decrease maternal and child mortality
3) combat HIV and Aids and decrease the burden of disease due to Tuberculosis
4) strengthen health system effectiveness.

(Department of Health, 2011)

1.3   BACKGROUND AND RATIONALE

The history of primary health care as we know it goes back to 1978 when the Alma Ata declaration gave rise to Primary Health Care (PHC) becoming a priority. The core outcome of the declaration included the right and duty of people to be part of planning and implementing their own health care, as well as the statement of "Health for all by the year 2000" (WHO & UNICEF, 1978).

The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), as well as 134 countries agreed upon setting the goal of "Health for all by the year 2000" (WHO, 1981).

Primary health care by definition is "essential health care based on practical, scientifically sound, and socially acceptable methods and technology, universally accessible to all in the community through their full participation, at an affordable cost and geared toward self-reliance and self-determination" (WHO& UNICEF, 1978).

Ramela (2011.np) reported that the Minister of Health, Dr Aaron Motsoaledi, stated at the 5th South African Aids conference that primary health care delivery in South Africa did not show the anticipated results. Moreover, he explained that the health system was failing in the provision of care. In addition, the minister explained that the focus of the new model of health care is on increasing life expectancy, decreasing maternal and child mortality, as well as decreasing the burden of disease from diseases such as Tuberculosis (TB) and Acquired Immune Deficiency Syndrome (AIDS).

The Department of Health (2010) stated that the lack of success in PHC delivery has prompted a change of the strategy in PHC delivery. Furthermore, there is even scientific proof that primary health care delivery in South Africa has deteriorated due to resources not being applied as allocated. Sanders and Chopra (2006:73-78) reported on a study conducted by the Cape Town Equity Gauge (CTEG), that the districts with the highest burden of disease, such as Nyanga and Khayelitsha in the Western Cape, received fewer health care resources than more affluent districts.

Moreover, it is stated that "vast proportions of resources" are not spent on the prevention of illnesses and the promotion of health as they should be, but rather on curative care. Frenk, Chen, Bhutta, Cohen, Crisp*et al.* (2010:1923) report that there are "glaring gaps and inequities" that are evidence of a worldwide struggle to meet health care demands.

Furthermore, the World Health Report (2008) titled "Primary Health Care – Now More Than Ever" states that even the most developed countries have yet to attain the goal to provide health care to all. The World Health Report (2008:1) suggests that early detection of disease and early intervention is of the utmost importance as the financial burden related to management of chronic diseases is far reaching. The burden of disease affects all aspects of health service delivery.

Countries such as Brazil have implemented variations of the original concepts that were adapted to address the needs of their unique circumstances. A South African contingency

visited Brazil to evaluate their health systems. They explored the approach to primary health care there, where they encountered *The Brazilian model of Primary Health Care* (Department of Health, 2010).

In response to the Brazilian model, the Western Cape Department of Health (2011:3) reported, in an executive summary, the current development of a strategic plan for execution by 2020. At present it is still in the form of a draft framework. The total strategy will be referred to as: "The Re-engineered Primary Health Care Plan of South Africa's Department of Health".

The South African contingency, assigned by The Department of Health (2010), conducted an investigation into the health delivery strategies utilized in Brazil. This resulted in the proposal of a strategy that will only succeed if competent members of interprofessional health teams work together and learn from each other (The Department of Health, 2010).

The success of the strategy is dependent on health care service delivery by collaborating health professionals. Both aspects, namely interprofessional collaboration and interprofessional education (IPC and IPE) are fully explored in chapter two by means of a literature review on the operational concepts related to the study.

The Sociologists Street and Cossman (2010:431) reported on flawed interprofessional relationships between physicians and nurses. The latter is characterised by the lack of the physician's knowledge of the changed scope of practice of nurses, with the result that hierarchical superiority and prejudice are clearly evident (Street &Cossman, 2010:431).

The researcher observed during two years of attendance at Stellenbosch University that Nursing at an undergraduate level, is no longer offered at the University's faculty of Health Sciences. This could result in even further opportunities for division amongst the members of the interprofessional team due to limited contact with undergraduate nurses. The undergraduate nurses were initially excluded from the PHC project in Avian Park until such time that collaboration between the academic facilities in Worcester took place. Nurses are at present included on an informal, ad hoc basis. The Western Cape College of Nursing (WCCN), Worcester campus was approached by Professor Clarke and invited to attend the Avian Park project.

The researcher will endeavor to make recommendations regarding the formal inclusion of nurses. Moreover, these recommendations will be forwarded to policy makers as suggestions for recurriculation of the current programme to formally include nurses in the future. The latter will include the integration of nurses which will contribute to student

education, collaboration to promote team work, professional development and ultimately, patient-centred care. Interprofessional collaboration (IPC) is promoted during the processes of interprofessional education and teamwork.

South Africa's Department of Health suggests that it should form a foundation, of competent health professionals, collaborating as interprofessional teams providing patient-centred care. The researcher is of the opinion that, although interprofessional health care students are provided with an excellent interprofessional education (IPE) programme, it is essential that IPC is promoted and researched in order to promote professional development, as well as patient-centred care within all healthcare settings.

Anderson, Smith and Thorpe (2010:229-240) published findings from a study on collaboration between medical and social work students. Evidence from the qualitative data of the study reflected that the aforementioned students were able to draw upon each other's knowledge and were able to learn from and teach one another. The students did not only learn about each other's roles and functions but also about the different cultures and attitudes towards care that existed among them.

Following a nine week development and evaluation of IPC and IPE at the Centre for Interprofessional Practice (CIPP) at the University of East Anglia (UEA) in Norwich, conducted on five undergraduate health professions, the following information from student feedback was confirmed. Firstly, 94% found working in a group helpful and secondly, 100% would *"like to be involved in the future"* (Lindqvist, Duncan, Shepstone, Watts & Pearce, 2005:509-520).

Lindqvist *et al.* (2005:509) reported that there were institutions that implemented interprofessional learning (IPL) at first year level, with as many as six health professions in attendance.

A group of interprofessional healthcare students, studying through the University of Stellenbosch and the Western Cape College of Nursing are participating in a project where interprofessional education and learning are being implemented (Ukwanda Rural School & Centre for Health Sciences Education). For the purpose of this study, and to support IPE, the researcher's investigation will explore the importance of IPC and IPE within the context of this project as implemented by the University of Stellenbosch.

The interprofessional group comprising nurses, physiotherapists, doctors and speech and hearing therapists worked together with the shared goal of learning from each other. They will be implementing the seven guiding principles of the strategic plan 2020, namely patient-

centred care, moving towards an outcomes-based approach, retention of a PHC approach, strengthening the District Health Model, equity, affordability and building strategic partners (The Western Cape Department of Health, 2012:3).

Lindqvist *et al.* (2005:509) explain that research should take place during this optimal period of interprofessional collaboration where learning can be described, planned, facilitated and evaluated. The researcher has taken cognizance of the literature and, with reference to the author, Lindqvist *et al.* (2005:509), has explored the need for further research to ensure interprofessional learning and collaboration.

The World Health Organization (WHO:2010) framework regarding interprofessional education (IPE) and interprofessional collaboration (IPC) practice, reports the following: "When two or more professions learn with, from and about each other, it facilitates not only learning about one another's roles, but simultaneously improves health care delivery and health care quality." Additionally, WHO declares that it is imperative that competent members of interprofessional health teams regard oneanother as equals in order to be able to learn from one another.

In response to the demand for quality community health care, the University of Stellenbosch, Department of Health Sciences has implemented an interprofessional education project in a rural community in Worcester, South Africa. The Faculty of Medicine and Health Sciences endorsed the IPE approach resulting in all undergraduate students participating in the implementation of the health strategy.

Included in the above-mentioned project are the medical, speech and hearing and physiotherapy students who participated in this study. The merging of universities as a common teaching platform in the Western Cape resulted in the University of Stellenbosch, Department of Nursing not catering for the education of undergraduate nurses since 2007. However, nursing students from the Western Cape Nursing College, Boland Overberg Faculty, were approached during 2011 by the Department of Health Sciences and theywere included, participating voluntarily.

The IPE project is taking place in Avian Park, an underserved area in Worcester. For the purpose of this study, the researcher focused on perceptions and experiences relating to IPC as a critical component within IPE in the clinical practice. The goals of this IPE strategy is to ensure that graduates have competencies to deliver patient-centred care and to improve health systems by working in interprofessional teams. To achieve the

aforementioned goals, the IPE strategy of the Faculty of Medicine and Health Sciences is based on three pillars:

1) Developing core competencies (graduate attributes);

2) Using the International Classification of Functioning (ICF). (The ICF is an assessment tool designed by the World Health Care Organisation. The ICF facilitates the rendering of patient-centred care, improving health systems and addressing community needs)and

3) Building the capacity of facilitators of learning to model interprofessional collaboration and practice.

A qualitative descriptive study was applied to explore the student experiences and perceptions regarding IPC within an IPE context in rural health care in South Africa.

1.4   PROBLEM STATEMENT

Chopra, Lawn, Sanders, Barron, Karim, Bradshaw, Jewkes, Abdool, Karim, Fisher, Mayosi, Tellman, Churchyard and Coovadia (2009:1023), explain that 15 years after the political reform of South Africa, the country is facing new challenges which require dynamic intervention. The epidemic of HIV/ AIDS is immense and it is threatening to prevent South Africa from attaining the Millennium Development Goals (MDGs). The re-engineering of Primary Health Care Strategy is in the process of implementation and requires competent members of inter-professional teams working together and learning from each other.

Frenk *et al.* (2010:1923) wrote extensively about the transformation required in education of health professionals. They explain that visualizing the process of reform within education or instruction, as well as of the operations of institutions will be essential. Furthermore, it is stated that there are two proposed outcomes that will guide and facilitate the process, namely transformative learning and interdependence in education.

Students learn at an early stage that there is an assumed hierarchy and social standing amongst the students of various interprofessional disciplines. In order to establish whether this assumption carries value, the researcher will explore student perceptions of interprofessional collaboration and education within the clinical environment.

1.4.1   Relevance of the study

A Stellenbosch University project focusing on primary health delivery, IPC and IPE in an underserved community was implemented in Worcester and information gained from this study will be invaluable for future interprofessional educational endeavors. The focus of this

research was to explore the perceptions and experiences of the attending final year health and allied health care students.

Stellenbosch University's Health Sciences Faculty does not present an undergraduate nursing programme. The Western Cape College of Nursing (Boland Overberg Campus) joined the program in 2007, prior to the commencement of the research project. Initially, the nurses participated on a voluntary basis in their own time as a personal enriching experience. During 2013 nurses no longer particated only on a voluntary basis. Nurses were placed at the facility for two hours on a Thursday whilst attending a community health care clinic. The outcome of the research will be made known to the policy makers and will include suggestions for recurriculation of current programmes to include nurses in the IPE project programme. The findings from this research project should be able to influence policy makers and will be of value for curriculum development.

The knowledge gained by health education institutions may be applied to revise curricula. The integration of findings could contribute to student education and collaboration to promote team work, professional development, as well as patient-centred care. Perceptions of different professions may be influenced during the process of interprofessional education and teamwork, and interprofessional conflict could be avoided.

The research could provide valuable information regarding the need for intervention to facilitate interprofessional learning and collaboration, which could in turn have a positive effect on the future provision of health care, education and training of health professionals.

1.5   RESEARCH QUESTIONS

- What are the experiences of students regarding interprofessional collaboration within an interprofessional education context in a rural health care setting in South Africa?
- What are the perceptions of students regarding interprofessional student education in a rural context in South Africa?

1.6   AIM

The exploration of the experiences and perceptions of health and allied health care students regarding interprofessional collaboration and education in a rural health care context in South Africa during their clinical placement.

1.7   OBJECTIVES

The specific objectives include:

- The exploration of the experiences of students regarding interprofessional collaboration within an interprofessional education context in a rural health care setting in South Africa.

- The establishment of the perceptions of students regarding interprofessional education within the interprofessional educational programme in a rural health care context in South Africa.

1.8   CONCEPTUAL FRAMEWORK

The researcher attempted to enter the research field without any known preconceived ideas. She used the principles of bracketing and intuiting regarding the research topic "*Interprofessional collaboration within an Interprofessional Education context in rural health care in South Africa*". A thorough study of theoretical literature on the aforementioned topic will be done after data analysis for control of the research results.

1.8.1   The Neuman Systems Model

The model and framework developed by Betty Neuman as described below serves as the foundation of a conceptual framework for this study (George, 1995:284). This model will be used to form the basis of the conceptual map guiding the study.

George (1995:284) explains that Betty Neuman refers to patient-centred care and holistic care within the community when she highlighted the physiological, psychological, socio-cultural, spiritual and developmental structures presented by *The Neuman System Model*. Moreover, this model refers to interpersonal role expectations which are clarified as interaction between people to promote and maintain wellness.

George (1995:284) explains that Neuman's personal philosophy of helping each other live supports the "holistic systems perspective", as well as the levels of the prevention of disease. The holistic approach in the Re-engineering of PHC is evident through the attendance of various health and allied health professionals who would ultimately provide holistic care. It is done by working on a preventative level and not only a curative level to address the burden of disease. The philosophy of the Neuman model correlates with the aims of the Re-engineering of PHC and the team approach.

1.8.2   Graphical presentation of theories and concepts

"Collaborative Practice in health care occurs when multiple health workers provide comprehensive services by working together synergistically along with patients, their

families, carers and communities to deliver the highest quality of care across settings"
(WHO, 2010).

The interprofessional team members (IPTMs) were identified and collaboration depicted. The role of the Community Health Worker (CHW) was clearly indicated. The holistic dimensions of the individual and family, as well as the community form the focus of the care of all IPTMs. The elements of the concept of required activities were listed and linked back to the IPTM and the CHW. The support services and strategies were clearly linked to all other concepts and role players, to show the return to optimal health and well-being on all levels of affliction including support care and assistance during end of life care.

1.8.2.1   *The interprofessional student implementation conceptual map*
"Collaborative Practice in health care occurs when multiple health workers provide comprehensive services by working together synergistically along with patients, their families, carers and communities to deliver the highest quality of care across settings"
(WHO, 2010).
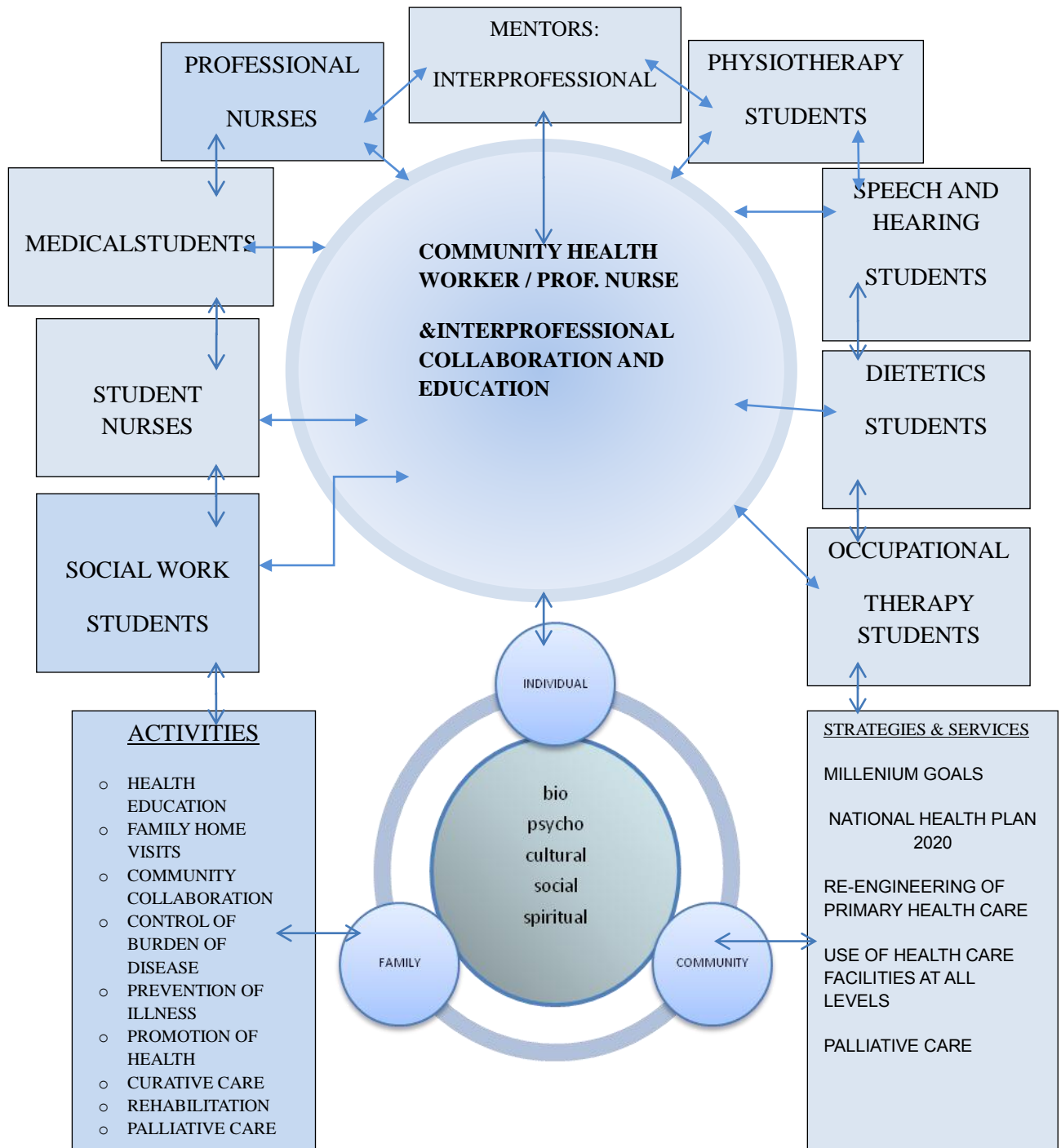
Flow diagramme 1.1: The interprofessional student implementation conceptual map

1.9   RESEARCH METHODOLOGY

During this discussion the researcher will explain and elaborate on the chosen design and research methodology that she deems to be the most suitable approach.

1.9.1   Research design

Brink, Van der Walt and Van Rensburg (2006:102) explain that a descriptive design is used where more information is required in a particular field, where a "picture of the phenomenon" occurs naturally. According to Creswell (2009:249) qualitative research is an inquiry process based on a specific inquiry method that is based on tradition, which investigates the human and the social aspects pertaining to the problems of life. The qualitative research process occurs in the natural setting and the research comprises of words, reports, personal views of respondents and a world view.

A descriptive design with a qualitative approach is appropriate for this study because little is known about the phenomenon which had to be clearly described. Burns and Grove (2009:696) explain a descriptive design as the identification of phenomena of interest, the identification of the variables within the phenomena with concept development, operational definitions of the variables followed by a description of the variables within the study situation. The qualitative design allows the researcher to investigate a phenomenon or lived experiences of participants as they occur naturally within the study. In this study, the experiences, opinions and perceptions of students exposed to a required period of interprofessional education and collaboration within a rural health care setting in South Africa is the focus of investigation.

During this study, the phenomenon of interest was the experiences and perceptions of students participating in IPC and IPE within the context of the clinical experience in Avian Park. The variables were the various professionals working from their own perspective and the learning and collaboration that may have taken place. This study was most suited to an explorative descriptive design as it aimed to analyse the experiences and perceptions of several students, relating to a subject about which little is known at present. It is not a narrative study of a single individual or the lived experience of a phenomenon which relates to phenomenological research (Burns & Grove, 2009:696).

Creswell (2009:58) explains phenomenological research as the study of "an object of human experience" which is a personal lived experience such as grief or anger. The students' experiences and perceptions do not fit the definition for intense lived experiences such as grief of anger. Furthermore, the research related to perceptions and experiences within the context of the Avian Park project does not adhere to the definition of Grounded Theory. Creswell (2009:62) states that the Grounded Theory moves beyond description and focuses on developing a theory or the discovery of a new theory, which is not the case within this descriptive design.

The conclusion that can be drawn from the explanations by the various authors above is that the most suitable research design for this study is the descriptive design and not a phenomenological approach or the grounded theory.

1.9.2   Research setting

The students worked under the guidance of interprofessional mentors and Community Health Workers (CHW). The CHW was the leader of the team during the contact sessions with members of the community. The CHW was the community expert and the link between the students' interprofessional health team and the clients.

1.9.3   Population and sampling

The student population was formed by students, either studying at the University of Stellenbosch, Tygerberg Campus or the Western Cape College of Nursing, working together in Avian Park; Worcester. Nursing students from WCCN attended the project on a voluntary basis as it is not currently an outcome included in their curriculum.

Interdisciplinary rotation schedules hampered the researcher's ability to determine an absolute number of the accessible population at any one time. An estimate population (N=31) over a six week period included the following disciplines: Physiotherapy (n=7), Speech and hearing therapy (n=14), Nursing (n=6) and Medicine (n=4). The student numbers varied from day to day as the various disciplines rotated at different times. The number of students who represented a specific discipline at any given time was not constant. The inclusion and exclusion criteria were set to ensure optimal clinical experience in the field to ensure that valid data was obtained. The ultimate accessible research sample consisted of all (n=8) of the purposefully selected final year undergraduate health and allied health care students. The respondents were purposefully selected due to the wealth of information that they shared regarding the topic. The total number of voluntary participants was (n=7). The focus group interviews were attended by the departments of Physiotherapy (n=2), Speech and hearing therapy (n=2), Nursing (n=2) and Medicine (n=1). The totals applied to both the pilot interview, as well as the formal study group, however the participants differed. The pilot interview included students who had attended the clinical rural placement during 2012 and the formal study participants were selected from the student groups who attended the clinical placement during 2013.

Purposive sampling was the method of choice in this instance. De Vos, Strydom, Fouché and Delport (2011:392) describe purposive sampling as a typical choice of sampling used in a qualitative design where a sample is selected who shares the same characteristics as the

typical population it represents. They represented a "microcosm" of the "real" situation and attitudes of health workers within health institutions.

According to Creswell (2007:125), a purposive sampling strategy allows the researcher to handpick participants that have lived and experienced the phenomenon being studied and can give a rich, in depth account thereof.

All students participating in the project were included in the purposive sample unless they exercised the right to decline their voluntary participation during the process of obtaining informed consent. Some students attended for varying periods of time ranging from periods of three weeks to three months at a time. The expected contact time between the groups was three hours per week, excluding university holidays and examination periods.

1.9.4   Inclusion and exclusion criteria

1.9.4.1   Inclusion criteria
The inclusion criteria were:
- The students of all the previously mentioned departments of the Health Sciences Faculty, as well as the nursing students from WCCN who voluntarily followed the interprofessional education programme.
- Undergraduate interprofessional student teams as discussed under point 1.9.3 were included in the study.
- Students within the IPE programme presented by SU who have attended their allocated period of practical experience of IPC and IPE at the same venue and participated in the same rural project.
- Students placed in the Worcester rural setting were recruited for the study.

1.9.4.2   Exclusion criteria
The exclusion criteria were:
- No postgraduate students were included in the study
- Students who did not attend the Thursday team activities were excluded.
- Students who did not adhere to 1.9.3 were excluded from the study.

1.9.5   Data collection
Focus groups with a maximum of two respondents from each discipline were included in the focus group interviews. The researcher conducted the interviews with the assistance of a field worker. The field worker attended the focus group interviews to observe and record any nonverbal cues or communication which might contribute to the completeness of the data.

De Vos *et al. (*2011:397) explain that the principle of bracketing should be applied during data collection and analysis to ensure that personal concepts and beliefs do not interfere with the results of the study. Furthermore, it is explained that bracketing is a method used in qualitative research to prevent the misleading effects of preconceptions that may provide inaccurate ideas that could taint the research findings.

Specific codes were allocated to individual disciplines to enable organised and rigorous data collection and the facilitation of data analysis.

1.9.5.1   *Data collection tool / instrumentation*

A semi-structured interview guide was used. An opening statement with seven probing questions was prepared. The aim was to ensure an anonymous account of their personal feelings, values and attitudes towards other health professionals with whom they had contact with during their placement at the Ukwanda Rural Clinical School.

The interview guide contained open-ended questions that were based on the objectives of the study. De Vos *et al.* (2011:352) mention that open-ended questions should be asked to allow the participants to express themselves freely. Furthermore, the interview guide contained probing words, for example 'perceptions' and 'experiences'. The guide was peer reviewed, evaluated and assessed by an expert in qualitative research methods.

The researcher and a competent fieldworker collected the data from the pilot interview at a venue that was comfortable for the participants and near the research site. The nature of the study was explained and written informed consent was obtained for conducting the study and recording the interviews before the commencement of the actual study. The data collection was recorded and transcribed for data analysis. Informed consent was obtained prior to the commencement of the interviews.

The data for the formal study was collected in two different ways. Firstly, a focus group with medical, nursing, speech and hearing students in attendance was held. The occupational therapists, who had been invited, chose not to attend. The physiotherapists were no longer in the area as they had already moved on to a further rotation, and an alternative arrangement was made to conduct a separate interview with them. A full description of the content of the interview guide will be discussed in chapter 3.

1.9.5.2   *Data collection technique*

Biographical data was collected following the introduction, whereby the nature and requirements of the study were explained. Each student was allocated a code depicting the field of study that represented a specific discipline but not an individual. This code was

utilised during the recording of the focus group interview. There was only one list with the identifying demographic information which remained confidential.

Data collection took place after the students had attended the predetermined period of education or a minimum of two educational experiences of interprofessional education and collaboration within the community health setting.

According to Creswell (2007:133), focus group interviews may be the best method to follow if the group interaction will encourage communication and the sharing of information.

The researcher conducted a focus group interview during the pre-test and during the formal research while the fieldworker observed the non-verbal interaction between the respondents. The groups comprising a maximum of two participants from each discipline participated in the focus group interview which lasted for a maximum period of 45 minutes. In addition, the researcher conducted an interview with two physiotherapists in attendance on a separate occasion.

The data collection technique consisted of focus groups, utilising a semi-structured interview with the following opening statement:

"In response to the demand for quality community health care, the University of Stellenbosch, Department of Health Sciences, has implemented an interprofessional education project. The latter is taking place in an underserved area of previously disadvantaged people in South Africa. The purpose of the study is to explore the experiences and perceptions of students regarding interprofessional education and collaboration amongst students in a rural healthcare setting in South Africa".

There were seven probing questions encouraging the students to explore their experiences and perceptions of IPC and IPE and team work in general.

Field notes of events and conversations that occurred when the students interacted with each other were recorded verbatim. The researcher also interacted with the students to seek clarification and meaning of actions, because there could be a rationale behind every act or behaviour.

1.9.5.3 Interview information

Reasonable measures were taken to ensure anonymity. An expert researcher conducted all the focus group interviews to enhance the validity and credibility of the data obtained.

Data collection continued until data saturation was reached, which meant that no new data emerged from the data collection process (Brink *et al.,* 2006:134). Terre Blanche, Durrheim

and Painter (2006:372) explain that saturation refers to the condition of an interpretive account where the account is richly fed by the material that has been collected.

1.9.6   Pilot testing

Following ethical approval, the proposed questions were posed to the group of interprofessional healthcare students who completed their practical study period during the year 2012. The purpose of this event was to ensure validity and credibility of the instrument. The pilot interview as the pilot test allowed changes to be made to the instrument before commencement of the actual study. Furthermore, the pilot interview enhanced the credibility and the validity of the study.

The discussion of the findings of the pilot interview will be dealt with in chapter three.

1.9.7   Trustworthiness / validity testing of the study

Validity is concerned with the accuracy and truthfulness of the scientific findings (Brink, Van der Walt & Van Rensburg, 2006:118).

Brink *et al.* (2006:118) elaborate and argue that in order to establish sufficient validity to facilitate conclusions, the empirical reality should be determined. When validity is established it will give rise to credibility, transferability, dependability and conformability.

The above-mentioned concepts will be discussed in depth under research methodology in chapter three.

1.9.7.1 Credibility

The data was verified with two other researchers following the initial analysis and "writing up" to ensure accuracy, trustworthiness and reliability. Reflexive thought, as described by Burns and Grove (2011:95), will be consciously noted so that decisions of coding will not be influenced by the researcher's personal feelings and judgments.

1.9.7.2 Transferability

As discussed by De Vos *et al.* (2011:420), transferability in qualitative research may be difficult; however, the fact that a microcosm of the greater heterogeneous population was sampled should facilitate the transferability to similar situations.

1.9.7.3 Dependability

De Vos *et al.* (2011:420) explain that the researcher appraises whether the research process was documented, logical and audited. All data was collected and analysed according to scientific principles to ensure the dependability of the study.

1.9.7.4 Conformability

According to De Vos *et al.* (2011:421), the results should be evaluated by another researcher to ensure conformability. The researcher provided all transcripts of data analysis, coding and conclusions to an independent researcher to confirm objectivity.

1.9.7.5 Instrument validity

De Vos *et al.* (2011:420) explain instrument validity as not looking at the validity of the instrument but rather at its "validities". The term instrument validity refers broadly to the ability of the instrument to measure what was intended to be measured.

1.9.7.6 Veracity

Pera and Van Tonder (2011:86) explain veracity as truth-telling with the fostering of trust as the result.

1.9.7.7 Bias

Burns and Grove (2009:686) describe bias as any influence or action in the study that could affect or distort the outcomes from the true results, therefore specific consideration was given to the prevention of bias. The researcher was well-known to the student group so special precautions were taken to prevent the Hawthorne effect, which may hamper full disclosure through triangulation.

1.9.8   Literature control

One of the main reasons for conducting a qualitative study is based on the fact that the study is explorative and descriptive in nature and not much has previously been written about the topic under study:

"*Interprofessional collaboration within an Interprofessional Education context in rural healthcare in South Africa*"

The researcher intended to listen to informants and build a picture based on their ideas (Creswell, 1994:21). A preliminary literature review was done (chapter two) to give an overview of the historical background with reference to the study and to explain the main concepts within the study. An in-depth discussion of the literature will be presented at the end of the study to form a basis for comparing and contrasting the findings (Creswell, 1994:23). The literature control will be carried out after the data has been analysed. The results, differences and similarities in the narrative form will then be presented and compared with the theory, as well as with the literature.

1.9.9   Data analysis

According to De Vos *et al.* (2011:351), qualitative analysis transforms data into findings. The process reduces the volume of raw data while it identifies significant patterns. Moreover, the process creates order, structure and meaning to the volume of data collected.

All preconceived notions and ideas were avoided and eliminated. The intention was to deal objectively with the data obtained.

An interpretive approach was applied during the data analysis process. De *Vos et al.* (2011:65) maintain that an interpretive approach implies that we describe and report on what we have seen, heard and understood. Creswell (2007:248) states that an interpretive approach is part of the characteristics of qualitative research and explains it as part of the role of the researcher. In addition, it is stated that the role of the researcher is to represent the individual who supplied the data and to interpret the data that the individual has provided.

Data files were organised and all data was transcribed by a professional and experienced person. Field notes were organised and typed to ensure that the researcher was able to incorporate the data as advised by De Vos *et al.* (2011:408).

Terre Blanche, Durkheim and Painter (2006:322-326) describe five steps in data analysis which refer to themes, categories, conceptualisation of phrases, encoding and interpretation. Cognisance was taken to ensure the best, most trustworthy and reliable outcomes.

1.10   ETHICAL CONSIDERATIONS

1.10.1   Confidentiality and anonymity

Data collection should be free from participant distress and anxiety relating to anonymity and confidentiality. All participants were assured that all answers would be treated as private and confidential within the research team.

Participants were able to refuse to answer any question that they might have felt uncomfortable with, or did not know the answer to.

The participants remained anonymous during the data capturing and codes were established to protect the subjects' rights to privacy and confidentiality. Names were not revealed in any written document or report resulting from this study. All information gained was only used for the purpose of this study. The researcher was the only one who was able to identify the key participants.

The only person who had access to the identifying codes was the primary researcher. These records will be maintained and locked up for a period of five years in a safe which may only be accessed by the researcher. The researcher adhered to the legal requirements for research data storage and preservation. All voice recordings will be kept confidential and in a safe place.

1.10.2   Consent and Informed consent

Consent for the study was obtained from the Ethics Committee of Stellenbosch University and the Department for Interprofessional Education at Stellenbosch University.

Participation in the study was voluntary and informed consent was obtained from all participants from the Centre for Health Sciences Education, as well as from those from WCCN. A thorough explanation of the research protocol was provided.

Sufficient information was provided to enable the participant to make an informed decision regarding voluntary participation.

Consent was written in understandable languages as per the policy of Stellenbosch University, without misleading content that could be classified as deception.

Clear guidelines were made available in the information document to ensure that all participants responded in a professional manner maintaining their own dignity and the dignity of others, as well as one another's professions.

1.10.3   Benefits and risks of participation

Participation was voluntary and there were neither direct risks to nor benefits for the participants. During the interview the participants maintained the right to decline further participation.

1.10.4   Recording of interview

Consent was obtained for recording of the interviews and the same measures relating to privacy, confidentiality, management and storage of other confidential information were applied to the recording and resulting transcripts. Transcripts were coded and incorporated in the form of a report. Participants' identities were not disclosed or discussed outside of the research team.

Verification of recorded conversations was done with focus groups and any uncertainties were addressed and rectified.

1.11   OPERATIONAL DEFINITION

1.11.1   Interprofessional collaboration
Interprofessional education and collaboration were investigated during this study.

Roget's International Thesaurus (1992:450) describes collaboration through the use of various synonyms, namely: cooperation, co-actions, consensus, commonality, community, fellowship, fellow feeling, pooling of resources, reciprocity, job sharing and team spirit.

The aforementioned synonyms clarify the nature of collaboration that will be explored.

1.11.2   Interprofessional education
The World Health Organization (2010) framework related to interprofessional education and collaborative practice reports that, *when two or more professions learn with, from and about each other, it facilitates not only learning about one another's roles, but it improves health care delivery and quality simultaneously.*

1.11.3   Community Health Workers (CHW)
A community health worker is a member of the community who has achieved a certificate which enables them to act as a health worker and a representative of the community.

1.11.4 Department of Interprofessional Education and PracticeIPEP (IPOP)

The acronym refers to the Department of Interprofessional Education and Practice (IPEP) / Service learning

1.11.5 ICF International Classification of Functioning

This acronym refers to a scientific assessment document for use of the classification of functioning.

1.12   DURATION OF THE STUDY
The duration of the study was from the time of ethical approval until completion of communication of the outcome.

The study was conducted over the period from January 2013 until August 2013 and written into thesis format.

1.13   CHAPTER OUTLINE
Chapter 1- Scientific Foundation
A succinct description of the rationale, the research problem, the research question, the aims and objectives, the research methodology and ethical matters related to the research are given.

Chapter 2- Literature review

A preliminary literature review, referring to the inception of primary healthcare as a strategy to minimize health problems and shortcomings will be explored.   In addition, an in-depth literature review will be referring to interprofessional collaboration and education as it has been practised to date.

Chapter 3 – Research methodology

It is a comprehensive research report on the research methodology that was applied to this specific study.

Chapter 4 – Data analysis, interpretation of findings and literature control

The results of the study are analysed and the data interpreted.

Chapter 5 – Discussion, conclusions, limitations and recommendations of the study

A discussion, including conclusions and recommendations based on the scientific findings of this study is given.

1.14   SIGNIFICANCE OF THE STUDY

The study results are aimed at influencing education strategies and the curriculum content of interprofessional health professionals which in turn should result in competent health care professionals providing holistic, preventative, patient-centred health care.

- To the University: it is the first study of this nature conducted by the Nursing Faculty
- To Research:an addition to a field where not much data from a South African perspective is available
- To Health Care: the findings supports the ideals of the "Re-engineering of Primary Health care in South Africa"
- To the Nursing profession: it will be a clear indication that nurses as the backbone of the healthcare system are equal members of the interprofessional health team and should be respected by their peers as equals.
- In general the data can be used to influence policy makers and curriculum designers, contribute to interventions in healthcare where the focus can now be placed on interprofessional learning and collaboration which in turn affect the provision of health care in South Africa.

1.15   SUMMARY

In this chapter a succinct description of the scientific foundation was presented.

The rationale, problem statement, aims and objectives, ethical considerations and research methodology were discussed. In the following chapter a detailed literature review will follow that will explore all current and relevant literature pertaining to the previously discussed aspects.

1.16   CONCLUSION

The research design contributed to the fact that valuable information was gained regarding interprofessional education and collaboration. The research results will be shared through publication, not only with academics in South Africa but could contribute worldwide to the knowledge base related to this important strategy.

CHAPTER 2: PRELIMINARY LITERATURE REVIEW

2.1   INTRODUCTION

The literature review in a research project is an appraisal and synthesis of "the current theoretical and scientific knowledge" pertaining to an identified research problem (Burns & Grove, 2007:135).

According to Burns and Grove (2009:90-91), literature reviews within qualitative studies are not done until the data is collected and analysed so that the literature will not influence the researcher's openness.

In this chapter the preliminary literature review was done to present an overview of the importance of collaboration between health care professionals (IPC) within the context of interprofessional education (IPE) in a rural setting in South Africa.

However, the purpose of this preliminary literature review is also to determine the historical background of the title under study, to clarify concepts under study and to highlight the threats to health care provision in order to contribute to overcoming them. Should health care professionals not work together in a team implementing IPC, a detrimental effect on patient-centred health care delivery can be expected. The problem is thus twofold as it relates to primary health care service delivery needs, as well as to IPC and IPE. At present the latter seems insufficient for the needs of optimal health care service delivery.

During the literature review the researcher focused firstly on the historical events that contributed to the development of the re-engineering of Primary Health Care (PHC) and secondly, on the nature of inter-professional relationships including IPC and IPE.

South Africa is facing an extraordinary challenge which requires the highest quality of effective intervention. According to research, HIV/AIDS in South Africa has taken on epidemic proportions, which is a major threat to the overall provision of health care and limits the country's potential to reach the Millennium Development Goals. (Chopra *et al.,* 2009:1023).

Furthermore, the World Health Report (2008), titled "Primary Health Care – Now More Than Ever", stated that even the most developed countries have yet to attain the goals to provide health care to all. This report suggests that early detection of disease and early intervention

are of the utmost importance, as the financial burden related to management of chronic diseases is far-reaching. It is affecting all aspects of health service delivery. The re-engineering of PHC focuses on the prevention and early detection of health threats and the establishment of competent inter-professional teams where there is IPC and IPE to facilitate a positive effect on health care delivery.

Following the liberation of South Africa in 1994, it was expected that greater strides would have been made towards improved living conditions, which consequently would have had a positive effect on health promotion and the prevention of illness. However, although some positive outcomes have been seen, the life expectancy of South Africans has decreased by an average of 20 years (Chopra *et al.,* 2009:1023). The absolute burden of disease in South Africa showed alarming statistics compared with other countries in 2004, emphasizing the urgency of the action required to make the re-engineering of PHC in South Africa a reality, as not enough attention has been given to the efficient health care delivery (Barron, Schasa & Schneider *et al.,* 2010:1).

Primary health care delivery in South Africa does not show the anticipated results. There is even scientific proof that primary health care delivery in South Africa has deteriorated due to resources not being applied as allocated (Chopra *et al.,* 2009:1023).

It is stated that "vast proportions of resources" are not spent on the prevention of illnesses and the promotion of health as they should be, but rather on curative care. Frenk *et al.* (2010:1923) report that there are "glaring gaps and inequities" that are evidence of a worldwide struggle to meet health care demands. These demands can be identified during analysis of the proposals contained in South Africa's strategy, the re-engineering of PHC. Community-based services with increased emphasis on health promotion and preventive services at household level, including oral, hearing, vision, rehabilitative and school health services, are called for. The re-engineering of PHC demands alignment with the District Health System, appropriate resource utilisation with effective referral procedures, appropriate emergency care and patient transport systems (Barron, Schasa, Schneider, Naledi & Subedar, 2010:1).

The Department of Health (2010) stated that the lack of success in primary health care delivery has prompted a change regarding the strategy in primary health care (PHC) delivery in South Africa.

2.2   HEALTH CARE PROBLEM

The Department of Health (2010) recognized the problem and identified the lack of success in the implementation of Primary Health Care in South Africa. Moreover, it is implied that the burden of disease has increased in South Africa and that resources are dwindling.

Primary health care by definition is "essential health care based on practical, scientifically sound, and socially acceptable methods and technology, universally accessible to all in the community through their full participation, at an affordable cost and geared toward self-reliance and self-determination" (WHO & UNICEF, 1978).

2.2.1   Historical overview of primary health care

The history of primary health care goes back to 1978 when the Alma-Ata declaration gave rise to Primary Health Care (PHC) becoming a priority.

The International Conference on Primary Health Care, on the 12 September 1978, expressed the need for urgent action by all countries and governments to attend to the health of the people. All health workers and the world community were urged to not only promote but to protect the health of people all over the world (WHO & UNICEF, 1978).

The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), as well as 134 countries agreed upon setting the goal of "Health for all by the year 2000" (WHO, 1981).

The Alma-Ata declaration embraces the right and duty of people to participate on an individual level as well as a nation in the planning and implementation of their health care needs. The declaration states the following:

"Primary health care is 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 the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both the country's health system, of which it is the central function and the main focus, and the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process" (WHO & UNICEF, 1978).

The quotation from the Alma-Ata emphasises the core outcome of the declaration which includes that people should have the right and duty to be part of planning and implementing their health care, as well as the goal of "Health for all by the year 2000" (WHO & UNICEF, 1978).

The Constitution of the Republic of South Africa (Act 108 of 1996) echoes the rights of people to democracy and self-determination. Chapter two of the act describes South Africa's Human Rights Charter.

A discussion document published by the Department of Health (2010) argues that much has been done to improve the health system to implement PHC; the country's nine provincial departments were established and racial and gender inequalities have been receiving much attention. However, it is also stated that although large investment in infrastructure was done, the case for a renewed approach to PHC has now become more urgent and compelling.

2.2.2   Exploration of health care strategy: Brazil

The Department of Health (2010) took cognisance of health threats and the lack of success in primary health care delivery. Moreover, South Africa not succeeding in providing preventive care, health promotion and eliciting community involvement by 2010 resulted in the ministerial and MEC advisory committee visits to Brazil in May 2010.

The South African contingency visited Brazil under the leadership of Dr Aaron Motsoaledi, the Health Minister at that time. The purpose of the visit was to evaluate the Brazilian health systems. The team explored Brazil's approach to primary health care, where they encountered *The Brazilian Model of Primary Health Care* (Department of Health, 2010).

Svitone, Garfield Vasconcelos and Craveiro (2000:293-302) reported on the positive results of this Brazilian model. The Brazilian Model of Primary Health Care has at its foundation, experienced trained agents who are managed by trained nurses.

A very poor area, Ceará, a state in Northeast of Brazil, follows a nurse-directed, auxiliary health worker approach which serves approximately 5 million people. The auxiliaries, or "Agentes de Saúde", live in the local communities where they provide basic screening and elementary care. Health agents then visit specific areas where the auxiliaries have provided care. These agents in turn, are managed by trained nurses. This programme developed into a nurse-directed, auxiliary health worker approach serving about 5 million people. The purpose of this nurse-directed approach is to provide care to people in their homes and to facilitate promotive and preventative health, early detection of health risks, timely referral

and supervision over auxiliary health workers (Svitone *et al.*, 2000:293).Research has indicated that since this system was launched there has been a rapid decrease in the infant mortality rate.

The Ceará system seems to be one of the most effective efforts in the world (Svitone *et al.,* 2000:293).

When the South African contingency returned from Brazil in 2010 they had a new vision for health care. The minister requested Dr Yogan Pillay, the head of PHC sub-committee on the Ministerial Advisory Committee, to develop a new strategy for "re-engineering PHC in South Africa" (Department of Health, 2010).

In response, the Western Cape Department of Health (2011:3) discussed the development of a strategic plan for execution by 2020. At present it is still in the form of a draft framework. The total strategy will be referred to as: "The Re-engineered Primary Health Care Plan of South Africa's Department of Health".

The success of this strategy will be dependent on members of inter-professional health teams working together and learning from each other (The Department of Health, 2010).

2.3   PAST EXPERIENCES AND CHALLENGES

As previously mentioned, the development of a new health system is based on the findings and experiences of the contingency to Brazil. Its success will depend on inter-professional healthcare collaboration and education (The Department of Health, 2010).

The achievement of success may be far more complex when one considers the history of collaboration and relationships between healthcare professionals and taking into account that the re-engineering of PHC will be focusing on a nurse-driven programme with interprofessional support and referral to appropriate resources. There will, however, be a PHC outreach team that will spend some time in a fixed clinic, as well as in the community. The latter will serve as an even greater motivation for establishing IPC amongst health care workers.

The lack of collaboration between health care providers has been the topic of discussion by members of the health professions over time. One of the main topics related to collaboration is the difficulties that exist between physicians and nurses.

Thomas, Sexton and Helmreich (2003:956) report in a research study during which they explored teamwork among physicians and critical care nurses, that physicians and nurses have different or "discrepant" views and attitudes towards teamwork. Specific contributing

factors which adversely affected teamwork included poor conflict resolution and interpersonal communication skills. The focus of the study is not to investigate the relationship between doctors and nurses only but the relationships amongst an interprofessional team consisting a several disciplines.

During the re-engineering of PHC which is primarily a nurse-driven process, conflict should be minimised and therefore promote teamwork such as IPC and IPE at an early stage of the health professional's career. Lindqvist *et al.* (2005:509) reported that there are institutions that implement interprofessional learning (IPL) at first year level, with as many as six health professions in attendance.

Students learn at an early stage that there is an assumed hierarchy and social standing amongst the students of the various professional disciplines. In order to establish whether this assumption carries value, the researcher will explore student perceptions of IPC and IPE within the clinical environment.

Interprofessional collaboration (IPC) is a reflection of the degree and quality of teamwork. The World Health Organization (WHO) (2010:7) explains in a key message that collaboration is preceded by interprofessional education, which is a necessary step in creating a "collaborative ready" health work team that will be able to respond to the health needs of the community. Furthermore, WHO elaborates and states that a "collaborative practice-ready" health worker is a person who has learned how to work in an interprofessional team and is competent to do so.

Interprofessional education (IPE) is explained by WHO (2010:7) as a situation where *two or more students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes.* In addition, WHO (2010:7) explains that interprofessional collaboration and education will play an essential part in addressing the world health workforce situation. Furthermore, it is stated that interprofessional education is the essential step in creating health workers who will be able to work together in collaborative practice.

To obtain the goal indicated above, competent members of interprofessional health teams will firstly have to regard each other as equals in order to be able to learn from each other. Cassanova, Day, Dorpat, Hendriks, Theis and Wiesman (2007:68-70) maintain that sound professional communication and mutual respect are the keys for successful collaboration. Interprofessional collaboration (IPC) will be a prerequisite for implementation of the learning experience and the implementation of the abovementioned strategy. Therefore, without

professional respect and equality, the current interprofessional education and collaboration programme will not be able to take place (Cassanova *et al.,* 2007:68-70).

All the various health professionals play an important role in the delivery of health care. Within the context of the re-engineering of PHC strategy, the different roles can be explained as follows:

- Nursing comprises holistic assessment practices, planning and prioritising care, implementation of health strategies including health education, evaluation of care and recording of findings with referral to appropriate resources. The re-engineering of primary health care will be a nurse-driven programme with optimal referral and resource utilisation.
- Doctors will perform their traditional function in terms of patient management; however, there will be the additional aspect of them being members of the teams and being available for referral and support. The contact will mainly be facility based with limited community outreach within the team concept.
- Physiotherapy, speech and hearing therapy, occupational therapy services and other allied health professions will be facility based with limited community outreach within the team concept.
- The role of the dietician will include providing nutritional health care over the lifespan.

All health care workers, with the exception of nurses, will predominantly be facility based; however, they will have a function of community outreach. District management teams will be supported by specialist teams such as mental health professionals, oral health professionals, as well as other essential services (Department of Health, 2010:3).

The community health worker (CHW) is a member of the underserved community who will be the community link representing the people as an expert of the specific needs of the community. The CHW will be the first contact person for all other community members, families and individuals. The CHW is an individual who has received specific training enabling him/her to identify problems, offer basic care and refer community members for consultation with the professional nurse allocated to the specific community. The CHW is an essential member of the team who acts as the expert representing the community, the culture and specific needs of this community.

In the discussion document of the Department of Health (2010:2) it is explained that essential key recommendations for the re-engineering of PHC are:

- To strengthen the district health system (DHS) and to perform the basic aspects of primary health care more effectively.

- Enhanced emphasis on population based health outcomes. This implies the inclusion of the new strategy for community based services. This outreach will take the form of PHC teams with community health workers (CHWs) in the participating communities.

To take cognisance of external factors that could influence the health sector such as social determinants and the role they play. The Department of Health (2010:1) claims that insufficient care has been given to disease prevention, health promotion and community participation. Moreover, it explains that the focus needs to shift to the population and the improvement of measures of health outcomes. The focus should be on the prevention of disease in order to have an impact on the absolute burden of disease.

The aforementioned roles of the team members have briefly been discussed, however, to gain insight into the potential obstacles or barriers to the success of team work, it is essential to explore the historical and current status of collaboration.

For the purpose of this study, the various relationships between doctors and members of health and allied health care will be explored.

2.3.1   Relationships between physicians and nurses

The following debate will be used to examine the relationship between doctors and nurses that has undergone significant changes over time.

To begin the exploration of relationships we turn to Pilletteri and Ackerman (1993:113). In an article where the "game" between doctors and nurses are discussed Pilletteri and Ackerman (1993:113) explain that Sarah Dock, reported in 1917 that: "the first and most helpful criticism I ever received from a doctor was when he told me that I was supposed to be simply an intelligent machine for the purpose of carrying out orders". In the same article it is written that a nurse, no matter how gifted she might have been, would never be seen as reliable unless she was able to obey without question.

However, even though it seems unlikely when taking the aforementioned into consideration, some degree of collaboration did exist as far back as 1888. In an article written by Pilletteri and Ackerman (1993:115) it was stated by the authors that an entry by a doctor in 1888 read "I did some work in the nursery fixing up the four-hour lines on the temperature chart for my nurse, Mil Carter".

Since 1888 significant changes have taken place and even as early as 1923 the Goldmark report, as discussed by Frenk *et al.* (2010:1930), had a remarkable effect on professional health care education. This report motivated nurses to attend university-based educational

programmes. It put nursing on the same academic path as medicine in the United States of America. Today nursing is a recognised profession which adheres to all internationally accepted criteria to be worthy of being referred to as a profession (Mellish, Oosthuizen& Paton, 2010:11).

Nurses, at an undergraduate level, study a large body of scientific knowledge that is presented at universities all over the world. The latter is in strong contrast to the training described by Pilletteri and Ackerman (1993:115) where it is mentioned that during 1888 nurses in the USA received "forty five hours of training from the doctors".

Research has shown that nurses are no longer satisfied with being treated as inferior members of the interprofessional team (Nursing91, 1991:60). The aforementioned status could be one of the factors hampering collaboration. Results from a 1991 survey conducted in Minnesota showed that, of the nurses who responded, 56% were dissatisfied with their relationship with doctors while 57% of the respondents stated that nurses are subordinate to doctors. However, the relationship between doctors and nurses is one of collaboration (Nursing91, 1991:60).

Stein, Watts and Howell (1990:546) refer to the "The Nurse-Doctor Game Revisited", where the rules of the 'game' are explained as follows: Nurses need to be bold but appear passive. Nurses should make recommendations about care although it should sound as if it was the doctor's idea. Moreover, if the doctor wants the nurse's input it should happen in such a way that it does not seem obvious that he needs her expertise.

In a study conducted by sociologists Street and Cossman (2010:431) it is stated that physicians who worked in the same practice as nurses had a more positive attitude towards them. However, it is also stated that regardless of their training and professional qualifications, physicians would not like nurses to work independently. There seems to be a lack of trust and relinquishing of authority. Furthermore, it is maintained that even if a physician with early collaborative training and education may have a positive attitude towards nurses, he/she would still not support nurses' independent practice.

It seems that the communities in need of healthcare do not share the same view. Street and Cossman (2010:432) report that nurses' and physicians' duties overlap to such an extent that patients in the community accept, without prejudice, care provided by professional nurses.

Maxon, Dozois, Holubar *et al.* (2011:31) examined the effects of interdisciplinary simulation training and subsequently reported information that can only be perceived as motivation for

future collaboration. It was reported that interdisciplinary simulation training in a team approach will have a positive effect on collaboration between the registered nurse and the physician in the clinical field.

The conclusion of their study states that not only did the aforementioned training promote collaboration between the two professional groups; it contributed further to the patient care decision-making process. In addition, it is stated that the need for interactive collaboration and exchange of information is great. Team training for professional health workers was highly effective in terms of improved communication and performance during crisis management (Maxon, Dozois, Holubar *et al.,* 2011:31).

2.3.2   Physicians and allied health care members

Anderson, Smith and Thorpe (2010:229-240) published findings from a study on collaboration between medical and social work students. Findings from qualitative data reflected that the students were able to draw upon each other's knowledge and were able to learn from and teach each other. Not only did they learn about one another's roles and functions but also about different cultures and attitudes to care.

Following a nine week development and evaluation of IPC and IPE at the Centre for Interprofessional Practice (CIPP), University of East Anglia (UEA), Norwich, involving five undergraduate health professions, the following information from student feedback was confirmed. Firstly, 94% found working in a group helpful and, secondly, 100% would "like to be involved in the future" (Lindqvist, Duncan, Shepstone, Watts & Pearce, 2005:509-520).

Lindqvist *et al.* (2005:509) reported that there are institutions that implemented interprofessional learning (IPL) at first year level, with as many as six health professions in attendance.

There seem to be many reports of collaboration and positive changes. However, during the following exploration of the re-engineering of PHC, it will become evident that more than an attitude change will be required to ensure the successful rendering of patient-centred care.

2.4   DEVELOPMENT OF A STRATEGIC PLAN

The re-engineered Primary Health Care Plan of South Africa's Department of Health (2010) provided detailed aspects of the strategic plan. However, only aspects relevant to this study will be discussed.

2.4.1 A different approach

According to a presentation titled "*Proposed way forward*" written by Baron (2011: np), who conducted a detailed analysis on behalf of Stellenbosch University Faculty of Health Sciences; the intervention will focus on the family. It will be pro-active in nature, which is in contrast to the traditionally individualistic approach which took on a more passive form. The focus will shift from a curative-centred approach to that of prevention of illness and promotion of health. Moreover, he stated that the previously fragmented health service will be integrated under one provider. Furthermore, he explains that there will be a census of households within an area and a teamwork approach will be rendered focusing on promoting strong family ties.

Baron (2011:np) elaborated on in the aforementioned, stating that the strategy will be incorporated into the district model of care with care being provided by the Primary Health Care outreach team (PHC team). This team will consist of Professional Nurses (PNs) as team leaders and Enrolled Nurses (ENs) who would be facility and community based. The link between the community and the Professional and Enrolled Nurses will be the Community Health Worker (CHW). This team of people will be responsible for 1500 families. Services will be rendered at homes, schools, crèches and early learning centers. The focus will be on preventive, promotive, curative and rehabilitative services within the context of the re-engineered PHC plan of South Africa.

The district will be divided into wards and the number of teams will be allocated according to the population size of the ward. It is proposed that one CHW will tend to 250 families which would be approximately 1000 members of the community. The PHC team will tend to 1500 families which could be as many as 6000 people and the clinic will be responsible for a total of 4500 families consisting of approximately 18000 individuals (Baron, 2011: np).

In the opinion of the researcher, IPC and IPE will be of utmost importance to ensure client-centred care, accurate and effective referral to services as described within the district health system and to ensure effective interim management.

2.4.2 The implications

Frenk *et al.* (2010:1923) wrote extensively about the transformation required in the education of health professionals. The aforementioned authors explain that three generations of education have affected the characteristics of reform. Visualising the process of reform in education or instruction and in the operations of institutions will be essential. Furthermore, Frenk *et al.* (2010:1923) state that there are two proposed outcomes that willguide and facilitate the process, namely transformative learning and interdependence in education.

South Africa's Department of Health (2010) will require as its foundation, health professionals collaborating in interprofessional teams providing superior patient-centred care.

The World Health Organization (2010) framework relating to interprofessional education (IPE) and collaboration practice reports the following: *When two or more professions learn with, from and about each other, it facilitates not only learning about one another's roles, but it improves health care delivery and quality simultaneously.*

2.5   STELLENBOSCH FACULTY OF HEALTH SCIENCES

In response to the demand for quality community health care, the University of Stellenbosch, Department of Health Sciences, implemented an interprofessional education project in Avian Park, Worcester, South Africa, in 2011. The aim of the project is to promote IPC and IPE.

The Faculty of Medicine and Health Sciences, where the Department of Health Sciences is situated, endorsed the implementation of an IPE strategy in 2010 for all undergraduate students. The goal of this IPE strategy is to ensure that graduates have competencies to deliver patient-centred care and to improve health systems by working in interprofessional and trans-professional teams.

A group of interprofessional healthcare students, studying through the University of Stellenbosch and the Western Cape College of Nursing, are participating in a project where interprofessional education and learning is being implemented (Ukwanda Rural School & Centre for Health Sciences Education).

The students are working together with the shared goal of learning from each other. They will be implementing the seven guiding principles of the strategic plan 2020; namely, patient-centred care, a move towards an outcomes based approach, retention of a PHC approach, strengthening the District Health Model, equity, affordability and building strategic partners (The Western Cape Department of Health, 2011:3).

The latter is taking place in an underserved area of previously disadvantaged people in South Africa. For the purpose of the study, the researcher will focus on interprofessional collaboration as a critical component within IPE in the clinical practice. Furthermore, for the purpose of the study and to support IPE, the research study will explore the importance of IPC and IPE within this context.

2.6   THE NEUMAN SYSTEM MODEL

The researcher is able to demonstrate the nature of interprofessional collaboration and education best by applying the principles of Betty Neuman's System Model to form a proposed model for interprofessional student activities within the context of the re-engineering of Primary Health Care. The graphical presentation can be seen in chapter 1.

The researcher set out to choose a theory that includes the community, a holistic approach, factors contributing to illness or disharmony, resources and services, as well as interventions. Although this is essentially a nursing model, it can be applied to health-related professions.

The Neuman System Model adhered to all the aspects and enabled the researcher to formulate a clear conceptual model inspired by the clarity and concepts of this specific model.

The model, as developed by Betty Neuman, was specifically designed to reflect the community. She drew from her knowledge of health and from her experience of the dynamics of communities and related illnesses. She related her findings to stressors from internal and external environments and the reactions to them. Her theory and conceptual map contain elements of interaction which imply collaboration, as well as relationships and wholeness. The levels of intervention, causes of illness, additional contributing factors, as well as intervention and prevention of illness are all clearly evident.

The Neuman Systems Model reflects the sentiment of the research and adds credence to the study. The characteristics of a theory, as described by Torres, cited in George (1995:10), are that it should consist of interrelated concepts to create a unique way of looking at a particular occurrence or phenomenon. In addition, it should follow a logical thought pattern, simplistic but applicable to other experiences and circumstances. Furthermore, it should lend itself to retesting and even facilitate expansion, which in turn could result in further expansion of knowledge and theory through research. Theories should act as guides for practitioners to improve practice; however, they should be in line with other validated theories but still facilitate opportunities for further research.

The role of the Community Health Worker (CHW) is clearly indicated. The support services and strategies are clearly linked to all other concepts and role players, to ultimately support the return to optimal health and well-being on all levels of affliction and support care including assistance during end-of-life care.

The Neuman Systems Model, as described by George (1995:281-299), is appropriate guide for use in all fields of health care and not only for nursing. Nursing is seen as a system because of the fact that interaction takes place between professionals. The team interaction between the professional members is the first motivation for the reference to this model in the research.

Furthermore, George (1995:282) explains the importance of each part within the system. The concept map, as explained by the researcher in chapter three, depicts the equal relationships between the team members. The whole is important but the special value of its individual parts is also recognised. Neuman's model focuses on the relationships that arise from the "wholeness" as it responds to stressors, which include factors from internal and external environments.

George (1995:284) explains that using a systems approach, based on Neuman's model allowsfor individuals, groups and communities who have all been exposed to stressors, to be represented. Neuman explains that stressors are forces which may have a positive or negative effect which can affect the stability of the system. The optimal achievement would be to obtain stability within the system.

Furthermore, the *Neuman Systems Model* identifies an additional system or environment which can be seen as a protective shield. The aim of this shield is to create and to provide a constantly changing positive stimulus towards the health of the client.

Specific aspects of relevance to the study at hand are as follows:

- Health education, more specifically the role of the interprofessional health care team to promote health and prevent illness through appropriate health education, which consequently could have a positive effect on the burden of disease.
- Seeing the individual within his family as a unit with all the dimensions included, namely bio-psycho, social, spiritual and the rendering of focused intervention. Both of the aforementioned may in turn have a positive effect on the health of the community.
- Collaborating team members can include the members of the community and the community leaders in decision making and health promotion. Again this could have a positive effect on the community and take the community one step closer to stability within the system.
- It is anticipated that interprofessional education and collaboration could result in health workers who become aware of the abilities of their colleagues, trusting their judgment to make appropriate referral to further services where specific curative,

rehabilitative care can be given. This availability of a full range of services promotes comprehensive care within the context of the holistic approach to health care.

- Situations which may require quality, empathic end-of-life care and palliative care facilities should be utilised.

In the concept map all the facilities and role players are depicted and can be seen within the context of the *Neuman Systems Model* where the implantation of the protective shield of the interprofessional team as explained in George (1995:287) can give rise to control of stressors and to system stability.

2.7   SUMMARY

In this chapter the preliminary literature review highlighted the status of health care provision and the proposed strategies to overcome shortcomings and challenges; emphasis was placed on primary health care delivery, interprofessional relationships and opportunities for interprofessional education and interprofessional collaboration. The ultimate advantage of this approach is holistic, client-centred care. In providing holistic patient care, a comprehensive approach to health care can be implemented as a human being functions as an integrated whole rather than as a separate system (Bailliére, 2009:190).

2.8   CONCLUSION

One of the main reasons for conducting a qualitative study is based on the fact that the study is explorative and descriptive in nature and that not much has yet been written about the topic: "Interprofessional Collaboration within an Interprofessional Education Context in Rural Health Care in South Africa". The researcher intended to listen to informants and build a picture based on their ideas (Creswell, 1994:21).

The researcher has taken cognisance of the literature and with specific reference to authors. Lindqvist *et al.* (2005:509) explored the need for further research to ensure future interprofessional learning and collaboration. The authors explain that research should take place during the period of interprofessional collaboration where learning can be described, planned, facilitated and evaluated.

Watts, Lindqvist, Pearce, Drachler and Richardson (2007:443) state that there is little research evaluating interprofessional learning programmes and teamwork. Furthermore, they argue that further research is needed to confirm the effects of interprofessional learning and teamwork and the benefits to patient care and safety.

An in-depth discussion of the literature will be presented at the end of the study to form a basis for comparing and contrasting the findings (Creswell, 1994:23). The literature control

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will be carried out after the data has been analysed. The results, differences and similarities in the narrative form will then be presented and compared with the theory, as well as the literature.

In chapter three an in-depth discussion will follow where the phases of the research methodology and design will be fully explored. Burns and Grove (2009:54) maintain that the application of methodological rigor is reflected by the methodological congruence, thoroughness in data collection and the understanding of the data.

CHAPTER 3: RESEARCH METHODOLOGY

3.1   INTRODUCTION

The previous chapter incorporated a preliminary literature review whereby providing a sound scientific foundation to the study.

The focus of this chapter is on providing a comprehensive description of the design and methodology that was applied during the execution of the study. A pilot interview was conducted to test the initial proposed methodology so that adjustments to the data collection instrument could be made to enhance the trustworthiness of the data obtained. A detailed description of the pilot interview will be presented.

The research methodology developed as the research steps progressed and includes the following:

- An overview of the research setting
- Research design
- Population and sampling
- Eligible criteria
- Data collection tool / instrumentation
- Pilot interview
- Trustworthiness
- Ethical considerations
- Data collection process
- Data / Content analysis

3.2   STUDY SETTING

3.2.1   Background

The study took place in an underserved informal settlement area named Avian Park. This settlement is situated on the outskirts of Worcester, which in itself can be seen as rural by nature as it is surrounded by farmland.

Interprofessional education and collaboration as explained by the National Department of Health (2010) are essential to ensure that health needs of people are met. If healthcare workers and allied healthcare workers study and work together throughout their studies, they will learn the value and importance of collaboration and coordination of care and activities.

Heineken, Voster and Du Plessis (2011:3) report in a 2011 socio-economic and social capital assessment of Avian Park residents in Worcester, that 216 face to face interviews selected through random sampling were done, and were found sufficient to generalise the findings to the inhabitants of Avian Park. Furthermore, the confidence level with which the relationship between variables was discussed was found to be 95%.

Heineken, Voster and Du Plessis (2011:11-15) reported that 40% of the population were farm workers of which a large proportion were seasonal workers. Seasonal workers only work during the fruit harvesting and processing period of the year. During January 2011, at the time the survey was conducted, it was the working season. Unemployment was calculated at 11%. It is suspected that this flow diagramme may be significantly higher outside of the working season.

Furthermore, on average there were six people living in each dwelling, within limited living space. The risk resulting from overpopulation is an added health concern as overpopulation is a predisposing factor to diseases such as tuberculosis. Moreover, it was reported that preceding the study that took place from 24 -27 January 2011, 13% of the population did not have enough food to feed all the people living together in a home and did not eat more than five times per week. In addition, a further 11% of the population did not have enough food to eat more than four times per week. In total, 24% of the population did not receive adequate sustenance due to poor socio-economic circumstances.

The role of the dietician is therefore vitally important to promote adequate education and intervention. Very few members of the population reported that their children received adequate nutrition. At times the children received food from a feeding scheme (Heineken, Voster & Du Plessis, 2011:19-20).

The findings from the research conducted by Heineken, Voster and Du Plessis (2011:19-20) highlight the risks, as well as the need for intervention to prevent further increase of the burden of disease, which is prone to occur in underserved areas.

Prior to conducting this research survey, the researcher was involved in the mentoring of nursing students at the Avian Park project. During that time the researcher observed that there was no fixed primary health care clinic in the Avian Park area. It became evident, through observation that potential health care users were in need of transport. Upon further investigation by the researcher, it was found that transport to the nearest clinic or hospital was available at a significant cost. However, Stellenbosch University established a medical

facility (Ukwanda Rural Clinical School) where medical students complete their practical community health component in their final year of study.

Furthermore, there is a venue in Avian Park, referred to as a clinic, where all final year interprofessional health care and allied health care students assess health care consumers under the guidance of a family physician, as well as their mentors. This clinic was established as a training facility for medical students during their family medicine component. The researcher became aware that the focus of the clinic was not on being an integral part of the district health services but rather on serving as an extension of the University of Stellenbosch, Health Sciences faculty.

The researcher observed that pre-dispensed, chronic medicines were delivered to the Ukwanda Rural Clinic, which is a clinical facility of the University of Stellenbosch where people were then able to collect their chronic medication. The researcher found this service to be an attempt by the personnel at the rural clinic to assist the community by increasing accessibility, enabling the collection of chronic medicines "closer to home".

The aforementioned information reflects the fact that health services are not readily accessible to the Avian Park community. The only way to reach the nearest clinic is by motor vehicle and this is very costly when considering the socio-economic status of the community (Heineken, Voster & Du Plessis, 2011:11-15).

3.2.2   Study environment

The setting was in the natural environment in the community as described in the background. The setting was not controlled as it was a real life setting, as explained by Burns and Grove (2011:35).

The study was conducted in an informal setting and took the form of an "around the table discussion". A non-threatening environment was created where friendliness and mutual respect were fostered. All participants, including the facilitator, the researcher and the field worker were given the opportunity to introduce themselves and to become familiar with the surroundings. A basic overview of the research aim and objectives was given, and participants' voluntary participation, confidentiality and privacy were reiterated.

Students from the University of Stellenbosch's Health Sciences Faculty, in the process of completion of their studies, attended the Ukwanda Rural Clinical School and were included in the study. The same inclusion and exclusion criteria were applied to participants who participated in the pilot interview as were applied to those students in the formal study.

Interdisciplinary rotation schedules hampered the researcher's ability to determine an absolute number of the accessible population at any one time. A potential study population (n=31) over a six week period included the following disciplines: Physiotherapy (n=7), Speech and hearing therapy (n=14), Nursing (n=6) and Medicine (n=4). The student numbers varied from day to day as the various disciplines rotated at different times. The number of students representing a specific discipline at any given time was not constant. The inclusion and exclusion criteria were set to ensure optimal clinical experience in the field to ensure that valid data was obtained. The ultimate accessible research sample consisted of all (n=8) of the purposefully selected final year undergraduate health and allied health care students. The respondents were purposefully selected due to the wealth of information that they shared regarding the topic. The total number of voluntary participants was (n=7). The focus group interviews were attended by the departments of Physiotherapy (n=2), Speech and hearing therapy (n=2), Nursing (n=2) and Medicine (n=1). The totals applied to both the pilot interview, as well as the formal study group, however the participants differed. The pilot interview included students who had attended the clinical rural placement during 2012 and the formal study participants were selected from the student groups who attended the clinical placement during 2013.

Nurses from the Western Cape Nursing College were recruited as voluntary participants. The nurses included in the pilot interview were studying towards completion of their second year of study, whilst the nurses included in the formal study were in their fourth year of study. The attending students' experiences and perceptions regarding IPC and IPE were investigated. These experiences and perceptions resulted from a community project conducted in Avian Park. Groups of interprofessional health care students conducted home visits, during which time a holistic assessment was done by students from their specialty perspective, through the use of the International Classification of Functioning (ICF).

A team management approach during the study period was implemented which implied that mentors from all professions were present to support students from each individual discipline. The mentors also facilitated IPC and IPE and through their collaboration with each other, in turn contributed to meaningful student IPC and IPE.

The pilot interview, as well as the first interview of the formal study, took place at the Ukwanda Rural School. However, the second formal study focus group interview took place at the Eros School in Bellville. During the pilot interview, one medical student, two nurses and two speech and hearing students were in attendance. During the formal study, one medical student, two nurses and two speech and hearing students participated in an interview at the Ukwanda Rural School. The physiotherapy students, who indicated their

willingness to participate, were not able to attend the interview at the Ukwanda Rural School. The physiotherapy students were attending a further rotation and they were not going to return to Ukwanda Rural Clinical School to attend the rural project again.Therefore, an additional focus group was conducted at the Eros School in Bellville as the students already rotated in Ukwanda Rural Clinical School.

3.3   RESEARCH DESIGN

The purpose of this section is to describe the research design and methods that were used for data gathering from participants, and to provide a thick description of the concept of interprofessional collaboration within an interprofessional educational context.

Burns and Grove (2011:696) define the research design as the blueprint for conducting a study which exerts maximum control over factors which could interfere in the validity of findings. In addition, De Vos, Strydom, Fouché and Delport (2011:143) infer that the choice of the research design depends on the researcher's knowledge and experience, as well as the problem, the purpose of the study and the goal to simplify the results of the study.

De Vos *et al.* (2011:96) explain that descriptive research presents a picture of the detail related to a specific situation. The focus is the "how" and "why" relating to the social setting and the relationships that exist. The aforementioned authors state that the study should commence with a well-defined subject, which needs to be accurately described. According to De Vos *et al.* (2011:96), descriptive research can have a *basic* or *applied* research goal and can be *quantitative* or *qualitative* in nature. Qualitative research can lead to a detailed and deeper description of the phenomenon.

Burns and Grove (2009:696) explain descriptive design as the "accurate portrayal or account of the characteristics of a particular individual or group in a real-life situation for the purpose of discovering new meaning, describing what exists, determining the frequency with which something occurs and categorising information." In addition, Burns and Grove (2009:696) explain that a descriptive design aims to gather more information about specific occurrences or situations as they happen naturally.

With reference to the aforementioned literature, a descriptive design, which aimed to explore real-life situations of students from different professions working together, cooperating and learning from each other in a natural setting, was the appropriate design to apply to the study. The aim of the researcher was to discover new data with regard to how different health profession students perceived and experienced working together, collaborating and learning from each other.

The study took place while student health professionals were working and studying together. The focus was to describe what was in existence and to give meaning to the events and changes that took place during the period of IPC and IPE in Avian Park.

The researcher was not conducting a phenomenological inquiry. Creswell (2007:59) states that phenomenology is not only a description but an interpretive process in which the researcher creates meaning and understanding of the lived experience. The researcher does not focus on deeply lived experiences such as individuals' feelings or living with AIDS and therefore choose an explorative descriptive qualitative research design.

An explorative, descriptive design is appropriate as perceptions and experiences related to IPC and IPE are under investigation and the interpretation of these aspects may contribute to the knowledge base of the subject. The study was conducted in the natural environment and relates to real-life situations, experiences and perceptions of the students. The aim was to describe the experiences and perceptions and not to conduct an in-depth exploration and interpretation of an "intensely" lived experience.

3.3.1   Qualitative research approach

According to Burns and Grove (2011:23), qualitative research is naturalistic interpretative and humanistic. This philosophical origin underpins this study. Furthermore, Burns and Grove (1993:777) referred to a qualitative research design as a systematic, subjective approach which is used to describe life experiences and give meaning to them.

This seems to be aligned with what Walker and Avant (1995:99) implied when they referred to qualitative research as descriptive of what the researcher is interested in, including the process, meaning and understanding gained through words. In this situation the researcher wanted to establish the meaning of a phenomenon based on the views of the participants. The focus was on exploring and describing the experiences of students regarding interprofessional collaboration within an interprofessional educational context in a rural healthcare setting.

Joubish, Khurram, Ahmed, Fatima and Haider (2011:2082) explain that qualitative research is asking questions relating to "why" regarding the topic, and it does not rely on statistics or numbers to gain insight into people's attitudes. Furthermore, they explain that qualitative research informs us about the way people feel and why they experience specific emotions. The researcher, taking into consideration the facts as explained above, concluded that a qualitative approach would be a more suitable approach than a quantitative one.

The researcher focused on perceptions and experiences in this study motivated by the aim to obtain maximum information regarding a new field about which there is not a great amount of research available. According to Burns and Grove (2011:45), the purpose of a descriptive research design is to describe new knowledge relating to a phenomenon about which not much is known. A descriptive design would best describe and identify relationships between the concepts of interprofessional collaboration and education, as well as the students' perceptions and experiences related to the implementation of IPC and IPE.

The researcher set out to explore the relationships that exist in the field between a group of various different health professionals, as well as their experiences and perceptions of interprofessional education and collaboration. Their experiences were personal and subjective. The findings may lead to a better understanding of their experiences, which could be able to influence practice in the future.

The research design and methodology is in accordance with the characteristics of qualitative research as explained by Burns and Grove (2011:23). The in-depth probing nature of qualitative research was well-suited to the task of describing and exploring unidentified phenomena in the case of this study.

Creswell (1994:34) explains that it is appropriate to use qualitative research when a problem or issue needs to be explored and a detailed understanding is required from the information obtained. Furthermore, the author states that qualitative research needs a strong commitment and that the researcher needs to spend an extended duration in the field, collecting data and getting an "insider" perspective.

3.3.2   Descriptive qualitative research design

A qualitative research approach focuses on describing the actions or experiences in detail (referred to as *thick description*). Babbie and Mouton (2001:81) regarded this as an attempt to understand the actions in terms of the actors' own beliefs and context, and furthermore indicated that events in the context will be placed so that the actors understand it themselves. The information obtained from students' lived experiences during the educational event in Avian Park, may be utilised to improve and restructure interprofessional learning and education.

The major concepts will be identified and synthesized, as well as analysed regarding interprofessional collaboration (IPC) within an interprofessional education (IPE) context.

3.3.3   Explorative qualitative research design

Babbie and Mouton (2001:79) are of the opinion that this method is typical when a researcher examines a new interest or when the subject of the study is relatively new and very little literature is available regarding the subject matter.

An explorative design was used in this study, with the aim of exploring the experiences and perceptions of health and allied health care students regarding interprofessional collaboration and education amongst students during their clinical placement in a rural health care context in South Africa.

No active intervention took place prior to the study. Students were undergoing a required period of interprofessional education and collaboration.

The aim of the study was to explore and describe the experiences and perceptions in order to identify the need for future adjustments to the current programme to improve IPE and IPC. De Vos *et al.* (2011:94) explain that the aim is something you would like to achieve. The researcher's aim was to explore the experiences and perceptions of health care students and to possibly influence the development and implementation of IPC and IPE in the future, as well as to ensure the formal inclusion of nurses.

The main reasons for conducting a qualitative study were that the study was explorative and descriptive by nature and that not much has been written about the topic*: "Interprofessional collaboration within an Interprofessional Education context in rural health care in South Africa".* The researcher also aimed to listen to informants and build a picture based on their ideas (Creswell, 1994:21).

A preliminary literature review was done in chapter two to give an overview of the historical background with reference to the study and to explain the main concepts within the study. An in-depth discussion of the literature will be presented at the end of the study to form a basis for comparing and contrasting the findings (Creswell, 1994:23). The literature control was carried out after the data had been analysed. The results, differences and similarities in the narrative form will then be presented and compared with the theory, as well as with the literature.

3.3.4   Paradigmatic perspective
Philosophical underpinning;

Paradigmatic perspective as explained by Guba and Lincoln (1194:108) includes;

The **ontological** *question* *"form and nature of reality and, therefore, what is there that, that can be known about it?"*   **What can there be to talk about?**

The **epistemological question** *"what is the nature of the relationship between the knower and would be knower and what can be known"?* What information can be obtained related to the nature of humans regarding their knowledge and understanding through investigation?

The **methodological question** is *"how can the inquirer go about finding out whatever he or she believes can be known?"*

The researcher firmly believes that all research is valuable and that during data collection and data analysis the value or importance of what the researcher was undertaking would direct thinking and activities (Botes, 1995:12).

Creswell (2007:19) explains a paradigm as a worldview which can be described as a basic set of beliefs that guide action. The term worldview could be viewed as synonymous with the term paradigm.

Creswell (2007:19) explains four different worldviews, namely post-positivism, constructivism, advocacy/participatory and pragmatism. The elements of this research study seem to correlate most appropriately with social constructivism due to the fact that the researcher was reliant on the participants' views and subjective meaning which was "constructed" during social interaction between them. Open-ended questions were used to obtain information which allowed for opportunities of self-expression. Creswell (1994:21) explains that a constructivist's approach is useful when describing individuals' experiences and perspectives of a situation.

3.4   POPULATION AND SAMPLING

3.4.1   Population

The term population refers to all elements that meet the sample criteria for inclusion in a study (Burns & Grove, 2009:42). The population of this study refers to students studying at the University of Stellenbosch (US) and the Western Cape College of Nursing (WCCN).

Burns and Grove (2009:42) define the target population as the entire group or set of individuals who meet the sampling criteria. The suitable target population is all the students studying towards a professional qualification in the field of health sciences. Burns and Grove (2011:344) explain that the accessible population is the section of the target population to which the researcher has access. The student group attending the IPE and IPC project in Avian Park in Worcester formed the accessible population. More detail relating to the

population will be presented later in this section. The various elements were the student group who attended Thursday afternoon home visits and assessments at Avian Park in 2013, which consisted of medical, physiotherapy, nursing and speech and hearing students. Two participants of each of the specific groups were identifiedto participate in the research.

The Ukwanda rural clinical campus is situated in Worcester. It was the observation of the researcher that there were no other facilities providing the same interprofessional learning and collaboration opportunities in the Overberg region of the Western Cape.

The nursing students from WCCN, Boland Overberg Campus, were studying within walking distance from Avian Park and were easily accessible for their participation.

The focus was to examine the interprofessional team regarding their perceptions and experiences related to interprofessional collaboration and education at the Ukwanda Rural Clinical School with the nurses in close proximity. The area of Avian Park in Worcester was the most suitable as the services were already being rendered by a group of interprofessional students from the University of Stellenbosch and the nursing students from WCCN who were already involved.

The selection of a rural area was not deliberate. The Ukwanda Rural Clinical School and WCCN happen to be situated very close to Avian Park, which made it a very convenient venue for the study to take place.

The student population differed from week to week as the academic rotation schedule between the professions changed constantly. An approximate total of students present on a Thursday, which was the day of the week when the students worked in a team, were twenty. This total was only an estimate and the researcher observed that no formal records were kept by the coordinator regarding the different group numbers attending. Individual professions seemed to have specific attendance record systems pertaining to their own disciplines.

The population of students was managed by the individual professions' mentors and facilitators. The latter supplied the researcher with a list of student names with telephone and email contact details. The researcher contacted the students telephonically and the first two students from each discipline, who voluntarily agreed to participate in the investigation, were included in the focus group. A total of two participants per professional group where included in the focus group. The group consisted of two of each of the medical students, physiotherapy students, nursing students and speech and hearing students.

An official request by Dr Stefanus Snyman (University of Stellenbosch) had to be made to the PhysiotherapyTherapy Department to request participation from their students. A list of names was provided to Dr Snyman which was then made available to the researcher.

The researcher followed the same procedure as for the other disciplines and contacted the students, inviting them to participate. Two students agreed to participate but did not attend the focus group interviews. The two students were from the Faculty of Medicine. One of the students did not participate in the focus group interview and the other did not participate in the formal group interview. The total number of prospective students approached was 16 of which 14 participated in the study, 7 of the participants in the pre-test investigation and 7 in the formal study. This total sample was representative the student population. A qualitiative approach with focus groups was applied and data collected until data saturation was reached.

3.4.2   Sampling

The sampling method was purposive sampling. Supported by relevant literature, this sampling method was found to be most suited to this specific study.

Creswell (2007:125-129) explains purposive sampling as the selection of individuals and sites for study due to them being able to understand and purposefully respond to the research problem and the focus or central phenomenon related to the study.

Furthermore, purposive sampling involves the choosing of all elements to participate in a study (Burns & Grove, 2009:35).

The aforementioned literature supports the purposeful selection of participants for this study. This sampling approach allowed the selection of "information-rich" participants who provided insight and new meaning pertaining to the purpose of the study, as advised by Burns and Grove (2009:355), as well as by Creswell (2007:125). The researcher purposefully approached the participants who adhered to the inclusion criteria and invited them to attend the focus group interviews. The researcher invited two members of each profession to each of the focus group interviews. The purpose of inviting the specific participants was to include information-rich people who might contribute the most to the information the researcher had set out to collect.

A list of students' names and contact details such as telephone numbers and email addresses was received from each of the clinical mentors who accompanied students from their specific professions. The researcher requested the mentors to provide the names of suitable potential participants, following a discussion with them regarding the requirements,

namely the inclusion and exclusion criteria. Only students who adhered to the inclusion criteria were included on the list received. Students were contacted telephonically and the first two students, who were contactable and voluntarily agreed to participate, were included in the focus group. The researcher was supplied with lists of approximately five names per individual professional group or discipline (refer to discussion of population under section 3.4.1).

Following the initial contact phase, formal informed consent was obtained from each participant prior to conducting the focus group interview. The consent was obtained in a group situation where detailed information regarding the study and ethical matters was discussed and students had the option to leave should they have felt that they did not want to continue participating. No students left the venue and the focus group interview followed after the consent and information session were completed.

The focus was to achieve the aim and the objectives of the research, namely to provide an account of the experiences and perceptions of the interprofessional team regarding interprofessional education and collaboration.

Burns and Grove (2009:721) explain that sampling includes inclusion and exclusion criteria which will be discussed in sections 3.4.3 and 3.4.4.

Please refer to tables 3.1.and 3.2 for the summary of the participants of the pilot interview and participants of the formal study.

Table 3.1: Target Population and Sampling, Purposive Sampling, Pilot Interview Group

Student population	Sampling size
Nursing	n =2
Medical	n =2
Physiotherapy	n=2
Speech and Hearing	n=2
Occupational therapy	n=2
TOTAL	**N=10**

Table 3.2: Target Population and Sampling, Purposive Sampling, Formal Study Group

Student population	Sampling size
Nursing	n =2

Medical	n =2
Physiotherapy	n=2
Speech and Hearing	n=2
Occupational therapy	n=2
TOTAL	**N=10**

According to Brink (2006:124), a sampling frame can assist in the drawing of a sample from a list of sampling elements. In the case of the student population, the sample frame of all participants on a Thursday afternoon who represented the specific professions in attendance at the time was obtained. Students were approached and had the opportunity to voluntarily agree to participate in the study once the background, aims and objectives had been explained. The informed consent was obtained at a later stage, prior to the commencement of the focus group interviews.

During the sampling stage of the pilot interview, two medical students and two occupational therapy students were invited to attend the interview; however, only one medical student accepted the invitation and no occupational therapists were in attendance. The potential accessible population as participants was recruited to participate on a totally voluntary basis. In attendance were n=1 medical student, n=2 nurses, n=2 physiotherapists, and n=2 speech and hearing students.

The total number of focus group interviews included one interview for the pilot interview and two focus group interviews for the formal study.

The formal focus group was divided into two focus group interviews due to the availability of the students who met the inclusion criteria. The first focus group was conducted with n=1 medical student, n=2 nurses and n=2 speech and hearing students in attendance. This focus group interview was conducted at the Ukwanda Rural Clinical School. The second focus group interview was conducted at the Eros School in Bellville. In attendance were n=2 physiotherapists.

Interdisciplinary rotation schedules hampered the researcher's ability to determine an absolute   number of the accessible population at any one time. An estimate population (n=31) over a six week period included the following disciplines: Physiotherapy (n=7), Speech and hearing (n=14) Nursing (n=6) and Medicine (n=4). The student numbers varied from day to day as the various disciplines rotated at different times. The students representing a specific discipline at any given time was not constant. The inclusion and

exclusion criteria were set to ensure optimal clinical experience in the field to ensure that valid data was obtained. The ultimate accessible research sample consisted of all (n=8) of purposefully selected final year undergraduate health and allied health care students. The respondents were purposefully selected due to the wealth of information that they shared regarding the topic. The total number of voluntary participants were (n=7). The focus group interviews were attended by the departments of Physiotherapy (n=2), Speech and Hearing (n=2), Nursing (n=2) and Medicine (n=1). The totals applied to both the pilot interview, as well as the formal study group, however the participants differed. The pilot interview included students who attended the clinical rural placement during 2012 and the formal study participants were selected from the student groups who attended the clinical placement during 2013.

The pilot focus group interview was conducted by the researcher and a field worker who observed noted the non-verbal communication that took place. The formal focus group interviews were conducted by Professor Marina Clark, a highly respected and esteemed researcher in order to prevent bias and to allow bracketing. The researcher acted as the field worker and kept detailed notes on non-verbal cues.

3.4.3   Inclusion criteria

Only students from University of Stellenbosch (US) and WCCN, studying towards a professional qualification in the field of Health Sciences were included. Furthermore, only participants who attended the Thursday afternoon groups that performed home visits as an interprofessional group were included in the study. In addition, each student should have attended a minimum of two afternoon sessions with the opportunity of interprofessional education and collaboration during each.

3.4.4   Exclusion criteria

There were no specific exclusion criteria. Burns and Grove (2011:699) define exclusion criteria as the exceptions to the inclusion criteria. The subjects in the accessible sample adhered to the inclusion criteria.

3.5   DATA COLLECTION TOOL / INSTRUMENTATION

Data collection as described by Burns and Grove (2011:535 refers to the identification of the subjects and the precise, systematic collection of data or information that is applicable to the research purpose, specific objectives or the questions of the study.

Adams, Khan, Raeside and White (2007:321) explain that qualitative data collection methods can also be used during data analysis. He explains that traditionally the uses of

transcripts are used but that pictures or any images may be used to facilitate the process. Flow diagrams and flow diagramme s could be seen as one of such images. Moreover, he explains that the data collection and analysis is a complex art or a "dynamic craft" that requires careful attention and accuracy.

3.5.1   The Pilot interview and data collection tool

Biographical data

Biographical data of each participant was officially collected following the signing of the voluntary informed consent. The name, surname and telephone number, as well as the specific profession to which the person belonged were collected on a separate document which was for perusal by the researcher only and for record purposes.

Following ethical approval, the proposed questions were posed to the group of interprofessional healthcare students who had completed their practical study period during the year 2012. The purpose of the pilot interview was to ensure validity and credibility of the instrument. This allowed changes to be made to the instrument before commencement of the actual study, thus enhancing the credibility and the validity of the study.

The participant group consisted of two members, in their final year of study, of each of the following professions: medicine, physiotherapy and speech and hearing therapy. The two nurses were, however, in their second year of study. During the formal study all participants were in their final year of study (please refer to tables 3.1 and 3.2 for details). Anonymity and confidentiality were assured during the agreement to voluntary consent**.**

The data collection tool consisted of open-ended questions and prompts. The tool was made available to the interviewer who conducted the interview. The participants did not receive a copy of the questions that were going to be asked. The participants were not required to record any information on the tool. The only recorded information was the informed consent and the biographical data supplied. It is the duty of the researcher to protect and hold all this biographical data in safekeeping for the required period of five years.

The data collection tool or interview guide for conducting the pilot interview to test the instrument, contained the following questions:

Question 1

What were your initial expectations regarding interprofessional collaboration within the interprofessional education programme, before you all started working together as an interprofessional group in the clinical field? Tell me about it.

Question 2

Were your expectations regarding interprofessional collaboration during this time that you all worked together in the rural setting met? Tell me about it.

Question 3

What was your personal experience of interprofessional student collaboration within the rural context after completion of the programme? (Elaborate on the question)

Question 4

How did you perceive interprofessional education within the programme in the rural healthcare setting, regarding peer teaching?

Question5

Do you think there are limitations within interprofessional collaboration and what are these limitations? Motivate your answers.

Question 6

How did your exposure to the interprofessional collaboration project influence your perceptions of interprofessional education?

Question 7

What suggestions do you have regarding interprofessional collaboration within the interprofessional education programme?

The following prompts were posed:
- Influence on professional development
- Influence on personal development

The pilot interview took place as a focus group with all disciplines in attendance at the Ukwanda Rural Clinical School administration block. A private room with comfortable seating was secured for the interview. Special care was taken to ensure comfort, professionalism and ethical conduct. All participants were welcomed and introduced to the researcher and the observer. The interview took place at 18:00 hours and refreshments were offered to ensure that the participants were physically comfortable, that they felt refreshed and were not adversely affected by hunger or thirst.

The aspects of voluntary participation were emphasised, as well as privacy, anonymity and confidentiality. Informed consent was obtained after the full explanation of the research background and aims, and included consent for the recording of the interviews. De Vos *et al.*

(2011:115) state that the respondents should be fully informed about the potential impact of the investigation. Although there may not be an obvious or observable impact in this case, informed consent and full disclosure still took place.

The interviewees consented to having the interview recorded, and the observer reported that it did not seem to interfere with their comfort levels as their degree of openness prior to the interview and after the commencement of the interview remained constant. De Vos *et al.* (2011:121) state that devices maynot be used under any circumstances without the knowledge of the participants. Participants were also informed that they could stop at any time and exit from the interview if they did not wish to continue.

A short period of debriefing following the interview took place, where the participants' experiences of the interview were discussed, as suggested by De Vos *et al.* (2011:122). The participants appeared happy and relaxed during their departure from the venue as observed by the researcher and the observer.

Feedback from the observer reflected an initial guardedness by all participants who did not want to say anything to offend any of the other attending professions. However, the participants soon relaxed and adopted a more open body posture. They all maintained good eye contact with the researcher and with the other participants. They seemed to have had an overall sense of "belonging" together as they referred to "we" and "us" with inclusion of more than only their own specific profession. Initially, the medical student seemed very quiet but soon participated and gave valuable input.

Following the pilot interview, the researcher had the opportunity to adjust the interview guide to ensure greater validity and credibility. During the pilot interview, the researcher identified that there seemed to be too much control over the content of the interview. The questions were too direct and hampered free expressions of the participant's experiences and perceptions.

3.5.2   The Formal study and data collection tool

3.5.2.1 Biographical data

Biographical data of each participant was officially collected following the signing of the voluntary informed consent. All participants who participated during the formal study were in their final year of study. The name, surname and telephone number, as well as the specific profession to which the person belonged were collected. This was, however, collected on a separate document which was for perusal by the researcher only and for record purposes. Anonymity and confidentiality were assured during the agreement to voluntary consent.

The researcher developed an unstructured guide with only two questions, of which one asked the participants to explore their perceptions relating to interprofessional education and collaboration and the other to explore their experiences of interprofessional education and collaboration. Burns and Grove (2011:350) explain that an unstructured interview, initiated by broad questions such as, "Describe your experiences of….." allows the participant to talk and the interviewer should then only encourage the participant to continue talking by nodding of the head and other techniques that indicate interest.

The data obtained seems to be very repetitive and it did require the researcher to become more involved with the participants than was initially anticipated. The flow of information seemed stilted. The researcher had to encourage the participants by paraphrasing more, rather than by making use of encouraging techniques such as nodding of the head and making sounds of interest, as advised by Burns and Grove (2011:350).

An interview guide with the following main question directed to the participants was used.

3.5.2.2 Opening question
"You were involved with other health and allied health care students in interprofessional collaboration and education activities in Avian Park.

Tell me how you experienced these interprofessional activities as part of your clinical placement in Avian Park."

The following examples of prompts were used for tracking, clarification and reflective summary:
- Experience as part of the interprofessional team
- Experience of interprofessional collaboration activities
- Experience of interprofessional education activities

The formal study consisted of two formal focus groups. The physiotherapists were unable to attend the first formal focus group due to the completion of their clinical placement in the area. In attendance were the medical, nursing and speech and hearing students.

The data collection took place on two occasions where the same interviewer (not the researcher) conducted the interviews. The researcher acted as an observer and field worker only. The interviewer, Professor Marina Clarke, a highly respected researcher with extensive experience in the art of interviewing, conducted all interviews. The same interviewer conducted all the interviews to ensure consistency in data collection and to enhance validity and trustworthiness and as well as the implementation of bracketing by the researcher.

Validity of the content of the data obtained, even in an interview, will increase the confidence in the study findings, as explained by LoBiondo-Wood and Haber (2010:288). It was the intention of the researcher to ensure absolute truthfulness in the method the data was obtained and therefore the interview was adjusted from a semi-structured format to an unstructured questionnaire in consultation with two other experienced and respected researchers.

3.6   TRUSTWORTHINESS

3.6.1   Validity and reliability

Validity is concerned with the accuracy and truthfulness of the scientific findings (Brink, Van der Walt & Van Rensburg, 2006:118). Brink *et al.* (2006:118) state and argue that in order to establish sufficient validity to facilitate conclusions, the empirical reality should be determined. When validity is established it gives rise to ensuring credibility, transferability, dependability and conformability.

LoBiondo-Wood and Haber (2010:286) define *reliability* as the ability of the instrument to measure the attributes of a concept the same in all cases and *validity* as the extent to which the instruments' measurements are accurate. The researcher attempts to demonstrate how greater trustworthiness was achieved by focusing on the achievement of reliability and validity.

3.6.2   Credibility

The data was confirmed with two other researchers following the initial analysis and "writing up", to ensure accuracy, trustworthiness and reliability. Reflexive thought, as described by Burns and Grove (2011:95), was consciously noted so that decisions of coding would not be influenced by the researcher's personal feelings and judgments.

3.6.3   Transferability

As discussed by de Vos *et al.* (2011:420), transferability in qualitative research may be difficult; however, the fact that a microcosm of the greater heterogeneous population was sampled should facilitate the transferability to similar situations.

3.6.4   Dependability

De Vos *et al.* (2011:420) explain that the researcher appraises whether the research process was documented logical, as well as audited. All data was collected and analysed according to scientific principles to ensure the dependability of the study.

3.6.5   Conformability

According to de Vos *et al.* (2011:421), the results should be evaluated by another researcher to ensure conformability. The researcher provided all transcripts of data analysis, coding and conclusions to an independent researcher to confirm objectivity.

3.6.6   Instrument validity

De Vos *et al.* (2011:420) explain instrument validity as not looking at the validity of the instrument but rather its "validities". The term instrument validity refers broadly to the ability of the instrument to measure what was intended to be measured.

3.6.7   Veracity

Pera and Van Tonder (2011:86) explain veracity as truth-telling with the fostering of trust as the result.

3.6.8   Bias and bracketing

Burns and Grove (2009:686) describe bias as *any influence or action in the study that could affect or distort the outcomes from the true results*, and therefore, specific consideration was given to the prevention of bias. The researcher was well-known to the student group so special precautions were taken to prevent the Hawthorne effect, which may have hampered full disclosure. This was achieved through triangulation.

Burns and Grove (2009:392) explain that validity is one of greatest concerns in qualitative research. However, they explain that there are strategies that can be implemented to examine validity, which could ultimately ensure trustworthiness.

A separate interview was done where only the physiotherapists were present. An added advantage of conducting a separate focus group with the physiotherapists was, as Burns and Grove (2009:392) explain, that it gave the opportunity to rule out spurious relations through triangulation. A spurious relation is the effect of a third variable influencing the data (Burns & Grove, 2009:392).

The researcher gave the opportunity to be interviewed to the physiotherapy students who had been exposed to similar circumstances. The same interviewer conducted the interview with the physiotherapists. This interview was a duplication of the first group interview. The second group interview provided an added advantage as the researcher was able to compare the levels of openness and freedom of expression between the heterogeneous group and the homogeneous group.

The researcher drew a comparison between the themes and the information obtained from the pilot interview, the focus group interview and the individual discipline interview to ensure validity. The researcher wanted to ensure that the participants had not changed their behaviour because they were in a heterogeneous group, and therefore wanted to investigate the possible presence of the Hawthorne effect during the focus group. Burns and Grove (2009:36) explain the Hawthorne effect as the changes in the behaviour of respondents simply because they are in a study.

The researcher observed that the homogeneous group did not display any other behaviour or provide any different information due to the fact that they were interviewed separately. The researcher and the interviewer were highly satisfied with the congruency of the information obtained in all circumstances. Data saturation was reached in both groups. It was found that in both cases the participants communicated freely and even though the first focus group was attended by medical, nursing and speech and hearing students, no difference to the openness of the communication was observed.

Truthfulness was further enhanced due to the fact that the researcher and the interviewer maintained a similar research milieu and setting throughout all the focus group interviews. There seemed to be no added variables that could have influenced the research information differently. The only difference was that the one group was heterogeneous and the other homogeneous.

A further attempt to enhance trustworthiness was the researcher's attempt to apply bracketing or "*epoche*", explained by Creswell (2007:59) as the investigator setting aside his/her own experiences to ensure an objective "fresh" perspective towards the phenomenon or situation. The researcher made a concerted effort to ensure bracketing at all times and remained very conscious of the fact that individual experiences can lead to bias and prejudice. It was the researcher's committed intention to ensure that all data and results were obtained as the absolute truth without any intentional distortion.

3.7   ETHICAL CONSIDERATIONS

3.7.1   Confidentiality and anonymity

The data collection was free from student distress and anxiety as anonymity and confidentiality were key considerations. All participants were assured that all answers would be treated as private and confidential within the research team.

Participants were able to refuse to answer any question that they might have felt uncomfortable with, or did not know the answer thereof.

The participants remained anonymous during the data capturing process and codes were established to protect the subjects' rights to privacy and confidentiality. Names were not revealed in any written document or report resulting from this study. All information gained was only used for the purpose of this study. The researcher was the only one who was able to identify the key participants.

The only person who had access to the identifying codes was the primary researcher. These records will be maintained and locked up for a period of five years in a safe which may only be accessed by the researcher. The researcher adhered to the legal requirements for research data storage and preservation. All voice recordings are to be kept confidential and in a safe place.

3.7.2   Consent and informed consent

Consent to proceed with the study was obtained from the Ethics Committee of Stellenbosch University and the Department for Interprofessional Education at Stellenbosch University.

Participation in the study was voluntary and informed consent was obtained from all participants from the Centre for Health Sciences Education and WCCN. A thorough explanation of the research protocol was provided.

Sufficient information was provided to enable the participants to make informed decisions regarding voluntary participation.

Consent was written in understandable languages, as per the policy of Stellenbosch University, without misleading content that could have been classified as deception.

Clear guidelines were made available in the information document to ensure that all participants responded in a professional manner, maintaining their own dignity and the dignity of others and each other's professions.

3.7.3   Benefits and risks of participation

Participation was voluntary and there were neither direct risks to nor benefits for the participants. During the interview the participants maintained the right to decline further participation.

3.7.4   Recording of interview

Consent was obtained for the recording of the interviews and the same measures regarding privacy, confidentiality, management and storage of confidential information were applied to the recording of interviews and the resulting transcripts. Transcripts were coded and incorporated in the form of a report. Participants' identities were not disclosed or discussed

outside of the research team. Verification of recorded conversations was done with focus groups and any uncertainties were addressed and rectified.

3.8   DATA COLLECTION PROCESS

Data collection, as defined by Burns and Grove (2009:695), is the precise systematic gathering of information which is relevant to the specific study, to reach its objectives or to answer the questions posed in the study.

The discussions were audio recorded and transcribed verbatim by a contracted professional data transcriber.

The same data collection process was followed during the pilot interview and the formal study. The pilot interview took place on 4 March 2013, with the researcher conducting the interview assisted by a field worker who was a fellow master's student from the University of Stellenbosch. The first formal interview took place on 23 May 2013 and the third interview on 11 June 2013.

Initially the participants were given information regarding the time and venue. Aconvenient time suitable for attendance by the participants was arranged. All venues were arranged with comfort and confidentiality in mind.

The venue for the pilot interview and the first formal interview was the administration block of the Ukwanda Rural Clinical School, while the second formal interview was conducted at the Eros School in Bellville.

Privacy, confidentiality and comfort were considered. Upon arrival the participants were made to feel comfortable, as they already knew each other, as well as the researcher. Only the interviewer was introduced to the participant group.

A detailed explanation and information leaflet was provided to all participants. Any misunderstandings were discussed and explored. The participants were informed that the researcher intended to use a voice recorder during the interview and that it would be transcribed by a typist. All participants agreed to the recording of the interview. All participants signed an informed consent document which was formally witnessed by two other participants.

The participants were made aware of all aspects related to the study, such as that there was no specific remuneration for participation and that they were free to leave the interview at any time should they wish to do so.

Each student was given and asked to use a specific code when he/she spoke on the recording. Nurse one; for example, was given the code of N1 and nurse two, N2. Prior to making a comment, the specific participant commenced the statement with N1 or N2. Each discipline followed suit with the medical student using the code M1, the physiotherapists using the codes P1 and P2 and the speech and hearing students using the codes SH1 and SH2.

Following the data collection and the recording of the data, the participants were thanked for their participation and were once again reassured of their anonymity.

During the pilot interview the fellow master's student fulfilled the role of the observer or field worker. The function of the observer included careful observation and recording of non-verbal cues throughout the interview. The observer made extensive notes during the interview and reflected directly after the interview on the overall content and impressions of the interaction. All field notes are in safe keeping together with all other documentation. The researcher will report and discuss the findings extensively during chapter four.

During the formal study, the researcher fulfilled the role of the observer and extensive theoretical notes were kept during both formal study interviews conducted. De Vos *et al.* (2011:410) explain that the researcher should attempt to critically reflect on what took place.

The researcher reflected upon the observation and the notes that were collected during the interview, and ensured that information was given as objectively as possible by clarifying observations with the interviewer as a method of comparison of finding. De Vos *et al.* (2011:408) maintain that spending time as a researcheron organising one's own notes facilitates immersion in the data which contributes to insight and clarity.

The researcher attempted to ensure bracketing by correlating the observation with the interviewer, as well as by asking an experienced and highly respected interviewer to conduct both the interviews of the formal study. This allowed for a greater degree of objectivity and a form of bracketing on behalf of the researcher.

3.9   DATA / CONTENT ANALYSIS

Creswell (2007:147-173) explains data analysis as a process where three general approaches can be used, by saying that qualitative data analysis "falls back on insight, intuition and impression," and furthermore, that data analysis is a process where researchers often learn as they are doing.

Creswell (2007:151) refers to the Data Analysis Spiral which starts at data collection and then moves up towards data managing or organisation. The organised data is then read, notes are written and content reflected upon. Some aspects are put together, compared and placed into categories. Description, classification and interpretation take place. Propositions are put forward and ultimately, a process of visualising and representing takes place. The final step in the process is when an account of the information is given.

Qualitative studies require the researcher to reflect on the interview (Burns & Grove, 2011:74). This process should be done on the same day that an interview is completed. Reflection on the nonverbal cues, the tone of voices of the recorded interview sessions and the notes taken on the same day that an interview was conducted, will assist the researcher in interacting with the data more effectively. The conclusions made during the actual interview are still fresh at this stage; therefore Brink *et al.* (2012:193) aver that data analysis happens concurrently with data collection.

The principle of bracketing was applied to ensure that the researcher's own views on the appraisal system did not distort the findings of the study and that the participants' responses were not biased. Burns and Grove (2011: 96) define bracketing as the process of identifying and laying aside what the researcher knows and feels about the topic under study by simply listening to what the participant is saying at any particular instance.

The data was analysed according to the 5 steps described by Terre Blanche, Durrheim and Painter (2006:322-325).

Step 1: Familiarization and immersion
The researcher reads and rereads the field notes, the transcripts of the interviews and listens to the audio recordings. Summary notes are written, diagrams drawn and brainstorming with the data takes place in an effort to become familiar and immersed in the data.

Step 2: Inducing themes
During step 2 the collected data is sorted into different categories. The researcher first sorts the data by using the language of the interviewees to label the categories and then moves to a higher level of complexity. The themes are then rearranged to include both main themes and sub-themes.

Step 3: Coding
Following the data collection the researcher consulted Professor Clarke and according to protocol the validation of themes and codes was explored. Coding of the data is done at the

same time as the process of developing themes. Burns and Grove (2011:94) define coding as the process of reading the data, breaking down the text into sub-parts and labelling them.

Step 4: Elaboration

The themes induced in step 2 are then explored and the coding system done in step 3 is revisited by the researcher. This exercise is done with the intention of capturing the finer details that could have been missed during step 2 and 3.

Step 5: Interpreting and checking

The final step involves putting together the interpretation of the data (Terre Blanche*et al.,* 2006:326). The findings of the study are placed in a larger context and a search for relationships between the various themes is undertaken.

The researcher applied the listed steps as follows:

- Firstly, the researcher had to become immersed in the data and gain greater insight and understanding. Once the researcher had experienced a sense of familiarity with the data and sufficient insight had been gained through the process of immersion, the data was reduced by generating categories and coding the data, as advised by De Vos *et al.* (2011:410).

- The researcher read and reread the data attentively and then categorised the content into themes. Following the initial categorising, the researcher reviewed all the data and grouped the data into main themes and sub-themes, and allocated all the relevant statements made by participants to the themes. The participant codes such as N1, M1 etc. were included in the analysis and the categorising into themes.

- All categorised data was explored and discussed and relevant literature was referred to, to validate the analysis. An extensive literature review was conducted during the discussion phase and will be presented in chapter four.

- The researcher collected the audio data and took it to a professional typist who transcribed the data verbatim. The researcher read through the data attentively and made notes throughout. Memos were kept of various themes that started to emerge and the themes were ultimately placed into main groups. All the participants' comments related to the aim and objectives were placed in a table format where the responses were coded and discussed. An in-depth literature review was conducted to examine all themes, sub-themes, codes and categories.

3.10   SUMMARY

During chapter three, the methodology and the research design were discussed with the intent of validating the chosen methods. It became clear that the most suitable design for the

purpose of achieving the research aim and goals was a qualitative descriptive design, with purposive sampling to achieve the most information-rich data and to ensure the reliability and validity of the data. The discussion of the research results will be presented in narrative form in chapter four.

3.11   CONCLUSION

A carefully selected study design resulted in obtaining relevant information that would be able to demonstrate the achievement of the research objectives.

The study groups who participated proved to be information rich sources and information saturation was reached. Valuable information was obtained that contributed to the knowledge base that will make a positive contribution to health professional's experiences and perceptions of interprofessional education and collaboration.

CHAPTER 4: DISCUSSION OF RESEARCH FINDINGS AND LITERATURE CONTROL

4.1   INTRODUCTION

Chapter three of the thesis dealt with a detailed discussion of the research methodology. Chapter four introduces the concept identification resulting from the research and will identify the main themes, as well as the sub-themes derived from the data collected. A preliminary literature control was conducted during chapter two. However, the researcher avoided conducting and in-depth literature control prior to the study to avoid creating biases. In this chapter, an in-depth literature control will be conducted to validate the findings derived from the study.

The pilot interview, as a pretest, was followed by the formal or actual study. Both interviews followed the same methodology. However, the questions posed in the formal interview were adjusted, to ensure that the data obtained addressed the objectives of the study. De Vos, Strydom, Fouché and Delport (2011:240) maintain that the researcher should conduct a smaller investigation using the same procedures as for the main investigation to test the measuring instruments and to allow for modification if necessary.

The formal study consisted of two focus group interviews. **Group A (N=5)** consisted of the medical students, the speech and hearing students and the nursing students. **Group B (N=2)** comprised the physiotherapy students who were interviewed separately from group A. The formal study consisted of two interviews because the physiotherapy students were unable to attend the focus group interview in Worcester. They had already moved to their next practical rotation at the Eros School.

Responses were all coded and placed under the appropriate themes and sub-themes. During the formal study the data from the two groups was analyzed separately and the data was depicted as Group A and Group B during the data analysis and reporting process. Participant response numbers and the participant codes were linked during the discussions in this chapter.

The **Group A** analysis represents the formal study with the heterogeneous group and the **Group B** analysis represents the formal study with the physiotherapists only. It was the observation of the researcher that there was no difference in openness between the groups

as the emergent themes of the groups remained the same and the content of the comments all correlated. The presented data included the researcher's impressions and interpretation of observations and field notes.

4.2   PRETEST–PILOT INTERVIEW FINDINGS

Table 4.1: Participants' codes

DISCIPLINE	CODE
Speech and Hearing students	SH
Nursing students	N
Medical students	M
Physiotherapy	P

Table 4.2: Participants' profile: Interview 1

Interprofessional group	participant	Participant codes
Speech and Hearing therapy students	n 2	SH1 and SH2
Nursing students	n2	N1 and N2
Medical students	n1	M1
Physiotherapy students	n 2	P1 and P2

4.2.1   Main theme: Organisation
(Refer to Appendices A & B)
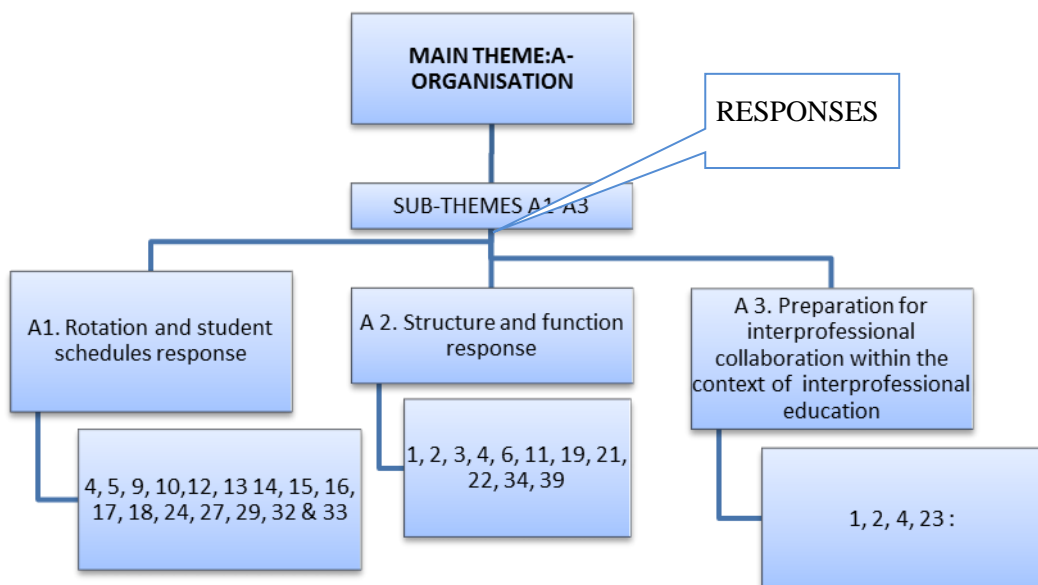
Flow diagramme 4.1: Main theme and sub-themes A1-A3

<u>**Introduction**</u>

The main theme of organisation was subdivided into various sub-themes.

<u>An in-depth discussion of the main theme: Organisation</u>

Huber (2010:796) defines strategic management as the management and organisation based on the vision and the mission strategy.

The vision strategy of the Interprofessional Education and Practice (IPOP) of the University of Stellenbosch includes the following statement: To ensure competent interprofessional health care professionals working together and learning from one another in order to provide health care services to communities.

The vision strategy of IPC and IPE includes the fact that people from an interprofessional group of health care workers should work together and learn from each other in order to render optimal quality patient-centred care.

It is evident that the participants did not initially see the programme as achieving its aim due to organisational aspects that need to be addressed. In addition, Huber (2010:35) defines organisation as "Mobilising the human and material resources of the institution to achieve the organisation objectives."

View flow diagramme 4.1: Main theme and sub-themes A1-A3 and follow the discussion below regarding the responses.

4.2.1.1 The sub-themes A1- A3

4.2.1.1.1 Sub-theme A1: Rotation and student schedules
<u>**Introduction**</u>

Rotation and student schedules were discussed as a sub-theme of the main theme of organisation. The relevance of the sub-theme will become evident during the discussion and the researcher's interpretation of the participant's responses.

> *SH2: "The thing is, because the speech therapists and physios were rotating the entire time and the medical students also rotated from block to block, so that ICF form, every time a new group comes in it needs to be explained again, and I think that is where the problem lies. Everybody is not sure on exactly how to fill in that form. I mean we haven't been trained at all to draw up genograms mean the physio taught us and they did a good*

job. So I think that's just a problem, there's gaps in the consistency of how the clinic is run" (4)

Researcher's interpretation of the sub-theme discussion

The participant displayed concern about the continuity of the service. The training needsto be repeated time after time and it is not clear who is responsible for the training. Important information may be lacking if transfer of information is done from one student to another and that may be a concern for the participant. Refer to the general discussion below regarding the sub-theme A1: Rotation and student schedules.The following response from the participant below is related to the sub-theme.

N2: *"If I may say, I was very excited about and I think it was a well thought-out thing that we did but something that really bothered me is like SH2 said, the students rotate a lot, so sometimes you go to the house of the patients, if we may call them that, and you kind of earn their trust by opening up to them and they're opening up to you and you'd like to follow up or a referral and we need to come back to them… you can't really build that bond with the people… It's something that can be improved, I just think, in the sense of the people really building a bond with you"* **(5)**

Researcher's interpretation of the discussion above

This participant is concerned about the welfare and the trust relationship that should exists between the healthcare worker and the healthcare user within the organisation. The following response from the participant below is related to the sub-theme.

SH1:*"I will. I think creating teams is quite important so that you get a chance to become a team and not just forced into, okay you five can go off and do a home visit… rotation that just causes chaos, it will help us learn from each other more because we're going to trust each other more and form bonds and get to know each other. I don't think it's possible if you're just seeing people once a week on an off chance"* **(32)**

Researcher's interpretation of the discussion above

The participantis concerned about the trust between healthcare workers and learning potential of a cohesive group. Constant change hampers cohesion and the learning opportunities. Refer to the general discussion below regarding   the sub-theme A1: Rotation and student schedules.

General discussion of the sub-theme A1: Rotation and student schedules

Huber (2010:624) maintains that staffing, which is what is in fact implied by rotation of participants or "scheduling of staff", can affect the patient and organisational outcomes.

Staffing can be defined as a human resource plan to fill positions in an organisation (Huber, 2010: 624).

Rotation and student schedules were perceived by all students as an obstacle to interprofessional learning and collaboration. Moreover, they perceived rotation as disruptive to the delivery of effective care. With the constant arrival of a new group at the project, care was disrupted and delays caused interruption of care.

The students, as reflected above, made a very clear argument against rotation and other students were also in agreement which was displayed by nonverbal confirmation such as head nodding.

All students, with the exception of the medical student, experienced the time period as too short for them to truly learn from the experience. The medical student explained that time constraints, the lack of prior education and preparation for the practical experience resulted in time wasting. The perception of the medical student was confirmed by the group through nonverbal gestures.

"Staffing" should therefore be applied to fulfill the needs of the organisation, which can be interpreted as the needs of the community, as well as the University regarding IPC and IPE. However, the challenge is to ensure that rotation, resulting in time wasting, does not prevent goal attainment. Huber (2010: 625) defines the Staffing Management Plan as "A structured approach to the process of identifying and allocating unit-based personnel resources in the most effective and efficient manner."

4.2.1.1.2 Sub-theme A2: The structure and function
Introduction

The structure and function was discussed as a sub-theme related to the main theme organisation. The relevance of this discussion became evident during the observation and interpretation of the participant responses. The following responses from the participants below are related to the sub-theme.

> **N2**:" I would like to say, I thought we were going to interact a lot more with the patients in a sense, with actually treating them and working with them, and as soon as we started it was all about forms we had to fill in like this thick form every time, and I felt that you're not really sitting down and talking to the patient… It felt a bit unpersonal, you can't really connect and I felt like I was intruding in their personal life… I never felt I actually helped them and treated them and see how their circumstances improve or how their illness actually improves"**(11)**

P1:" *I was taken aback after the first because it was not as structured as it is now. It was a bit confusing at the end because you didn't really know what was expected, how it should be done, but it was something that, after the six weeks of us working here and the whole process falling into place, you kind of got a better idea. So at first it was very confusing and then, when we all sat down, all of it was explained, it all gained structure and you had a better understanding"* **(21)**

SH2:"Yes, but I mean six months from now, two years from now it may be very successful, depending on how hard we are willing to work. So I think it's just like little things need to be addressed, it's like designing a car or something, you need to find ... for it to work. But it is valuable, I've learned from the physios and the OTs. I wish we had the nurses, I love nurses (thank you), they know their patients so well" **(52)**

Researcher's interpretation of the discussion

The project was still in its early phase and the lack of structure during that time caused much confusion. However, SH2 saw the potential of the project and the future benefits for the participants and the community. The experiences and perceptions were described as totally negative with N2 stating that she did not feel as if she ever helped anyone. SH 2 saw the potential for growth and development. Refer to the general discussion regarding the sub-theme A 2: The structure and functionbelow.

General discussion of sub-theme A2: The structure and function

The above statements can once again be related to the participants who are working as "staff" in the process of learning and collaborating with each other.

Huber (2010:592) argues that there are strategies that help ensure adequate, competent staff, such as comprehensive orientation programmes for new staff, sufficient staff development programmes, retention of experienced staff and leaders who participate in decision making.

It is evident that a well-structured orientation programme will prevent students from feeling "initially confused".

The fact that the respondent stated that *"Initially ...after six weeks the process falls in place"* is proof of required intervention to ensure optimal IPE and IPC sooner during the clinical experience.

4.2.1.1.3 Sub-theme A3: Preparation prior to IPC and IPE

<u>**Introduction**</u>

Preparation prior to IPC and IPE was discussed as a sub-theme of the main theme of organisation.The relevance of this discussion became evident during the researcher's observation and interpretation of the participant responses. The following responses from the participants below are related to the sub-theme.

> **SH2:** *"Knowing that we are going to work in an interdisciplinary team, what was said, it looks better on paper than it is organised in real-life…So without having been prepared in your own class or your own setting before going into that scene…in the end we learnt a lot in the end, you could see how valuable it is, but just the preparation beforehand was the key part in terms of admin and knowing what to expect"***(2)**

> **P2: "***Ja, I think, well a suggestion, if you get all the disciplines together, everyone you know who will be that day participating in IPLO, get them together…. So get everyone together in a more relaxed environment where you say this is an example of the form and this is what we would expect of you, and to clear up anything that needs understanding before you actually get there and you need to go out"***(23)**

<u>**Researcher's interpretation of the discussion**</u>

The responses from the participants clearly indicated the need for better preparation prior to participating in the Avain Park project. There is an educational need related to the ICF that should have been addressed by the various departmental lecturers prior to the clinical experience. The lack of adequate preparation hampered the learning opportunity. Refer to the general discussion regarding the Preparation prior to IPC and IPE below.

<u>**General discussion of the sub-theme A3: Preparation prior to IPC and IPE**</u>

All of the above statements relate to organisation and ultimately to achieving the desired expected outcome, as proposed within the vision and mission statement.

Collaboration is defined by Huber (2010:284) as "*an assertive, cooperative strategy in which individuals work together to find a mutual satisfying solution."*

From an organizational perspective, Huber (2010:796) explains that specific tactics should be used to implement a strategy and defines tactics as *"operational choices for action that are made to implement a strategy".*

It has become evident that the participants' statements reflected upon regarding the organizational structures in place, should be addressed in order to obtain the ultimate

outcome of IPC and IPE including optimal patient-centered care within the context of the re-engineering of PHC for South Africa.

Participant M1 attends the rural clinical school with a group of her fellow medical students. She is more often in the community and working under direct mentorship of a specialist. She has more contact and continuity in her clinical experience. She has learnt to use the ICF (International Classification of Functioning) in academic practice (refer to statements from SH2, N1 and N2) and is using it on a daily basis in clinical practice. The response of M1 is in adherence to the literature as she has become an experienced member of the team who can be seen as a leader to newcomers by her sharing of information. M1 expressed satisfaction with the format and adapted quickly to the circumstances which took other participants longer to achieve.

Muller, Bezuidenhout and Jooste (2011:3) state that competence and experience depend on conceptual, interpersonal and technical abilities. Respondent M1 was more experienced due to prior training at university level and her conceptual abilities reflect her extended period of use of the ICF.

In conclusion, this positive experience should be used as a measurement against which a standard should be set to facilitate quality IPC, IPE and service delivery.

4.2.2   Main theme: Perceptions and experiences related to interprofessional team structures prior to following interprofessional collaboration and interprofessional education
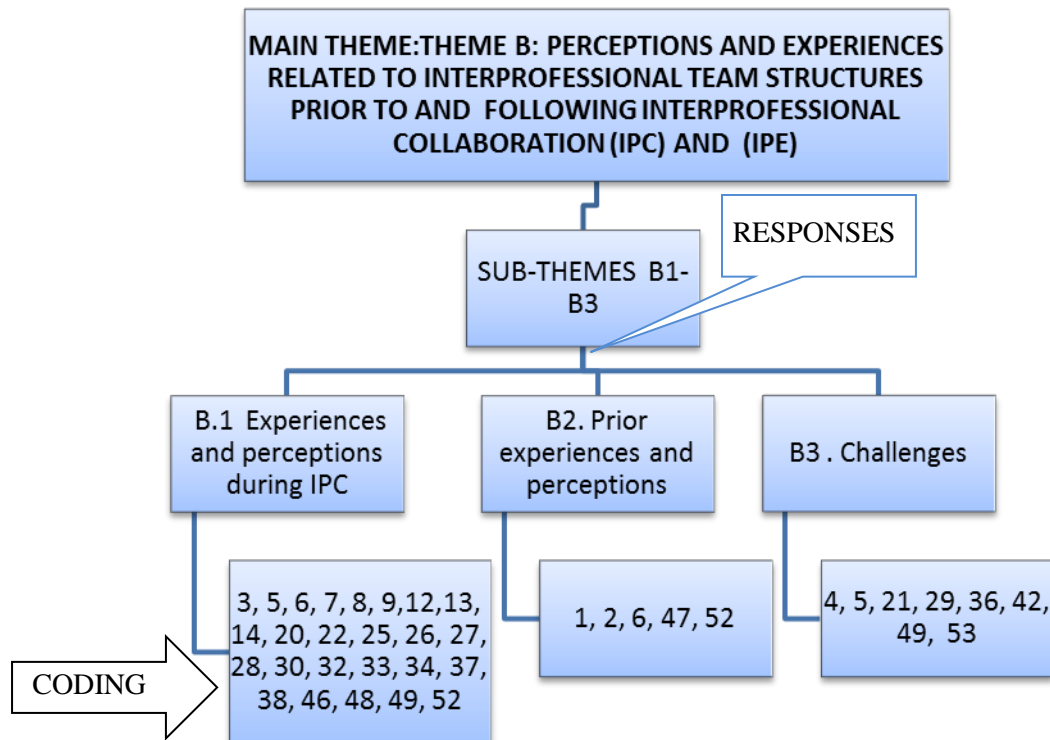
Flow diagramme 4.2: Sub-themes B1-B3

Introduction

The main theme related to perceptions and experiences related to interprofessional team structures, prior to and following interprofessional collaboration and education was discussed by referring to the participant responses, observations and descriptions that were interpreted. View the flow diagramme 4.2 above regardingthe discussions of the main theme B below.

An in-depth discussion of the main theme B: perceptions and experiences related to interprofessional team structures prior to and following interprofessional collaboration and interprofessional education.

Frenk *et al.* (2010:1923) stated that the education of health professionals has become outdated and has disintegrated, with the result that health professionals of today are not prepared for the responsibilities that they face. Furthermore, poor teamwork and stratification of status, with prestige awarded to specific professions, result in competition and conflict.

The problems as listed above resulted in a comprehensive commission of health professionals and academics from diverse countries getting together to develop an interprofessional strategy with a "global outlook" (Frenk *et al.,* 2010:1923).

4.2.2.1 Sub-themes B1 –B3 Experiences and perceptions as it relates to IPC and IPE as stated in the main theme

Introduction

The sub-themes as illustrated in flow diagramme 4.2 were discussed following thorough analysis, description and interpretation of participant responses.

4.2.2.1.1 Sub-theme B1: experiences and perceptions during IPC and IPE

Introduction

The experiences and perceptions during IPC and IPE were discussed as a sub-theme of the main theme.The relevance of this discussion became evident during the observation and interpretation of the participant responses. The following responses from the participants below are related to the sub-theme.

> **SH1: "**…it is a great learning experience and today we talked to the physios and the OTs about neurogenic communications disorders and what to look out for, just small signs that make referrals easier…"**(25)**

> **SH2: "**…I would love to actually go on a home visit with a doctor and a nurse and a physio and an OT and a speech therapist because it would be nice experience to see everybody's role and you can pick each other's brains…"**(27)**

> **P2: "**…they needed us here; we are kind of placed here, so we'll do something for the patients… in Worcester that interdisciplinary thing is so focused on and doing the home visits I think for any medicine student to see like, wow, they are so much needier than just what they specialise in, or the speech therapist says, wow, there's so much more than just speech therapy needed or the physio, so it's the whole community and just the rural setting itself kind of gives the opportunity for you to see that you can't really have a hierarchy here because that patient's needs in every aspect of his life is almost just as big or equal size"**(48)**

Researcher's interpretation of the discussion

The desire to be a team member whose individual contribution has value as a respected member of a team became evident. In addition, the participants recognised the value of each member when the importance of putting everybody's contributions together ensured the implementation of a holistic approach to patient care.

The participant expressed the value of learning from each other and the insight that they gained from seeing the patient's needs and problems from a different perspective. It seems that IPC and IPE exceeded all the participant's expectations and contributed to harmonious relationships. Refer to the general discussion of sub-theme B1 below.

General discussion of sub-theme B1: experiences and perceptions during IPC and IPE
Frenk *et al.* (2010: 1923) state that there is a new century for health professionals where redesigning of professional health education is necessary. This strategy of redesigning professional health education, including interprofessional team collaboration and education is under investigation in this study.

It seems that it is not only IPC and IPE that are under investigation but also the combination of both factors which results in the improvement in health care delivery. The latter is evident when taking into account the World Health Organization's views.

The World Health Organization (WHO) (2010) framework related to interprofessional education (IPE) and collaboration (IPC) practice reports that "when two or more professions learn with, from and about each other, it facilitates not only learning about one another's roles, but it improves health care delivery and quality simultaneously". The aim of the University of Stellenbosch's IPE and IPC project is to create an environment where health professionals work together and learn from oneanother.

The participants of the pilot interview echoed the same sentiments during their focus group interview. Comments such as "it was a positive experience", "we learnt a lot from each other" and "see things from a different perspective" were made. The value of the participation of the team was evident from the positive attitudes towards IPE and IPC. However, it also became evident that the process needs to be developed over time.

One of the factors that were singled out was the "easiness" of collaboration without the assumption of a hierarchical structure. The participants experienced and perceived the collaboration as an experience among equals.

Jooste (2009:73) explains motivation using Herzberg's two factor theory. She reports that "followers", in this case the participants are motivated by pleasurable events and the need to move away from unpleasantness. Furthermore, it is stated that the absence of shame and the fostering of pride are motivators that will result in achievement and satisfaction.

The following comments were made by participants: P2: "*There was no hierarchy- we were all the same; we were kept humble by the challenge"* and "*At University Stellenbosch*

hierarchy is set there because of people's preconceived ideas there, so personally that was kind of a barrier I overcame here." SH2 stated*, "In time six months or 2 years from now it may be very successful."* These statements provide clear evidence of the emotional discomfort resulting from the imposed hierarchy.

The statement made by P2 gives evidence of the challenge entailed in applying interprofessional collaboration in an environment where an unofficial hierarchy exists, as is reportedly the case at the University. P2 was able to overcome this barrier during the project at Avian Park, where IPC and IPE were actively encouraged. It can be observed that the lack of shame and feelings of "inferiority*" as well as the encouragement of equality contributed to her sense of satisfaction when she said "we were all the same."* It is thus evident that nobody was more or less significant or valuable; all present had an important role to play.

4.2.2.1.2 Sub- theme B2: Prior experiences and perceptions of IPE and IPC
<u>Introduction</u>
The experiences and perceptions prior to IPC and IPE were discussed as a sub-theme of the main theme.The descriptions and observations were interpreted from the participant responses. The following responses from the participants below are related to the sub-theme.

> *SH2: "…I thought it would be nice to have access, to finally find out exactly what the physios do, what the OTs do, and how the doctors are involved in a specific patient that we might also see. … I think it's a better idea than it is in practice because we tend to miscommunication with each other as well, but it's nice to be able to go to someone and say, listen, I have this patient, and he needs this and this and this and how can I do it or can you maybe see him to help out? So for me the whole IPLO is a very good idea, it's just the execution that's still a bit rickety"* **(6)**

> *P2: "Personal development, I think maybe before this I was kind of skeptical about how the hierarchy of different professions would influence the approach we have, but I can say I was kind of positively surprised that the hierarchy really, because it was new to everyone and everyone was kind of on the same level in terms of trying to keep themselves humble towards the challenge, so personally that was a good surprise for me because I think in a way maybe at university and how the hierarchy was kind of set there, not because it is there but because people's preconceived ideas of it is there, so personally that was kind of a barrier I overcame. And then I think what I long for was to rather be part of a team where either the nurse or the speech therapist or the OT have*

*their evaluation and I can really see it and not that all of us have the same fixed form we have to fill in"***(47)**

<u>Researcher's interpretation of the discussion</u>

The participants were hesitant as they did not now what to expect. It seems as if there were certain anticipated barriers or limitationsrelated to "set"hierarchy as explained by P2. It seemed that they were pleasantly surprised by the absence of the hierarchy and the degree of IPC and IPE as a result thereof. Refer to the general discussion of the sub-theme B2 below.

<u>General discussion of sub-theme B2: Prior experiences and perceptions of IPE and IPC</u>

Lachman, Ponzer, Johansson, Benson and Karlgren (2013:137) explain that previous studies proved that collaboration with students from various other disciplines is valuable and enjoyable.

Watts, Lindqvist, Pearce, Drachler and Richardson (2007:443-449), in a study evaluating IPE in East Anglia, Norwich, reported "a changed team climate which raised awareness of professional roles within established teams". Furthermore, the report explained that a high quality of teamwork is associated with reduced patient mortality. The study continued for a period of four months before the research was conducted and the total study extended over eight months.

It can be deduced from the extended time period of the research under discussion, that time spent learning played a significant part in the changed team climate. The rotation system could be linked to this statement as the disciplines were in constant attendance, but the healthcare workers within a particular discipline only remained at the project for a limited or interrupted period of time.

Watts *et al.* (2007: 443) report that the National Health System in the UK has placed much emphasis on interprofessional teamwork and that across professions within the healthcare settings, it is now considered essential to deliver "first class" patient care and uncomplicated service.

Regardless of the time constraints, rotation schedules and other listed barriers, the interprofessional health care workers still express the need to learn from and work with one another in a team.

The study reported on by Watts *et al.* (2007:443) reveals that educational facilitators had meetings with the team every two to four months. It was compulsory to attend three of the five meetings that were conducted over a period of eight months. The rest of the time teams managed themselves. Furthermore, it is stated that the results of the study were encouraging and motivating.It is argued that experienced facilitators should assist the participants to set their own goals.

Chapter two of the Constitution of the Republic of South Africa (Act 108 of 1996) addresses the Human Rights Charter. From the Human Rights Charter, the Patient Rights Charter was developed, as well as the Batho Pele principles. The aforementioned writings address the rights of individuals and the people in need of health care. It is a fundamental right of each and every person, ill or not, to be respected and included in decision making about their own lives and to take responsibility for their own health. All of the latter implies that informed consent should be obtained from patients and the patient should fully understand what health care professionals' intentions and interventions are.

4.2.2.1.3 Sub- theme B3: Challenges

Introduction

The sub-theme was discussed as part of the main theme as it related to the perceptions and experiences prior and following IPC and IPE. The challenges described and interpreted illustrated potential barriers that should be addressed to promote IPC and IPE.The following responses from the participants is related to the sub-theme.

P1: "I was taken aback after the first because it was not as structured as it is now. It was a bit confusing at the end because you didn't really know what was expected, how it should be done, but it was something that, after the six weeks of us working here and the whole process falls into place, you kind of got a better idea. So at first it was very confusing and then, when we all sat down, all of it was explained, it all gained structure and you had a better understanding" (21)

M1:"I think that would be ideal, but there are so many families missing out then, or patients missing out, so it's kind of quality versus quantity" (36)

SH2:"It's also because we are all in the medical field and we have all our own terminology and words we just throw around and the poor patient is sitting there and thinking, what are you saying" (42)

M1:"… we need a leader and I think the home-based carer who goes on home visits with us and who is responsible for that family or that patient is a very good person to start

with. From my experience they are very quiet. I would like to hear them speak more or just take leadership ..." **(49)**

Researcher's interpretation of the discussion

The various participants expressed their personal view related to the challenges as a concern for IPC and IPE, as well as for the wellbeing of the patients.

Cognisance should be taken of the challenges to ensure that steps are taken to resolve the barriers to IPC, IPE and theexperiences of the community members. Refer to the general discussion of the sub-theme B3 below.

General discussion of sub-theme B3: Challenges

M1**:** "*The community health worker (CHW) should lead us to what to expect, guide us. They are very quiet at present.*" Participant M1 recognized that not all members participated and that the CHW seemed very quiet. During an earlier conversation the researcher had with the CHW, the feeling in general was that CHW lacked assertiveness to speak to professional people. The CHW is a person skilled in approaching problems from the perspective of identification, referral to PHC, prevention and promotion of health through basic health education, however, it is a new experience for the CHW to work with an interprofessional team. The researcher interpreted the problem as conflicting expectations and differing confidence levels amongst the team members.

According to Miers, Rickaby and Clarke (2009:681) a group of health and social care students working together expressed the following regarding their own collaborative skills:

- The group stated that they were "*still getting to know each other.*"
- "*Very assertive people are able to assert themselves to the point of saying that they do not agree.*"
- "*Some people just sat there and didn't contribute unless they had to.*"
- "*Either they weren't interested or they felt unconfident.*"

A comment made by respondent N1 in the pilot interview is significant and needs to be highlighted. The respondent N1 stated the following: *"Follow up visits to some family becomes a better learning experience when people trust you especially where there were there is more than one visit to the people."* Much can be said about a relationship of trust, which is a prerequisite for an effective therapeutic interaction. Trust is defined in Collins English Dictionary (1979:1557) as: *"the obligation of a person in a responsible position: a position of trust. A person or thing in which confidence and faith is placed."* In summary, the response made by N1 emphasizes the need for health care workers to establish trust and

maintain professional respect and conduct, in order to be able to create a relationship with the patient and the family.

Comments made by respondents M1 and P2 refer to being adequately prepared to interact with each other, document findings and having enough time to be able to communicate with the health care users. The researcher related these comments during the interview to an experience of needing more time to become comfortable with IPC and IPE within the home environment of the patients and their families. Being professionally and emotionally comfortable within the situation is an important factor in establishing a relationship of trust, not only for the patient and family, but for the health care provider as well.

4.2.3   Main theme C: Team cohesion – IPC and IPE at Avian Park
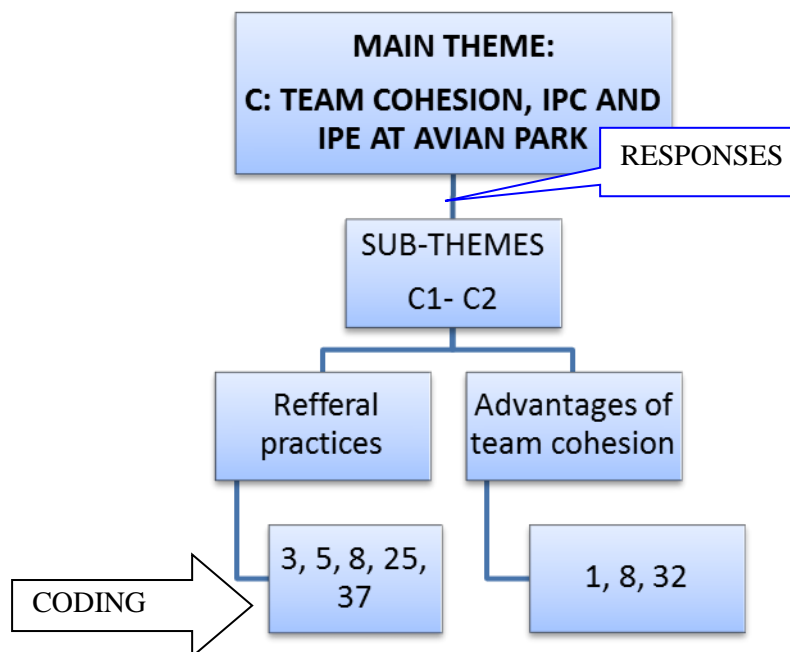
Flow diagramme 4.3:Sub-themes C1-C2

An in-depth discussion of main theme C: Team cohesion, IPC and IPE at Avian Park

The main theme relates to team cohesion and the value of the team. Statements referred to the positive experiences that resulted from being able to function as a team and the sharing of knowledge and responsibility. However, student SH2 stated that although it was nice to see the various roles, not enough happened in terms of sharing at the time, but that a good learning discussion took place after the home visit. Hawes, Nunney and Lindqvist (2013:1) found that a group of nurses, doctors and pharmacists, following a seven week interprofessional learning experience, related more positively towards each other.

Hawes, Nunney and Lindqvist (2013:6) argue that a student needs to develop an identity within their own profession, but should have the opportunity to develop shared identity with

other professionals as well. Furthermore, students who work together can examine their own perceptions for misconceptions to be clarified. Moreover, when the misconceptions are resolved then effective collaboration can take place in the best interest of the patient, thus avoiding time wasting and waste of resources.

View flow diagramme 4.3:Sub-themes C1-C2 for the general discussion of the sub-themes.

4.2.3.1   General discussion of sub-themes C1-C2

4.2.3.1.1 Sub-theme C1: Referral practices

Introduction

The referral practices were discussed as a sub-theme of the main theme which explored team cohension, IPC and IPE at Avian Park.

The following responses from the participants below are related to the sub-theme.

> **SH1:** *"Ja, there is a lot of admin that goes with it but there's a lot of paperwork that needs to be filled out, especially with referrals. I think it's quite time-consuming filling out all those forms but I do think a valuable part of Avian Park is the home visits… We often, speaking for myself, see a problem or a patient in isolation and we don't realise that their home circumstances are what is actually causing the issue in the first place… it allows all the professionals to get together and decide on an actual plan, and you need to be involved instead of just doing the verbal referrals or the paper referrals because then everyone is part of the actual team"(3)*

> **SH1**: *"I think everyone has a lot to learn as well as a lot to give. I don't know a lot in terms of physio or dietetics or medicine and I think that we can learn a lot from each other, but we must also remember that us as speech therapists are not training to be physios and we are not training to be OTs, we are just familiarising ourselves with what these other professions do, so we are able to make appropriate referrals. I think the big issue is referring. That's why we are doing the interprofessional learning, it's to be able to make appropriate referrals for our patients"(8)*

Researcher's interpretation of the discussion

The participants valued the opportunity to learn from each other as it facilated appropriate referral. When people work together and function as an interprofessional team during a home visit the patient will have the benefit of immediate referral and inclusion of various professions at the same time. Additional referrals will take place with greater efficiency as the students would have learnt how and when to refer the patient to the most suitable

member of the team. Refer to the general discussion of sub-theme C1: Referral practices below.

General discussion Sub-theme C1: Referral practices

"…The main purpose is to learn to make appropriate referrals..." Learning from each other will ensure that the team will know who will be the best person to manage specific problems. Collaboration may facilitate trust in own judgment and in the abilities of the team. Wilhelmsson, Svensson, Timpka and Faresjö (2013:156) argue that professionals educated in IPE were more confident regarding professional interaction, perception of their own personal skills and regarding the relationships among the team members.

4.2.3.1.2 Sub-theme C2: Advantages of team cohesion

Introduction

The advantages of team cohesion are a sub-theme of the main theme C: Team cohesion, IPC and IPE at Avian Park. Observation and participant responses contributed to the descriptions that were analysed and interpreted. The following responses from the participants below are related to the sub-theme C2.

> **SH1**: *"I think everyone has a lot to learn as well as a lot to give…"* **(8)**

> **SH1:***"… it's important as health professionals that we trust our other health professionals … I can't do everything… it will help us learn from each other more because we're going to trust each other more and form bonds and get to know each other…"* **(32)**

Researcher's interpretation of the discussion

The participants realised the value of team cohesion as it did not only make their tasks easier but it contributed to trust and personal and professional growth. Refer to the general discussion regarding the Sub-theme: Advantages of team cohesion below.

General discussion of Sub-theme C2: Advantages of team cohesion

Wilhelmsson, Svensson, Timpka and Faresjö (2013:156) report that students, who have been educated with an IPE curriculum, have positive attitudes which extend to their own and other professional groups. In addition, the aforementioned authors report that Swedish medical doctor's who were exposed to IPE, seemed much more confident and had interprofessional skills to cooperate with other professions. Furthermore, the authors confirm that the abovementioned have been constant for the past ten years.

The need for the team interaction and learning from each other filters through in all main and sub-themes. Hawes, Nunney and Lindqvist (2013:1) report that the study conducted by them

confirmed that first year medical, pharmacy and nursing students changed their preconceived ideas and appeared more positive after they had worked together. Therespondents perceived each other's professions as being more caring after they had worked together. Prior to working together, they had perceived their own professions as being more caring.

4.2.4   Main theme D: Advantages of practices within the re-engineering of PHC
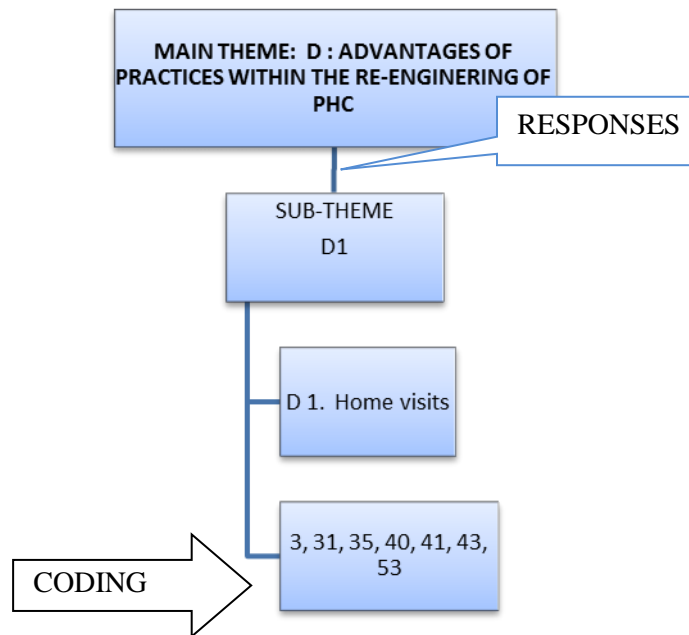
Flow diagramme 4.4: Sub-theme D1

An in-depth discussion of the main theme: Advantages of practices within the re-engineering of PHC

<u>**Introduction**</u>

The discussion document: "Re-engineering Primary Health Care in South Africa (2010:1) explains that services were adapted and "massively scaled up" to cope with the burden of disease facing this country. The diseases include HIV/ Aids and TB which are placing an enormous burden on health care. The Flexner report (1910) as discussed by Frenk *et al.* (2010:1923) reported on studies, relating to the education of health professionals that a change should take place. This report contributed to "groundbreaking reforms".

It is evident from the mentioned literature that a change in health professional's education has been in the process of changing for longer than a decade and the Department of Health delegates recognised this need when they visited Brazil and responded with the plan for the re-engineering of Primary Health Care in South Africa.

In response to the changes that will be taking place in the future, theeducation of health professionals have to adapt and interprofessional education and collaboration will become an essential strategy to address the needs associated with the increasing burden of disease.

View flow diagramme 4.4: Sub-theme D1 for an in-depth discussion of respondents below.

4.2.4.1   Discussion of sub-theme D1

4.2.4.1.1 Sub-theme D1: Home visits

Introduction

The sub-theme of home visits was discussed aspart of the main theme related to the advantages of practices with the re-engineering of PHC. The following responses from the participants below are related to the sub-theme D1 homevisits.

> **P1:**"…*You have to think of what you are saying and how you are treating the patient in that context*" **(41)**

> **SH1: "***I don't think in Avian Park it is all that prevalent. I think everyone that's there, is there for the patient. If we're speaking about IPLO and the hospital, that's a completely different story. If we say it's Avian Park, I think we do consider the patient a patient and not just an illness*" **(45)**

> **N1: "***... You just start to talk to the people, you will ask them other questions, you have time to ask and they build up that trust in you, so then its better when you go back on the big house*" **(31)**

Researcher's interpretation of the discussion

When patients are seen in the homes within the context of their lives, the patients are treated as individuals and do not become depersonalised as is so often the case in an institutional environment. Refer to the general discussion on the sub-theme D1 below.

<u>General discussion Sub-theme D1: Home visits</u>

The statements imply that considerable thought should go into the manner in which people enter the homes of others, which includes the homes of health care users. The underlying aspects of reference are ethical issues pertaining to patient contact. Mellish, Oosthuizen and Paton (2010:183) explain that care and consideration for human worth and dignity should be embraced and that care and concern should be for the total well-being of the health care consumer.

It seems to be that the ethical considerations are a shared sentiment between professions and that cognisance is taken of the needs of the health care user. Moreover, it is seen as important to attend the visit well prepared to avoid unnecessary discussion which could add to the anxiety of the patient.

One can conclude that the re-engineering of primary health care, where health care personnel are providing personal care to the health care users in their own homes should incorporate the ethical principles of conduct. Home visits should be seen as learning situations, not only between professions but also about the people whom they are visiting.

WHO (2010:12), in a *Framework for Action,* stated that the need to strengthen health systems based on PHC principles has become an urgent priority and challenge around the world. Furthermore, the framework explains that governments around the world are seeking effective new ways to *"mix and distribute the workforce".*

The re-engineering of PHC is the South African Department of Health's approach, with the focus on IPC and IPE. This approach to health care users, of a preventative and promotive nature, includes the visiting of the health care users in their homes.

4.2.5   Conclusion of pretest

One can conclude that the re-engineering of primary health care, where health care personnel are providing personal care to the health care users in their own homes should incorporate the ethical principles of conduct. Home visits should be seen as learning situations, not only between professions but also about the people who they are visiting. It is a valuable experience to see and treat the patient within the context of their day to day living conditions whilst having the benefit of the interventions of a team approach to assist in practical problem solving strategies.

Several themes were identified and discussed in relation to relevant literature. In general, positive themes were reflected; however, challenges do exist and need to be addressed.

Chapter four explored and highlighted all of the responses and linked all observations, descriptions and interpretations to an in-depth literature review.

The aim of the pilot interview was to test the interview guide under similar conditions as the formal or actual study and no pitfalls were determined.The formal study data analysis and discussion followed the pilot interview and could be compared with each other.

4.3   DISCUSSION OF FORMAL STUDY: PRESENTATION OF FINDINGS - GROUPS A AND B INTERVIEWS 2 AND 3

4.3.1   Introduction

The formal study consisted of two separate interviews. The interviews are defined as **interview A (group A)** and **interview B (group B)**

The participants in **group A were Afrikaans speaking** and to accommodate the participants the interview was conducted inAfrikaans. The interview was transcribed verbatim. The participants in **group B were English speaking** and the interview was also transcribed verbatim. The findings from both groups will be discussed under all themes and sub-theme sub-themes of the analysis. The researcher will give an interpretation of discussions within the findings.

Group A was a heterogeneous group whilst **group B** was a homogeneous group. The researcher did not observe any changes such as a greater degree of openness or freedom of speech due to the fact that group B was a homogeneous group.

Response numbers were allocated to each response and the responses linked to the themes and sub-themes during the data analysis and the discussions which were done.

The results were presented by firstly listing all the participant responses under the main themes in table form, with a response number allocated to each response. Secondly, each numbered response was allocated to a specific sub-theme.

A literature review of each sub-theme was done and a discussion to summarize the content will be presented. The same approach will be followed for each individual main theme.

The main themes and sub-themes of the formal study correlated with the themes and sub-themes of the pilot interview. However, some additional sub-themes were identified and are included in the discussion of the formal study results. In addition, a comprehensive discussion provides details of the research analysis and research results.

4.3.2 Participants codes and profile of the formal study A and B

Table 4.3: Participants' codes: Formal study A and B

DISCIPLINE	CODE
Speech and Hearing students	SH
Nursing students	N
Medical students	M
Physiotherapy	P

Table 4.4: Participant's profile: Formal study A and B

Interprofessional group	participant	Participant codes
Speech and Hearing therapy students	n 2	SH1 and SH2
Nursing students	n2	N1 and N2
Medical students	n1	M1
Physiotherapy students	n 2	P1 and P2

Table 4.5: Participants' codes for formal study A

DISCIPLINE	CODE
Speech and Hearing students	SH
Nursing students	N
Medical students	M

Table 4.6: Participant's profile for formal study A: Interview 2

Interprofessional group	participant	Participant codes
Speech and Hearing therapy students	n 2	SH1 and SH2
Nursing students	n2	N1 and N2
Medical students	n1	M1

Table 4.7: Participants' codes for formal study group B: Interview 3

DISCIPLINE	CODE
Physiotherapy	P

Table 4.8: Participant's profile for formal study B: Interview 3

Interprofessional group	participant	Participant codes
Physiotherapy	n 2	P1 and P2

Interview B consisted only of the physiotherapy students. The interview took place at the Eros School in Athlone and conducted by Professor Marina Clarke as in interview A.

The same basic conditions applied as for formal interview A.

Table 4.9: Themes and sub-themes of the formal study (Interviews A and B)

MAIN THEME	SUB-THEMES
A. Organisation	A.1 Rotation and student schedules A.2 People, Structure and Function A.3 Preparation prior to IPC / IPE
B. Perceptions and experiences related to interprofessional team structures prior to and following interprofessional collaboration (IPC) and interprofessional education (IPE)	B.1 Experiences and perceptions during IPC B.2 Prior experiences and perceptions B.3 Challenges B.4 CHW as a team member
C. Team cohesion – IPC and IPE at Avian Park	C.1 Referral practices C.2 Advantages of team cohesion C.3 The need for further IPC and IPE
D. Advantages of practices within the re-engineering of PHC	D.1 Home visits D.2 Quality of home visit

(Read table 4 .13 above in conjunction with formal test A and B analysis: Appendix E)

4.3.3   Main theme: Organisation
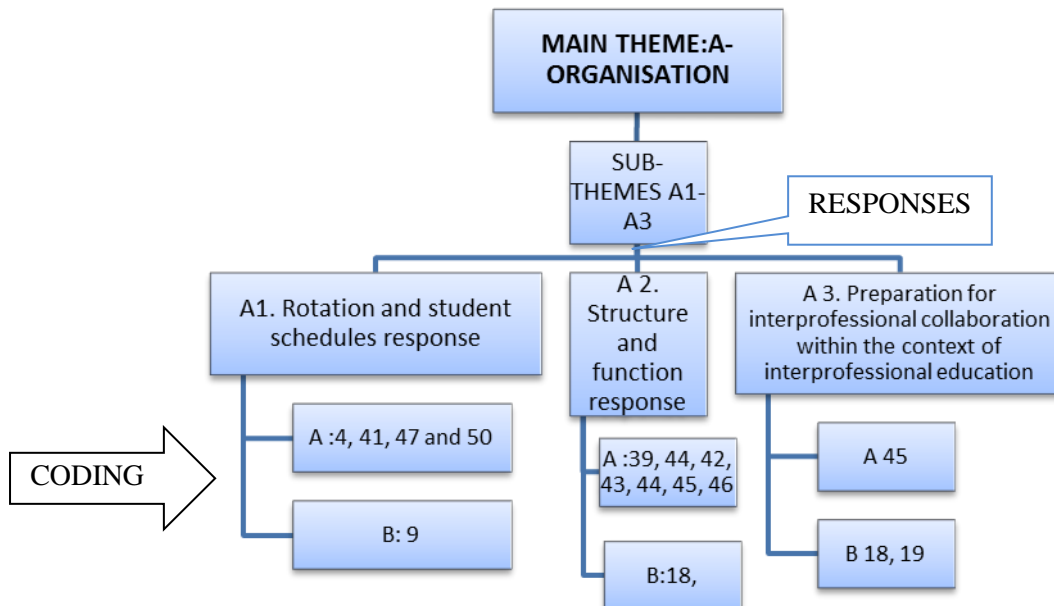
Flow diagramme 4.5: Main themes: Organisation

An in-depth discussion main theme A: Organisation:

Introduction

(Read in conjunction with 4.2.1)

It is evident that the participants did not initially see the programme as achieving its aim due to organisational aspects that need to be addressed. In addition, Huber (2010:35) defines organisation as "mobilising the human and material resources of the institution to achieve the organisation objectives".

4.3.3.1   Discussion of the sub-themes A1 – A3

A discussion of the sub-theme within the main theme will follow below.

4.3.3.1.1 Sub-theme A1: Rotation and student schedules

Introduction

Rotation and student schedules were discussed as a sub-theme of the main theme.The participants in group A were Afrikaansand the participants in group B were English speaking. Both interviews were transcribed verbatim.All observations and descriptions were analysed and the interpretations were done in English.

The following responses are related to the sub-theme above.

> **SH1:**"*Ek weet nie rêrig nie, Medies ..ons het nie so baie met hulle te doen gekry nie. As ons uitgegaan het, het hulle ingekom. Ons was op 'n paar home visits saam met hulle gewees.*" **(A4)**

> **SH1:**"*Omdat die groepe ruil elke tweede week, daar's gedurig nuwe spanne en elke keer dan moet jy ingelig worden along the way verloor ons inligting.*" **(A41)**

> **M1:**"*Ag, mens moet verstaan, die mediese studente doen 'n huisbesoek elke vier weke en intussen het ons baie ander akademiese verpligtinge en so aan. Op die stadium is ons nie heeltemal ge-'gear' nie en ek is baie onseker. Ek weet nie wat van my verwag word om daar te doen nie.*" **(A47)**

> **SH1:**"*Maar tog is dit ook lekker. Party van ons se tyd is baie kort of baie lank maar ons oorvleuel so perfek dat daar altyd mense is wat weet wat om te doen, wat mekaar kan help. So die Fisio's is sê nou maar nou nuut en die Spraakterapeute is nou al daar vir 'n paar weke en hulle neem net so oor by mekaar.*" **(A50)**

<u>Researcher's brief translation of the Afrikaans response</u>

The Afrikaans speaking participant's responses can be translated as: that there was not much time for contact with the medical students. They found the rotation schedules disruptive. They were all feeling lost as they did not know what was expected from them.

> **P2:**"*Or any other health professional. Why did you tell them to do this? It's not like you read it in a letter, the patient is doing this and this or they can't eat this or they mustn't do this. OK, I can see this, but why? That was nice to actually have the opportunity to talk to somebody about it and then you think, maybe I can change this or incorporate this.*"**(B9)**

<u>Researcher's brief interpretation sub-theme A1: Rotation and student schedules</u>

The information correlated perfectly with the findings of the pre-test. The problems related to the lack of organisation during the clinical placement and the confusion created a delay of IPC and IPE. There were no differences noted in the perceptions or experiences between groups A and B. The constant change was found to be disruptive and not in the interest of the participants or of the community. Refer to the general discussion below regarding sub-theme A1 and the responses of the participants.

General discussion of Sub-theme A1: Rotation and student schedules

Rotation and student schedules were perceived by all students as obstacles to interprofessional learning and collaboration. Moreover, they were perceived to create a disruption in the delivery of effective care. With the arrival of a new group at the project care was disrupted and delays caused interruption of care.

The students as reflected above made a very clear argument against rotation. The rotation schedule can be interpreted as a staffing issue. *"Staffing"* should therefore be applied to fulfill the needs of the organisation, the community as well as the needs of the University as it relates to IPC and IPE.

It was a challenge to ensure that rotation, resulting in time wasting, did not prevent goal attainment. Huber (2010: 625) defines the Staffing Management Plan as: *"A structured approach to the process of identifying and allocating unit-based personnel resources in the most effective and efficient manner."*

Huber (2010:624) also argues that staffing, which in fact is implied by rotation of participants or "scheduling of staff", can affect patient and organisational outcomes. Staffing can be defined as a human resource plan to fill positions in an organisation (Huber, 2010: 624).

In this instance, where there are many factors that impact on *"staffing"* for example, allocation and rotation of students has become a very complex situation. Staffing did not only impact on permanent staff but on students who had to follow an academic programme with specific outcomes to achieve. The students were all final year health care students who had to comply with the educational directives and standards to enable them to qualify as health care professionals.

The South African Nursing Council, a statutory body, controls the academic and practical requirements prior to the registration of a nurse as a professional health care provider. In the case of medical students, there is registration with the Medical and Dental Council. Not only is rotation based on the requirements of each individual profession but it is controlled by professional councils as well. The latter complicates the aspect of rotation and scheduling even further. It can be argued that student *"staffing"* causes a problem which is impacting on the students' experiences of interprofessional education and collaboration.

Muller, Bezuidenhout and Jooste (2011:89) argue that a problem-solving approach rather than a decision-making approach should be applied. Solutions should be found and strategies, policies and standards should be developed to overcome the "*undesirable gap*", a term used by the authors to define a problem.

Furthermore, Muller, Bezuidenhout and Jooste (2011:89) state that the "staff", in this case the students, should participate in problem-solving approaches, which will in turn empower them and lead them to take ownership of the situation.

The leaders should manage time resources which draw heavily on effective communication (Marquis & Huston, 2012: 193). It has become evident that the leaders of all departments of attending professionals should communicate amongst each other in order to ensure the most effective use of time and opportunities for IPC and IPE. The rendering of optimal health care should be considered as equally important as IPC and IPE.

4.3.3.1.2 Sub-theme A2: People, structure and function

Introduction

The description and interpretations of this aspect of the investigations correlates with the findings in the pre-test. The same concerns and barriers exist in the formal study as in the pre-test. The descriptions of both groups A and B were analysed and interpreted.

The following responses relate to the sub-theme A2 above.

> **M1:** "*Ek sou baie daarvan hou as die werk net bietjie meer georganiseerd kan wees. Ek voel dit is nie goed genoeg gestruktureerd nie. Ek sou baie gelukkiger wees as ons vooraf bietjie beter riglyne kan kry oor presies wat gedoen moet word in huise en waarvoor ons moet soek, want ek voel ons word net 'n bietjie in die diepkant ingegooi. Ek sou daarvan hou.*"**(A39)**

> **SH1:** "*Van Spraak se kant af sou ek sê, ek wil nou nie vir die community care workers meer werk maak in 'n sin nie, maar as hulle dalk net voordat ons weer gaan, partykeer is die opvolgbesoeke oor twee weke of later, dalk net voor dit weer gaan seker maak, net 'n vinnige inloer en hoor of daar nog 'n probleem is en seker maak wat die adres is.*"**(A44)**

> **SH2:** "*Dit gebeur wel met Spraak dat ons ... Elke dissipline het pasiënte wat hulle moet sien op die tuisbesoeke en 'n mens kom dan nie altyd by almal uit nie.Ek dink dis 'n baie groot administrasieprobleem,…beter liasseerstelsel was, goed gemerk, almal moet hulle goed daarin sit. 'n Community care worker of een persoon elke dag gaan kyk dat almal hulle goed teruggesit het, dat dit onder die persoon se naam alfabeties geliasseer is sodat die volgende mense wat kom, kan sien, o hier's dit, en dat mens nie oor ses maande kom, o, ons het nou hierdie persoon se file gekry, gaan doen hulle gou hierdie Donderdag op 'n tuisbesoek, wanneer daar eintlik ander mense was waarop mens kon fokus wat jy sê nou maartwee weke terug gesien het, wat dan moontlik sou kon voorkom dat die vinger septies raak.*" **(A46)**

<u>Researcher's brief translation of the Afrikaans response</u>

The participants expressed the desire to have received an initial orientation, guidance and support. Participant **SH1** requested that the CHW provide information about the "home" which they will be visiting. **SH2** felt that here was a great administrative defecit with a filing system and suggested that the CHW should maintain the records.

> **P1:** *"Yes. Another thing about Avian Park is that I sometimes felt it was a bit disorganised, like each profession didn't know what they were supposed to do, because we were the first group there. Everyone was a bit lost, we didn't even have the OTs and Speech therapists but it sounds as though it became more organised, but it felt like with us we didn't quite know what was expected of us. …in the beginning of the year it might be nice to have a big lecture or talk or something to say exactly what was expected and how to ask the questions and each person must speak up otherwise they will not get a turn. Just something each time with new students. I don't know how you guys felt, if you were a bit lost. It took a long time to get used to the system and all the information. It would be helpful."***(B18)**

> **P2:***"Yes, it think the organisation part, Because I was in the second group,so by my time we got there the other professions had been there, so they could tell us what's going on. ..I don't think we had that much confusion, but I can understand if everybody is new at the same time there is going to be confusion. We also didn't know but I don't think it was much confusion because there were other and then later on we had to explain to the new groups what's going on."* **(B41)**

Researcher's interpretations: Sub-theme A2: People, structure and function

There was no difference between the perceptions and experiences of the pre-test group and the formal study group. Both the Afrikaans heterogeneous group (group A) and the English homogeneous group (group B) expressed the same concerns. There was no greater degree of openness or freedom of expression observed or described by the members of group B as a result of the fact that it was a homogeneous group. Refer to the general discussion below regarding the sub-theme A2.

General discussion of the sub-theme A2: People, structure and function

An organisation can be defined as follows: *"An organisation is a group of people with specific responsibilities who act together for the achievement of a specific purpose"* (Huber, 2010:388).

Du Toit and Van Staden (2009:157) explain that organisation of human resources includes providing for the basic needs of the employees. In this case the *"employees"* were the student groups. Humans have many different needs which include a sense of belonging and the need for support. It is the responsibility of the health care facility as an institution to provide for the needs of the students. The identified needs were the need for prior knowledge and the need for orientation regarding the total experience in Avian Park.

Huber (2010:388) explains that institutions such as hospitals are created to achieve several goals and that health care delivery is the ultimate goal. Furthermore, the author states that the individual person's personality and disposition or nature must be taken into account seeing that they participate in reaching the goals of the organisation.

Organisation provides direction and it should be accompanied by clear and realistic perceptions, expectations and standards, in other words, systems and structures to facilitate the health of the working environment (Huber, 2010:397).

Muller, Bezuidenhout and Jooste (2011:300) explain that employees who have clear goals usually perform better than those who do not. In addition, employees who receive frequent feedback concerning their performance are far more motivated than those who do not. This leads to a greater sense of achievement, improved self-esteem and self-worth and facilitates positive outcomes.

4.3.3.1.3 Sub-theme A3: Preparation for IPC within the context of IPE
Introduction
The descriptions of this sub-theme were conducted as part of the main theme of organisation. All participant descriptions and observations were analysed and interpreted.

The following responses relate to the sub-theme A3.

> **SH1:"***Ja, om te hoor of dit rêrig 'n probleem is en om te sê nee, dis nie nodig dat 'n mediese student saamkom nie. Daar's baie ander probleme wat hulle beter kan hanteer. Hierso is spesifiek 'n Spraakterapeut en 'n Fisioterapeut nodig, want dit help nie ons gaan na 'n persoon toe wie se been geamputeer is nie. Ek as Spraakterapeut kan niks daar doen nie. Vat eerder 'n Fisio en 'n Arbeidsterapeut saam, maar stuur my eerder na 'n ander huis toe waar ek meer nodig gaan wees."* **(A 45***)*

Researcher's brief translation of the Afrikaans response
The participant expressed the idea that only the appropriate members of a team should visit a home. The needs of the person should be taken into account.

P1: "Yes. Another thing about Avian Park is that I sometimes felt it was a bit disorganised, like each profession didn't know what they were supposed to do, because we were the first group there. Everyone was a bit lost, we didn't even have the OT's and Speech therapists but it sounds as though it became more organised, but it felt like with us we didn't quite know what was expected of us. So I think in the beginning of the year it might be nice to have a big lecture or talk or something to say exactly what was expected and how to ask the questions and each person must speak up otherwise they will not get a turn. Just something each time with new students. I don't know how you guys felt, if you were a bit lost. It took a long time to get used to the system and all the information. It would be helpful."(B18)

P1:"It was, yes. Maybe if each discipline had their own questions to ask or something, because sometimes people didn't say anything. But I think they didn't know what to do."(B19)

Researcher's interpretation: Sub-theme A3: Preparation for IPC within the context of IPE

There was a great need for preparation and organisation within the sytem prior tp IPC and IPE. The disorganisation resulted in time wasting and a delay in performing the required tasks. Orientation and interdepartmental collaboration was required to make the experience more meaningful.

General discussion Sub-theme A3: Preparation for IPC within the context of IPE

Marquis and Huston (2012:142) maintain that proactive planning, which is an interactive process, should be used by organisations to plan for the future.

From the responses listed it is evident that proactive planning should be done to ensure that daily functions can take place effectively within the context of the Avian Park project.

Furthermore, Marquis and Huston (2012:143) explain that "proactive planning is dynamic, and adaptation is considered to be a key requirement since the environment changes so frequently".

Although student rotation schedules and practical allocation periods were planned well ahead by the individual departments, it seems that the individual planning within departments contributed to student adaptation delay and to a decrease in productivity during service delivery.

Proactive planning on an interprofessional level, with clear orientation and student preparation, seems to be a need expressed by the participants. Mentoring by all individual professions seems to be essential to ensure the smooth transition from hospital clinical practice to community-based practice.

Donner and Wheeler (2008:37) explain that "*by helping the group see its strengths, its obstacles and its potential, the coach creates the groundwork for the group to deepen its learning and curiosity, better manage itself and ultimately become a high-functioning interprofessional team*" this clearly relates to the discussion of the respondents above.

Chan and Woods (2012:23) explain that students who participated in IPE activities displayed an increase in knowledge regarding the roles and functions of other health professionals. They had a greater respect for the abilities and unique contributions of other health care professionals.They also understood the importance of IPC to achieve optimal health outcomes.

Researcher's interpretation: Organisation as the main theme and related sub-themes
The Avian Park project serves as a good learning experience which includes IPC and IPE. The students found the experience most beneficial. The lack of adequate organisation resulted in prolonged decreased student productivity. Profession specific educational support and mentoring should have been much more evident. Students relied on each other to teach each other about aspects which should have been addressed prior to the clinical experience such as the use of the ICF and genograms.

Students would have benefited from a detailed orientation programme where all concerns and educational needs could have been addressed.

The various departments within the Faculty of Health Sciences should work together and plan the clinical experience and educational support during the experience to avoid extended periods of decreased learning and productivity in the clinical environment.

4.3.4   Main theme B: Perceptions and experiences related to interprofessional team structures prior to following IPE and IPC
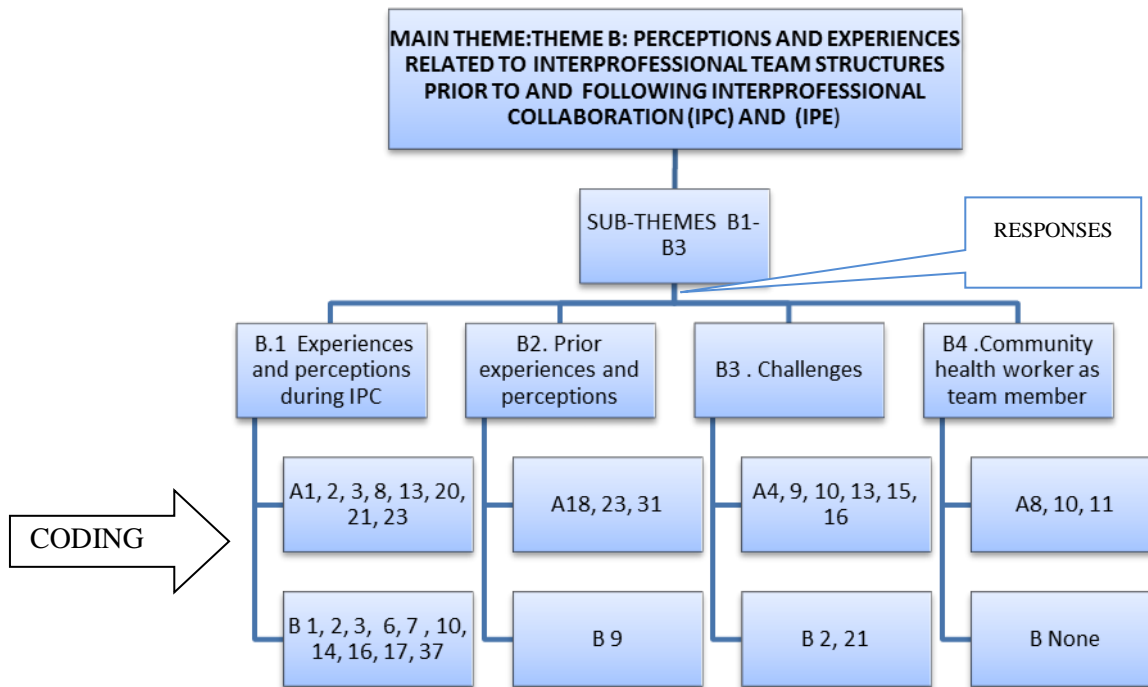
Flow diagramme 4.6: Main theme B: Perceptions and experiences related to interprofessional team following interprofessional collaboration (IPC) and interprofessional education (IPE)

An in-depth discussion of the main theme: Perceptions and experiences related to interprofessional team following interprofessional collaboration (IPC) and interprofessional education (IPE)
(Read in conjunction with 4.2.2)

Introduction

Frenk *et al.* (2010:1923) stated that health professional's education has become outdated and has disintegrated with result that the health professionals of today are not prepared for the responsibilities that they are facing. Furthermore, poor teamwork and status, with prestige awarded to specific professions resulted in competition and conflict.

View flow diagramme 4.6 related to the discussion of the sub-theme within the main theme.

4.3.4.1 Discussion sub-themes B1-B4

4.3.4.1.1 Sub-theme B1: Experiences and perceptions during IPC and IPE

Introduction

Experiences and perceptions were described, analysed and interpreted as a sub-theme of the main theme of Perceptions and experiences related to interprofessional team structures prior to and fllowing IPC and IPE.

A significant amount of data related to IPC and IPE was obtained as IPC and IPE are central to the objectives of the study. Due to the number of responses available, the researcher only emphasized selected responsesrelated to the sub-theme above under 4.3.4.1.1

> *SH1: "Ja, dit was 'n lekker ervaring. Ek dink net ek het by tye 'n bietjie weerloos gevoel in die gemeenskap… dit het gehelp dat die community care workers daar was, hulle het mens baie meer op jou gemak gestel, hulle ken die mense en weet waarnatoe, maar dit was lekker gewees."(A8)*

> *SH2:"…die dokters werk met 'n persoon wanneer hulle akuut is en wat ek opgetel het,spesifiek op die home visit en so aan, is hulle is baiekeer gefrustreerd,want nou kom hulle in hierdie huislike omgewing, soos die meisie wat saam met ons gegaan het, en al wat sy eintlik wou gehad het is dat die man in 'n ambulans kom….Nou word daar van haar verwag om hierdie vorms in te vul en te praat oor hoe dit gaan met die kinders en eintlik al wat sy wil hê, is dat hy reggemaak moet word. Ek dink nie dit kom altyd, as mens in die gemeenskap werk by 'n kliniek soos Avianpark, kom dit nie so goed voor nie. As 'n mens nou nog bloed trek of net na die ore moet kyk, meer meganiese goed …., mens voel dat jy meer kan doen, maar ek dink sy't gevoel daar's 'n baie groot gaping tussen wat in die hospitaal gedoen word en wat by die huis of in die klinieke gedoen kan word.*

Researcher's brief interpretation and translation of the Afrikaans response

The participant **SH2** expressed the view that the medical students felt frustrated as they wanted to apply mechanical aspects and did not feel comfortable or useful if they had to communicate or was required to use "soft skills". There is a great gap in the treatmentof modalities between the hospital and the community.

> *Prof. Clarke (interviewer) "Dan het jy ook vir ons basies gesê dat dit vir jou 'n positiewe ervaring was"*

Researcher's brief translation of the Afrikaans response

Prof. Clarke (interviewer) stated that the participant said that her experiences were positive.

Interviewer Pause

"…en van Verpleging se kant af het jy ook gevoel jy kon 'n bydrae maak".

Researcher's brief translation of the Afrikaans response

Prof. Clarke (interviewer) addressed the nurse commenting on the fact that "nursing" made a contribution.

N1: *respondent made the following statement in response "Die collaboration tussen die verskillende spanne?"……. (A 21a)*

Researcher's brief translation of the Afrikaans response

The nurse agreed that nursing contributed to the collaboration within the teams.

Pause

"*Definitief, ons het by mekaar geleer.Sy het nog nooit gehoor van sekere goed wat ek van gehoor het nie. En jy vra ook: 'Wat is 'n Road to Health chart?' Wat is dit? Wat is dit? Op die ou end is dit meer 'n verduideliking as wat ons eintlik wou doen."**(A21b)*

Researcher's brief translation of the Afrikaans response

The nurse continues by stating that they all learnt from each other. Questions were asked about aspects such as the Road to Health booklet and then an explanantion could be given not onlyabout the booklet but about the role of the nurse as well.

Researcher's brief translation of the Afrikaans response

The discussion between the interviewer and the participants included a validation of statements made and a clarification of information through the use of paraphrasing.

P1:*"Yes, but at the same time the patients would say which medication they were on and then the medical students realised that some of those medications were clashing against each other which could cause further problems…"(B3)*

P2": *I had a really nice time. It's the first time that I actually got to deal with them. It's the first time ever we experienced that, like when you're in the hospital the doctor gives you the order and you go. But here you can actually sit and ask why do you say that? Why do you want to do that? Why did you ask him that? Why did you throw those many patients together?"(B8)*

> **P1:** *"Same thing with the man who was trying to sit and say pen, the Speech therapist realised that better posture will make him speak better, so they have to sit him up."* **(B37)**

Researcher's interpretation: Sub-theme B1: Experiences and perceptions during IPC and IPE

The medical model is not a suitable model for implementation in the community care environment. The medical students felt at a loss and did not realy know what was expected when they entered a patient's home. If there was a specific disease or injury they could address then they were able to act. It seemed as if the concept of prevention of illness and the promotion of health in primary health care setting results in great anxiety for the medical students as it seemed as if they became incapacitated by the "foreign" expectations.

The participants found IPC and IPE a very enlightening experience that added value to their professional development. It was the observation of the researcher that collaboration took place and "partnerships" were created between the participants of the various professional groups. The participants were able to work together, learn from each other and solve problems together. The latter took place in the interest of both parties; the participants needed to learn and develop and at the same time address the needs of the community by providing quality holistic care. Refer to the general discussion on sub-theme B1 below.

General discussionsub-theme B1: Experiences and perceptions during IPC and IPE

Van Rooyen and Jordaan (2009:7) explain that many health professionals adhere to the medical model, which is also known as the biomedical model. This model is focused on illness and a curative approach whereas the social model considers the society in which we live. Furthermore, the aforementioned authors elaborate by explaining that improved health results from better housing, public health care delivery and adequate sanitation.

The patient-centered model, as described by Carl Rogers (1951) and explained by van Rooyen and Jordaan (2009:8), indicates a widely used or *"dominant"* model in modern health care. The main focus of this model is by placing the patient's own perception of their physical and psychological health as the departure point for the negotiation for provision of health care.

It is evident when one compares the literature and the responses between the interprofessional teams, that there are several health care models being taught. **SH1**made a comment related to the medical students' discomfort when required to make use of other skills than only *"mechanical"* skills. (This comment was translated by the researcher in the

aforementioned analysis).The statement was a reference to the medical model whereas the other disciplines include models such as the patient centered model and other models.

The statement by M1 below emphasises the experiences and the perceptions of SH1 as discussed above.

M1, a medical student, clearly indicates the need to discover and treat a physical problem, and should this not exist then the role or *"usefulness"*of the medical professional is perceived to be in question.

The medical model, which is a deductive model, does not facilitate the exploration of the holistic dimensions of human life but rather the identification of a health problem accompanied by the appropriate curative action (Van Rooyen & Jordaan, 2009:7).

The researcher as a nursing educator experienced that the nursing profession reflects a patient-centred, holistic approach to care, which includes the biological, psychological, social and spiritual dimensions of the individual and extends even further to the needs of the family, the community and the society at large.

Pera and Van Tonder (2011:117) explain during their discussion regarding relationships between nurses and the families of patients, that anyone who is significant to the patient is seen as family and that by expanding the concept of family, the patient's total well-being will be addressed and improved.

Although all professionals have a different approach and focus, IPC and IPE still took place. A more holistic, patient-centered approach to health care in the future may make the interprofessional learning experience more meaningful to all professions.

4.3.4.1.2 Sub-theme B2: Prior experiences and perceptions
<u>Introduction</u>
Prior experiences and perceptions were discussed as a sub-theme of the main theme related to perceptions and experiences to interprofessional team structures prior to and following IPC and IPE. Refer to participant responses below.

> **N2:**"*As ek vanVerpleegkunde af kyk, was ek baie skepties gewees aan die begin…Toe het die mediese student vir my gesê, 'Moet jy so baie praat?' en vrae vra, maar ek het geleer, as ek nou kyk van Verpleeg se kant af, jy moet belangstelling toon in die persoon sodat hulle gemaklik met jou kan raak en begin praat…Toe sê die mediese student hy het niks ommeer te doen nie, so hy gaan maar vir ons dophou. En toe het ons nou vir hom betrek en vir hom verduidelik dis waarna ons kyk… en hy het toe vir ons mooi*

verduidelik hoe hy die prentjie sien, en toe ons nou almal bymekaar sit, was dit heel interessant, toe ons bymekaar sit dat ons nie saam met ander mense wil werk nie… Ek het geleer, as jy nou kyk van jou persoonlike agtergrond af na ander mense toe, dan besef jy die lewe is nie regtig so maklik hierbuite nie, en as ek nou na 'n pasiënt in die hospitaal kyk, kyk ek net, kom die pasiënt nie van Avianpark af met so 'n agtergrond nie? Wat is die omstandighede by die huis waaruit die pasiënt kom? As ek vir 'n pasiënt sê, meneer, onthou nou, jy moet was – is daar water waarin die pasiënt kan was? Hoe beweeg die pasiënt, so dinge het vir my meer prakties geraak met daardie agtergrond, nie net gedink almal moet was nie."(A31)

Researcher`s brief translation and interpretation of the Afrikaans response

The participant N2 was asked by the medical student if it was necessary for her to speak so much to the patient. N2 informed the medical student that this is what is taught in nursing. You need to be able to communicate. The medical student then decided that he will observe only. N2 decided to involve him and then information was shared about the different approaches. IPC and IPE took place and a close bond was created which caused some emotional distress when the educational experience in Avian Park came to an end.

P2:"Or any other health professional. Why did you tell them to do this? It's not like you read it in a letter, the patient is doing this and this or they can't eat this or they mustn't do this. OK, I can see this, but why? That was nice to actually have the opportunity to talk to somebody about it and then you think, maybe I can change this or incorporate this."(B9)

Researcher's interpretation: Sub-theme B2: Prior experiences and perceptions

There were no differences between the pre-test group and perceptions and experiences of groups A and B.

All participants expressed some apprehension and difficulties which was overcome during the team experience. The support, inclusion and mutual respect opened up a "new world" to several of the participants. The researcher was able to identify this "enlightenment" as she observed the facial expressions and gestures of joy and excitement during the interviews.

Refer to the general discussion that relates to the sub-theme of B2: Prior experiences and perceptions.

General discussion Sub-theme B2: Prior experiences and perceptions

Collaboration within this context resulted in valuable information being shared between disciplines, namely the nurses and the medical students.

Throughout the ages, the relationship between doctors and nurses has been hampered by misconceptions and preconceived ideas.The relationship can only benefit from positive interaction which will ultimately be to the benefit of health care delivery.

When people can learn from each other and work together, preconceived ideas are changed and a new set of ideas can develop that could be beneficial to learning and working together in the future. It was evident from the comment made by N2 above that the nurses had found the experience very useful and satisfying when they had been able to purposefully include the medical student and when this student had seemed to participate as one of the team.

The researcher would like to refer to the translated and interpreted statement of N2 in this instance to validate the above statement.

4.3.4.1.3 Sub-theme B3: Challenges to IPE and IPC
Introduction
The challenges of IPE and IPC were discussed as a sub-theme to the main theme perceptions and experiences related to interpersonal team structures prior to and following IPC and IPE.

The following responses of he participants within the main study relate to the sub-theme.

> **SH1:**"*Ek weet nie rêrig nie, Medies – ons het nie so baie met hulle te doen gekry nie. As ons uitgegaan het, het hulle ingekom. Ons was op 'n paar home visits saam met hulle gewees.*"**(A4**)

Researcher's brief translation of the Afrikaans response
The participant stated that not much was known about medicine and that they did not have that much to do with the medical doctors. They went on a few home visits together.

Pause
> **SH1** "*Ja, al was ons in 'n groep, was dit nog steeds so. Ek bedoel jy ry nie daarnatoe nie, so jy is afhanklik van die gemeenskap se goedgesindheid.*"**(A9**)

Researcher's brief translation of the Afrikaans response
SH1 stated that they relied on the goodwill of the community even if they worked together in a group.

> **SH2:** "*As 'n meisie voel 'n mens maar outomaties bietjie meer weerloos as jy op jou eie stap, selfs al stap jy dan saam met ander meisies. Maar ek moet saamstem, ek dink nie mens besef in hierdie interdissiplinêre span, ons fokus so op die Fisioterapeut, OT,*

Arbeidsterapeut, dat ons nie agterkom hoe baie ons die community care worker nodig het totdat ons fisies met hulle werk nie. Voordat ek op Worcester gekom het, het ek nie verstaan van mense soos community care workers nie. Ek was nog glad nie op 'n home visit nie, ek was maar in die hospitaal op my vorige blok. So dit was vir my interessant, want mens het die mense nodig wat die omgewing ken, wat so half die mense ken. Mens voel maar dis 'n onbekende omgewing, mans het mos maar die tendency as hulle daar rondsit en meisies stap verby om goeters te sê, so dit bring vir mens 'n gevoel van veiligheid. So dit was 'n interessante ding gewees wat ek geleer het."(A10)

<u>Researcher's brief translation of the Afrikaans response</u>

SH2: "Wat ek aan gedink het toe ons gepraat het oor die mediese spanlede, is dit was vir my persoonlik –die dokters werk met 'n persoon wanneer hulle akuut is en wat ek opgetel het, spesifiek op die home visit en so aan, is hulle is baiekeer gefrustreerd…maar ek dink sy't gevoel daar's 'n baie groot gaping tussen wat in die hospitaal gedoen word en wat by die huis of in die klinieke gedoen kan word"(A13)

<u>Researcher's brief translation of the Afrikaans response</u>

SH2 stated that medical students work with a person when they are acutely ill and that being in a situation where this is not the case is frustrating for them. There is a major gap between what they do in the hospital and what is required in the community.

SH2: "Ek weet nie of ek so diep daaroor gedink het of dit iets vir my beteken het nie. Ek dink dit het wel vir my ook geleer van daardie tipe frustrasie, want ek mag dalk eendag ook 'n pasiënt teëkom wat ek baie graag net by 'n hospitaal wil uitkry, maar ek kan nie, want ek kan nie sy elektriese rolstoel vervoer nie, en ek weet hy het eintik hierdie tipe masjien of hierdie tipe ding nodig en ek kan dit nie by hom uitkry nie. So ek het bietjie van daardie frustrasie geleer."(A16)

<u>Researcher's brief translation of the Afrikaans response</u>

SH2 explained that there may be a different type of frustration in the community that getting a patient from the community in the hospital may be another type of challenge or frustration.

Researcher's interpretation: Sub-theme B3: Challenges to IPE and IPC

Several challenges were identified such as the safety and security of the female participants who felt particularly vulnerable walking in the streets in an area where gang violence and crime is very high.

The other challenge is the various models to which the various disciplines are exposed to. There should be a uniform model taught to all health personnel that addresses the bio

psycho social and spiritual needs of an individual as the situation in the community requires a different approach.

General discussion Sub-theme B3: Challenges to IPE and IPC

Chambers-MacMillan (1996:347) explains fear and fearful as being afraid of something or of doing something, whereas fearsome is explained as when something is described as horrible or frightening.

The aforementioned emotions such as *frustration fear and feeling vulnerable in the community as* experienced by the participants are not unrealistic. The participants were subjected to the general concerns that face all South Africans today.

Heineken, Vorster and Du Plessis (2011:29) explain in the conclusion of their study of the socio-economic and social capital assessment of Avian Park residents in Worcester, that many living in the community feel unsafe and insecure. Moreover, the residents are reported to feel powerless against the vigilantism of the gangs.

Furthermore, the authors explain that drugs and gangsterism are major problems within the community and that there is little faith in the law enforcement authorities being able to address the problems.

Not only was it the fear experienced for their own safety which was a challenge, but also the lack of infrastructure in the informal settlements (see the discussions above). It was a challenge to provide good health education when the facilities were not there to support the intervention for basic needs to be met.

The lack of housing and infrastructures such as clean running water, toilet facilities and environmental health was a real challenge while attempting to improve the health status of the people in Avian Park.

The safety of all people is a concern. It is the experience of the researcher that young females may feel especially vulnerable in areas where there is a perceived or real threat. Rape and murder is reported upon on a daily basis in South Africa and affects even the very young and the elderly.

4.3.4.1.4 Sub-theme B4: Community health worker as team member

Introduction

The sub-theme B4: Community health worker as a team member relates to the main theme which reflects the perceptions and experiences of the interprofessional team prior to and following IPC and IPE**.** The following responses relate to the sub-theme.

> **SH1:"***Ja, dit was 'n lekker ervaring. Ek dink net ek het by tye 'n bietjie weerloos gevoel in die gemeenskap…dit het gehelp dat die community care workers daar was, hulle het mens baie meer op jou gemak gestel…(A8)*

Researcher's brief translation of the Afrikaans response

SH1 stated that it was a nice experience but the she fels vulnerable at times and the community health worker contributed to her feeling more comfortable.

> **SH2:** *"…Ek was nog glad nie op 'n home visit nie, ek was maar in die hospitaal op my vorige blok. … Mens voel maar dis 'n onbekende omgewing…so dit bring vir mens 'n gevoel van veiligheid. So dit was 'n interessante ding gewees wat ek geleer het"(A10)*

Researcher's brief translation of the Afrikaans response

SH2 stated that home visits were a new experience for her and that the CHW contributed to her sense of safety. She found it to be an interesting learning experience

> **SH2:"***Hulle is ook die persone wat so half die span bymekaar hou in 'n sin, want hulle is konstant. Hulle is daar. Ons ander mense, die span self, verander die heeltyd, maar sy is heeltyd konstant daar, so sy weet wat aangaan, sy help almal"(A11)*

Researcher's brief translation of the Afrikaans response

SH 2 stated that the CHW keeps the team together and that they are a constant factor in the team.They know what is going on and they help the participants.

Researcher's interpretation of Sub-theme B4: Community health worker as team member

The CHW is an extremely important person in the team. During the introduction of the Neuman's system model the researcher used various aspects of the model as a guide but the researcher also added several concepts not evident in the Betty Neuman's model. One of these concepts was the presence and value of the CHW. It is the researcher's interpretation that the respondents are requesting" *dit het gehelp dat die community care workers daar was, hulle het mens baie meer op jou gemak gestel"* as illustrated in the

framework in chapter 1 flowdiagramme 1.1., that the CHW should be a team leader within IPC and IPE. SH2 stated that the CHW is the constant factor (person) in the team who knows what is going on.

(Refer to the conceptual framework in chapter five)

Refer to the general discussion below.

General discussion Sub-theme B4: Community health worker as team member

Baron (2011:np) states in a discussion document related to the re-engineering of Primary Health Care, that there should be 41440 community health workers in primary health care services when the aforementioned strategy is implemented. In addition, he states that the community health worker should be the first contact for the community for health care delivery and that the community health worker should be the "key" to have access to the community by the health professionals.

The community health care worker's role as a team member is imperative. The statements made by the participants were clearly evident of the important role the community health care worker plays.

Researcher's interpretation of: Perception and experiences related to interprofessional team structures prior to and following IPE and IPC

The participant'sexperiences of IPC and IPE were very positive. Participants were all very positive about the value of IPC and IPE in terms of personal and academic growth and development.

Some ambivalence and uncertaintly existed prior to the team work but experiences and perceptions soon changed following the experience of support and safety within a team.

Although there may be challenges, the advantages far outweighted the obstacles. No participant of both the pre-test, as well as the formal study groups A and B remained positive and never did any of the participants even suggest that it was anything but an enriching experience.

It contributed to respect for all and the value of the CHW regardless of their "lesser" academic status were highly respected for the role they play and the value they add. The hierarchical judgements seemed to have lost its power in the "real" world.

4.3.5   Main theme C: Team cohesion – IPC and IPE at Avian Park
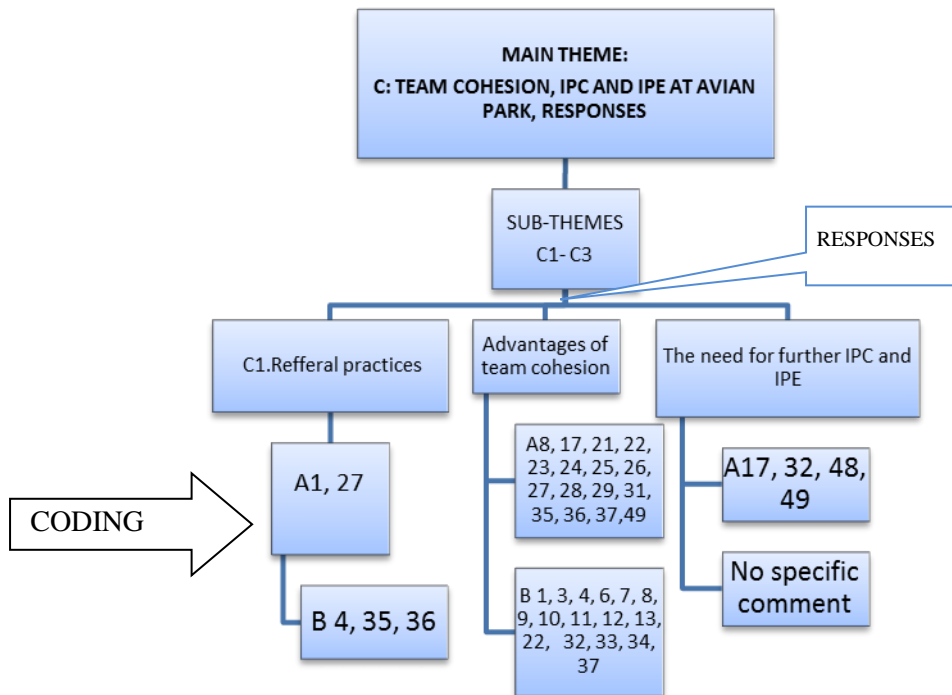
Flow diagramme 4.7: Team cohesion – IPC and IPE at Avian Park

An in-depth discussion of the main theme: Team cohesion – IPC and IPE at Avian Park

Introduction

Hawes, Nunney and Lindqvist (2013:6) argue that a student needs to develop an identity within their own profession, but should have the opportunity to develop shared identity with other professionals as well. Furthermore, students who work together can examine their own perceptions, and misconceptions can be clarified. Moreover, when the misconceptions are resolved then effective collaboration can take place in the best interest of the patient, thus avoiding time wasting and waste of resources. View the flow diagramme 4.7 for the sub-themes.

(Read in conjuction with 4.2.3)

The following sub-theme was identified within the main theme.

4.3.5.1 Discussion of sub-themes Team cohension - IPC and IPE at Avian Park: C1 – C3

4.3.5.1.1 Sub-theme C1: Referral practices

<u>Introduction</u>

Referral practices were as discussed a sub-theme of team cohesion – IPC and IPE. All observations and descriptions were analysed and interpreted. The following responses relate to the sub-theme.

> **SH1:** *"Dit was lekker gewees.Eerstens omdat jy, sê nou maar jy werk saam met 'n Fisio en jy weet nie eintlik wat hulle doen nie, so dan is dit nogals lekker om te sien wat hulle doen, om te weet as jy eendag moet verwys, om te weet waarnatoe om te verwys, so om te sien wat hulle doen, dit was nogals lekker gewees."(A1)*

<u>Researcher's brief translation of the Afrikaans response</u>

SH1 stated that she learnt a lot when she worked with the physiotherapists and that it contributed to her knowledge and ability to refer the patients appropriately.

> **M1:**"*…die meeste van sosiale werkers … ID-dokumente het nie en dan reël die sosiale werker dat die mense ID-dokumente kry… is ouer mense wat met 'n klomp klein kinders saamlewe wat dwelms gebruik, dan help die sosiale werker om daardie ouer kinders uit die huis uit te kry."* **(A27)**

<u>Researcher's brief translation of the Afrikaans response</u>

M1 stated that learning from the social workers were very valuable.They help in obtaining ID documents with parents and children where there is drug abuse.

> **P2:** *"Yes. I think in class they always tell us about the multidisciplinary team and you know of it but you never realise what it entitles, because we went with the medical students, the dieticians, the speech therapists. In my case we were all together, and the social workers as well, and it was so nice and you hear your patient has this wrong and that wrong, and you think: How am I going to solve this? And you realise, it's actually not my problem. It is my problem but I don't have to solve it. And then it was so nice to know you can actually get the best for your patientby referring him to somebody else who knows what's going on."(B4)*

> **P1:**"*I just like the personal part, like we went and spoke to the Speech therapist about the patient instead of writing a referral letter. We spoke to them and then we got feedback afterwards from them and said how did it go and then they told us about it. And there's the OT who said there's this patient who needed help and there's much more talking about it, whereas at Tygerberg Hospital you write a letter and then you never hear*

about the patient again.So that is nice, you got the feedback about the patient as well."(B35)

P2:"We also sometimes had the opportunity, if this was my patient but he needed speech therapy, I could attend the speech therapy session and then they would talk and you would think 'I never asked him that' or 'maybe I should also try that' and you discover something new from the patient that was quite helpful. Maybe I should teach him to sit more uprightor do this better or help him with that. It is nice to see that and afterwards you could discuss, why did you do that? If I do this for him, do you think it would help you?"(B36)

Researcher's interpretation sub-theme C1: Referral practices

There were no differences between themes and sub-themes of the pre-test and group A and B. All the participant responses reflected the same general perceptions and experiences.

The same aspects of "on the spot" referral were evident in the pre-test and in the formal formal study groups. It was theresearcher's impressions that participants who do formal referrals will be able to do it with greater insight.

Refer to the general discussion below.

General discussion of sub-theme C1: Referral practices

From the comments made it can be deduced that team cohesion took place and that the selected comments depict a very positive outlook on potential referral practices.

The referrals were not necessarily formal referrals but they included informal discussions of problems and obtaining of information. There is a clear indication that interprofessional education and collaboration took place.

Interactive learning and collaboration took place and for the duration of the teamwork a "partnership" took place amongst the members where the participants felt free to network and learn from each other. Refer to response by M1 in this section as translated by the researcher.

Respondentslearnt about the roles and scope of practice of the other professions and would in the future be able to make a meaningful referral in the interest of the patient and of health care in general.

Ruiz, Ezer and Purden (2013:1) explain, in the introduction to the article, that interprofessional education (IPE) is increasingly recognized as a method to ensure that health care students have the skills and knowledge to participate in collaborative practice.

4.3.5.1.2 Sub-theme C2: Advantages of team cohesion

Introduction

The participant's responses related to team cohesion were observed, described, analysed and interpreted as part of the main theme: Team cohesion, IPC and IPE at Avian Park.

The following responses relate to the sub-theme C2 above:

> **SH2:**"*…'n punt wat baie Medies en Verpleging aangeraak het... van in die groep sit en daarna daaroor praat, en dan was dit interessant,bv sy het agtergekom die babas het nie Road to Health charts nie… Spraakterapeut sou waarskynlik nou gekyk het hoe praat die ouma wat 'n beroerte gehad het, terwyl die Fisioterapeut sou gekyk het hoe mobiel is die ouma… verskillende goed waarna verskillende mense kyk, dit gee vir mens 'n baie beter beeld van wat aangaan en wat dan daardie persoon se beperkinge is, maar ook die goed wat daardie persoon dan help…So dit is baie interessant, elke ding waarna elke persoon kyk, en dan sit jy partykeer en dan dink jy, ek sou nou glad nie daaraan gedink het nie.*" **(A28)**

Researcher's brief translation and interpretation of the Afrikaans response

SH2 explains how various disciplines will look at the the same situation differently. The focus will be profession specific, e.g. speech therapists will look at how speech is affect by a CVA, whereas a physiotherapist will focus on mobility. It is a revelation to this participant as she has never thought about it in that way before.

> **SH2:** "*Spraak – dit voel asof al die probleme word vinniger identifiseer en dit word vinniger behandel, want almal kyk gelyk daarna, as wanneer dit net jy is en jy moet verwys onmiddellik, dis net wat jy dink en jy sien dalk nie alles raak nie.*"**(A29)**

Researcher's brief translation of the Afrikaans response

SH 2 stated that problems are indentified sooner and treated faster when everybody is involved. A referral can take place immediately. It is not only one person looking but everybody is looking and can see more.

> **N2:**"*… want toe ons nou in die hospitaal mekaar raakloop, het jy die vrymoedigheid om vir die een te vra…. en dan verduidelik hulle vir jou…*" **(A35)**

Researcher's brief translation of the Afrikaans response

N2 stated that even after the IPE and IPC, when participants saw each other in the hospital they still worked together and had the freedom to approach one another.

SH1:" Ek dink ook nou net soos sy nou genoem het, dat jy in die span vir almal leer ken …en jy sou nie noodwendig na die tyd… doen julle ander aktiwiteite ook saam,soos in die interdissiplinêre span, wat nie noodwendig die geval sou gewees het nie…, maar ek het al so baie ander aktiwiteite gedoen saam met die Fisio's en die mediese studente en so, maar dit is omdat jy leer ken hulle in die werksopset en dan doen julle soos buitemuurse goed ook saam, en dis ook baie nice." **(A37)**

Researcher's brief translation of the Afrikaans response

SH1 stated that the participants even socialised outside of the working environment as a result of getting to know each other.

P1: "We went with a team of medical students and other students. I thought it was really interesting, I learned a lot from the other students, how they interacted with the patients and their role in it. I think it was interesting because us as Physios, I don't think they realised what our role was and in a way we did our bit and they were surprised at what we did.So it was nice, because we all learned from each other and what each role was, because often we think we know but we don't really know." **(B1)**

*P2:"That day I also realised that my actual treatment for the day is not exercise, it's actually just education. That's what my job was for the day. We never think about it, we always go, 'Talk exercise'. That's what we want to do. You can't do it; it's not going to work."***(B32)**

Researcher's interpretation: Sub-theme C2: Advantages of team cohesion

The information between the pre-test group and groups A and B remained the same. The value of team cohension extended beyond the Avian Park project and found its way back into the hospital were participants who collaborated in the community continued the IPC and IPE in the hospital environment.

The IPC and IPE broke down barriers between the professions and resulted in social interaction between the professions.Refer to general discussion below.

General discussion of the sub-theme: Advantages of team cohension

Due to the vast number of responses relating to the advantages of team cohesion only a selected few responses were highlighted for the discussion.

From the responses it became evident that team cohesion results in a wider outlook and more meaningful educational experience for the student, while at the same time it enhances the patient's opportunity for quality health care.

Fewer significant health interventions will be missed, such as the immunization of the child, as explained by participant SH2. The focus of this participant was not the immunization schedule but the speech and hearing of the child.

Participant P1 described the experience as becoming "blurred" which can be interpreted as looking wider as opposed to the "tunnel vision" of an individual discipline working in isolation.

Donner and Wheeler (2008:37) argue that the ultimate objective of building an interprofessional team is to learn how to become a team that *"advances collective practice and quality patient care."*

4.3.5.1.3 Sub-theme C3: The need for further IPC and IPE
Introduction
The need for further IPC and IPE was discussed as a sub-theme of team cohension, IPC and IPE at Avian Park.

The following responses relates to the sub-theme C3.

> **N2: "***Ja, ek was teleurgesteld, ek wou weer gegaan het. Ek was die eerste een van die groep, so ek het hulle lekker aangesteek van die Verpleegse kantaf, vir hulle vertel hoe lekker dit was..."* **(A32)**

> **M1:"***Ja, ek dink so 'n program het geweldige potensiaal. As dit reg gedoen word, kan dit baie goed werk."***(A48)**

> **SH2:"** *En die interdissiplinêre groep…het ook groot implikasies vir die toekoms, want ek dink, nee, ek dink nie, ek weet, dit help ons om mekaar beter te verstaan. Soos wat nou net ook al genoem is, dit begin dalk in Avianpark, maar dit skuif hospitaal toe…want almal het daardie respek vir mekaar aangeleer ….Ek verstaan jy het ook baie werk, ek verstaan dit wat jy doen, ek weet bietjie van jou scope of practice …doen of wat is nou eintlik wat die Verpleegsters moet doen of wat is wat die Arbeidsterapeute moet doen…* **(SH2)**

Researcher's brief translation of the Afrikaans responses above
The participants N2, M1 and SH2 expressed their positive views related to the project. N2 stated that she is disappointed that she has to leave and she would like to return in the future. M1 stated that the project has tremendous potential if things are done properly. SH2 stated that people understood each other better and that respect and understanding resulted as they now know what others do as well.

Researcher's interpretation of the need for further IPC and IPE

The IPC and IPE proved to be so valuable that most participants expressed or displayed the desire to continue or to return to such an environment. Refer to the general discussion below.

General discussion of sub-theme: the need for further IPC and IPE

A loud and clear message comes through the comments of the participants who echoed the advantages of IPC and IPE and their need to be involved in the IPE and IPC experience.

The sentiments expressed in the two statements above were not the only indication of the need for further IPC and IPE. Comments indicating the benefits of comprehensive assessment, holistic care, as well as the ability to work in a team where team discussion leads to a greater feeling of being able to practise safely within the team, are all relevant to motivate the ongoing experience of IPC and IPE.

Disciplines learnt from each other, previous prejudice and conflict seemed to have faded and dominance of one profession over another seemed to have decreased.

Leever, Hulst, Berdendsen, Boenemaker, Roodenburg and Pols (2010:612) explain that many professions are involved but the relationship that is singled out is that of the nurse and the doctor. It is essential that collaboration between nurses and doctors is emphasized. There is a growing need for collaboration between all health professionals but optimal collaboration between nurses and doctors is absolutely essential in the quality of the care process.

The self-esteem of health workers, including the valuable contribution of the community health worker was highlighted during the interview process. Working in a team as equals is ultimately to the advantage of the health profession and its ongoing quest to deliver optimal health care.

The World Health Organization (2010:10) explains that "*A collaborative practice-ready workforce is a specific way of describing health workers who have received effective training in interprofessional health education.*"

4.3.6　Main theme D: Advantages of practices within the re-engineering of PHC
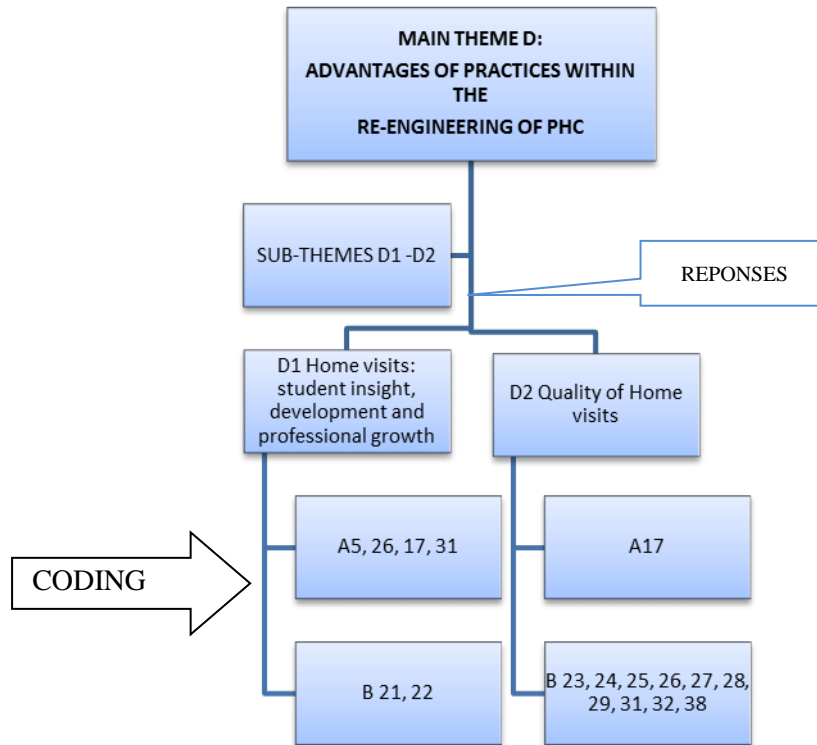
Flow diagramme 4.8: Main theme D: Advantages of practices within the re-engineering of PHC

4.3.6.1 An in-depth discussion of the Main theme D: Advantages of practices within the re-engineering of PHC

(Read in conjuction with 4.2.4)

<u>Introduction</u>

The discussion document: "Re-engineering Primary Health Care in South Africa (2010:1) explains that services were adapted and "massively scaled up" to cope with the burden of disease facing this country. The diseases include HIV/ Aids and TB which are placing an enormous burden on health care. The Flexner report (1910) as discussed by Frenk *et al.* (2010:1923) reported on studies relating to the education of health professionals, recommending that a change should take place. This report contributed to "groundbreaking reforms".

The following sub-theme sub-themes were identified within the main theme.

4.3.6.1.1 Sub-theme D1: Home visits, student insight, development and professional growth

<u>Introduction</u>

The participants' responses were observed, described, analysed and interpreted within the main theme of: Advantages of practices within the re-engineering of PHC.

The responses below relates to the sub-theme above:

> **SH1:"***… Ons was een keer saam met 'n mediese student gewees... ek dink ons het meer ervaring, of dis die idee wat ons gekry het, dat ons meer ervaring het en veral soos die Verpleegsters ook…hulle het bietjie onseker voorgekom, nie onseker in die sin van wat om te doen nie, maar net oor hoe om die mense te benader in 'n huis, of dit was in die...Ek dink ons benader dit op 'n ander manier,ons praat meer met die mense, maar hulle is baie meer op die punt af en weet wat hulle wil hê, maar dit is hoe ons moet werk."***(A5)*

> **M1***"Ja, mens kry 'n groot idee hoeveel mense bly op een perseel. Dit is eintlik vir my 'n groot ding. Ek het mense met krukke huis toe gestuur en gesien wat hulle alles moet oor beweeg met hulle krukke en hoekom dinge soos tuberkulose so maklik kan versprei, onder andere." **(A26)*

> **N2:"***…sê die mediese student hy het niks om meer te doen nie, so hy gaan maar vir ons dophou…toe het ons nou vir hom betrek en vir hom verduidelik dis waarna ons kyk, of hy nie goed kan link na waarna hy kan kyk nie, en hy het toe vir ons mooi verduidelik hoe hy die prentjie sien…Wat is die omstandighede by die huis waaruit die pasiënt kom? As ek vir 'n pasiënt sê, meneer, onthou nou, jy moet was – is daar water waarin die pasiënt kan was? Hoe beweeg die pasiënt, so dinge het vir my meer prakties geraak met daardie agtergrond, nie net gedink almal moet was nie." **(A31)*

<u>Researcher's brief translation of the Afrikaans responses</u>

SH1 stated that they have more experience in dealing with people in the community and personally than the medical students. The doctors are too much to the point. M1 stated that a great deal was learnt from seeing the environment where the patients come from. N2 stated that the medical students observed them and then they shared information which was a mutually beneficial experience.

> **P1:"***I think there's nothing that can prepare you for that, because you walk into a home and it's quite shocking sometimes. It opens your eyes quite a bit."***(B21)*

P1:" …I found the families so welcoming and friendly, I thought they might be like 'who are these people, these professionals walking into my house?' I thought they might be a bit nervous but they were so welcoming. I think that was surprising to me. Some of them gave us hugs and welcome to our home and offer you food and that was very welcoming."(B22)

Researcher's interpretation: Sub-theme D1: Home visits, student insight, development and professional growth

The participants were all in agreement that IPE and IPC contributed greatly to their enhanced understanding of the patient's lives. They are able to place the patients in context of their lives and now understand the limitations that the patients are facing.

All participants gained insight and showed professional growth and development following IPC and IPE experience. Perceptions and expectations were changed by IPC and IPE.

Refer to the general discussion below.

General discussion of sub-theme D1: Home visits, student insight, development and professional growth

Due to the large number of responses relating to this theme only a few responses which are relevant to the subtheme are listed above. It is evident from the comments made that the learning that took place did not only relate to interprofessional education but to understanding life and the circumstances of others.

There are many barriers in the lives of the people who are living in informal settlements which do not even cross the minds of the health workers who are working in the hospital or clinical environment. It is only once one is face to face with the realities of life that one then sees the person within context of his life circumstances.

The majority of the specific population in Avian Park was found to be functionally illiterate. More than 51% of the respondents who participated in an earlier study conducted by the University of Stellenbosch's Sociology Department did not complete 12 years of schooling (Heinecken, Vorster & Du Plessis, 2011:7).

The environment and the terrain where people have to move about are not controlled and roads are not tarred, toilets are outside and in most cases not easily accessible.

To instruct a mother, who does not have enough money to feed her children more than five meals a week, to ensure that the children receive several portions of fruit and vegetables per

day, is not being realistic. Approximately 10% of the households in Avian Park have a per capita income of R316.00 per month (Heinecken, Vorster & Du Plessis, 2011:11).

Insight into a situation, as defined by Chambers-MacMillan (1996:503), is the ability to quickly and clearly understand the real nature of a complex situation or problem.

The insights drawn from the experience resulted in students understanding the challenges which health care is up against and the importance of adapting and working within the constraints placed upon the people.

4.3.6.1.2 Sub-theme D2: Quality of home visits
(Refer to flow diagramme 4.17 for discussion)

Introduction

The sub-theme was analysed as a part of the main theme of: Advantages of practices within the re-engineering of PHC. The responses below relates to the sub-theme.

> **N1:"** … hierdie projek sien as iets wat kan voortgaan in die toekoms, want die verskillende spanne bymekaar, hoe hulle ge-collaborate het met mekaar, is vir my fantasties…julle kan nou maar stry, as jy daarvandaan kom en jy het iets vir iemand beteken, dis iets positief. Avianpark is nou net die regte plek om met die projek mee aan te gaan vir die toekoms, want daar is verskriklik baie probleme daar. So ek het baie geleer, geleer hoe om met die multi-disciplinary team saam te werk en my input te kon gee – dit was vir my nice. "(**A17)**

Researcher's brief translation of the Afrikaans response

N1 sees this project as continueing in the future with all the teams together. N1 learnt a lot about ther interprofessional team and about working together. She also identified the great need for intervention in the community.

> **P2:"**I think it was nice to see the patient in their house, to see what they have in their house. Because you ask them, 'do you have a step?' Sometimes it's only a few centimetres, not really a step…I'll just adjust your chair for you and you can sit, and she just cried – she was so happy. She didn't expect that. And if I saw her in hospital, I wouldn't have known that." **(B23)**

> **P2: "**I was really happy about it. It was nice to do something nice for somebody and to know they really appreciate it."**(B 25)**

P2:"I had a lady, she had, I think, osteoporosis in her spine and the doctor told her your spine is busy breaking and she was petrified. She didn't want to move because she says she knows if her spine breaks she will be a paraplegic. She eventually was in so much pain and everything. I thought, actually you're fine, you must just talk to them, and explain to them… she did her exercises and she became so much better… because we know it, we expect other people to know it, too. That really brought me down, realising they don't know it."(B31)

P2:"That day I also realised that my actual treatment for the day is not exercise, it's actually just education. That's what my job was for the day. We never think about it, we always go, 'Talk exercise'. That's what we want to do. You can't do it, it's not going to work."(B32)

Researcher's interpretation: Sub-theme D2: Quality of home visits

The IPC and IPE experiences were very rewarding for the participants. They found inspiration, professional andpersonal satisfaction in the knowledge that they helped another person whose life might not have been so easy if it was not for their intervention.

If it was not for the opportunity to participate in this experience the participants would never have had the experiences that they shared. It is the researcher's opinion that the positive experiences changed the perceptions of many advantaged student and that greater empathy will be displayed towards disadvantaged people. Refer to general discussion below.

General discussion of the sub-theme: Quality of home visits

It is the researcher's view that this aspect can be best illustrated discussed by making reference to participant responses as they have the "personal experience".

The statements of P2 do not only depict the *"quality"* of the home visit but it includes the value of the practice of *"home visits".*

A patient who did not understand what was said to her by the doctor was subjected to unnessary pain and discomfort and this was rectified all because a home visit took place and a person was treated within the personal context of their own lives.

P2:"I think it was nice to see the patient in their house, to see what they have in their house. Because you ask them, 'do you have a step?' Sometimes it's only a few centimetres, not really a step…I'll just adjust your chair for you and you can sit, and she just cried – she was so happy. She didn't expect that. And if I saw her in hospital, I wouldn't have known that."

P2:"I had a lady, she had, I think, osteoporosis in her spine and the doctor told her your spine is busy breaking and she was petrified. She didn't want to move because she says she knows if her spine breaks she will be a paraplegic. She eventually was in so much pain and everything. I thought, actually you're fine, you must just talk to them, and explain to them… she did her exercises and she became so much better… because we know it, we expect other people to know it, too. That really brought me down, realising they don't know it."

M1"Ja, mens kry 'n groot idee hoeveel mense bly op een perseel. Dit is eintlik vir my 'n groot ding. Ek het mense met krukke huis toe gestuur en gesien wat hulle alles moet oor beweeg met hulle krukke en hoekom dinge soos tuberkulose so maklik kan versprei, onder andere."

Brief translation from the above statement made by M1

The participant explains the value of home visits and the quality of the care that results from the home visit when she said that you get an idea of how many people live there under the circumstances. It became clear to M1 that sending a person home with crutches seems to be the right thing to do until you see where they live. Furthemore, M1 gained insight into the contributing factors that relate to the spread of TB.

Home visits facilitate the provision of appropriate care to patients. Health care workers gain insight that is required to intervene and implement a "tailormade" plan for each individual. This plan can be done to accommodate the unique circumstances that the specific person faces as a member of a family within a greater community.

The evidence has shown that interprofessional collaboration and education can be strategies to facilitate the success of the re-engineering PHC for South Africa.

IPC and IPE form the basis of providing good primary health care with prevention and promotion of health as the focus in the homes of the individuals.

4.4   SUMMARY OF FORMAL STUDY FINDINGS RELATED TO THE MAIN THEMES

Within this chapter an analysis of the pre-test or pilot interview, as well as the formal study findings were presented.

The researcher gave a brief translation of the Afrikaans text of the respondents within the chapter. Data were found saturated when the researcher analysed both the findings of the pilot interviews as pretest and that of the formal study as the main study. In both studies the main themes came up repeatedly.

The themes of the pre-test and the formal study therefore correlated. The following themes were identified and upon reflection the overall conclusions can be summarised as follows, **A: Organisational** aspects need to be addressed in the future to ensure smooth functioning and the prevention of prolonged periods of orientation due to added confusion during a self-orientation process.

B: Perceptions and experiences related to interprofessional team structures prior to and following interprofessional collaboration (IPC) and interprofessional education (IPE). There were mainly positive perceptions and experiences following the experience of IPC and IPE, which differed from the students' perceptions prior to IPC and IPE. The community health worker seemed to be a key person in the system of primary health care and visits, as she fulfilled the role of the *"community expert".*

C: Team cohesion – IPC and IPE at AvianPark. The students enjoyed participating in the project and experienced the time together as educationally and professionally very rewarding. It was mentioned by several respondents that it greatly benefited the community although there had been some barriers. The growth and development that took place within the interprofessional team was not only academic but included many personal benefits such as feelings of confidence and an improved self-esteem. The latter was evident during the observation of team interaction and nonverbal communication during the focus group interviews. They student's attitudes were clearly friendly and engaging toward each other.

D: Advantages of practices within the re-engineering of PHC. A positive attitude on reflection of the experience was evident in the comments provided. There are many professional and health-orientated benefits but the individuals who are in need of quality health care will benefit the most from IPC and IPE.

In chapter four a detailed analysis of themes and sub-themes was conducted. The research findings were supported by relevant literature. The overall outcome was very positive regarding IPE and IPC in general.

Chapter five will include a discussion of the conclusions drawn in which the important role of the community health worker, as shown in the framework that was developed from the concept map with the Neumans System's as a guide. Recommendations will be made for future implementation and research opportunities.

4.5   CONCLUSION

The past practices related to the health professionals' education proved to be a barrier to the expectations of health care users in South Africa. A global strategy has been initiated with

the envisaged solution being: Interprofessional Education and Collaboration. This study explored the perceptions and experiences of the students of the various health professions prior to and during interprofessional learning and collaboration. Nurses felt valued and respected and proved to be an essential member of the interprofessional team. Although there may be challenges, the response to the initiative was very positive, resulting in not only collaboration and the enhancing of interprofessional respect, but also in patient-centred care.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1   INTRODUCTION

In chapter four the findings were presented and a concept analysis was done in order to determine the aspects to be considered regarding collaboration within an interprofessional context.

In chapter five conclusions are drawn resulting from the investigation of the experiences and perceptions of health and allied health care students during a clinical placement period. These experiences and perceptions of interprofessional collaboration and education were explored. The students worked in a rural healthcare setting in South Africa during this placement.

The conclusions are discussed in relation to the study objectives which demonstrate the achievement thereof. Furthermore, a succinct discussion is presented to demonstrate the conclusions relative to the conceptual map as introduced in chapter two. Based on empirical evidence, recommendations for future endeavours are presented. Chapter five describes certain limitations and challenges and draws together the final conclusions of the study.

5.2   CONCLUSIONS

5.2.1   Objective 1: The identification of the health and allied health care students placed within the interprofessional education and collaboration context in the rural area.

The inclusion and exclusion criteria were specific.

The inclusion criteria were as follows:

- The students of all the mentioned departments of the University of Stellenbosch Health Sciences and the nursing students from WCCN, who voluntarily participated in the interprofessional education programme, were included.
- Undergraduate interprofessional student teams were included in the study.
- Students within the interprofessional education and collaboration programme presented by Stellenbosch University who had attended their allocated period of practical experience of interprofessional collaboration and interprofessional education at the same venue and who had participated in the same rural project.
- Students placed in the Worcester rural setting were recruited for the study.

The exclusion criteria were as follows:

- No postgraduate students were included in the study.
- Students who did not attend the Thursday team activities were excluded.

Race and age were not considered as inclusion or exclusion criteria, as only the experiences and perceptions of students attending the clinical placement were explored and not the perceptions and experiences of differing race and age groups. The aforementioned may be a suggested research topic for future investigation.

5.2.1.1 The pilot interview as a pre-test

The pilot interview was conducted prior to the formal study and students who had attended the Avian Park clinical placement during the period of 2012 were invited to participate.

The pilot interview was conducted to test the validity of the semi-structured interview guide. The pilot interview proved very beneficial and insightful as an adjustment was then made to the interview questions to ensure that the most relevant information was obtained. Brink (2006:166) explains that the purpose of the pilot interview is to identify flaws which could adversely affect the quality of the data obtained. Consent was obtained to record the interviews.

A purposive sampling method was used to ensure maximum contribution potential by information-rich individuals. Eight students who adhered to the inclusion criteria were invited to attend a focus group interview. Students from various professional groups were invited to participate; however, only seven participants attended the interview. The group consisted of nurses (n=2); physiotherapists (n=2), a medical student (n=1) and speech and hearing therapists (n=2). All the aforementioned students participated voluntarily in the research study. All ethical principles related to voluntary participation and confidentiality were strictly implemented. The formal study was conducted after the pilot interviews had been completed.

Adjustments to the semi-structured interview guide were made to ensure that the objectives of the study would be met.

5.2.1.2 Formal study

The formal study group consisted of two separate focus group interviews. These students underwent their clinical placement in Avian Park during 2013. This group consisted of nurses (n=2); physiotherapists (n=2), a medical student (n=1) and speech and hearing therapists (n=2). All the participants had the opportunity to participate in the clinical field where they

participated in interprofessional learning and collaboration activities. The participants of both the focus group interviews of the formal study proved to be highly suitable as their contribution to the data obtained was of a standard to ensure valid results and achievement of the study objectives. Informed consent was obtained to record the interviews.

5.2.2   Objective 2: The description of the demographic placement situations and educational status of the health and allied health care students placed in the rural area.

The health care students who were invited to attend consisted of medical students from the University of Stellenbosch, as well as nursing students from the Western Cape College of Nursing, who were studying towards either the qualification of Nurse (General, Psychiatric and Community) or Midwife. Nursing students must comply with the South African Nursing Council regulation R.425 of 22 February 1985: Regulations relating to the approval of and the minimum requirements for the education and training of a Nurse (General, Psychiatric and Community) and Midwife leading to registration as a professional nurse.

The allied health care students included students from Speech and Hearing Therapy, as well as from Physiotherapy. Students from both groups were studying at Stellenbosch University working towards the completion of their final year of study.

Ukwanda Rural Clinical School placed the medical students and the allied health care students at Avian Park for the purpose of providing primary health care to the community, under guidance from their own mentors. Avian Park is an underserved, previously disadvantaged community which is facing severe socio-economic challenges (Heineken, Vorster & Du Plessis, 2011:29).

The participants were all final year health and allied health profession students. There were students present from two institutions, namely The University of Stellenbosch and the Western Cape College of Nursing (WCCN).

The students from the University of Stellenbosch were from the departments of Medicine, Physiotherapy and Speech and hearing therapy. The final year nursing students, who studied at the Western Cape College of Nursing during 2013, attended the Avian Park Clinic as part of their community health practical component.

5.2.3 Objective 3: The exploration of the experiences of students regarding interprofessional collaboration within an interprofessional educational context in a rural healthcare setting in South Africa.

The pilot interview with participants, as explained in 5.2.1, consisted of a focus group interview where a semi-structured interview guide was used. Following the pilot interview, the questions were adapted to ensure that the objective of exploring the experiences of the participant group was reached.

Literature comprising historical and recent writings depicted varying views regarding the nature of interprofessional collaboration. The literature reflected mainly upon the unsatisfactory nature of the relationship between doctors and other health professionals, with emphasis on the poor relationship between doctors and nurses. (Please refer to responses in addenda 1 and 2.)

During the study, the participants related that they perceived hierarchy, and the negative impact the latter has on teamwork to be a potential barrier. However, the relationships between all participants seemed positive with no unsatisfactory incidents. The conclusion that can be drawn from this is that interprofessional education contributes to interprofessional collaboration.

Beunza (2013:110) explored the doctor-nurse relationship and came to the conclusion that conflict prevention programmes should be implemented so that individuals could be trained to produce positive emotions within themselves, on a one to one, as well as interprofessional level. He explained that emotions will always be a part of us no matter how much we try and ignore them. It is essential to identify the causes or origins of such emotions. (Please refer to responses in addenda 1 and 2).

An example of an emotion experienced by the participants was the frustration expressed by the medical profession (medical student M1) due to the fact that, on occasion, no specific disease or disorder was able to be treated. The other participants at the time identified this frustration and were able to offer support to the medical student. This was a very significant event for the team as they were able to see that they could learn from each other and they realised that they wanted to stay together as a team. However, due to the rotation schedule, this was not possible.

The rotation schedule was generally experienced as a barrier to the learning and collaboration experience of the interprofessional group.

Hawkes, Nunney and Lindqvist (2013:e1) report that, during a study done by the University of East Anglia, it was found that there was noticeable tension between pharmacists, doctors and nurses. In the listed aspects in the aforementioned study, it was noted by the authors that the attitudes of different health professionals had an adverse impact on how teams work together and affected the quality of patient care.

Although tension does exist as explained in the literature in chapter two, the relationship between the doctors and nurses at the rural project was far more relaxed.

It is the researcher's opinion and observation that the informal environment of the community may have contributed to the change in general conduct towards each other. The participants were also far more dependent on each other for emotional support and physical safety.

Fear was also one of the emotions which were expressed by the participants. The participants themselves identified the need to work in groups and expressed that as a group they had felt far more protected. As reflected in addenda one and two, the female participants stated that they felt fearful when walking in the streets of Avian Park.

Beunza (2013:110) explains that there are five basic concerns when attempting to attach value to what other people say and think. According to Beunza (2013:110), one needs to: "*turn an enemy into a colleague, respect autonomy, acknowledge status and choose a fulfilling role."* It became evident from the students' comments, which were highlighted and quoted in chapter four and the addenda, that working together and getting to know each other as individuals had contributed to achieving some of the aforementioned objectives.

An incident had occurred where a medical student displayed his frustration by becoming agitated. He had asked the nursing student if she should be asking so many questions. She had replied that it was necessary to get to know the patient better and that that was the reason why she was asking questions. It seemed from the manner in which she had approached the situation, that she had been able to include the medical student in her assessment and that they then both had worked harmoniously together from there on. The nursing student stated that they had felt sad when they had to part due to the fact that the allocation had come to an end. A potentially negative situation was diffused and the two participants from different professions, the relationship between which is traditionally seen as unsatisfactory, worked in collaboration and they could learn from each other.

Beunza (2013:111) asks, *"Why do some younger doctors smoothly accept nurses' corrections and others get into a panic mode?"* Furthermore, he states that there are often struggles between health care professionals but especially so between doctors and nurses.

Gordon, Uppal, Holt, Lythgoe, Mitchell and Hollins-Martin (2013:191) report that *"interprofessional teamwork is a key to the successful delivery of healthcare as well as being a crucial element to ensuring patient safety".*

When taking into account the aforementioned statements, it is evident that intervention should take place as ultimately the patient may be the suffering party. It is clearly evident that teamwork goes a long way in enhancing patients' well-being.

It has become evident that the need for the resolution of conflict between doctors and nurses has never been more crucial. Professional nurses are at the centre of health care delivery within the context of the re-engineering of Primary Health Care. Mutual trust and professional respect between professionals and professions will be the foundation of its successful implementation. Moreover, highly competent and motivated health care workers, who have worked together and learnt from each other, are required for the implementation of appropriate health interventions. The aforementioned statement is in accordance with the definition for interprofessional education and collaboration.

Doll, Packard, Furze, Hugget, Jensen, Jorgensen, Wilken, Chelal and Maio (2013:195), reflect on an interprofessional education experience. They report that a comparative analysis of themes and core competencies revealed that patient care goals were the main priority and that all participants "*overwhelmingly*" placed patient care as the main priority in teamwork and health care. A call was made for professionals to focus on patient-centred care and not on struggles with professional identity.

It can be concluded that health care providers place high value on the well-being of the patient but that negative interprofessional relationships pose a risk to safe patient care, and therefore, a suitable solution should be explored to overcome the problem.

5.2.4   Objective 4: The establishment of the perceptions of students regarding interprofessional education within the interprofessional educational programme in a rural health care context in South Africa.

The interviewer, as referred to in 5.2.3, through the use of her excellent interviewing skills, ensured that the study objective above was successfully reached.

As the main focus of the study was to explore student experiences and perceptions of interprofessional education and collaboration, a related discussion will follow in section 5.4.2.

The summary of perceptions includes the perception that organisational aspects needed to be addressed between the healthcare departments, as well as at the project at Avian Park in order to ensure that interprofessional learning and education could take place at the same time as the rendering of patient-centred care. One of the main barriers, as expressed by the students during the data collection, proved to be the rotation schedules of students from the various professional groups.

From the students' responses it became clear that a further barrier was the lack of preparation prior to attending the project. The individual disciplines will have to find common ground between them to ensure that a comprehensive orientation and preparation schedule can be put in place to enhance the learning and collaboration process.

Thorough orientation, as part of organisation and creation of a collaborative environment, will ultimately lead to positive relationships where students will be able to function together and be able to trust each other (Beunza, 2013:111).

Several positive comments were made by all participants. The students felt that they had benefited greatly by working together and learning from each other. Positive relationships had developed which extended beyond professional conduct to general respect during social contact. The participants expressed their gratitude for having had the opportunity to learn from each other, not only to enhance their own profession but also to gain insight from others in general and to learn about each other's professional abilities. It became evident that skills such as the appropriate and effective referral of patients were improved. Hawkes, Nunney and Lindqvist (2013:e2) report the following: "*During interprofessional learning students are given the opportunity to recognise and appreciate their similarities, as well as their differences, with the intention to enhance future collaborative working and service delivery*".

It can be concluded that a positive collaborative environment, where positive emotions can be expressed, will contribute to students taking initiative and showing respect towards each other. The positive emotions will satisfy basic needs such as being valued and recognised for individual and specific roles.

5.3   CONCLUSIONS RELATING TO THE THEORETICAL FRAMEWORK AND CONCEPTUAL MAPPING USED WITHIN THE METHODOLOGY OF THE STUDY

The previously described model and framework, as developed by Betty Neuman served as the foundation of a conceptual framework for this study (George, 1995:284). The concept map was discussed in detail in chapter one.

George (1995: 284) explains that Betty Neuman refers to patient-centred care and holistic care within the community, which are represented in *The Neuman System Model* by the physiological, psychological, socio-cultural, spiritual and developmental structures.

The re-engineering of Primary Health Care is elaborated on by Baron (2011:np) in a document titled: "The Re-engineering Primary Health Care for South Africa: proposed way forward." He explains the nature of the community outreach teams. The outreach teams are to be allocated to community wards consisting of about 1500 families, where six community health workers, two professional nurses (team leaders), a facility-based enrolled nurse and a professional nurse (facility-based) will be responsible for rendering preventative, promotive, curative and rehabilitative services. Health care will extend to community service providers such as schools, crèches and early learning centres. It is anticipated that one community health worker's services will extend to as many as 250 families; the team will attend to about 1500 families and a clinic to as many as 4500 families, which is approximately 18000 people.

The demands that will be placed on health workers of all professions will be immense and these demands give validation to the urgent need for interprofessional education and collaboration, as well as the essential need to address the interprofessional discord that is highly evident from the listed literature. It will be imperative that doctors and nurses work very closely together in a relationship based on mutual trust and respect. The latter does not only pertain to the relationship specifically between doctors and nurses but should extend throughout the entire spectrum of health care professionals and allied health care workers.

As depicted in the conceptual map in chapter one, the centre of the map demonstrates the focus of the community team, with the health care worker (CHW) and the professional nurse at the centre. The interaction and the collaborative relationships between health care workers were evident from responses by various participants. The following comments validate the collaborative relationship (refer to responses document for formal study in Appendices D and E).

> *SH1:"Explain during assessment to others as well – not only afterwards. N1, N2, P1 – OT's to show us during assessment. We need the team."*

> *SH1:"Home visit then IPC occurred…"*

> *SH1: "Health professional can after home visit, we discussed management plan then we get structure discussion…"*

> *M1: "Students have a lot to give…"*

N1: *"Physiotherapy called us and drew our attention to physiotherapy, good IPL experience…"*

N2: *"…good learning discussion afterwards"*

The interprofessional team members (IPTMs) were identified and collaboration depicted. The role of the Community Health Worker (CHW) was clearly indicated. The holistic dimensions of the individual and family, as well as the community form the focus of the care of all IPTMs.

The elements of the concept of required activities were listed and linked back to the IPTM and the CHW. The support services and strategies were clearly linked to all other concepts and role players to ultimately support the return to optimal health and well-being on all levels of affliction or to provide support and assistance during end of life care.

Rispel, Moorman, Chersich, Goudge, Nxumalo and Ndou (2010:38) explain, in a document titled "Revitalizing Primary Health Care", the three main recommendations for the revised package of health care. The proposed services include:

- Assisting with the achievement of health outcomes and a reduction of mortality and morbidity from major causes of ill-health.
- Having a population orientation, focusing on priority health needs of geographically diverse populations.
- Focusing on prevention, promotion and good quality essential care.

The researcher set out to include all aspects, namely the health care workers, interprofessional collaboration and education, community-centred care with holistic care to the individual, the family, the community and the society. All of the previously mentioned were included within the available resources in the community in an attempt to demonstrate a comprehensive primary health care service where the re-engineering of primary health care and the utilization of health care workers are depicted. The health care workers, within the context of interprofessional education and collaboration were illustrated by the graphical presentation of arrows and lines connecting the entire system. In conclusion, the conceptual map used to guide the researcher to complete the study may be used as a conceptual framework for placements of students within an IPE context to promote IPC.

5.3.1   Graphical presentation of theories and concepts

"Collaborative Practice in health care occurs when multiple health workers provide comprehensive services by working together synergistically along with patients, their

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families, carers and communities to deliver the highest quality of care across settings."
(WHO, 2010).

The conceptualmap as discussed in chapter one and used in chapter three as a guide to implement the currect study may be used as a framework for placement of interprofessional groups within a similar setting (see framework below) .
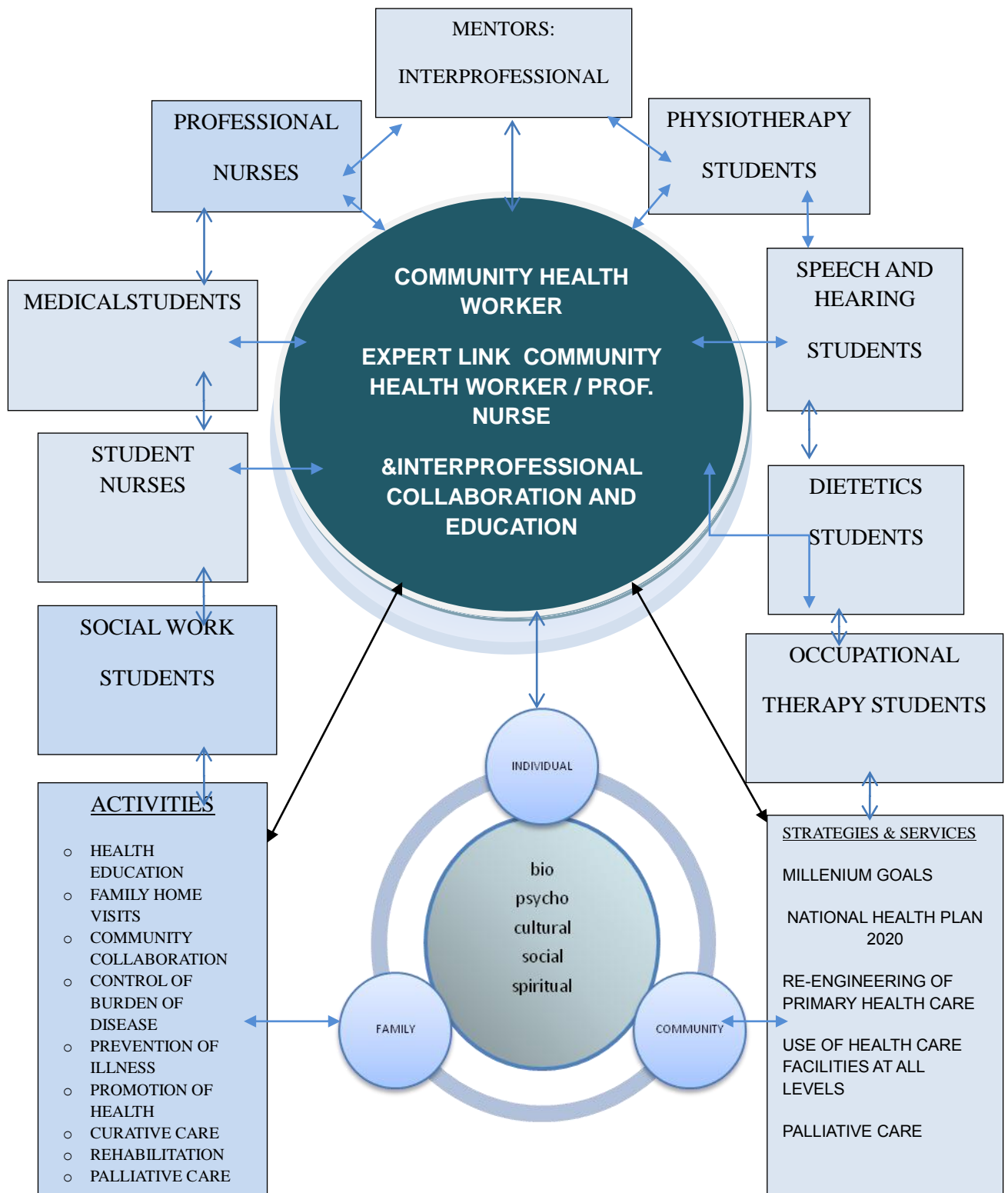
The interprofessional student implementation conceptual framework with the interprofessional student implementation conceptual map

5.4   LIMITATIONS

The study was conducted in a real life situation in Avian Park where poor socio-economic circumstances prevailed. Poverty, malnutrition, communicable diseases, drug abuse and other chronic diseases contributed to the burden of disease and affected daily living. The majority of students had experienced some form of "culture shock" and had required additional preparation prior to participating in the clinical allocation.

Students who attended the Thursday afternoon home visits were specified in the inclusion criteria which then excluded some of the other professions, such as the social workers who did not participate in a specified group. Students from the occupational therapy and the dietetics departments were approached and invited to attend but did not participate. Two of the medical students decided to exercise their right not to participate after they had voluntarily agreed to attend the focus group interview. Although it would have been preferable if two medical students could have been present, valuable information was obtained from the attending medical student. This may be listed as a limitation to the study; however, it did not hamper the data collection.

5.5   RECOMMENDATIONS RELATED TO THEMES AND SUB-THEMES

5.5.1   Introduction

All students from all health and allied health care professions should be included in a study to explore their perceptions and experiences relating to IPC and IPE, to ensure that barriers can be addressed and that this very valuable experience can be to the benefit of all concerned.

The research findings and conclusions of the above-mentioned proposed study should be taken into account and inter-departmental and inter-institutional collaboration could take place to ensure that interprofessional collaboration and education is promoted in the interest of health and wellness in South Africa.

The students participating in this study did not seem to have the experience or the academic background necessary to have prepared them for the circumstances that they encountered. It was a major discovery and "insight producing" experience that rural facilities do not facilitate modern medicine in the same way as urban medical facilities, but it taught the health care provider to "think on his/her feet". For example, modern technology is of very little use where there is no power supply.

A need for additional emotional, academic and physical preparation before the placement was identified. This need was related to limitations of the current student rotation practices.

The medical students, who had been trained to render curative care (see evidence discussed in chapter four), found it very difficult to identify their role in the health promotion and the prevention of illness.

A common preventative and promotive approach to health care could have a desirable impact on the implementation of the re-engineering of Primary Health care in South Africa.

All of these aspects may be areas for investigation in the future. A discussion related to the study results will be presented to serve as evidence for the recommendations. Recommendations for further research opportunities will be fully discussed later in this chapter.

5.5.2   Rotation and student schedules

The students reflected upon the organisational aspect of rotation schedules and made a very clear argument against the current practices of student rotation. The rotation schedule can be interpreted as a necessary action by the academic institution and the various departments to achieve their learning outcomes, however, in its current form it can be seen from the data obtained that it is a barrier to interprofessional education and collaboration. With the arrival of a new group at the project, care was disrupted and the delay caused interruption of care.

Dow, Blue, Konrad, Earnest and Reeves (2013: 3) argue that while the focus of interprofessional education is on maintaining professional competency, it may not be long lasting as the current approach does not prepare graduates optimally for future practice. Furthermore, they state that the campus leaders should never lose sight of doing everything that is necessary so that an individual can graduate having been given the foundation to be able to provide collaborative, patient-centred care.

It is therefore very important to learn from the students, address their needs and concerns relating to issues such as orientation, rotation schedules and preparation prior to attending such learning opportunities.

It is not only the preparation of the students that is of importance but the lecturers should also be supported and encouraged to participate and learn so that mentoring of students across the professions can take place. Mentoring across the professions could further enhance interprofessional collaboration as it can be modelled by the mentors.

Delany, Kuziemsky and Brandt (2013:1) explain that for the successful delivery of interprofessional collaboration and education, focus should be placed on the bridging of academia and practice.

5.5.3   People, structure and function

Organisation and structure provide direction and should take the form of realistic perceptions and expectations of the environment, clearly identified expectations and standards, and systems and structures to facilitate the health of the working environment (Huber, 2010:397).

The participants felt lost and did not know or understand what was expected from them. The literature explains that the organisational structure should facilitate clear direction and create a milieu of support and understanding. According to the statements listed as the evidence of the findings, it became evident that the need for knowledge regarding the clinical programme was not being met. The participants felt lost and uncertain until some of the students who had been at the project longer than them, showed them what to do.

Time was lost and patient care opportunities may have been missed due to the lack of clear structure and guidance to the new students on the project. This guidance and structure should be provided by the educators and mentors of the students and should not be the sole responsibility of fellow students. However, this lack of guidance and structure may have contributed to the interprofessional collaboration that took place as students needed to collaborate from the start to achieve their outcomes and to do the required home visits.

5.5.4   Preparation prior to interprofessional education and collaboration

Donner and Wheeler (2008:37) explain that "*by helping the group see its strengths, its obstacles and its potential, the coach creates the groundwork for the group to deepen its learning and curiosity, better manage itself and ultimately become a high-functioning interprofessional team.*"

Hawkes, Nunney and Lindqvist (2013: e2) argue that professional boundaries need to be clear, but at the same time flexible, and that knowledge and skills should be fully developed and utilized. Orientation and guidance could go a long way in preparing students for the demands that are placed upon them during the clinical experience.

From the responses of the participants within this study as listed in chapter four, it is evident that activities, such as orientation and thorough preparation prior to the clinical experience, should be done to ensure that daily functions can take place within the context of the expectations of the Avian Park project. Time wasting and interruption of care resulted from a period of confusion when new arrivals joined the project.

5.5.5 Perceptions and experiences related to interprofessional team structures prior to and following interprofessional collaboration (IPC) and interprofessional education (IPE)

According to the comments as listed in chapter four, interprofessional collaboration and education proved to be a very positive experience for all participants. The evidence from the student interviews showed that the benefits far outweighed the obstacles, with comments such as:

> **N1:**"*The other interprofessional team members listened to us and we were able to teach them. It was the first time that we all came in contact with each other and we can learn so much from each other. I enjoyed working with all the people and we learnt to adjust to each other, we adjusted to the team.*"

> **M1:**"*It is definite art to learn to work together with all the different personalities.*"

> **M1:** "*I like going into the patient's home, you understand your patient better. We learnt a lot about other professions.*"

> **SH1:** "*It is so nice to get to know everybody. You get to know people at work and then you even get together socially and do extramural activities together.*"

5.5.6 Experiences and perceptions during interprofessional collaboration

There was a general sense of excitement and positivity when the students expressed their experiences related to collaboration. The following statements can be seen as evidence to support the positive experiences and perceptions of the students following the opportunity to experience interprofessional education and collaboration.

> **SH2:** "*Speech and occupational therapists realise that everything in the community takes time, and with rehab. You can work with the patient in his home you do not need to take him to hospital.*"

> **N1:**"*I can see this project going on in future, all the teams working together. I went out on one home visit together with occupational therapists and a physio. It was a follow-up visit. Following the visit we all went back to the clinic and we discussed the case. We decided together. I learnt there that we can work together in a multi-disciplinary team and I was able to give my input as well.*"

> **N1:**"*Nursing could make a contribution to the team.*"

> **N1:** "*There was collaboration between the team members. IPC worked.*"

M1:"For me I learnt, until now, the most from social workers and the social problems that are in the community. So many people do not have ID books, older people living with children who abuse drugs and the social workers trying to get the children out those homes."

P2:"One morning we had a speech therapist who presented a talk about they do in the field. We do this and this test and we had to look in each other's ears and we had to do the test and it was quite nice. So now we know more what they do. It was nice that it was us students talking to another group of students. It was not a lecturer telling us this is what you can do."

N2:"There was a sense of support for each other even at the hospital. The students attended ward rounds and if a specific member was asked a question members from the other disciplines would whisper the answer. It was nice to help each other and you felt the freedom to ask for help from other team members."

The participants were able to work together, learn from each other and solve problems together. Teamwork and partnerships were created. The latter took place in the interest of both parties; the participants needed to learn and develop and at the same time address the needs of the community to provide quality holistic care.

A significant amount of data related to interprofessional education and collaboration was obtained as these specific aspects closely relate to the objectives of the study.

5.5.7   Prior experiences and perceptions

Collaboration within the context of the clinical care experience in Avian Park resulted in valuable information being shared between disciplines. The relationship between doctors and nurses, which had been hampered by misconceptions and preconceived ideas throughout the ages, can only benefit from positive interaction which will ultimately also be to the benefit of health care delivery. A discussion follows regarding the relationship between doctors and nurses to support the aforementioned statement.

To begin the exploration of relationships we turn to Pilletteri and Ackerman (1993:113). In an article where the "game" between doctors and nurses are discussed Pilletteri and Ackerman (1993:113) explain that Sarah Dock, reported in 1917 that: "the first and most helpful criticism I ever received from a doctor was when he told me that I was supposed to be simply an intelligent machine for the purpose of carrying out orders". In the same article it is written that a nurse, no matter how gifted she might have been, would never be seen as reliable unless she was able to obey without question.

In 1986, Kennedy, Gillis, Jacobs, Burton and Rogers (1986:745) explained that the doctor-nurse relationship had been a concern for many decades. In their writings they explore the early relationship during the time of Florence Nightingale and state that already then the nurses' worthiness was compared to their helpfulness towards the doctor, "*much as the good wife to her husband."* They go on to explain that there has been a change in the nature of the relationship between medical and nursing professions.

Kennedy, Gillis, Jacobs, Burton and Rogers (1986:745) argue that nurses are more aware of their role and their impact on health care. As women, and as nurses, they are becoming more assertive which in itself is producing difficulties and conflict.

It seems that it is not only the nurses suffering as a result of the unsatisfactory relationship between doctors and nurses. However, the researcher found a far greater volume of literature available exploring the relationship where nurses seemed to be the suffering party.

Graf (1974:151) argues in an article titled "A doctors view", that doctors are trained to have an attitude of self-assurance and confidence, however, when they are new housemen they are often faced with patients that they do not know what to do with. The houseman is then subjected to the opinion of the nurse telling him indirectly what to do. In addition, doctors are subjected to ward sisters who prefer the new houseman to be an "*incompetent zombie"* (Graf, 1974:151)*.* Farrell (2001:26) argues that nursing, which is mainly a female occupation, is an oppressed discipline which is traditionally dominated by male doctors.

This is of concern taking into account that patient-centred care should be the priority in health care today. Gordon, Uppal, Holt, Lythgoe, Mitchell and Hollins-Martin (2013:191) maintain that interprofessional teamwork is the key to successful health care delivery. There is significant evidence that interprofessional education and collaboration can have positive outcomes for teams working together and for patient-centred care.

The re-engineering of Primary Health Care strategy depends on interprofessional teams working together. To work together there needs to be mutual respect and trust. Without these basic values in interprofessional working relationships, the plan for health care for the future will be doomed. If individuals cannot even respect each other as people, how will they be able to respect each other as equals and as colleagues?

Taking into account the role of the nurse and the level of trust that her position would require within the proposed health care system as planned within the re-engineering of Primary Health Care, drastic action should take place to ensure that interprofessional collaboration between all health care workers is promoted and facilitated. The relationship between

doctors and nurses should receive urgent attention as available literature emphasises that this relationship is particularly problematic.

Interprofessional education and collaboration seems to be a very good way to begin addressing the problems in this relationship. It was evident from the comments made by nurses in this study, that they found the experience beneficial and rewarding when they were able to purposefully include the medical student and when this student seemed to have participated as one of the team.

> **N2:**"I am inquisitive and I decided to ask the patient questions and then the medical student said to me 'do you need to talk so much?' I replied, 'You need to show interest in the patient, to set the patient at ease.' The medical student said that he will not say anything more because he does not have much to do there. He will now only observe. We then took the time to explain to him and included him purposefully. He then started seeing the picture and when we had to leave it was sad because then it was our last day."

> **N2:** "There was a sense of support for each other even at the hospital. The students attended ward rounds and if a specific member was asked a question members from the other disciplines would whisper the answer. It was nice to help each other and you felt the freedom to ask for help from other team members."

> **N2:**"I would have liked to go again. I was disappointed when it was completed. We watched each other's backs in Smarty Town. We were part of the team."

> **N1:**"The other interprofessional team members listened to us and we were able to teach them. It was the first time that we all came in contact with each other and we can learn so much from each other."

> **N1:** "I enjoyed working with all the people and we learnt to adjust to each other, we adjusted to the team."

When referring to these statements, it becomes clear that when different health professionals can learn from each other and work together, preconceived ideas are changed and new ideas can develop that could be beneficial to learning and working together in the future. There will hopefully be opportunities for new, more positive literature to be written about the relationships between interprofessional health care workers.

5.5.8   Challenges of IPC within IPE context

Heineken, Vorster and Du Plessis (2011:29) explain in the conclusion of the study of the Socio-economic and Social Capital assessment of Avian Park residents in Worcester, that many living in the community feel unsafe and insecure. Moreover, the residents are described as feeling powerless against the vigilantism of the gangs. Furthermore, the authors explain that drugs and gangsterism are major problems within the community and that there is little faith in the law enforcement authorities to address the problems.

As recently as 15 October 2013, home visits in Avian Park had to be temporarily suspended due to the threat that gang violence posed to the safety of the health care students.

Chambers-MacMillan (1996:347) explains fear and fearful as being afraid of something or of doing something, whereas fearsome is when something is horrible or frightening.

It seemed that the only way that the safety of the health care students could be assured was to suspend the clinical placement in the area. The aforementioned action taken was not unrealistic. Taking into account the lack of control over gang violence in the Western Cape, the students were experiencing the general concerns that face all South Africans today. Even more recently (November 2013), the death of an elderly man in the area caused by a stray bullet was reported.

The safety of all people is a concern. It is the experience of the researcher that young females might feel especially vulnerable in areas where there is a perceived or real threat to safety and security. Although the ages of the participants were not part of inclusion and exclusion criteria, and therefore not recorded, it can be stated that the participants were young females with their ages estimated to be between 20 and 28 years. There was only one male participant, the doctor, who was also in his twenties and who participated in the formal study.

5.5.9   The community health worker as a team member

Baron (2011) states in a discussion document related to the re-engineering of Primary Health Care, that there should ideally be 41440 community health workers in primary health care services when the aforementioned strategy is implemented. In addition, he states that the community health worker will be the first contact for the community for health care delivery and that the community health worker will be the "key" to access the community for health professionals.

The community health care worker's role as a team member is paramount. The study results clearly identified that a valuable contribution was made by the community health worker. It

can be stated that without the community health worker access to the community is hampered. It was the experience of the researcher that the community health worker acted as the "expert link" between the health care workers and the community. The term "expert link" refers to the fact that the community health worker is a member of the community and therefore he/she is personally involved and part of the community, the culture and the environment.

The community health worker facilitated relationships of trust which enabled the health care workers to access the homes of the people more easily. It was due to the actions of the community health workers that the other health workers were welcomed into the homes of the community. (See conceptual map above 5.3).

The following comments are only two examples of the many comments related to the importance of the community health worker.

> **SH2:** *"You do not realise how much you need the community care worker (CHW). Before I came to Worcester I did not understand about community care workers (CHWs)."*

> **SH2:** *"The CHW sort of keep the team together."*

In the graphical presentation of the concept map, the community health worker's role is clearly evident as a very important role player and central flow diagramme in the health care delivery system.

5.5.10   Team cohesion and interprofessional collaboration and education at Avian Park

From the comments made it can be deduced that team cohesion took place. The selected comments depict a very positive outlook on potential referral practices.

Ruiz, Ezer and Purden (2013:1) explain that interprofessional education (IPE) is increasingly recognised as a method to ensure that health care students have the skills and knowledge to participate in collaborative practice.

Several students, as reflected in chapter four, stated that they learnt about the roles and scope of practice of other professions. This facilitated referral practices in the interest of the patient decreased the impact of illness on their lives.

5.5.11   Referral practices as a learning experience within the study

The interprofessional group of students learnt about each other's professions and, on an informal basis, started eliciting assistance from each other during the management of

specific patients. This can be interpreted as a form of referral between professions. The participants later realised that they were actually making use of "patient referral" opportunities. The referrals were not necessarily formal referrals but included the informal discussion of problems and the obtaining of information. There was a clear indication that interprofessional education and collaboration took place.

The following comments can be seen as evidence of the referral practices:

> **N2:** *"On way back doctors explained nicely to referrals he would require of SH1, we learn about disorders from each other, makes referrals easier."*

> **SH1: "***The main purpose is to learn to make appropriate referrals."*

> **SH2:** *"There is a faster referral because problems are identified much sooner."*

Many participants expressed their relief when they realised that they were not the only responsible "caretakers" or carers of the people and that it was a shared responsibility.

It was stated that referrals take place more appropriately and sooner which in turn benefits the maintenance of health and the prevention of illness.

5.5.12   Advantages of team cohesion

Gordon, Uppal, Holt, Lythgoe, Mitchell and Hollins-Martin (2013:191) explain that interprofessional teamwork is the main aspect that determines the success of health care delivery. They state that evidence shows that education which focuses on interprofessional groups has positive results on team functioning and on outcomes for the patients.

It is evident that team cohesion resulted in a wider outlook and more meaningful education experience for the student, while at the same time it enhanced the patients' opportunities for quality health care.

Fewer significant health interventions are missed, for example, the immunization of the child as explained by a speech and hearing therapist. It was not the area of focus or expertise of the speech and hearing therapist but awareness through interprofessional collaboration and education that was created. Participants aptly described the experience as the roles becoming "blurred" which can be interpreted as looking wider without the "tunnel vision" of an individual discipline working in isolation.

5.5.13   The need for further interprofessional collaboration and education

The analysis of the findings revealed perceived and experienced advantages of IPC and IPE, as well as the need for health and allied health professionals to be involved in the interprofessional collaboration and educational experience in the future.

Disciplines learnt from each other, previous prejudice and conflict seemed to have faded and dominance of one profession over another decreased. The hierarchy as described in the literature study in chapter two seemed to have faded for the duration of the experience. It is the opinion of the researcher that one positive experience should be followed up with ongoing positive experiences to be able to make a difference in the long term.

Leever, Hulst, Berdendsen, Boenemaker, Roodenburg and Pols (2010:612) explain that many professions are involved but the relationship that is singled out is that of the nurse and doctor. It is essential that collaboration between nurses and doctors is emphasised. There is a growing need for collaboration between all health professionals but optimal collaboration between nurses and doctors is absolutely essential in the delivery of quality health care.

The valuable contribution of the community health worker was highlighted during the focus group interviews with the participants. Working in a team as equals is ultimately to the advantage of the health profession and its ongoing quest to deliver optimal health care. The community health worker was seen as a highly valuable member of the team.

The World Health Organisation (2010:10) explains that "*a collaborative practice-ready workforce is a specific way of describing health workers who have received effective training in interprofessional health education.*"

The majority of the specific population in Avian Park was found to be functionally illiterate. More than 51% of the respondents who had participated in an earlier study conducted by the University of Stellenbosch's Sociology Department, did not complete 12 years of schooling (Heinecken, Vorster &Du Plessis, 2011:7).The community is in need of quality health care and health education as it appears that the majority of the community are not able to read the information available at clinics and health care facilities. The people of Avian Park need to receive appropriate information aimed at their level of understanding and within the context of their life situation. It is of no use to tell them to eat three meals a day as many of the people living in Avian Park do not even have enough money or food to have more than one meal a day. Approximately 10% of the households in Avian Park have a per capita income of R316.00 per month (Heinecken, Vorster & Du Plessis, 2011:11).

The environment and the terrain where people have to move about are not controlled and roads are not tarred, toilets are outside and in most cases not easily accessible.

These factors are only but a few of all the aspects that became evident to the participants. Insight was gained by the participants due to the fact that they were in the living environment of the people of Avian Park and they could experience the life and the living circumstances first hand.

The insights drawn from this experience resulted in participants understanding the challenges which health care is up against and the importance of adapting and working within the constraints placed upon the people.

Thakur, Arnold and Johnson (2009:167) argue that a strategy which could assist in dealing with the challenges would be to focus on gender and social protection. They explain gender and social protection as empowering females to improve nutrition and school attendance which may in the long run lead to the eradication of hunger. Gender protection can lead to food distribution taking place equally between genders.

Another form of social care within a society is Ubuntu. Pera and Van Tonder (2011:51) explain Ubuntu as an African worldview of life, which can also be described as an African tradition and way of life. In reality it translates as the concept that the individual is not alone and that there is an interconnectedness which binds all people together. It is essentially a system whereby there is a social responsibility towards one another and that the needs of the less privileged become the social responsibility of the community. With reference to children it can be described as "*your child is my child.*" This means that all of society is responsible for caring for each other and each other's children, however, it is everyone's responsibility and the participation of all people in a particular community is required.

5.5.14   Advantages of practices within the re-engineering of PHC

5.5.14.1 Home visits
The participants had all experienced the home visits very positively. They had been made to feel welcome in the homes of the families that they visited. This was in itself an educational experience where the participants were faced with the realities of the lives of their clients. The interprofessional group of students was forced to assess the situation and manage the problems within the context of constraints such as poverty, lack of infrastructure and lack of access to other health care facilities.

Several of the participants expressed a sense of personal and job satisfaction because they had been able to help another person by making a slight alteration to an existing situation. The evidence showed that participants were valued by the clients in the community, as well as by fellow students who participated in IPE and IPC.

5.5.14.2 Quality of home visit

Several of the responses related to insight and to the quality of care that was rendered during the home visits. The people of Avian Park were the recipients of health care delivered by specialists in their field, who were collaborating with each other to ensure optimal care.

One participant reported that misconceptions were resolved and health and well-being was restored to a person who had had a hip replacement, as well as to a person suffering from osteoporosis. The aforementioned interventions would never have taken place had it not been for the participant's involvement in the interprofessional collaboration and education that took place in the area.

The evidence has shown that interprofessional collaboration and education can be one of the strategies to facilitate the success of the re-engineering of Primary Health Care in South Africa. Interprofessional collaboration and education form the basis of providing good primary health care, focussing on the prevention and promotion of health in the homes of the individuals.

5.6   FURTHER RESEARCH RECOMMENDATIONS

Further research should be conducted to explore the following:

1) The attitudes and perceptions of other facilities, such as other nursing colleges and other universities towards interprofessional education and collaboration.

2) The differences and similarities between the experiences and perceptions of IPC and IPE of various age and race groups.

3) Methods to establish collaboration between departments at university level and to get the traditional educators involved in interprofessional education and collaboration.

4) The management of perceptions and attitudes amongst health professionals to minimise preconceived ideas and prejudice.

5) Organisational aspects that could contribute to more effective and efficient operational matters within the implementation of interprofessional education and collaboration.

6) The establishment of a universal curriculum for specific health subjects where all health professions spend time studying together and have the opportunity to

specialise in a specific field such as medicine, nursing, physiotherapy or any other field.

7) The promotion of teamwork within the established health care system.

8) The changes (impact study) within the community following intervention by health care professionals where team collaboration and interprofessional education have taken place.

There is an endless flow of thought and ideas for recommended research that could be done but the most urgent are as follows:

- The restoration of flawed relationships between doctors and nurses and other health care professionals, so that the primary health care approach as planned, can be given a chance to succeed in South Africa.

- The perceptions and experiences of the communities relating to interprofessional collaboration and the effectiveness of the services rendered in the light of the plight of people sharing similar socio-economic circumstances as the population group living in Avian Park. The exploration of the needs as seen by the community.

5.7   CONCLUSION

A qualitative descriptive design with a purposive sampling method proved to be a suitable choice for this investigation. This choice aptly facilitated the reaching of all the research objectives of this study.

Valuable information was obtained from all participants. The aspects that were a hindrance to interprofessional collaboration and education were mainly related to organisation and rotation of students during the year. (Refer to appendices B and E).

The most valuable experiences included the experience of team members working together and learning from each other, as well as seeing what the other professionals do in their field of expertise. The participants saw this learning as very beneficial for future referral purposes and for possible early identification of problems that might be best addressed by health care workers from a different profession.

Previous prejudices, such as the perceived hierarchy explained by participants were altered, even if only for the short period of time of being involved in the project. People valued each other and respected each other's contribution to patient-centred care.

The training and curricula of health professionals should be adapted to address the challenges and the needs of South Africa and to ensure the success of the re-engineering of Primary Health Care in South Africa.

The experiences and perceptions of health and allied health professionals regarding interprofessional collaboration and education within the rural clinical placement in Avian Park near Worcester were successfully investigated.

The experience as a whole proved to be beneficial and positive; therefore it is recommended that further investigation and planning be done to guarantee future success and optimal patient-centred care within the re-engineering of Primary Health Care.

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APPENDICES

Appendix A: Transcript of the pilot interview / Interview 1

INTERVIEW CONDUCTED BY RESEARCHER

PARTICIPANTS CODES AND PROFILE OF THEPILOT INTERVIEW

SH - Speech and Hearing students

N- Nursing students

M – Medical students

P- Physiotherapy students

AT – Interviewer

PARTICIPANTS PROFILE

Interprofessional group	participant totals	Participant codes
Speech and Hearing therapy students	n 2	SH1 and SH2
Nursing students	n2	N1 and N2
Medical students n= 1	n1	M1
Physiotherapy students n= 2	n 2	P1 and P2

AT: Thank you very much for participating this afternoon. This is a constructed interview guide that I am going to use just for the purpose of the interviewing. The topic of the research is *'The interprofessional collaboration within an interprofessional education (IPE) context in rural health care in South Africa, looking at student experiences and their perceptions.'* So I would really like it if you could be as honest as possible and as you know this is completely anonymous and your confidentiality and your privacy will be protected at all times. So don't feel that you are restricted to speak your mind – I'd really appreciate it if you could speak your mind and tell us how you honestly feel.

Good, first of all, just a brief description of the project: In the response to the demand for quality community healthcare the University of Stellenbosch: Department Health Sciences has implemented an interprofessional educational project. The latter is taking place in an underserved area of previously disadvantaged people in South Africa. The research will focus on experiences and perceptions of students related to interprofessional collaboration

and interprofessional education. The purpose of this research is to explore the experiences and perception of health and allied healthcare students regarding interprofessional collaboration and education amongst students in a rural healthcare context in South Africa during their clinical placement.

The first question I would like to ask you is:

What were your initial expectations regarding interprofessional collaboration and professional education within the clinical program before you all started working as an intern and the professional group within the clinical field? Would you like to tell me about it? What was your expectations prior to going to Avian Park?

SH1: I think I was very excited about it when first I heard about it. I think it is something that looks very good on paper and then when you get to the clinic it's a lot of organisation and a lot of admin. I think there are some of the finer details that slip through the cracks but eventually we went out, we did the home visits. When we got going I think I started to realise that when you are working in a community you really can't do everything yourself. So it was a good experience in the end. (1)

AT: An eye-opening experience in a sense.

N1: Yes.

AT: Thank you.

How did you (B2) feel about going to Avian Park?

SH1: Knowing that we are going to work in an interdisciplinary team, what N1said, it looks better on paper than it is organised in real-life. Also, when we heard that that's going to be the opportunity, our preparation for it at university level, I'd say that was the first thing we got to do with that you would actually be in that setting, never has it been introduced to us at just normal undergraduate university level. So without having been prepared in your own class or your own setting before going into that scene, that was never there.So what N1 said, in the end we learnt a lot in the end, you could see how valuable it is, but just the preparation beforehand was the key part in terms of admin and knowing what to expect. (2)

AT: So in both your opinions it was a valuable experience but you needed maybe some more preparation prior to attending and you needed better clarification in terms of the expectations during that period?

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N1 & B2: Yes.

AT: How did you guys experience it?

SH1: Ja, there is a lot of admin that goes with it but there's a lot of paperwork that needs to be filled out, especially with referrals. I think it's quite time-consuming filling out all those formsbut I do think a valuable part of Avian Park is the home visits, where we as health care professionals are able to see our patients in their context. We often, speaking for myself, see a problem or a patient in isolation and we don't realise that their home circumstances are what is actually causing the issue in the first place. There is not a lot of parent involvement, just speaking from a speech therapy point of view, there's not a lot of parent involvement and it's difficult for us to carry our therapy over into the home environment, so I think the home visits are actually, they work quite well. We've only done it once but it allows all the professionals to get together and decide on an actual actual plan, and you need to be involved instead of just doing the verbal referrals or the paperreferralsbecause then everyone is part of the actual team. (3)

AT: Tell me, in terms of the paperwork that you were referring to,is that the ICF that you are referring to? So do you think that that was actually a barrier to the collaboration or did it enhance collaboration?

SH2: The thing is, because the speech therapists and physios were rotating the entire time and the medical students also rotated from block to block, so that ICF form, every time a new group comes in it needs to be explained again, and I think that is where the problem lies. Everybody is not sure on exactly how to fill in that form. I mean we haven't been trained at all to draw up junior grams.I mean the physio taught us and they did a good job. So I think that's just a problem, there's gaps in the consistency of how the clinic is run. (4)

AT: How did you feel?

N2: If I may say, I was very excited about and I think it was a well thought-out thing that we did but something that really bothered me is like SH2 said, the students rotate a lot, so sometimes you go to the house of the patients, if we may call them that, and you kind of earn their trust by opening up to them and they're opening up to you and you'd like to follow up or a referral and we need to come back to them, then they already rotated and it's new people,so you can't really build that bond with the people and I think that might be something that we can work on.It's somethingthat can be improved, I just think, in the sense of the people really building a bond with you. (5)

AT: So you feel that at this point in time there's just a bit too much change all the time and you can't really get into it? Is that what you are saying?

N2: Yes.

AT: In terms of the collaboration, if we think of it, this is your perceptions now, your perception when you went there.How did you feel about what you think the collaboration amongst interprofessionals would be like and your perceptions beforehand, and what you feel now in terms of the collaboration, working as groups together, sharing, exploring, referring, learning from each other?

SH2: The thing is, I thought it would be nice to have access, to finally find out exactly what the physios do, what the OTs do, and how the doctors are involved in a specific patient that we might also see. The thing is, I think it's a better idea than it is in practice because we tend to miscommunicate with each other as well, but it's nice to be able to go to someone and say, listen, I have this patient, and he needs this and this and this and how can I do it or can you maybe see him to help out? So for me the whole IPLO is a very good idea, it's just the execution that's still a bit rickety. (6)

AT: So there's still a lot of stuff that needs to be done to sort that out?

SH1: I think if there were like a set group of students that go to Avian Park, the OTs are all here and the medical students are all here, so if there was a set of 8 to 10 students that almost run Avian Park by themselves, it can actually work, because it's such a good idea, because the community that we work in, there aren't a lot of resources and patients can't come to us four times a week for four different therapies, it's not feasible. So if there was 10 students that were dedicated to Avian Park and collaborated amongst themselves and sorted out their own system, I think it's a great idea because it serves the community and it serves us as learning students, because we get to interpersonal learning and interprofessional learning. (7)

AT: So am I correct in understanding that the interruption and the change of students are not conducive to collaboration?

SH1: Yes.

AT: And in terms of education?

SH1: I think everyone has a lot to learn as well as a lot to give. I don't know a lot in terms of physio or dietetics or medicine and I think that we can learn a lot from each other, but we

must also remember that us as speech therapists are not training to be physios and we are not training to be OTs, we are just familiarising ourselves with what these other professions do, so we are able to make appropriate referrals. I think the big issue is referring. That's why we are doing the interprofessional learning, it's to be able to make appropriate referrals for our patients. (8)

AT: You were going to say?

P2: About the collaboration that N1 said in the beginning, that by the end o it, once you get into it you become acquainted with it and you become comfortable with how the interdisciplinary system, how it is supposed to run. Also what SH1 said, in your own specific field you are well-acquainted with what you know how to do assessment by, but once you are in the set-up you kind of realise your own limitations in assessment and you also realise other people's outlook, but as a physio you look at something specific but then you realise, oh but there's actually that dimension to an assessment, too, that needs to be assessed that only comes out when the medical student asks the question or the speech therapist asks the question or the nurse. But I would say the main barrier at the moment with rotating blocks of the physios and the OTs, "ag" not the OTs this year then, but the speech therapists that you come into it but it's that whole giving over of information that kind of causes a lag in where you got to, so like in the beginning it is the giving over of the information from the person in charge to the people starting and then they come into it, but once the red block is rotated then it's the next people and then there's that lag and no-one really knows what's going on and then they get into it and then they rotate and then ... (9)

AT: Soit's interrupted all the time?

P2: Yes.

SH2: And I think in the end it could even affect the quality of care that we give because maybe there might be problems that can slip through the cracks, while there are three people treating one patient a year instead of a one to one relationship ratio. (10)

AT: Any other thoughts on your expectations initially when you first went to IPLO?

N2: I would like to say, I thought we were going to interact a lot more with the patients in a sense, with actually treating them and working with them, and as soon as we started it was all about forms we had to fill in like this thick form every time, and I felt that you're not really sitting down and talking to the patient. It was just like, this is your first time and I see you do not have any grants. It felt a bit unpersonal, you can't really connect and I felt like I was

intruding in their personal life – they don't have to tell me these things. It's kind of, not demanding, but I think they might feel overpowered and then it was more about finding out about them and then writing referrals, but I never felt I actually helped them and treated them and see how their circumstances improve or how their illness actually improves. (11)

AT: So actually the barriers that you are experiencing are far more prevalent than what you are experiencing in collaboration amongst members? Is that correct when I say that?

Interviewees: Yes.

AT: So the barriers are so great that you haven't really had time to really get into the real working together, the real collaborating?

Interviewees: Yes.

AT: I would like to move on to the next question. *Were your expectations regarding the IPC met within the time that you all worked together in the rural project?* Now obviously you said to me that it wasn't, but if you could maybe just tell me a little bit more just in terms of the collaboration amongst yourselves as student groups together and your expectations of that interaction, not necessarily with the patient itself but amongst yourselves. What was good about the interaction that you have sort of identified and what would not be such a good thing? Anybody?

N2: I think one of the things that really worked, we are all different specialities but in the end we are all people and we have the same goal and we want to help people, and I think that made a connection amongst us, although we don't really know each other. Some of the not bad things, but we didn't really get to know our team members on a personal level. You got there, you were divided into groups and then you would go out and it was about the patient, you don't really get a bonding time or get to know each other, especially with the people rotating a lot as well, so we couldn't really bond. (12)

AT: So collaboration is not something that really took place?

SH2: When we divided into the groups to go into the homes, there isn't very much structure within the groups so you don't know this person is going to do the interview, that one is going to fill out the form. It should just be more structured so each person has a specific role within that group, otherwise one does all the work and four just sits there. (13)

AT: Just sit and watch? OK.

From that perspective you didn't think that there was good collaboration in terms of team work at the actual patient's home?

Interviewees: No.

AT: Did you have any discussions afterwards in terms of the patient's visit or the home visit where you feel that maybe collaboration was coming a little bit more to the fore?

SH1: After our home visits we would get together and discuss patients who are on their way back from the home visit. It would be a case of one person fills out the form and completes the junior gram. We kind of discussed it and discussed a management plan and made an appropriate referral, so in that sense it does work in favour of the patient, because there is now a system in place, coming in place where we prioritise which home visits need to be re-evaluated or followed up on, and that's just started recently. I think it all comes down to referring, you've got to know what you're looking for and you have to know all the disciplines to be able to know something about each discipline and that does require having a team that knows something about it. (14)

AT: If I make a statement like e.g. that collaboration would have been fantastic in the sense where, if one person is absent, let's say there was a physiotherapist absent, and there was a great need to do some intervention, that the collaboration would have been of such kind that some of the other disciplines would have been able to step in for a short while or for that one session until such time that the physio could attend. Because you write out the referral but this referral may take two or three weeks before the patient can actually get to see them, so someone's got to do something in between. Do you think that collaboration at this level could facilitate that kind of action?

P2: My opinion of it is that you have a fixed form that you have to fill out and it doesn't really allow any discipline to really go in depth with what their discipline would assess, so at the moment it feels like to me, even if you have a medicine student, and there's a physio and a speech therapist that we have this fixed form we have to fill out, so if the physio isn't there it's not going to make a difference because we're just filling in this form. I think the physio also would have just looked at the form and would have known what to ask, so if one person is not there it's not going to make it different because the form is telling us what questions to ask, so in a certain manner this form is definitely a good guideline for us but it is also a barrier for each discipline to really put in what their discipline kind of comprises of. (15)

AT: So if you could remedy the situation, how would you do that?

SH2: I would change the format of the ICF. (16)

AT: Change the format?

SH2: Yes, because the thing is, you go in, you are a team of five people, and we fill out this form. The physio's don't find out what they need to find out to rehab the patient, the speech therapists don't find out, the medicine students don't know what to prescribe or how to treat because we have this set form and this is what you have to ask. We are so focused on filling out this form and whatever that you kind of, you don't see the patient any more, you only see the form. You are so fixed on the admin, so it would be better to just have like a case history and when you go and see a specific patient, ask about a specific patient,and you can notice things and you can see with your eyes what the house looks like and the environment without having to fill out something. Then one person can do a case history and the physios can get to do a screening or an assessment so that they know specifically what to treat, and the speech therapists and the medicine students and the OTs, so that we can each have something specific to our field to assess and maybe the physios do something that we notice as well but that might be a problem for speech. (17)

AT: Thank you for your input. Any other input from this side of the group?

N1: I think with the form it's nice as a guideline but also what SH2 said, it would be a better idea to have a little guideline and then we can write a report on that house. So we have a guideline to go back to if there's not a physio there that day then we can go back and what is the type of things the physio would look at and then we can just see that and do the report on what we found there at that house. (18)

AT: Some more information?

M1:I kind of liked the format of the form as it is. Yes, it is time-consuming for the first visit, but it gives you something to build on. I mean you're not going to be repeating your first visit. If the form is in the file it gives the next person something to improve on or build on or maybe just inquire about the part that they are interested in. I think, we've only had a first visit, I've only been on one home visit but I don't think it should be, I think it's going to be different later on in the year, so I don't have a lot to go on now but I am still optimistic. (19)

AT: In terms of collaboration for you, in terms of working with other people, feeling that you are learning from them and working together – how did you experience that?

M1: Unfortunately I am in the Thursday group so I think it's only physios that go with us, so it's a little difficult but it was very nice when we worked together and she had a bit of insight

into what the OTs do as well, and I think the sharing of information was very good and it really made me feel like I'm not alone responsible for this patient or the entire family. (20)

AT: That there's a shared responsibility?

M1: Yes.

AT: Okay. The next question. *Your personal experience of interprofessional collaboration within a rural context.* After you have completed that first visit there, what was the thoughts that you had immediately after this experience, after your very first time that you went there and you thought back? Did you think what was this year about or what did you think?

P1: I was taken aback after the first because it was not as structured as it is now. It was a bit confusing at the end because you didn't really know what was expected, how it should be done, but it was something that, after the six weeks of us working here and the whole process falling into place, you kind of got a better idea. So at first it was very confusing and then, when we all sat down, all of it was explained, it all gained structure and you had a better understanding. (21)

AT: So you had a bit of a longer exposure to the project than some of the other participants in this group, so in terms of your experience and your initial perception, did that change over time? 25:45

P1: Definitely, it definitely got more structure. I think on the first home visit at the end of this session there was no actual team work collaboration as such. It wasn't that nobody wanted to give their input or something like that, it was just that everyone's role wasn't stipulated clear enough. Everyone wasn't informed on what their role should be and how does it work. But then we went and I think it was last week when we got a clearer picture, everybody was in full informed, the whole process was explained. We had a home visit where we filled in the form. It was nicely done and the doctor did his part, did the quick test, the physio, I did the quick test and the OT that was there did her test. At the end we came back, we filled in the ICF and we had our treatment plan and we referred appropriately. So it's not something, the teamwork doesn't necessarily happen in the house but after you come back, after you have done all the tests, you come and you talk because it's not always nice to sit before a patient and say, okay, so I think this is the problem. It's something you do at Avian Park when we came back. (22)

AT: Okay, so with more time, working together and that consistent contact between the same people, you can get back and then you can sit together and basically put your thoughts

together in a sense and come up with a plan that is more sort of like encompassing, addresses more aspects in terms of the patient, instead of just one person from one discipline going there. Is that correct? Is that how I understood what you said? 27:30

P1: Yes.

AT: Regarding the project, what would have made it better for you in terms of collaboration? From what I've heard so far it's just ideas that it seems like better preparation beforehand. Is that correct?

P2: Ja, I think, well a suggestion, if you get all the disciplines together, everyone you know who will be that day participating in IPLO, get them together and have an example of what the form would belike, so you have everyone together. So there you have all the disciplines, asking questions about the form and then to clear any misunderstandings up before you get there and you have to rush now to get everyone together and go to a home and so no-one really knows what's going on. Rather sit everyone down because Avian Park itself is also like a small toothpick container with a small space in front and the patients are there. So get everyone together in a more relaxed environment where you say this is an example of the form and this is what we would expect of you, and to clear up anything that needs understanding before you actually get there and you need to go out. (23)

AT: In terms of knowing about each other, in terms of peer teaching – did you teach each other about what was going on? Did you have any input in each other's learning?

SH1: Our first visit to Avian Park, the physios that were there filled us in on all the forms that needed to be filled out, they were very helpful. So in that regard I know two of our other students that are not here today went and observed a session that the physios were conducting, I think it was an assessment and I think they learned quite a bit. And I know we've seen each other do sessions and also we can ask each other, even if it's not at Avian Park, we can ask each other professional advice in terms of our patients that we see because I don't know everything, well I don't know anything about observing to be honest, or enough to be able to help my patients in a way that is holistic because we all think that our profession is tops. (24)

AT: The beginning and the end.

SH1: Yes, everyone thinks so. But I think it is a great learning experience and today we talked to the physios and the OTs about neurogenic communications disorders and what to look out for, just small signs that make referrals easier. (25)

AT: So what you were saying is that you and the physios worked really well together. And in terms of with other disciplines?

SH1: We actually haven't been exposed to other disciplines. On the home visit that I went on there wasn't a doctor coming with us, or a medical student coming with us, it was just us and the physios and then today was the first time that we had OTs there and they were also part of our group. But we did home visits that day so we've only seen the physios. (26)

AT: So you haven't really had the exposure of a full interprofessional team working together?

Interviewees: No.

AT: I think we've discussed quite a bit in terms of the limitations and that is the next question. *Do you think there are limitations?* Maybe I can just summarise that and maybe get some more input if you can think of something else but it's basically that it should be better organised in terms of what's actually happening. And then furthermore you said that there's quite a lot of documentation involved although you felt,N1, that the documentation gave a nice basis to work from because one needs to be able to communicate through recordkeeping. Also the fact that it's a bit haphazard, the way the people are attending and then people come in and people don't come and the full team wasn't together. For example the nursing students, there are fourth year nursing students that will be attending from now and there were already professional nurses that were already qualified that were specialising in primary healthcare that did attend in the past, so none of you had that kind of experience with those disciplines, which is in a sense you've got a blank back there again?

SH2: Yes, the thing is we're eight speech therapists in Worcester at the moment and the four of us that were on Avian Park now are rotating again with the other 4. So that's the whole thing, I would love to actually go on a home visit with a doctor and a nurse and a physio and an OT and a speech therapist because it would be a nice experience to see everybody's role and you can pick each other's brains, but we haven't had that opportunity. (27)

AT: But that is what it really should be about, isn't it, and to really learn from each other? Because I think one also doesn't really know that much about the other professions as you say, you know, there is a wealth of information and expertise amongst this group here and it almost needs to be together as one in a sense, isn't it?

SH2: Yes.

AT: OK. How did your exposure to this project, and I think we've already basically discussed this, how did it affect your perception of interprofessional education? Collaboration and

education, do you think that those things go together and that there is a possibility of that? Have you had a bit of a taste of it? From what you've said it sounds like it so far. For you?

M1: I would like to see what the rest of the year brings. I think it's just a little bit too little at the moment. (28)

AT: Okay, so maybe in time you will be able to give greater input. Well, the good news is that in three months' time this will be repeated and we will look at the difference in perception and experiences now to experiences and perceptions in three months' time and hopefully one can change some of the concerns and maybe bring it into making it more meaningful.

P2: Just what M1talked about, we've only been on the first time home visit, so you have your form and the aim of the visit is kind of just to fill in the form, well I'm not clear on that but I don't know if we follow up on that visit and we have sent out the referrals where, if we would say the referral was to the speech therapist and the physiotherapist, would the second home visit then be that we would focus on them, because at the moment if the aim of IPLO is to actually know what the nurse does I would know then this person definitely needs referral, the speech therapist does that thing. If that is the aim of giving the form then that's not working at the moment because if you want me to know what the speech therapist does, let me just go with and let them do their assessments and I'll observe and I will know so much better. If the doctor wants to know what a physio does, let the doctor go with and see an assessment rather, because at the moment we're kind of all on the same level doing the same thing, that is filling in a form. So three months from now to know when you are following up on that home visit, does this specific discipline kind of get a bit more responsibility to go further in depth with what they were referred to, or is it just going back to the form and filling in gaps. (29)

AT: I think maybe those questions could be answered later for you if you had to go back thereagain and spend more time in the situation, as M1 said, she'll see what the year brings. The two students sitting here from nursing have had exposure to IPLO over a period of more than a year and I don't know if they'd like to answer. How did the exposure to IPC project influence your perception of interprofessional education?

N2: During the visits, I must say I didn't learn that much from each other because like P2 said, it was all about the form and you had to fill in the form and you can give that to any speciality to fill in.On the way back when we discussed the patient and the doctor would say he needs referral to whatever, then I did learn because they explained to you nicely why they say this and howpeople can help the patient further, but in a sense we didn't get to go back

with these physios whichever they were referred to, if they were referred to a physio, we never had the opportunity to go with the physio to observe how they treated the patient. So I wouldn't say we didn't learn theoretically but we didn't get to see practically how the different specialities worked together. (30)

N1: We once also had a house that had I think four people in the house so on one visit we could have done the whole interview and we've looked for any possible referrals and everything, but then we get a house that has got fifteen, sixteen people living on the yard or on the plot, whatever, at the address and then we had to get back and if we go back everything just opens and you will see, all the records you've taken, now you can look back on it but now you understand. You just start to talk to the people, you will ask them other questions, you have time to ask and they build up that trust in you, so then it's better when you go back on the big house. (31)

AT: So I think what you were also saying, that initially it looks as if it's just about forms but then if you go back again and again it might start getting more meaningful and then you can gain greater depth in terms of what it is that you will be doing. I think just in summary you've already made some suggestions but I would just like to go around and just ask everybody, if you have got a suggestion of your own that you would like to put in regarding your own professional development and your own personal development and what you can actually achieve in this process, how would you like this to happen and what could you achieve out of this. And if you feel that you didn't achieve how would you like to change it so that you can achieve? Who would like to start?

SH1: I will. I think creating teams is quite important so that you get a chance to become a team and not just forced into, okay you five can go off and do a home visit. I think it's important as health professionals that we trust our other health professionals and the med students in their profession and if we are making these referrals it is almost a trust basis that you are going to do something to help, because I can't do everything. And having a team like a specific team that has a time every week that does their home visits and not doing a rotation that just causes chaos, it will help us learn from each other more because we're going to trust each other more and form bonds and get to know each other. I don't think it's possible if you're just seeing people once a week on an off chance. (32)

N1: I agree with SH1. I think it should be more organised in the sense that we get the opportunity to learn more from each other, because I've been on a home visit and I have been to Avian Park where there were other disciplines but I haven't honestly found like I had

the opportunity to really learn from them. What's nice is, you do have access to me because you can go and ask a question but I would like to actually see them in action. (33)

AT: I really think we can do that. If I can just think of an idea, initially before you all go out to homes to maybe teach each other first before you go and demonstrate your skills to one another? Do you think that would be a good idea?

N1:I think it would be a good idea to take just ten minutes before the home visit and discuss. The physio can say I want to do this type of assessment and the OT can say I am going to do this type of assessment and the doctor says I am going to look at these factors and do these tests and the speech therapists and the nurses, everybody gets a chance to say exactly what they're going to do and a home visit is about an hour or so. Just divide up the times, so you know you have a specific amount of time when you need to do everything, and if it's more organised I think they have a better opportunity for better learning. (34)

AT: Better organisation, better learning.

M1: I really like what the speech therapists are saying. But I think make it relevant, maybe do it afterwards, maybe do it in small chunks or something, whoever is most involved. I think for what they have in mind you would have to have the basics already, you would have to have the ICF and you have to have an idea of what's going on in the patient's life or in that household, whatever is relevant, but I really like the idea of teaching, I think the time constraints, I think the timing is very difficult. You have to do three home visits and if you get stuck on one – we were supposed to leave by four I think, but many times we left after five. (35)

AT: So would you say that in a sense you would like fewer allocated various families and maybe just work intensely with maybe two or three families? Would that make a difference?

M1:I think that would be ideal, but there are so many families missing out then, or patients missing out, so it's kind of quality versus quantity. (36)

AT: I'm just trying to think how can one overcome that kind of barrier because the whole focus is basically also on education at the same time as providing a service, so it's basically focused on your professional development and on your personal development at the same time, but not to take away from the quality that we would like to render in terms of care to the community.

N1: Also when we do home visits maybe the physio sees someone. There was a little boy once, you could see his one leg was much smaller than the other one and they will say

come, come, come here and then they will look and they will show us what they were looking for and the parents maybe sometimes they come also, looking what we're doing, so that's nice on the spot there. When we go back it's also nice to discuss the problems that we found there and then maybe do a speech referral or maybe say we can do this and this and make the right referral. (37)

AT: So maybe just a short discussion 5 or 10 minutes before, then go in and do the assessment and learn as much as you can at that time and then come back and sort of summarise what has been done and discuss about where you are going further. Is that sort of what I am picking up?

Interviewees: Yes.

AT: Okay, so there was some learning that did take place.

N2: I agree with N1. I think it's a really great idea while you do the assessment to explain what you are doing and why you are doing it, not only to inform the patient but also at the same time you teach the other occupations. I think that's a really nice idea. Also, you don't have to explain afterwards, do your decision now and afterwards go back to the containers, then explain why you did it. It's a lot easier to learn on the spot and if you have questions then you can ask them on the spot, you may forget on the way back something you wanted to ask them. (38)

P1: Out of experience, it's more structured if you sit beforehand and you and the team that's going in discuss, so this is the patient profile, this is what I want to test, this is what the physio wants to test, this what the OT wants to test and then you do it after you have filled in the form. And you come back and you discuss the whole process and why you did what and what did you find out of assessing it, just more discussion within the team. (39)

AT: So talking to each other will allow more education taking place.

N2: Yes.

M1: I just think we forget the patient is also part of the team, so maybe instead of coming back to the clinic, maybe you can have your full discussion with the patient. I have seen it done at the hospitals, that they would have a weekly meeting with people so that everybody can say what they have observed the week and then they would have the discussion with the patient and with each other around the bedside.So obviously with a home visit maybe you can just sit down with the patient and discuss, maybe choose a main topic, you can't sort out everything in one visit, and it's not like you're never going to see the patient again.It

might be a long time before you see the patient again, but maybe just prioritise and have a discussion around the main problem. (40)

AT: The most significant.

P1: I just want to say with regards to the other, I just had a short discussion this morning on the topic of ward rounds.It just always has to be important that the person or the team involved knows how to be respectful and what they discuss, they must have a barrier what's appropriate and what's inappropriate because sometimes it's just like really sjoe, are you saying this in front of a patient?There has to be this respect and appropriateness.You have to think of what you are saying and how you are treating the patient in that context. (41)

AT: Oh definitely.

SH2: It's also because we are all in the medical field and we have all our own terminology and words we just throw around and the poor patient is sitting there and thinking, what are you saying?(42)

AT: It must be so threatening for them.

SH2: Yes. So it's just when we are talking, if we do that, that we break it down easily so they understand. (43)

N2: If I may say, I think it's very important to forget that this isn't procedure-driven, it's not finding out as much as you can about the patient medically and only treating the patient medically. You have to look at them socially as well and their well-being overall, make sure they're understanding what you are doing, because sometimes they just say yes, yes, because they're also scared because we use all these big words and they're not really sure what we want to do and where we're from. They feel so overpowered and just say okay, go ahead, so I think it's very important to really include the patient and make sure they understand everything you do and not just make this like go and do your thing and get it over with. (44)

AT: So you feel that maybe to a certain extent the patient's dignity and worth is being affected in this situation and they're not really regarded as the actual focus of the intervention?

SH1:I don't think in Avian Park it is all that prevalent. I think everyone that's there, is there for the patient. If we're speaking about IPLO and the hospital, that's a completely different story.

If we say it's Avian Park, I think we do consider the patient a patient and not just an illness. (45)

AT: It's different when you actually enter the patient's home than seeing the patient in the hospital, is it?

SH2: It was a very eye-opening experience because most of us up until now, we've never actually made contact with the environment that the patient comes from they normally came to Tygerberg Hospital and you see them and you see them go. But now to actually see where they live, it's such a culture shock actually to see where they live and what they're used to and it gives you a better idea on, right, next time I see a patient that I know is from the rural area I'm going to adapt my therapy and assessments and techniques so that it is suitable for his or her environment and not for Tygerberg Hospital or Worcester Hospital. It has to be applicable for that little house where sixteen people live in. (46)

AT: So it's not just about interprofessional discipline, it's also teaching you to be able to adapt, to change.

SH2: Yes.

AT: Your feelings and your last words in terms of the influence of this on your professional and personal development?

P2: Personal development, I think maybe before this I was kind of sceptical about how the hierarchy of different professions would influence the approach we have, but I can say I was kind of positively surprised that the hierarchy really, because it was new to everyone and everyone was kind of on the same level in terms of trying to keep themselves humble towards the challenge, so personally that was a good surprise for me because I think in a way maybe at university and how the hierarchy was kind of set there, not because it is there but because people's preconceived ideas of it is there, so personally that was kind of a barrier I overcame. And then I think what I long for was to rather be part of a team where either the nurse or the speech therapist or the OT have their evaluation and I can really see it and not that all of us have the same fixed form we have to fill in. (47)

AT: That everybody just runs and does their little bit.

P2: Yes.

AT: You've used a very interesting concept and if you don't mind, I'd like to elaborate a little bit on that. In terms of the hierarchy, how do you find the hierarchy functioning within interprofessional collaboration?

P2: Especially here in Worcester and Avian Park and how I think our backgrounds of working at, say, Tygerberg Hospital, there it is a fixed hierarchy like personal experiences may have kind of lead some us to feel that okay, well we are here, they needed us here, we are kind of placed here, so we'll do something for the patients. So I think and because Avian Park in Worcester that interdisciplinary thing is so focused on and doing the home visits I think for any medicine student to see like, wow, they are so much needier than just what they specialise in, or the speech therapist says, wow, there's so much more than just speech therapy needed or the physio, so it's the whole community and just the rural setting itself kind of gives the opportunity for you to see that you can't really have a hierarchy here because that patient's needs in every aspect of his life is almost just as big or equal size. (48)

AT:I f I can bring someone else into the hierarchy – community health worker.

M1: I think we basically serve a hierarchy but we need a leader and I think the home-based carer who goes on home visits with us and who is responsible for that family or that patient is a very good person to start with. From my experience they are very quiet. I would like to hear them speak more or just take leadership. (49)

AT: To just take leadership ...

M1: Guide the rest of us on what should be happening. (50)

AT: Because I truly expect that of the community. It's great that this came up, I was waiting for this to come up. Any last thoughts in terms of collaboration and working together and just how much you can give and learn from each other – is this a worthwhile exercise?

SH2: Yes, it is a worthwhile exercise. I think it's in the beginning stages now, that's why it's so frustrating and it feels like it's not working. (51)

AT: Because you're not really getting into it.

SH2: Yes, but I mean six months from now, two years from now it may be very successful, depending on how hard we are willing to work. So I think it's just like little things need to be addressed, it's like designing a car or something, you need to find ... for it to work. But it is

valuable, I've learned from the physios and the OTs. I wish we had the nurses, I love nurses (thank you), they know their patients so well. (52)

AT: Any other ideas, any other thoughts, any other perceptions?

N2: I think something that we can focus on is health education because we are treating the existing problems but some of the problems can be prevented and I think prevention is better than cure. We don't really spend a lot of time in educating the patients and every special day I'm sure they have a little something they can add to that education, even if you take five or ten minutes and just, maybe you get a house and there's not really problems, you can still educate the people. (53)

AT: Prevent this burden of disease.

N2: Yes.

AT: I would like to thank you very much for attending and for being so open and discussing this in such detail. I have the fortunate role to play now to put it all together, draw out the main themes of it and we will give you feedback at the project and maybe in time this will have a positive input in terms of how the process is being fine tuned in future, but thank you very much for your participation.

Appendix B: Pilot interview analysis

PARTICIPANTS CODES AND PROFILE OF THEPILOT INTERVIEW

SH - Speech and Hearing students

N- Nursing students

M – Medical students

P- Physiotherapy students

PARTICIPANTS PROFILE

Interprofessional group	participant totals	Participant codes
Speech and Hearing therapy students	n 2	SH1 and SH2
Nursing students	n2	N1 and N2
Medical students n= 1	n1	M1
Physiotherapy students n= 2	n 2	P1 and P2

PARTICIPANT RESPONSES

PILOT INTERVIEW RESPONSES	RESPONSE NO
N1: "*I think I was very excited about it when first I heard about it. I think it is something that looks very good on paper and then when you get to the clinic it's a lot of organisation and a lot of admin. I think there are some of the finer details that slip through the cracks but eventually we went out, we did the home visits. When we got going I think I started to realise that when you are working in a community you really can't do everything yourself. So it was a good experience in the end.*"	1
SH2*"Knowing that we are going to work in an interdisciplinary team, what was said, it looks better on paper than it is organised in real-life. Also, when we heard that that's going to be the opportunity, our preparation for it at university level, I'd say that was the first thing we got to do with that you would actually be in that setting, never has it been introduced to us at just normal undergraduate university level. So without having been prepared in your own class or your own setting before going into that scene that was never there. So what SH1 said, in the end we learnt a lot in the end, you could see how valuable it is, but just the preparation beforehand was the key part in terms of admin and knowing what to expect"*	2

SH1: *"Ja, there is a lot of admin that goes with it but there's a lot of paperwork that needs to be filled out, especially with referrals. I think it's quite time-consuming filling out all those forms but I do think a valuable part of Avian Park is the home visits, where we as health care professionals are able to see our patients in their context. We often, speaking for myself, see a problem or a patient in isolation and we don't realise that their home circumstances are what is actually causing the issue in the first place. There is not a lot of parent involvement, just speaking from a speech therapy point of view, there's not a lot of parent involvement and it's difficult for us to carry our therapy over into the home environment, so I think the home visits are actually, they work quite well. We've only done it once but it allows all the professionals to get together and decide on an actual plan, and you need to be involved instead of just doing the verbal referrals or the paper referrals because then everyone is part of the actual team"*	3
SH2: *"The thing is, because the speech therapists and physios were rotating the entire time and the medical students also rotated from block to block, so that ICF form, every time a new group comes in it needs to be explained again, and I think that is where the problem lies. Everybody is not sure on exactly how to fill in that form. I mean we haven't been trained at all to draw up genograms. I mean the physio taught us and they did a good job. So I think that's just a problem, there's gaps in the consistency of how the clinic is run"*	4
N2: *"If I may say, I was very excited about and I think it was a well thought-out thing that we did but something that really bothered me is like SH2 said, the students rotate a lot, so sometimes you go to the house of the patients, if we may call them that, and you kind of earn their trust by opening up to them and they're opening up to you and you'd like to follow up or a referral and we need to come back to them, then they already rotated and it's new people so you can't really build that bond with the people and I think that might be something that we can work on. It's something that can be improved, I just think, in the sense of the people really building a bond with you"*	5
SH2: *"The thing is, I thought it would be nice to have access, to finally find out exactly what the physios do, what the OTs do, and how the doctors are involved in a specific patient that we might also see. The thing is, I think it's a better idea than it is in practice because we tend to miscommunication with each other as well, but it's nice to be able to go to someone and say, listen, I have this patient, and he needs this and this and this and how can I do it or can you maybe see him to help out? So for me the whole IPLO is a very good idea, it's just the execution that's still a bit rickety"*	6

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SH1: *"I think if there were like a set group of students that go to Avian Park, the OTs are all here and the medical students are all here, so if there was a set of 8 to 10 students that almost run Avian Park by themselves, it can actually work, because it's such a good idea, because the community that we work in, there aren't a lot of resources and patients can't come to us four times a week for four different therapies, it's not feasible. So if there was 10 students that were dedicated to Avian Park and collaborated amongst themselves and sorted out their own system, I think it's a great idea because it serves the community and it serves us as learning students, because we get to interpersonal learning and interprofessional learning"*	7
SH1: *"I think everyone has a lot to learn as well as a lot to give. I don't know a lot in terms of physio or dietetics or medicine and I think that we can learn a lot from each other, but we must also remember that us as speech therapists are not training to be physios and we are not training to be OTs, we are just familiarising ourselves with what these other professions do, so we are able to make appropriate referrals. I think the big issue is referring. That's why we are doing the interprofessional learning, it's to be able to make appropriate referrals for our patients"*	8
P2: *"About the collaboration that N1 said in the beginning,that by the end of it, once you get into it you become acquainted with it and you become comfortable with how the interdisciplinary system, how it is supposed to run.Also what SH1 said, in your own specific field you are well-acquainted with what you know how to do assessment by, but once you are in the set-up you kind of realise your own limitations in assessment and you also realise other people's outlook,but as a physio you look at something specific but then you realise, oh but there's actually that dimension to an assessment, too, that needs to be assessed that only comes out when the medical student asks the question or the speech therapist asks the question or the nurse.But I would say the main barrier at the moment with rotating blocks of the physios and the OTs, "ag" not the OTs this year then, but the speech therapists that you come into it but it's that whole giving over of information that kind of causes a lag in where you got to, so like in the beginning it is the giving over of the information from the person in charge to the people starting and then they come into it, but once the red block is rotated then it's the next people and then there's that lag and no-one really knows what's going on and then they get into it and then they rotate and then …."*	9
SH2:*"And I think in the end it could even affect the quality of care that we give because maybe there might be problems that can slip through the cracks, while there are three people treating one patient a year instead of a one to one relationship ratio"*	10

N2:" I would like to say, I thought we were going to interact a lot more with the patients in a sense, with actually treating them and working with them, and as soon as we started it was all about forms we had to fill in like this thick form every time, and I felt that you're not really sitting down and talking to the patient. It was just like, this is your first time and I see you do not have any grants. It felt a bit unpersonal, you can't really connect and I felt like I was intruding in their personal life – they don't have to tell me these things. It's kind of, not demanding, but I think they might feel overpowered and then it was more about finding out about them and then writing referrals, but I never felt I actually helped them and treated them and see how their circumstances improve or how their illness actually improves"	11
N2: "I think one of the things that really worked, we are all different specialities but in the end we are all people and we have the same goal and we want to help people, and I think that made a connection amongst us, although we don't really know each other. Some of the not bad things, but we didn't really get to know our team members on a personal level. You got there, you were divided into groups and then you would go out and it was about the patient, you don't really get a bonding time or get to know each other, especially with the people rotating a lot as well, so we couldn't really bond"	12
SH2: "When we divided into the groups to go into the homes, there isn't very much structure within the groups so you don't know this person is going to do the interview, that one is going to fill out the form. It should just be more structured so each person has a specific role within that group, otherwise one does all the work and four just sits there.	13
SH1:"After our home visits we would get together and discuss patients who are on their way back from the home visit. It would be a case of one person fills out the form and completes the genograms. We kind of discussed it and discussed a management plan and made an appropriate referral,so in that sense it does work in favor of the patient, because there is now a system in place, coming in place where we prioritise which home visits need to be re-evaluated or followed up on, and that's just started recently. I think it all comes down to referring, you've got to know what you're looking for and you have to know all the disciplines to be able to know something about each discipline and that does require having a team that knows something about it"	14

P2: *"My opinion of it is that you have a fixed form that you have to fill out and it doesn't really allow any discipline to really go in depth with what their discipline would assess, so at the moment it feels like to me, even if you have a medicine student, and there's a physio and a speech therapist that we have this fixed form we have to fill out, so if the physio isn't there it's not going to make a difference because we're just filling in this form. I think the physio also would have just looked at the form and would have known what to ask, so if one person is not thereit's not going to make it different because the form is telling us what questions to ask, so in a certain manner this form is definitely a good guideline for us but it is also a barrierfor each discipline to really put in what their discipline kind of comprises of"*	15
SH2:*"I would change the format of the ICF"*	16
SH2:*"Yes, because the thing is, you go in, you are a team of five people, and we fill out this form. The physiosdon't find out what they need to find out to rehab the patient, the speech therapists don't find out, the medicine students don't know what to prescribe or how to treat because we have this set form and this is what you have to ask. We are so focused on filling out this form and whatever that you kind of, you don't see the patient any more, you only see the form. You are so fixed on the admin, so it would be better to just have like a case history and when you go and see a specific patient,ask about a specific patient,and you can notice things and you can see with your eyes what the house looks like and the environment without having to fill out something.Then one person can do a case history and the physios can get to do a screening or an assessment so that they know specifically what to treat, and the speech therapists and the medicine students and the OTs, so that we can each have something specific to our field to assess and maybe the physios do something that we notice as well but that might be a problem for speech"*	17
N1: *"I think with the form it's nice as a guideline but also what SH2 said, it would be a better idea to have a little guideline and then we can write a report on that house.So we have a guideline to go back to if there's not a physio there that day then we can go back and what is the type of things the physio would look at and then we can just see that and do the report on what we found there at that house"*	18
M1:*"I kind of liked theformat of the form as it is. Yes, it is time-consuming for the first visit, but it gives you something to build on. I mean you're not going to be repeating your first visit. If the form is in the file it gives the next person something to improve on or build on or maybe just inquire about the part that they are interested in. I think, we've only had a first visit, I've only been on one home visit but I don't think it should be, I think it's going to be different later on in the year, so I don't have a lot to go on now but I am still optimistic"*	19

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M1: "*Unfortunately I am in the Thursday group so I think it's only physios that go with us, so it's a little difficult but it was very nice when we worked together and she had a bit of insight into what the OTs do as well, and I think the sharing of information was very good and it really made me feel like I'm not alone responsible for this patient or the entire family*"	20-
P1:" *I was taken aback after the first because it was not as structured as it is now.It was a bit confusing at the end because you didn't really know what was expected, how it should be done, but it was something that, after the six weeks of us working here and the whole process falling into place, you kind of got a better idea.So at first it was very confusing and then, when we all sat down, all of it was explained,it all gained structure and you had a better understanding*"	21
P1:"*Definitely, it definitely got more structure.I think on the first home visit at the end of this session there was no actual team work collaboration as such. It wasn't that nobody wanted to give their input or something like that, it was just that everyone's role wasn't stipulated clear enough. Everyone wasn't informed on what their role should be and how does it work. But then we went and I think it was last week when we got a clearer picture,everybody was in full informed, the whole process was explained.We had a home visit where we filled in the form.It was nicely done and the doctor did his part,did the quick test, the physio, I did the quick test and the OT that was there did her test.At the end we came back, we filled in the ICF and we had our treatment plan and we referred appropriately.So it's not something, the teamwork doesn't necessarily happen in the house but after you come back, after you have done all the tests, you come and you talk because it's not always nice to sit before a patient and say, okay, so I think this is the problem. It's something you do at Avian Park when we came back*"	22
P2: "*Ja, I think, well a suggestion, if you get all the disciplines together, everyone you know who will be that day participating in IPLO, get them together and have an example of what the form would be like, so you have everyone together. So there you have all the disciplines, asking questions about the form and then to clear any misunderstandings up before you get there and you have to rush now to get everyone together and go to a home and so no-one really knows what's going on. Rather sit everyone down because Avian Park itself is also like a small toothpick container with a small space in front and the patients are there. So get everyone together in a more relaxed environment where you say this is an example of the form and this is what we would expect of you, and to clear up anything that needs understanding before you actually get there and you need to go out*"	23

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SH1: "Our first visit to Avian Park, the physios that were there filled us in on all the forms that needed to be filled out, they were very helpful. So in that regard I know two of our other students that are not here today went and observed a session that the physios were conducting, I think it was an assessment and I think they learned quite a bit. And I know we've seen each other do sessions and also we can ask each other, even if it's not at Avian Park, we can ask each other professional advicein terms of our patients that we see because I don't know everything, well I don't know anything about observingto be honest,or enough to be able to help my patients in a way that is holistic because we all think that our profession is tops"	24
SH1: "Yes, everyone thinks so. But I think it is a great learning experience and today we talked to the physios and the OTs about neurogenic communications disorders and what to look out for, just small signs that make referrals easier"	25
SH1: "We actually haven't been exposed to other disciplines. On the home visit that we went on there was a doctor coming with us, or a medical student coming with us. It was just us and then the physios and then today was the first time that we had OT's thereand they were also part of our group. But we did home visits that day so we've only seen the physios"	26
SH2: "Yes, the thing is we're eight speech therapists in Worcester at the moment and the four of us that were on Avian Park now are rotating again with the other 4. So that's the whole thing, I would love to actually go on a home visit with a doctor and a nurse and a physio and an OT and a speech therapist because it would be anice experience to see everybody's role and you can pick each other's brains, but we haven't had that opportunity"	27
M1: "I would like to see what the rest of the year brings. I think it's just a little bit too little at the moment"	28

P2:*"Just what M1 talked about, we've only been on the first time home visit, so you have your form and the aim of the visit is kind of just to fill in the form, well I'm not clear on that but I don't know if we follow up on that visit and we have sent out the referrals where, if we would say the referral was to the speech therapist and the physiotherapist, would the second home visit then be that we would focus on them, because at the moment if the aim of IPLO is to actually know what the nurse does I would know then this person definitely needs referral, the speech therapist does that thing.If that is the aim of giving the form then that's not working at the moment because if you want me to know what the speech therapist does, let me just go with and let them do their assessments and I'll observe and I will know so much better. If the doctor wants to know what a physio does, let the doctor go with and see an assessment rather, because at the moment we're kind of all on the same level doing the same thing, that is filling in a form. So three months from now to know when you are following up on that home visit, does this specific discipline kind of get a bit more responsibility to go further in depth with what they were referred to,or is it just going back to the form and filling in gaps"*	29
N2:*"During the visits, I must say I didn't learn that much from each other because like P2 said, it was all about the form and you had to fill in the form and you can give that to any speciality to fill in.On the way back when we discussed the patient and the doctor would say he needs referral to whatever, then I did learn because they explained to you nicely why they say this and howpeople can help the patient further, but in a sense we didn't get to go back with these physios whichever they were referred to, if they were referred to a physio, we never had the opportunity to go with the physio to observe how they treated the patient. So I wouldn't say we didn't learn theoretically but we didn't get to see practically how the different specialities worked together"*	30
N1": *We once also had a house that had I think four people in the house so on one visit we could have done the whole interview and we've looked for any possible referrals and everything, but then we get a house that has got fifteen, sixteen people living on the yard or on the plot, whatever, at the address and then we had to get back and if we go back everything just opens and you will see, all the records you've taken,now you can look back on it but now you understand.You just start to talk to the people, you will ask them other questions, you have time to ask and they build up that trust in you, so then it's better when you go back on the big house"*	*31*

SH1:"I will. I think creating teams is quite important so that you get a chance to become a team and not just forced into, okay you fivecan go off and do a home visit. I think it's important as health professionals that we trust our other health professionals and the med students in their profession and if we are making these referrals it is almost a trust basis that you are going to do something to help, because I can't do everything. And having a team like a specific team that has a time every week that does their home visits and not doing a rotation that just causes chaos,it will help us learn from each other more because we're going to trust each other more and form bonds and get to know each other. I don't think it's possible if you're just seeing people once a week on an off chance"	32
N1: "I agree with SH1. I think it should be more organised in the sense that we get the opportunity to learn more from each other, because I've beenon a home visit and I have been to Avian Park where there were other disciplines but I haven't honestly found like I had the opportunity to really learn from them. What's nice is, youdo have access to me because you can go and ask a question but I would like to actually see them in action"	33
N1: "I think it would be a good idea to take just ten minutes before the home visit and discuss.The physio can say I want to do this type of assessment and the OT can say I am going to do this type of assessment and the doctor says I am going to look at these factorsand do these tests and the speech therapists and the nurses, everybody gets a chance to say exactly what they're going to do and a home visit is about an hour or so. Just divide up the times, so you know you have a specific amount of time when you need to do everything,and if it's more organised I think they have a better opportunity for better learning"	34
M1:" I really like what the speech therapistsare saying. But I think make it relevant, maybe do it afterwards, maybe do it in small chunks or something, whoever is most involved. I think for what they have in mind you would have to have the basics already, you would have to have the ICF and you have to have an idea of what's going on in the patient's life or in that household, whatever is relevant,but I really like the idea of teaching, I think the time constraints, I think the timing is very difficult.You have to do three home visits and if you get stuckon one – wewere supposed to leave by four I think, but many times we left after five"	35
M1:"I" think that would be ideal, but there are so many families missing out then, or patients missing out, so it's kind of quality versus quantity"	36

N1: "Also when we do home visits maybe the physio sees someone. There was a little boy once, you could see his one leg was much smaller than the other one and they will say come, come, come here and then they will look and they will show us what they were looking for and the parents maybe sometimes they come also, looking what we're doing, so that's nice on the spot there.When we go backit's also nice to discuss the problems that we found there and then maybe do a speech referral or maybe say we can do this and this and make the right referral"	37
N2: "I agree with N1. I think it's a really great idea while you do the assessment to explain what you are doing and why you are doing it,not only to inform the patient but also at the same time you teach the other occupations. I think that's a really nice idea. Also, you don't have to explain afterwards, do your decision now and afterwards go back to the containers, then explain why you did it.It's a lot easier to learn on the spot and if you have questions then you can ask them on the spot, you may forget on the way back something you wanted to ask them"	38
P1:"Out of experience, it's more structured if you sit beforehand and you and the team that's going in discuss, so this is the patient profile, this is what I want to test, this is what the physio wants to test, this what the OT wants to test and then you do it after you have filled in the form. And you come back and you discuss the whole process and why you did what and what did you find out of assessing it, just more discussion within the team"	39
M1: "I just think we forget the patient is also part of the team, so maybe instead of coming back to the clinic, maybe you can have your full discussion with the patient. I have seen it done at the hospitals, that they would have a weekly meeting with people so that everybody can say what they have observed the week and then they would have the discussion with the patient and with each other around the patient again, but maybe just prioritise and have a discussion around the main problem.bedside.So obviously with a home visit maybe you can just sit down with the patient and discuss, maybe choose a main topic, you can't sort out everything in one visit, and it's not like you're never going to see the patient again".	40
P1:"I just want to say with regards to the other, I just had a short discussion this morning on the topic of ward rounds.It just always has to be important that the person or the team involved knows how to be respectful and what they discuss, they must have a barrier what's appropriate and what's inappropriate because sometimes it's just like really sjoe, are you saying this in front of a patient?There has to be this respect and appropriateness.You have to think of what you are saying and how you are treating the patient in that context"	41
SH2:" It's also because we are all in the medical field and we have all our own terminology and words we just throw around and the poor	42

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patient is sitting there and thinking, what are you saying"	
SH2:*"Yes. So it's just when we are talking, if we do that,that we break it down easily so they understand"*	43
N2:*" If I may say, I think it's very important to forget that this isn't procedure-driven, it's not finding out as much as you can about the patient medically and only treating the patient medically.You have to look at them socially as well and their well-being overall, make sure they're understanding what you are doing, because sometimes they just say yes, yes, because they're also scared because we useall these big words and they're not really sure what we want to do and where we're from. They feel so overpowered and just say okay, go ahead, so I think it's very important to really include the patient and make sure they understand everything you do and not just make this like go and do your thing and get it over with"*	44
SH1: *"I don't think in Avian Park it is all that prevalent. I think everyone that's there, is there for the patient. If we're speaking about IPLO and the hospital, that's a completely different story. If we say it's Avian Park, I think we do consider the patient a patient and not just an illness"*	45
SH2: *"It was a very eye-opening experience because most of us up until now, we've never actually made contact with the environment that the patient comes from they normally came to Tygerberg Hospital and you see them and you see them go.But now to actually see where they live, it's such a culture shock actually to see where they live and what they're used to and it gives you a better idea on, right, next time I see a patient that I know is from the rural area I'm going to adapt mytherapy and assessments and techniques so that it is suitable for his or her environment and not for Tygerberg Hospital or Worcester Hospital.It has to be applicable for that little house where sixteen people live in"*	46
P2: *"Personal development, I think maybe before this I was kind of sceptical about how the hierarchy of different professions would influence the approach we have,but I can say I was kind of positively surprised that the hierarchy really, because it was new to everyone and everyone was kind of on the same level in terms of trying to keep themselves humble towards the challenge, so personally that was a good surprise for me because I think in a way maybe at university and how the hierarchy was kind of set there, not because it is there but because people's preconceived ideas of it is there,so personally that was kind of a barrier I overcame. And then I think what I long for was to rather be part of a team where either the nurse or the speech therapist or the OT have their evaluation and I can really see it and not that all of us have the same fixed form we have to fill in"*	47

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P2: "Especially here in Worcester and Avian Park and how I think our backgrounds of working at, say, Tygerberg Hospital, there it is a fixed hierarchy like personal experiences may have kind of lead some us to feel that okay, well we are here, they needed us here, we are kind of placed here, so we'll do something for the patients.So I think and because Avian Park in Worcester that interdisciplinary thing is so focused on and doing the home visits I think for any medicine student to see like, wow, they are so much needier than just what they specialise in, or the speech therapist says, wow, there's so much more than just speech therapy needed or the physio, so it's the whole community and just the rural setting itself kind of gives the opportunity for you to see that you can't really have a hierarchy here because that patient's needs in every aspect of his life is almost just as big or equal size"	48
M1: "I think we basically serve as hierarchy but we need a leader and I think the home-based carer who goes on home visits with us and who is responsible for that family or that patient is a very good person to start with. From my experience they are very quiet. I would like to hear them speak more or just take leadership ..."	49
M1: "Guide the rest of us on what should be happening"	50
SH2: "Yes, it is a worthwhile exercise. I think it's in the beginning stages now, that's why it's so frustrating and it feels like it's not working"	51
SH2: "Yes, but I mean six months from now, two years from now it may be very successful, depending on how hard we are willing to work. So I think it's just like little things need to be addressed, it's like designing a car or something, you need to find ... for it to work. But it is valuable, I've learned from the physios and the OTs. I wish we had the nurses, I love nurses (thank you), they know their patients so well"	52
N2: "I think something that we can focus on is health education because we are treating the existing problems but some of the problems can be prevented and I think prevention is better than cure. We don't really spend a lot of time in educating the patients and every special day I'm sure they have a little something they can add to that education, even if you take five or ten minutes and just, maybe you get a house and there's not really problems, you can still educate the people"	53

AppendixC: Transcript of the formal study A / Interview 2

INTERVIEW CONDUCTED BY PROFESSOR MARINA CLARKE

Prof. Clarke: Dit is vandag die 23ste Mei en ons is hier in Worcester en ons doen 'n fokusgroep bespreking. Ek het nou die vraag in Engels geskryf. Kan ek dit so lees en dan kan ons dit vertaal of wat ookal, ek dink ons is almal tweetalig, né?

You were involved with other health and health care students in interprofessional collaboration and education in Avian Park. So what I want you to do is to tell me about how you experienced the interprofessional activities in Avian Park. There's no right or wrong answer. It's not an exam, it's just candid, just how did you experience those activities?

SH1: Dit was lekker gewees.Eerstens omdat jy, sê nou maar jy werk saam met 'n Fisio en jy weet nie eintlik wat hulle doen nie, so dan is dit nogals lekker om te sien wat hulle doen, om te weet as jy eendag moet verwys,om te weet waarnatoe om te verwys, so om te sien wat hulle doen, dit was nogals lekker gewees. (1)

Prof. Clarke: So jyhet spesifiek uitgevind wat Fisio's doen?

SH1: Nee, nie spesifiek Fisio's nie. Ons het saam met mediese studente gewerk en Arbeidsterapeute en Dieetkundiges. (2)

Prof. Clarke: En dit het vir jou laat besef, as ek reg hoor, jy het agtergekom wat hulle doen in gesondheid en wanneer jy dan na hulle toe moet verwys? Is ek reg?

SH1: Ja.

Prof. Clarke: Wil jy bietjie daaroor vir ons sê? Vertel my bietjie daaroor. Is daar 'n spesifieke geval waaraan jy kan dink, of 'n item?

SH1: Byvoorbeeld nou die dag het die Dieetkundiges vir ons 'n voordrag gedoen oor vitamine A en sulke goed en hoe hulle die babas meet en sulke goed en dit was nogals interessant, want ek het nie 'n idee gehad hoe om dit te doen nie, ek het nie geweet hulle doen dit nie. Hulle het al met ons kom praat, die Dieetkundiges, oor wat hulle doen, maar dit was nogals interessant gewees, dit is wat hulle doen, dat daar 'n spesifieke manier is wat en hoe hulle dit doen. (3)

Prof. Clarke: So jy as Spraakterapeut het agtergekom die ander deel van die span doen baie spesifieke aktiwiteite, spesifiek nou Dieetkunde en hoe hulle dit meet en jy het dit interessant gevind.

SH1: Ja, dit was lekker.

Prof. Clarke: Is daar nog iets van die ander groepe of so?

SH1: Ek weet nie rêrig nie, Medies – ons het nie so baie met hulle te doen gekry nie. As ons uitgegaan het, het hulle ingekom. Ons was op 'n paar home visits saam met hulle gewees. (4)

Prof. Clarke: Vertel my 'n bietjie van die home visits.

SH1: Die home visits – ons was nog net twee keer daar gewees. Ons was een keer saam met 'n mediese student gewees. In 'n sin het ek gevoel, soos die Arbeidsterapeute en die Fisio's en die Spraak – ek dink ons het meer ervaring, of dis die idee wat ons gekry het, dat ons meer ervaring het, en veral soos die Verpleegsters ook, met home visits, in die sin van hulle het bietjie onseker voorgekom, nie onseker in die sin van wat om te doen nie, maar net oor hoe om die mense te benader in 'n huis, of dit was in die spesifieke geval, maar ek weet nie hoe die ander daaroor gevoel het nie, so dit was nogals interessant om te sien. Ek dink ons benader dit op 'n ander manier,ons praat meer met die mense, maar hulle is baie meer op die punt af en weet wat hulle wil hê, maar dit is hoe ons moet werk. (5)

Prof. Clarke: So wat ek hoor jy sê vir my is dat die Medies baie gefokus is op waarvoor hulle daarheen gegaan en dit eerder aan te spreek so gou as moontlik, is dit reg, en waar jy gevoel het die ander ...

SH1: Ons is maar partykeer meer gefokus op die omgewing ... (6)

Prof. Clarke: Julle is meer gemaklik,het ek ook gevind, om eers net 'n gesprek te voer met die persone in die huis, en so aan ...

SH1: Ja, ek bedoel, ons is immers spraakterapeute. (7)

Prof. Clarke: So ons moet darem goed byhou by julle?

SH1: Ja.

Prof. Clarke: Was dit vir jou 'n lekker ervaring, so 'n tuisbesoek met die verskeie beroepe?

SH1: Ja, dit was 'n lekker ervaring. Ek dink net ek het by tye 'n bietjie weerloos gevoel in die gemeenskap. Mens weet, dis 'n normale gemeenskap, dis net omte loop daarnatoe, dalk was ek net bietjie meer op my senuwees met sulke goed. Maar dit het gehelp dat die community care workers daar was, hulle het mens baie meer op jou gemak gestel, hulle ken die mense en weet waarnatoe, maar dit was lekker gewees. (8

Prof. Clarke: So wat ek hoor: dit was lekker en jy hetamper veilig gevoel met die community care worker, maar jy het ook weerloos gevoel om alleen daar te stap.

SH1: Ja, al was ons in 'n groep, was dit nog steeds so. Ek bedoel jy ry nie daarnatoe nie, so jy is afhanklik van die gemeenskap se goedgesindheid. (9)

Prof. Clarke: Maar dit het vir jou senuweeagtig laat voel.

SH1: Ja.

Prof. Clarke: Enigiemand anders wat wil bylas? Dis net 'n gesprek.

SH2: As 'n meisie voel 'n mens maar outomaties bietjie meer weerloos as jy op jou eie stap, selfs al stap jy dan saam met ander meisies. Maar ek moet saamstem, ek dink nie mens besef in hierdie interdissiplinêre span, ons fokus so op die Fisioterapeut, OT, Arbeidsterapeut, dat ons nieagterkom hoe baie ons die community care worker nodig het totdat ons fisies met hulle werk nie. Voordat ek op Worcester gekom het, het ek nie verstaan van mense soos community care workers nie. Ek was nog glad nie op 'n home visit nie, ek was maar in die hospitaal op my vorige blok. So dit was vir my interessant, want mens het die mense nodig wat die omgewing ken, wat so half die mense ken. Mens voel maar dis 'n onbekende omgewing, mans het mos maar die tendency as hulle daar rondsit en meisies stap verby om goeters te sê, so dit bring vir mens 'n gevoel van veiligheid. So dit was 'n interessante ding gewees wat ek geleer het. (10)

Prof. Clarke: So die interessante aspek van hierdie ondervinding wat jy gehad het in die gemeenskap was spesifiek met betrekking tot die gemeenskapsgesondheidswerker (community care worker) wat jy genoem het, wat saam met jou geloop het. Dit wil voorkom asof toe die dame, ek aanvaar dit was 'n dame gewees, saam met jou gestap het wat geweet het waar die plekke is, dat jy nie so blootgestel gevoel het nie.Dit hetjou laat veilig voel, maar terselfdertyd het jy besef hierdie persoon is 'n baie belangrike skakeltussen jou wat in die hospitaal blootgestel was en nou ewe skielik in die gemeenskap.

SH2: Hulle is ook die persone wat so half die span bymekaar hou in 'n sin, want hulle is konstant. Hulle is daar. Ons ander mense, die span self, verander die heeltyd, maar sy is heeltyd konstant daar, so sy weet wat aangaan, sy help almal. (11)

Prof. Clarke: So dit wil voorkom asof hierdie community care worker vir julle op julle gemak gestel het, vir julle welkom laat voel het en dan ook vir julle laat voel het julle is nie so erg blootgestel nie, veral as 'n dame wat daar loop. Is dit reg? Jy het gepraat van die mans wat daar sit, hulle is werkloosbes moontlik.

SH2: Outjies wat na skool op straat kuier, tieners, hulle is mos maar altyd 'n vreemde soort. (12)

Prof. Clarke: Ja.

SH2: Wat ek aan gedink het toe ons gepraat het oor die mediese spanlede, is dit was vir my persoonlik –die dokters werk met 'n persoon wanneer hulle akuut is en wat ek opgetel het,spesifiek op die home visit en so aan, is hulle is baiekeer gefrustreerd,want nou kom hulle in hierdie huislike omgewing, soos die meisie wat saam met ons gegaan het, en al wat sy eintlik wou gehad het is dat die man in 'n ambulans kom, by 'n hospitaal kom, dat iemand na sy vinger kan kyk, want dit is besig om septies te raak.Nou word daar van haar verwag om hierdie vorms in te vul en te praat oor hoe dit gaan met die kinders en eintlik al wat sy wil hê, is dat hy reggemaak moet word. Ek dink nie dit kom altyd, as mens in die gemeenskap werk by 'n kliniek soos Avianpark, kom dit nie so goed voor nie. As 'n mens nou nog bloed trek of net na die ore moet kyk, meer meganiese goed wil ek amper sê, is dit bietjie makliker, mens voel dat jy meer kan doen, maar ek dink sy't gevoel daar's 'n baie groot gaping tussen wat in die hospitaal gedoen word en wat by die huis of in die klinieke gedoen kan word. (13)

Prof. Clarke: So wat ek hoor is, spesifiek die mediese beroep in jou ervaring, en asseblief, 'n mens kan nie hierdie ervaring veralgemeen nie, maar die ervaring spesifiek waaraan jy blootgestel was, dat die spesifieke mediese student basies die probleem gesien het en dit dan aanspreek so gou as moontlik om die septiese vinger dan te voorkom en basies dat die ou se vinger kan genees en kan regkom.

SH2: Maar die frustrasie dat dit nie kan gebeur op daardie stadium nie. (14)

Prof. Clarke: Nie gou genoeg kan gebeur nie.

SH2: Soos ons Spraakterapeute of Arbeidsterapeute wat met rehab werk, ons verstaanlang prosesse. Jy kan 'n paar keer gaan, 'n paar keer met die persoon werk, jy kan daar in sy

huis met hom werk meeste van die tyd. Mens hoef hom nie eers na die hospitaal toe te vat nie. So dit was hierdie spesifieke ervaring. (15)

Prof. Clarke: Goed, dit was jou ervaring. Het jy geleer deur daardie ervaring?Wil jy vir ons vertel?Jy het dit gesien, geobserveer, maar het dit vir jou iets beteken vir jou toekoms, vir jou beroep, dink jy?

SH2: Ek weet nie of ek so diep daaroor gedink het of dit iets vir my beteken het nie. Ek dink dit het wel vir my ook geleer van daardie tipe frustrasie, want ek mag dalk eendag ook 'n pasiënt teëkom wat ek baie graag net by 'n hospitaal wil uitkry, maar ek kan nie, want ek kan nie sy elektriese rolstoel vervoer nie, en ek weet hy het eintik hierdie tipe masjien of hierdie tipe ding nodig en ek kan dit nie by hom uitkry nie. So ek het bietjie van daardie frustrasie geleer. (16)

Prof. Clarke: So daardie blootstelling aan daardie frustrasie wat jy spesifiek opgelet het, gesien en ervaar het, het vir jou laat besef dit kan ook met jou gebeur eendag in dieselfde situasie, maar terselfdertyd blyk dit asof jy besef het dit is 'n proses as jy in die gemeenskap werk.

SH2: Ja.

Prof. Clarke: Enigiemand anders? Welcome. I'm Marina Clarke and I'm going to facilitate the interview. Do you follow Afrikaans? [Yes] I'm just going to re-read the question, so that we are all on the same page.

You were involved with other health and allied health care students in interprofessional collaboration and education activities in Avian Park. So I would like you to tell me about how you experienced these interprofessional activities in your placement in Avian Park. There's no right or wrong answer. It's just the truth. I would not want you to disclose your name, however just the kind of student that you are, the profession that you study, for instance Nursing, and then you just continue with what you want to contribute.

N1: Nursing.

Prof. Clarke:OK. Is there anybody else who want to share with us your experience? This is very valuable, I don't know if this is the last contribution from that side.

N1: Nursing. Ek kan nogals hierdie projek sien as iets wat kan voortgaan in die toekoms, want die verskillende spanne bymekaar, hoe hulle ge-collaborate het met mekaar, is vir my fantasties. Van die Nursing perspective af het ek eenkeer uitgegaan na 'n woning in

Avianpark saam met Arbeidsterapeute en Fisio's. Dit was 'n gesin van elf gewees en dit was half 'n shack, half in 'n huis gebou. Die eerste ding wat ek opgetel het, was die omgewing. Soos jy inkom, kyk jy mos maar na alles – holistic moet jy mos maar alles approach. Ek kom toe agter dit was 'n follow-up. Ons kom bymekaar by die kliniek en dan gaan jy deur 'n paar lêers en dan kyk jy wat moet opgevolg word. Dan beweeg ons in groepe uit en in elke groep is 'n member van elke beroep en dan gaan julle na die wonings en julle kyk van julle perspective af. Van die Nursing perspective af het ek agtergekom daar is in die gesin van elf drie babas en nie een van hulle het Road to Health charts nie. Drie tieners het nie identiteitsboekies gehad nie. Die ma en die pa bly eenkant in die geboude gedeelte van die huis en die res bly in die ander gedeelte van die huis. Die omgewing was nie so vreeslik skoon nie, maar die oomblik toe ons daar aankom, toe begin hulle vinnig skoon te maak, hier kom die groep mense, hulle is mos nou vreemdelinge, ons mense is mos maar so. Wat ek eintlik wil sê, met die teruggaan kliniek toe bespreek ons wat ons ervaar het. Elkeen gee sy input. Ons besluit saam.Kan dit 'n referral wees na 'n Fisio toe, kan dit 'n referral wees kliniek toe of na SASSA toe? Maar waarna ek eintlik gekyk het, is hoe die span kan saamwerk aan een probleem, wat elkeen sy input kan gee. Soos sy gesê het, jy voel maar blootgestel in 'n gemeenskap wat jy nie ken nie, want dis mos nou vreemd, maar jy stap in doelgerig, want jy weet wat jy nou daar gaan doen. En julle kan nou maar stry, as jy daarvandaan kom en jy het iets vir iemand beteken, dis iets positief. Avianpark is nou net die regte plek om die projek mee aan te gaan vir die toekoms, want daar is verskriklik baie probleme daar. So ek het baie geleer, geleer hoe om met die multi-disciplinary team saam te werk en my input te kon gee – dit was vir my nice. (17)

Prof. Clarke: So van Verpleging se kant hoor ek jy sê vir my daar was drie babatjies wat nie immuniseringskaarte (Road to Health kaarte) gehad het nie. Daar was drie mense wat nie ID-boeke gehad het nie, hulle was al klaar tieners gewees, en dan die ouers bly eenkant en die kinders bly aan die ander kant. Maar dit was 'n follow-up, soos jy genoem het, 'n opvolgbesoek, en toe, wat jy waardeer het, as ek dit reg verstaan, was toe julle teruggaan na die kliniek toe en dit bespreek as 'n interprofessionele spanen toe besluit het die persoon moet hiernatoe of daarnatoe verwys word, of dit nou SASSA of Spraak of wat ookal was, en dat dit vir jou 'n groot leergeleentheid was.

N1: Ja.

Prof. Clarke: Jy het ook blootgestel gevoel, maar dit wil voorkom asof jy heeltemal veilig in die spannetjie gevoel het?

N1: Ek sou nie sê ek het so blootgestel gevoel soos wat sy byvoorbeeld gesê het nie. Dit was 'n vreemde omgewing, maar ek het rêrig nie blootgestel gevoel nie. (18)

Prof. Clarke: Jy het nie bang gevoel nie?

N1: Nee, seker omdat ek ouerig is, kyk ek anders na dinge. Ek voel anders oor dinge en ek approach dinge anders. (19)

Prof. Clarke: Maar dis jou eie filosofie, dis hoe jy daaroor voel.

N1: Dis hoe ek daaroor voel.

Prof. Clarke: Dan het jy ook vir ons basies gesê dat dit vir jou 'n positiewe ervaring was [S: Definitief], en van Verpleging se kant af het jy ook gevoel jy kon 'n bydrae maak.

N1: Definitief. (20)

Prof. Clarke: Het ek dit reg opgesom? Is daar iets wat ek uitgelaat het, wat ek verkeerd verstaan het?

N1: Die collaboration tussen die verskillende spanne. (21a)

Prof. Clarke: Ja, dit het gewerk.

N1: Dit het gewerk.

Prof. Clarke: Het jy gevoel dat die mense van die ander beroepe geluister het na jou?

N1: O ja.

Prof. Clarke: En jy het na hulle geluister?

N1: Definitief. Ons het eintlik by mekaar geleer. Sy het nog nooit gehoor van sekere goed wat ek van gehoor het nie. En jy vra ook: 'Wat is 'n Road to Health chart?' Wat is dit? Wat is dit? Op die ou end is dit meer 'n verduideliking as wat ons eintlik wou doen. (21b)

Prof. Clarke: Maar dit is baie positief, want wat ek hoor dan, is dat julle eintlik by mekaar leer. Sy het gepraat van die Dieetkundige wat die kindjie meet en vitamine A en wanneer en what-have-you. 'n Spraakterapeut word nie noodwendig daaraan blootgestel nie, soortgelyk aan die Road to Health chart, selfs nie aan daardie konsep nie, en julle kan dan saam met mekaar dit bespreek en by mekaar leer. Dit klink vir my asof julle mekaar respekteer het as 'n eweknie, op dieselfde vlak in die span.

P1: Dan net iets van Fisioterapie. Dit was die eerste keer eintlik hierdie jaar wat ek rêrig in kontak gekom het in 'n interdissiplinêre span. Dit was vir my eintlik baie lekker om saam met al die ander mense te werk en dan leer jy ook so by mekaar. Maar ek dink mense verskil, so jy moet ook leer om aan te pas, want sekere groep mense, al wil jy dit nie glo nie, jy het jou traits, dan moet jy gewoond raak aan hoe mense dan is, net by hulle aanpas in die span. (22)

Prof. Clarke: Dis eintlik 'n wonderlike ervaring waarvan jy vir ons vertel, want jy het basies geleer hoe om mense se persoonlikhede amper te analiseer en dan hulle so te hanteer en te aanvaar as deel van die span. Is dit reg? Dit was vir jou 'n positiewe ervaring.

P1: Ja.

Prof. Clarke: OK.

M1: Ja, van Medies af, soos wat jy nou sê, om so half in 'n span saam te werk en 'n klomp verskillende persoonlikhede te hê, dit is nogal definitief 'n vaardigheid wat jy kan aanleer hoe om te werk. Wat ek ook nogal van gehou het, dit gee vir jou meer 'n perspektief van jou pasiënt se agtergrond, jy gaan in sy huis in, jy verstaan jou pasiënt baie beter, ek dink dit maak 'n groot verskil. Ek het definitief baie geleer omtrent die ander professies. Ek dink in Medies is ons baie probleem-geöriënteerd. Ons is baie, ek meen ons begin alles met 'n probleemstelling. Ek dink ons raak baie gefrustreerd as ons nie 'n probleem vind nie. Ek dink dit is eintlik tans my grootste frustrasie by Avianpark. Ek kom by die mense se huise aan en ek soek vir 'n fout en ek kry nie die fout nie en dit frustreer my. (23)

Prof. Clarke: Maar die vaardighede van daardie soft skills, daardie persoonlikhede en verskillende beroepe wat hulle bydra, het vir jou waarde toegevoeg.

M1: Ja definitief, ek meen, as ek nie 'n probleem kan vind nie, dan help hulle my weer. (24)

Prof. Clarke: Nou weet ons hoekom daardie ander mediese student so bly was dat die septiese vinger gesond is.

M1: Ja, definitief.

Prof. Clarke: En daar leer ons nou vanmiddag iets, want die mediese student word opgelei om te sien wat is die probleem en hulle soek die probleem, sodat hulle so gou as moontlik dit kan aanspreek om daardie mense se gesondheid te verbeter. Is ek reg? Daardie swak gesondheidsaspek aan te spreek sodat die persoon weer kan terugkeer na normaal. En as hulle nie die probleem vind nie, het ons nou vanmiddag gehoor, dan word hulle gefrustreerd.

Maar ons moet hulle help om die probleem te vind. Maar terselfdertyd het hierdie mediese student vir ons gesê hy het begin besef wat die omstandighede is waar die pasiënt wat hy in die hospitaal sien, waar die pasiënt tuisgaan en dan weet jy ook waar die pasiënt vandaan kom en mag ek ook dan sê waarnatoe die pasiënt ontslaan word. 24:12

M1: Ja, dis definitief 'n groot ding daardie. Dit help jou om jou pasiënt beter te verstaan. (25)

Prof. Clarke: Wil jy 'n bietjie vir ons daaroor uitbrei om die pasiënt beter te verstaan?

M1: Ja, mens kry 'n groot idee hoeveel mense bly op een perseel. Dit is eintlik vir my 'n groot ding. Ek het mense met krukke huis toe gestuur en gesien wat hulle alles moet oor beweeg met hulle krukke en hoekom dinge soos tuberkulose so maklik kan versprei, onder andere. (26)

Prof. Clarke: So jy het tot 'n groot besef gekom in terme van die lewensomstandighede en tot 'n besef gekom, jy het spesifiek krukke genoem, maar die persoon gaan nou huis toe met die krukke en dan het hy soveel goed waaroor hy moet loop om dan by sy lêplekkie uit te kom.

M1: Dis reg.

Prof. Clarke: Die ander beroepe, het hulle vir jou enige bydrae gelewer, anders as om die probleem te vind? 25:23

M1: Ek dink tot dusver het dit die meeste van sosiale werkers opgelewer in 'n omgewing waar sosiale probleme groot is. Daar is baie mense wat bv nie ID-dokumente het nie en dan reël die sosiale werker dat die mense ID-dokumente kry. Of daar is ouer mense wat met 'n klomp klein kinders saamlewe wat dwelms gebruik, dan help die sosiale werker om daardie ouer kinders uit die huis uit te kry. (27)

Prof. Clarke: So dit is daardie besef dat mense wat u in die hospitaal of in die kliniek of kantoor of waar ookal spreek, hulle kom uit 'n agtergrond, hulle kom uit 'n huisvesting wat u nou aan blootgestel was, so dit laat u beter besef die omstandigheid waarbinne die mense leef wat u dienste gebruik.

SH2: Ek dink ook (Spraak) 'n punt wat baie Medies en Verpleging aangeraak het, was dit van perspektief,wat u nou gesê het van in die groep sit en daarna daaroor praat, en dan was dit interessant,bv sy het agtergekom die babas het nie Road to Health charts nie, en ek en die ander Spraakterapeut sou waarskynlik nou gekyk het hoe praat die ouma wat 'n beroerte gehad het, terwyl die Fisioterapeut sou gekyk het hoe mobiel is die ouma. So al daardie

verskillende goed waarna verskillende mense kyk, dit gee vir mens 'n baie beter beeld van wat aangaan en wat dan daardie persoon se beperkinge is,maar ook die goed wat daardie persoon dan help. Die jong meisie wat ook in die huis bly wat die ouers noudalk nie 'n grant voor het nie, maar sy kan dan die ouma help in die dag en haar was, sy kan na die kindertjies kyk. So dit is baie interessant, elke ding waarna elke persoon kyk, en dan sit jy partykeer en dan dink jy, ek sou nou glad nie daaraan gedink het nie. (28)

Prof. Clarke: So wat ek hoor dan is dat die tuisbesoek word amper 'n meer volledige besoek. Julle het vroeër gesê van holisties kyk en dit was verskeie beroepe wat die woord holisties gebruik het, maar dit lyk vir my as julle bymekaar is met die verskeie beroepe, is dit meer holisties. So het hy die septiese vinger raakgesien.

SH2: Spraak – dit voel asof al die probleme word vinniger identifiseer en dit word vinniger behandel, want almal kyk gelyk daarna, as wanneer dit net jy is en jy moet verwys onmiddellik, dis net wat jy dink en jy sien dalk nie alles raak nie. (29)

Prof. Clarke: Sou dit reg wees vir my om te sê dat 'n mens ook kyk met hoe jy opgelei is? Bv die verpleegpersoneel word opgelei met immunisasieskedules, so hulle sal dadelik daarna kyk.

S1: Daar is 'n goeie kans dat ek nie daarna sal kyk nie. Ek weet dis belangrik, maar ek is so gefokus op die spraak en die taal en hoe die kind ontwikkel. (30)

Prof. Clarke: Ek verstaan dit.So 'n mens bly altyd by jou fokusarea in 'n mate as net jy of jou beroep gaan.

N2: As ek vanVerpleegkunde af kyk, was ek baie skepties gewees aan die begin, want ek het nie geglo dit is studente nie.Ek het geglo ons Verpleging is al studente, julle is almal klaar geleerwat daar was. Net toe ons uitgaan, toe gooi hulle my aan die diepkant in en ek moes skryf. Toe het die mediese student daardie hele geografie, daardie blokkies-ding wat die familie voorstel. Toe dink ek 'wat is dit?'en toe het ek gevra dat ek dit kan teken en ek het nou van die voorbeeld af gewerk en die familie was regtig 'n groot familie gewees waar daar 'n ouma was, daar was 'n Spraakterapeut gewees, daar was 'n gewone Arbeids-terapeut gewees, die hele multi-disciplinary team was bymekaar gewees. So toe ons nou bymekaar sit, toe wil niemand praat nie en ek dink, dit is my eerste dag en ek is so nuuskierig, kom ek vra maar vrae. En ek begin vrae vra en ek dink toe ons geleer was om ook vrae te moet vra vir die kliënt om mos nou te kan antwoord, en ek onthou dit was die kleindogter gewees. Toe het die mediese student vir my gesê, 'Moet jy so baie praat?' en vrae vra, maar ek het geleer, as ek nou kyk van Verpleeg se kant af, jy moet belangstelling toon in die persoon

sodat hulle gemaklik met jou kan raak en begin praat. Toe vra die een, ek kan nie meer onthou wat was sy gewees nie, toe sê sy vir my ek moet vir die persoon vra, want sy het na haar ouma gekyk wat 'n stroke gehad het, hulle was klaar besig gewees, dit was net follow-up gewees, die spraak het herstel, sy was met fisio besig gewees, sy't 'n loopraam gekry. Toe sê die mediese student hy het niks ommeer te doen nie, so hy gaan maar vir ons dophou. En toe het ons nou vir hom betrek en vir hom verduidelik dis waarna ons kyk, of hy nie goed kan link na waarna hy kan kyk nie, en hy het toe vir ons mooi verduidelik hoe hy die prentjie sien, en toe ons nou almal bymekaar sit, was dit heel interessant, toe ons bymekaar sit dat ons nie saam met ander mense wil werk nie. Toe was ons baie kwaad want dit was ons almal se laaste dag saam gewees. Ek het geleer, as jy nou kyk van jou persoonlike agtergrond af na ander mense toe, dan besef jy die lewe is nie regtig so maklik hierbuite nie, en as ek nou na 'n pasiënt in die hospitaal kyk, kyk ek net, kom die pasiënt nie van Avianpark af met so 'n agtergrond nie?Wat is die omstandighede by die huis waaruit die pasiënt kom? As ek vir 'n pasiënt sê, meneer, onthou nou, jy moet was – is daar water waarin die pasiënt kan was? Hoe beweeg die pasiënt, so dinge het vir my meer prakties geraak met daardie agtergrond, nie net gedink almal moet was nie. (31)

Prof. Clarke: So dit was vir jou eintlik 'n ervaring ook om te besef om almal te betrek, maar dit lyk vir my jy was op die uiteinde 'n bietjie teleurgesteld?

N2: Ja, ek was teleurgesteld, ek wou weer gegaan het. Ek was die eerste een van die groep, so ek het hulle lekker aangesteek van die Verpleegkantaf, vir hulle vertel hoe lekker dit was, maar ek het nie vertel ons was daar in Smartytown en dit was baie rof in daardie gedeelte nie, so ons het letterlik mekaar se rûe gewatch. As die een loop, kyk die ander een rond, maar in die reis-opset was ons baie veilig gewees en ons het gery, ons het nie geloop nie. (32)

Prof. Clarke: Maar jy het darem gekoester gevoel in die span?

N2: Ja, en ek het gevoel elkeen is deel van die span. Toe ons maar begin gesels het, toe was dit nie van jy voel uit of jou inligting wat jy gee, is nie van belang nie. Ons het almal s'n saamgevat. (33)

Prof. Clarke: Jy het gevoel die bydrae wat jy maak, word ook in ag geneem?

N2: Ja.

Prof. Clarke: En dan was dit vir jou 'n ervaring om te sien dat almal wat daar sit, is studente en nie Spraak en OT's nie?

N2: Ja, dit was vir my 'n skok gewees. (34)

Prof. Clarke: So ons is almal by dieselfde pasiënt of huisgesin en jy kon ook 'n bydrae maak van Verpleeg se kant af?

N2: Ja.

Prof. Clarke: En jy het gevoel hulle het dit waardeer?

N2: Ja, ek het so gevoel, want toe ons nou in die hospitaal mekaar raakloop, het jy die vrymoedigheid om vir die een te vra. Die een het miskien nou 'n tendon wat geskeur het en dan kom hulle en hulle sê die OT's moet nou soontoe gaan en dan wonder jy wat gaan jy nou doen, en dan verduidelik hulle vir jou, dis wat hulle fisies met die pasiënt gaan doen. (35)

Prof. Clarke: Dis 'n baie interessante feit wat jy nou op die tafel sit. So dit was nie net in Avianpark se saamstap nie, maar selfs nou in die hospitaal erken julle mekaar en julle collaborate in die hospitaal.

N2: Ja, so sê nou ons stap op doktersrondte. Ek werk in C3, die Ortopediese saal, en daar is twee firmas, Dr. Franken se firma en Dr. Basson se firma. As dit Dr.Franken se firma is, is ons almal baie bang, niemand wil praat nie. Toe het ons geleer as die een student antwoord en die ander een sy input gee, het Dokter nie so baie vrae om te vra nie. Maar toe het ons agterna gesê ons weet nie en sal ons vir mekaar vra. Sy wil graag weet hoe hanteer hy sekere wonde, veral as dit nou 'n totale heupvervanging was, dan vra hy ons vasvra en dan sien jy die ander een sukkel, want ons is van twee verskillende beroepe, so die een is miskien Medies en ek is nou by Verpleging. Nou ken ek die antwoord, dan fluister jy net die antwoord, dan sal Dokter sê 'ek soek julle nie weer saam nie', dan skei hy vir ons. Maar dit was lekker om vir mekaar te help en vir mekaar te kan vra, jy het die vrymoedigheid gehad. (36)

Prof. Clarke: Wat ek hoor, is dat julle amper soos een span gevorm het, en dit maak nie saak of dit Spraak, Medies ofOT of Fisio was nie, julle sou vir mekaarbasies, as jy die antwoord geken het, sou jy dit gefluister het.

N2: Ja.

Prof. Clarke: Is daar nog ervaringe wat julle gehad het?

SH1: Ek dink ook nou net soos sy nou genoem het, dat jy in die span vir almal leer ken (van Arbeidsterapie se kant af) en jy sou nie noodwendig na die tyd dan gaan julle en dan doen julle ander aktiwiteite ook saam,soos in die interdissiplinêre span, wat nie noodwendig die geval sou gewees het nie. Ek dink persoonlik ek is baie stil, ek hou van my space en so, maar ek het al so baie ander aktiwiteite gedoen saam met die Fisio's en die mediese studente en so, maar dit is omdat jy leer ken hulle in die werksopset en dan doen julle soos buitemuurse goed ook saam, en dis ook baie nice. (37)

Prof. Clarke: So julle voel veilig om in mekaar se geselskap te wees, julle geniet dit, lyk dit vir my, want ook in na-uurse aktiwiteite sosialiseer julle self. Dan maak dit nie saak nie, jy het nie 'n sticker, Verpleging of OT of wat ookal nie, jy het jou naam en jy word deel van die span, buite werk en binne die werk.

SH1: Wat ek nie dink sou gewees het as jy nie daardie blootstelling gekry het nie. (38)

Prof. Clarke: Sonder die blootstelling sou dit nie gebeur het nie. Nog iets van daardie kant af?

M1: Ek sou baie daarvan hou as die werk net bietjie meer georganiseerd kan wees. Ek voel dit is nie goed genoeg gestruktureerd nie. Ek sou baie gelukkiger wees as ons vooraf bietjie beter riglyne kan kry oor presies wat gedoen moet word in huise en waarvoor ons moet soek, want ek voel ons word net 'n bietjie in die diepkant ingegooi. Ek sou daarvan hou.

Prof. Clarke: So jy sal eintlik tipe van voor julle gaan, ingelig word dat julle weet waarvoor julle gaan en wat dit behels.

M1: Ja, ek sal baie daarvan hou as iemand net saam met ons sit, hierdie is mevrou so-en-so, sy het 'n rukkie terug hierdie operasie gehad. Gaan net asb en evalueer vir hierdie en hierdie tipe dinge. Want op die stadium, ons stap net na 'n huis toe, ons weet nie wat om te verwag nie en baie van die tyd weet ons nie regtig wat ons heeltemal daar doen nie. (39b)

Prof. Clarke: So julle voel eintlik soos los laslappies tipe ding. Jy gaan soontoe, maar jy weet nie dat dit mev X is wat die heupvervanging is nie. Jy weet nie dit nie. Is daar nog voorstelle van julle af?

N1: Van die Nursing af – ek sal saam met hom stem, want eintlik moet die carersvoor jy uitgaan vir jou oorgee, dit is die profiel van die pasiënt of die kliënt,dit is 'n follow-up of dit is 'n first visit, ons gaan hierna kyk en ons gaan daarna kyk, dit is 'n bestaande probleem. Sodat as jy daar kom, kan dit eintlik beter gedoen word. Jy gaan mos dan nou spesifiek

nadaardie persoon se probleem kyk van die verskillende velde af en dit kan gouer gedoen word. Jy kan dan ten minste twee besoeke doen in plaas van een. (40)

Prof. Clarke: Wat ek hoor, is dat as dit beter gestruktureer is, kan julle eintlik meer mense gaan sien, en wat jy voorstel is dat die gemeenskapsgesondheidswerker vir julle net 'n bietjie inligting gee.

N1: Ja, voor jy gaan, sommer langs die pad.

Prof. Clarke: Kan ek dan vra, net om uit te klaar, dit wil vir my voorkom of julle nie altyd bewus is of dit 'n eerste besoek is en of dit 'n herhaalbesoek is nie?

SH1: Omdat die groepe ruil elke tweede week, daar's gedurig nuwe spanne en elke keer dan moet jy ingelig worden along the way verloor ons inligting. (41)

Prof. Clarke: So kry jy daardie inligting tydens die huisbesoek?

M1: Ag, ek het al baie keer daar aangekom en dan is dit iemand wat eintlik geen probleme het nie, alles is reeds uitgesorteer, dan kom ek daar aan en dan is dit letterlik, kom ons haal die persoon van die tuisbesoeke af. Dit het al twee keer met my gebeur. (42)

Prof. Clarke: En dis tyd wat gemors word.

SH1: Of van Spraak se kant af,ons het al eenkeer daar aangekom en dan die eintlike probleem, die kind wat die eintlike probleem is, is nie meer daar nie, hy's by die ma. Ons moet nog steeds met die ouma en almal praat, maar ek voel net op die oomblik is dit nie eintlik 'n probleem nie, maar dis 'n opvolg. Ons wil eintlik – dis bietjie frustrerend. (43)

Prof. Clarke: Kan julle 'n voorstel maak? Wil julle 'n voorstel maak? Ons het nou gesê dat julle vooraf moet weet watter tipe besoek dit is, nawie julle toe gaan en die rede is ook omdat julle elke tweede week 'n ander groep studente is, maar wil julle nog 'n voorstel maak? Die ander deelnemer het nou genoem julle gaan na 'n spesifieke kind toe en as julle daar kom, is die kind nie daar nie, so dit mors ook tyd. So is daar nog voorstelle, behalwe dat julle moet weet is dit 'n eerste besoek, is dit 'n herhaalbesoek, wat is die probleem en of die persone tuis is aldan nie?

SH1: Van Spraak se kant af sou ek sê, ek wil nou nie vir die community care workers meer werk maak in 'n sin nie, maar as hulle dalk net voordat ons weer gaan, partykeer is die opvolgbesoeke oor twee weke of later, dalk net voor dit weer gaan seker maak, net 'n vinnige inloer en hoor of daar nog 'n probleem is en seker maak wat die adres is. (44)

Prof. Clarke: So die uitklaar van die adresen die probleem sal 'n bydrae maak.

SH1: Ja, om te hoor of dit rêrig 'n probleem is en om te sê nee, dis nie nodig dat 'n mediese student saamkom nie. Daar's baie ander probleme wat hulle beter kan hanteer. Hierso is spesifiek 'n Spraakterapeut en 'n Fisioterapeut nodig, want dit help nie ons gaan na 'n persoon toe wie se been geamputeer is nie. Ek as Spraakterapeut kan niks daar doen nie. Vat eerder 'n Fisio en 'n Arbeidsterapeut saam, maar stuur my eerder na 'n ander huis toe waar ek meer nodig gaan wees. (45)

SH2: Dit gebeur wel met Spraak dat ons ... Elke dissipline het pasiënte wat hulle moet sien op die tuisbesoeke en 'n mens kom dan nie altyd by almal uit nie. Ek dink dis 'n baie groot administrasieprobleem, as daar dalk 'n effens beter liasseerstelsel was, goed gemerk, almal moet hulle goed daarin sit. 'n Community care worker of een persoon elke dag gaan kyk dat almal hulle goed teruggesit het, dat dit onder die persoon se naam alfabeties geliasseer is sodat die volgende mense wat kom, kan sien, o hier's dit, en dat mens nie oor ses maande kom, o, ons het nou hierdie persoon se file gekry, gaan doen hulle gou hierdie Donderdag op 'n tuisbesoek, wanneer daar eintlik ander mense was waarop mens kon fokus wat jy sê nou maartwee weke terug gesien het, wat dan moontlik sou kon voorkom dat die vinger septies raak. (46)

Prof. Clarke: So jy praat van 'n beter liasseerstelsel, beter orde wat dit aan betref en dat julle weet dat elke spannetjie wat elke twee weke kom, weet wat is die situasie, en as dit net 'n afteken is van die persoon, dan kan jy bloot as 'n hele span, net daar verbyloop op pad na die ander een. So 'n beter gekoördineerde stelsel. Jy wil ietsie sê?

M1: Ag, mens moet verstaan, die mediese studente doen 'n huisbesoek elke vier weke en intussen het ons baie ander akademiese verpligtinge en so aan. Op die stadium is ons nie heeltemal ge-'gear' nie en ek is baie onseker. Ek weet nie wat van my verwag word om daar te doen nie. (47)

Prof. Clarke: So wat die mediese kant sê is, hulle weet nie regtig wat word van hulle verwag nie. Hulle gaan elke vierde week uit na huise toe en natuurlik is hulle studieprogram baie vol, ek weet, want hulle is op roep en al daardieklas van ding. As ons almal slaap dan, ek weet, as jy nagdiens doen, dan slaap jy in die dag. So elkeen van ons met ons aktiwiteite en ons verpligtinge, ek dink wat hierdie mediese student vir ons as bydrae lewer, is dat ons elkeen se verpligtinge moet respekteer en dit dan inwerk by so 'n koördinering, en dit is 'n groot taak, maar ek dink dit is doenbaar. Dit is ook hoe om elke beroep baie beter toe te spits op

hul spesifieke opleiding weer en dat hulle almal 'n bydrae kan lewer, beide by die gesprek, na die tyd, voor die tyd en by die besoek. OK, dis nou nie logies georden nie, maar ...

M1: Ja, ek dink so 'n program het geweldige potensiaal. As dit reg gedoen word, kan dit baie goed werk. (48)

Prof. Clarke: Dis 'n baie positiewe bydrae daardie, dat as dit reg gedoen word, kan dit 'n baie goeie bydrae lewer.

SH2: En die interdissiplinêre groep, van Spraak se kant af, het ook groot implikasies vir die toekoms, want ek dink, nee, ek dink nie, ek weet, dit help ons om mekaar beter te verstaan. Soos wat nou net ook al genoem is, dit begin dalk in Avianpark, maar dit skuif hospitaal toe. Ons is nou almal studente, maar eendag as ons werk, dan is dit ook iets, want almal het daardie respek vir mekaar aangeleer en almal het geleer dat elkeen waardevol is en ek hoop dit sal dan maak dat mense minder geneig is om sommer net goed van 'n dissipline te verwagwat hulle nie heeltemal so vinnig dalk kan doen of op daardie oomblik kan doen nie. Net daardie basiese 'Ek verstaan jy het ook baie werk, ek verstaan dit wat jy doen, ek weet bietjie van jou scope of practice'.Want ek dink ons kry maar in ons opleiding self baie min daarmee te doen. Wat weet ek tog eintlik van wat 'n mediese student doen? Ek sit in my klasse en ek spandeer my vier jaar om net deur al my werk te kom om my goed te leer, so die tyd wat ek kan afstaan aan, wat is nou eintlik wat hulle moet doen of wat is nou eintlik wat die Verpleegsters moet doen of wat is wat die Arbeidsterapeute moet doen, is baie minder, en dis maar vir almal so. (49)

Prof. Clarke: So die blootstelling wat jy uitspreek is dan, spesifiek as studente, word julle blootgestel interprofessioneel, en julle besef dat elkeen het 'n bydrae wat julle maak, uniek vir die pasiënt, die Mediese student, Verpleegster, Spraakterapeut en Arbeidsterapie. Julle het julle spesifieke bydrae wat julle maak, elkeen is ewe belangrik, maar dat julle ook sal besef daardie persoon kan dit nie nou doen nie, maar jy het meer 'n besef van wat hulle doen en jy verwys na hulle scope of practice. Dat jy 'n beter besef daarvoor het as student en dan hopelik ook wanneer jy dan praktiseer as jy gekwalifiseerd is. Nog iets wat iemand wil bydra van julle ervaring in Avianpark as deel van die span interprofessioneel, en ook die opleiding wat julle ontvang in terme van dit? Niks verdere bydrae nie?

SH2: Net dat dit goed was.

Prof. Clarke: Dat dit goed was. Dis wonderlik.

SH2: As ons bietjie meer blootstelling kry, dan sal dit nog beter wees.

Prof. Clarke: Praat jy van 'n langer plasing?

SH2: Ons is vir vir ag weke op 'n blok, so ons het lang plasing.

Prof. Clarke: Goed, so jou plasing, vind jy die ag weke behoort ...

SH2: Dit sal vir my goeie blootstelling gee.

Prof. Clarke: Niks meer nie?

SH2: My plasing was mos te kort.

Prof. Clarke: So die tyd is baie min vir so 'n plasing, maar wat ek ook vind is, party word twee weke of ag weke of wat ookal geplaas en dat dit dalk hersien moet word sodat dit genoegsaam is dat julle wel die bydrae kan maak en dat dit ook 'n bydrae tot julle kan maak en julle praktyk.

SH1: Maar tog is dit ook lekker. Party van ons se tyd is baie kort of baie lank maar ons oorvleuel so perfek dat daar altyd mense is wat weet wat om te doen, wat mekaar kan help. So die Fisio's is sê nou maar nou nuut en die Spraakterapeute is nou al daar vir 'n paar weke en hulle neem net so oor by mekaar. (50)

Prof. Clarke: So die Engelse woord is 'you overlap'. So daar is altyd ou studente of vorige studente wat die ander spannetjie kan help in die huidige, maar terselfdertyd is daar party van julle wat voel dat julle plasing, julle weet nie, lyk my as ek so na die non-verbale taal kyk, julle weet nie of julle nog verdere tyd gaan spandeer nie, maar dit is vir julle belangrikdie tyd en dit voeg waarde toe tot julle huidige praktyk, kennis van mekaar en julle bedrywe en scope of practice soos jy dit genoem het, bestek van praktyk, en dan hopelik dat julle dit sal oordra in julle nagraadse aktiwiteite dat julle met mekaar dan op 'n eweknie kan koördineer en mekaar se insette kan verstaan en waardeer. Is dit korrek?

SH2: Ja.

Prof. Clarke:Goed, as daar niks nuuts is nie, sê ek vir julle baie dankie. Ek het dit baie waardeer.Julle bydrae sal goed benut word.Baie dankie.

AppendixD: Transcript: Formal study B / Interview 3

INTERVIEW CONDUCTED BY PROFESSOR MARINA CLARKE

Prof. Clarke: Good afternoon. It's great to be here. As you know, you were involved in the Health and Allied Care Student Interprofessional Collaboration and Education activities in Avian Park, Worcester. So this discussion will just be related to that and your experience related to that. So I will ask you a question and obviously I will clarify during the time to see that we understand exactly what you want to communicate.

Could I ask you just to tell me how you experienced those interprofessional activities as part of your clinical placement in Avian Park?

P1: We went with a team of medical students and other students. I thought it was really interesting, I learned a lot from the other students, how they interacted with the patients and their role in it. I think it was interesting because us as Physios, I don't think they realised what our role was and in a way we did our bit and they were surprised at what we did. So it was nice, because we all learned from each other and what each role was, because often we think we know but we don't really know. (1)

Prof. Clarke: Would you like to tell me specifically what role you didn't know about regarding the other professions?

P1: Well, we only went with the medical students, not the Speech or the OTs because they weren't around then, but theirs was medical related. In a way they didn't communicate, they didn't make the patient feel open to talking as they were just asking straight medical questions and the Physios were much more interactive and much more physical with the patients, so I think they learnt quite a lot from us as well to interact. With the stroke patients we would teach them how to go from sitting to standing and I think the medical students didn't realise we did that, so we showed them our little treatment, which was nice. (2)

Prof. Clarke: So you've actually discovered the different roles of the healthcare professionals and that you had a particular role to play as a Physiotherapist, which you discovered that the medical students were not aware of what you could do, and how you interacted with the patients was much more physical, if I hear correctly, and also that you

could relate to the patient where you found that the medical student went in and focused their questions specifically on the medical issues at hand.

P1: Yes, but at the same time the patients would say which medication they were on and then the medical students realised that some of those medications were clashing against each other which could cause further problems. So they delved into that part whereas I was obviously clueless of that. (3)

Prof. Clarke: So even if the roles were different you seem to have discovered that the patient had the benefit of being interpreted that the medication that they were on could have caused the problem they experienced. So you kind of saw the role of the medical student as part of the team because as you said Physios were clueless on that particular issue. But you also said earlier on that in fact you discovered that the medical student was also clueless on how to for instance get the stroke patient ambulant.

P2: Yes. I think in class they always tell us about the multidisciplinary team and you know of it but you never realise what it entitles, because we went with the medical students, the dieticians, the speech therapists. In my case we were all together, and the social workers as well, and it was so nice and you hear your patient has this wrong and that wrong, and you think: How am I going to solve this? And you realise, it's actually not my problem. It is my problem but I don't have to solve it. And then it was so nice to know you can actually get the best for your patient by referring him to somebody else who knows what's going on. (4)

Prof. Clarke: Tell me a little more about that.

P2: There's just some things you can't change for your patients. Like my one patient, she hadlike ... and I said, sorry, I can't do anything about it. I can get somebody ... she said, 'really, can you do that?' and I said yes, I will get somebody, and problem solved. Well, not solved, but they're working on it. (5)

Prof. Clarke: So what you are saying, that you have identified because she only worked with medical students whereas you seemed to have worked in a much bigger team that represented dieticians, social workers, OTs, Speech and Physio and of course medical students. And that particularly you identified where there was a patient with a particular issue on drugs and children you could do nothing about but at least it was kind of relieving that you knew someone in the team who could address it and to whom you could refer it. Any other experiences, because you've had quite a vast experience?

P2: What I also saw with the medical students is that they ask the questions and yes/no, and then they go on. With us we ask what do you want to do, what can you do? What do **you** want? It's not like I can give you this and I can do that. The one thing I also realised when we walked in there is that you must ask the patient what do they know about physio, because we ask them, 'do you know why I'm here?' and they say 'no'. But if you tell them I can help you with this and this and this, then they are more open to you. I also found you can't go in there and ask them questions. You have to become, not their friend, but you have to ask them how is their home situation, and then they'd say, oh, there's drugs, and I learnt a lot more about how to ask questions, especially if there's a team of people coming in and they ask questions, they don't really like it.I learnt a lot. (6)

Prof. Clarke: So your learning curve was experiencing quite a peak in as much that you have discovered how to approach a home in a community and that you couldn't just delve into the problem – I was sent here for X,and so you would mention drugs.You actually have to tread a bit softer as you approached.But you also said earlier on, please correct me, that you found that the medical students in your team just weren't in the home on the medical problem and they addressed that and then that's it, because they came for the problem, whereas you said that there are actually other issues in the community and that you have learned so much because of that.8:18

P1: Another thing I learned was the team work. Often we feel the medical students should take over the interview for some reason, then for us to step up and give our part, just to get everyone in the team to say their part, because they often feel oh, their part's not relevant or during an interview they mustn't say anything. It actually taught us to step up and say our part. (7)

Prof. Clarke: So did you in a way feel that you were at an even level of hierarchy, you didn't feel sort of a lower profession, that if you don't speak as part of the team that you have an equal innings to present your case. OK? Anything else you've learned or experienced? 9:20

P2: I had a really nice time. It's the first time that I actually got to deal with them. It's the first time ever we experienced that, like when you're in the hospital the doctor gives you the order and you go. But here you can actually sit and ask why do you say that? Why do you want to do that? Why did you ask him that? Why did you throw those many patients together?(8)

Prof. Clarke: So it was a learning curve for you also from the medical side, why the doctor would prescribe XYZ.

P2: Or any other health professional. Why did you tell them to do this? It's not like you read it in a letter, the patient is doing this and this or they can't eat this or they mustn't do this. OK, I can see this, but why? That was nice to actually have the opportunity to talk to somebody about it and then you think, maybe I can change this or incorporate this. (9)

Prof. Clarke: So you felt that you've learned in a way why people would then request certainexercises or whatever the case might be,that you would also be able to ... (have no idea!) 10:44 it whatever they prescribe and say why don't you do this, so you could engage in the discussion for the benefit of the patient. Is that right?

P2: Yes, and even between, we were four Physios there, but two worked together and I didn't even with my colleague tell her, why did you say that. I don't need to agree with you, just tell me how did you get there? Now we worked together, not like I have my patient and you have your patient but there we have the same patient, then we can actually discuss it and say why do you want to do that or what do you think of that. That was also a nice experience. (10)

Prof. Clarke: So it actually teaches you clinical judgement and clinical debate but if I hear correctly, to the benefit of the patient.

P2: Yes.

Prof. Clarke: OK. But you also referred to the fact that you had to explain what Physios do. Did you only have to explain that to the community members or also did you feel that you actually had to explain it to the interdisciplinary team?

P2: Oh definitely. What do you do? Do you just massage the whole day? No, I'm done with massage. You can actually take something stupid like getting them to sit or stand. It's something you just do but you don't realise people can't do it, and if they can't do that they can't get out and they can't move. They have an idea but they don't know specifics, so it was nice for them as well. They will also know, oh this patient can't do this, so maybe they need a Physio. (11)

Prof. Clarke: So you had the opportunity to relate to the other members of the team what Physiotherapists do, but did you also learn from them what they did?

P2: Yes, we did. One morning we had a Speech therapist who presented a talk about what do we do in the field. We do this and this test and we had to look in each other's ears and we had to do tests and that was quite nice. So now we know more what they do. (12)

Prof. Clarke: So it's also obviously a learning curve in as much that if I get to a patient like that I know to refer him or her to a Speech therapist or whatever the case might be.

P2: And it was nice that it was us students talking to another group of students. It wasn't the lecturer telling us this it what you can do. You felt comfortable talking to them, they were friends. So it was a nice environment to learn in. (13)

Prof. Clarke: Now I would like to ask you a little more about your calling the other members of the interprofessional team friends. Could you clarify that a little bit? Did you become friends, socially as well?

P2: I wouldn't say friends but I was comfortable with them. I would talk to them about patients if there was something I wanted to know, but not that we became best friends. But we had a good relationship. (14)

Prof. Clarke: You didn't feel threatened. You felt completely comfortable.

P2: And in the hostel you also become friends. Sometimes we had supper together. (15)

Prof. Clarke: Alright.

P1: And also the Speech therapists. What I learned, we did our home visits with the Speech therapists and we were trying to get the patient from lying to sit, and that was our main focus and that was all I was thinking about. Then it was the Speech therapist's treatment and he was teaching the patient to name a pen or a toothbrush, because the patient didn't know that this was a pen and that was a toothbrush, so they were teaching him that. And I thought to myself what's the point of him sitting by himself if hedoesn't know what a toothbrush is. Everything was so blurred. It was a simple concept, but I thought that he can't even name things or speak. (16)

Prof. Clarke: It almost makes me feel that one is sometimes blunted by what your profession is asked to do.

P1: When I watched their treatment I actually thought that their treatment was more important than mine!(17)

Prof. Clarke: But it all works together as a whole. It was a wonderful experience and a wonderful example that you've used. Because in that pen and toothbrush you also discovered your patient maybe?

P1: Yes. Another thing about Avian Park is that I sometimes felt it was a bit disorganised, like each profession didn't know what they were supposed to do, because we were the first group there. Everyone was a bit lost, we didn't even have the OTs and Speech therapists but it sounds as though it became more organised, but it felt like with us we didn't quite know what was expected of us. So I think in the beginning of the year it might be nice to have a big lecture or talk or something to say exactly what was expected and how to ask the questions and each person must speak up otherwise they will not get a turn. Just something each time with new students. I don't know how you guys felt, if you were a bit lost. It took a long time to get used to the system and all the information. It would be helpful. (18)

Prof. Clarke: So what you are saying is that the organisation and even preparation of students before you go out to a place like Avian Park, that you would be prepared, that you would know what is expected of you during the placement and also the participation, that you are encouraged to participate, and which disciplines will be there for you to work with.

P1: Yes.

Prof. Clarke: OK. You also said that at the end it became easier. Was it as you discovered or was it conveyed to you?

P1: As we discovered.

Prof. Clarke: As you discovered, so it was a discovery, a survival route.

P1: It was, yes. Maybe if each discipline had their own questions to ask or something, because sometimes people didn't say anything. But I think they didn't know what to do. (19a)

Prof. Clarke: So you are actually feeling a little bit lost, and may I say then that you perhaps have lost a bit of your clinical placement time because of your discovery.

P1: Yes, and the confusion. Even if there were notices up in Avian Park saying who's going, where they're going, what car are they going in, because all that takes so much time, which limited our time with the patients. (19b)

Prof. Clarke: Did you go to the patient, you went into their home?

P1: Yes.

Prof. Clarke: Tell us a bit about that.

P1: We went with the community care worker who took us to the homes, and we would sit in the home and have a discussion with the head of the home or whoever was at home, and we would discuss and ask questions. (20)

Prof. Clarke: And how did you experience that?

P1: I think there's nothing that can prepare you for that, because you walk into a home and it's quite shocking sometimes. It opens your eyes quite a bit. (21)

Prof. Clarke: Would you just like to tell me a little bit more about that? You go into a home, especially if you've never been to an informal structure, you're a bit shocked. Am I right?

P1: For me it wasn't so bad, because I've been to Transkei a few times, so I was expecting that sort of thing, whereas I think for the other students it might have been more of an experience. To me it was okay. I found the families so welcoming and friendly, I thought they might be like 'who are these people, these professionals walking into my house?' I thought they might be a bit nervous but they were so welcoming. I think that was surprising to me. Some of them gave us hugs and welcome to our home and offer you food and that was very welcoming. (22)

Prof. Clarke: Is there anything more you want to say about that experience, the home visit?

P2: I think it was nice to see the patient in their house, to see what they have in their house. Because you ask them, 'do you have a step?' Sometimes it's only a few centimetres, not really a step. Or you get there and you see, like we had a lady and she had a medicine cabinet or something and she couldn't open it because it was too high up. So we just put a string in the door so she could pull it, that we had thought of ourselves, otherwise she would've struggled for the rest of her life. It's something simple. You wouldn't be able to change that if you can't see it. And I saw a lady who had a hip replacement and she was so negative because she said she needs to lie in bed for the next six weeks. So I said you can sit, I'll just adjust your chair for you and you can sit, and she just cried – she was so happy. She didn't expect that. And if I saw her in hospital, I wouldn't have known that. (23)

Prof. Clarke: So what you are saying is that it actually exposed you to the environmentto which you refer patients back home or from where patients are coming into the hospital. If you didn't go, you wouldn't have seen the little things that people experience problems with. You've used the example of the medicine cabinet and the string so that she can open it, so that you can give little ideas of how to rectify such big problems. Also this lady who was allowed to sit in her adjusted chair. How did you feel about it?

P2: I felt well, this is just an adjusted chair, it's something stupid, and she was going wow, she was so happy about it. So I was thinking I can actually make a difference and I didn't even have to do something big. (24)

Prof. Clarke: And how did it make you feel?

P2: I was really happy about it. It was nice to do something nice for somebody. And to know they really appreciate it. (25)

Prof. Clarke: And know that they appreciate it, but it is also that it is applicable in her home, so you've actually changed the lady's life and her mindset, I think, because it almost sounds as if she was a bit depressed just at the thought of spending six weeks in the bed and develop bedsores as well. So you've actually contributed a great deal to that lady's life.

P2: And it's something simple like adjusting a chair. (26)

Prof. Clarke: But sometimes we take things so for granted and I think you are also saying that. Let me just take for granted that I can ask nothing but for other people it is a big thing.

P1: We ask the patients in the hospital, do you have a wheelchair-friendly house, is your bathroom inside or outside, just go through the list you have to ask, all these steps. Then you go to their home and you see no bathroom. And you have to ask, where's your bathroom, oh, it's just outside, and I looked and I ask where outside, and he says over there, and it was far and it was gravel and he was in a wheelchair. And I realised this is actually the main problem in this situation and I realised it's not the hospital, where outside, how's the ground, and understand where and how. And then I realised this is the main problem, how are we going to solve it. You think much broader. And also the wheelchair-friendly house, the one man was lying in bed near the wheelchair. But he couldn't get from his bed outside because the kitchen was so narrow, he couldn't fit through. That was the main problem, so I had to ask the son to move the kitchen counter, so that he could get the wheelchair through and he could then eventually, so it's that simple, and now I understand. (27)

Prof. Clarke: And it is such for you both, you both said it's so simple, so small, but it moved such a big leverage, the leverage of that small thing that you've moved had such a great effect on the other side. So in fact it's not so small, I hope that you realise that. So what I then hear you say is that your experience going home, you've referred to the step, yes, we've got a step and then your fingers were about two or three centimetres high and that's not really a step. That's not what you had in mind as a step, perhaps as an uneven floor but not as a step. Then her bathroom, and highly likely that outside bathroom was bitterly cold in

Worcester because Avian Park can get as hot as anything and as cold as anything, so they've got the extreme temperatures, and then apart from that the unevenness. But it's obvious also the way in which you dealt with it that she actually showed you to keep his dignity, and you obviously dealt with it in that way. So you've learnt a lot about the environment and you've learnt a lot about each other. Was there anything you learnt from your patients, other than being helpful?

P2: I was giving a pain class and I said we all experience pain and my one patient laughed at me and said, 'my sweetheart, you've never experienced pain'. She could see I was privileged and she was suffering. For me I realised I mustn't try to pretend I can relate because there are times you really can't. And that taught me a lot. Often we say, oh we all go through this and meanwhile I had no idea of what's actually going on in their lives, so that taught me quite a lot. (28)

Prof. Clarke: And that sort of puts you on the spot?

P1: Yes. I did learn from the patients all the time. You also learn how they deal with their situation like it wasn't us going in and saying you must do this and this, but rather how do you do this, what is the easiest way? We also ask questions like do you understand your condition, what do you understand this to mean, or what do you think is wrong with you? Then you get their perspective which is totally different. (29)

Prof. Clarke: So what you are also saying is that you've learnt from your patient that, even though we can say that we all go through XYZ in fact it's more complex than that. You've realised that in fact I'm very privileged, and perhaps I don't even know what pain is. Real pain and not having something that I can do for it to address it. Then you also learnt to ask the person rather how do you cope, rather than say this is how to cope.

P1: Their way is usually better than our way. (30)

Prof. Clarke: Exactly, and they've worked it out because it fits their environment. Anything that you've particularly learnt from your patient, other than what was said?

P2: I had a lady, she had, I think, osteoporosis in her spine and the doctor told her your spine is busy breaking and she was petrified. She didn't want to move because she says she knows if her spine breaks she will be a paraplegic. She eventually was in so much pain and everything. I thought, actually you're fine, you must just talk to them, and explain to them, what do you know about your condition? She said but the doctor told her her spine was breaking, good-bye. And I said, yes, but you could still move, because we gave her

exercises the first week and we asked her are you doing it, and she said no. And we asked her why didn't you do it? We want to help you here, even if you're so scared to move. And then she did her exercises and she became so much better. You must just ask them what do they know. For us, because we know it, we expect other people to know it, too. That really brought me down, realising they don't know it. (31)

Prof. Clarke: But also they know it as they have understood the doctor to say. Maybe the doctor didn't say it like that but that is what it became. You know that little game of broken telephone. If your spine is breaking up, then obviously you can have your own mental picture how it's brittle and what have you. And what you've experienced, is that one in fact has to hear what the patient heard and reiterate and explain.

P2: That day I also realised that my actual treatment for the day is not exercise, it's actually just education. That's what my job was for the day. We never think about it, we always go, 'Talk exercise'. That's what we want to do. You can't do it, it's not going to work. (32)

P1: And we became a psychologist for one session. It was a session, and even if I'm not, I have to be here in order to get wherever we wanted to. (33)

Prof. Clarke: But there's a separate discovery,if I understand correctly, that you became an educationist and psychologist and you wanted to do exercise, but you discovered that you couldn't move to the exercise without that buy-in and understanding of the patient. And this allowed you to do that. Was it the interprofessional that allowed you to do it or was it just the home visit that allowed you to do it? Do you think it was because the others were there with you in this visit that you discovered it or just the home visit?

P1: I think we had to play another role which made us understand better, what was more important, was it the exercises or the education?(34)

Prof. Clarke: So working together as a team allowed you to see, is that right, that in fact it's more than the exercise, it involves a person. Anything else of the collaboration with the different professions that you want to talk about? You spoke about that you will refer, you will know what to refer, how to refer, when to refer, better than you would've done, much better than you would've if you hadn't been part of this interprofessional program? Anything else in terms of that?

P1: I just like the personal part, like we went and spoke to the Speech therapist about the patient instead of writing a referral letter. We spoke to them and then we got feedback afterwards from them and said how did it go and then they told us about it. And there's the

OT who said there's this patient who needed help and there's much more talking about it, whereas at Tygerberg Hospital you write a letter and then you never hear about the patient again.So that is nice, you got the feedback about the patient as well. (35)

Prof. Clarke: So you got feedback but also got an update and you could actually discuss your patient with the other colleague and get a verbal feedback,which often is more rich and you could clarify.

P2: We also sometimes had the opportunity, if this was my patient but he needed speech therapy, I could attend the speech therapy session and then they would talk and you would think 'I never asked him that' or 'maybe I should also try that' and you discover something new from the patient that was quite helpful. Maybe I should teach him to sit more uprightor do this better or help him with that. It is nice to see that and afterwards you could discuss, why did you do that? If I do this for him, do you think it would help you? (36)

Prof. Clarke: So you could actually discuss, earlier on you said, you could then ask the different professions, why did you prescribe that, why did you ask for this and that and so forth. But here you say even taking it further and can I in my session incorporate X, so will it help your therapy? So that you are actually working together very closely to the benefit of the patient.

P1: Same thing with the man who was trying to sit and say pen, the Speech therapist realised that better posture will make him speak better, so they have to sit him up. (37)

Prof. Clarke: Is there anything else in terms of the interprofessional educational activities that you want to talk about?

P1: We tried to do education at Avian Park, activities in classes, have the community come in and give them class. But also lack of communication. We tried to advertise on the radio and do everything we could, use word of mouth to see if people would come and listen to the talk, but there was a lack of people coming to listen to the talk. So I don't know what we could have done to improve that. But I think that is one of the main health promotion things that would've been good. (38)

Prof. Clarke: Have you reflected on that, why people did not come?

P1: We were the first group.

Prof. Clarke: Yes, but did you talk about it in your group? What did you come to?

P1: I don't know. They didn't want to leave their homes and come. It was far for them to walk, to come for a little lesson. I don't think the lesson gave them enough. Some were very motivated to come. I think it's just a new project, it needs to be developed and hope more people will come as time went. That was one very important thing.Then we discovered we should maybe do the talk where all the patients were waiting anyway for their medication. There was a lot of people waiting at one stage, so we just did our talk, which was great, and they heard it anyway. (39)

Prof. Clarke: So you thought on your feet.

P1: Yes, we did.

Prof. Clarke: And I think you also came to discover at community level there are other issues and things that happen in the context that people don't just rush down for an input, because they don't know what you are going to tell them. They haven't come to your student talks, because student talks have not been advertised well enough and become known in the community. You said yourself people have to come far and they would have to leave their homes to come. But you did very well to think on your feet and say, they are sitting here, let us do it, and I want to compliment you on that. And that could perhaps be the way forward.

P2: Thank you.

Prof. Clarke: Anything you would like to say?

P1: No.

Prof. Clarke: Well, I know you have been called and I also want to be respectful about that, but could I then just say in terms of your experience of interpersonal education collaboration, you've actually had a very positive experience, getting to know what other professions in the allied health are doing and you also had the platform to tell them what you are doing. At the same time you had the wonderful privilege and opportunity to go into a home and discover where you are referring people to and where do people come from that come to your clinic or in the hospital, your consulting room or whatever the case might be. You've also discovered going to the homes and to the community, you in fact can, with a very minor adjustment, make such a big impact on somebody's life and people's lives, and at the same time you could learn from the people, how they cope. And as you said quite rightly they could do it better than what I thoughtI could do. But you had to go there to actually discover what is an outside bathroom and what sometimes is referred to as a step and what people experience in sitting up and identifying a pen or toothbrush. That your profession, helping the person to

sit up, actually benefited the Speech therapist indirectly and that you could learn from each other, even asking each other,why do you do it, what can I do in my session to benefit your session with a patient, obviously for the benefit of the patient's health. Is that correct?

P1 & P2: Yes.

Prof. Clarke: And then you did say that in fact the organisation and arrangements should be more organisedso that you can come more prepared and not waste a lot of time along the way.

P2: Yes, I think the organisation part, because I was in the second group, so by the time we got there the other professions had been there, so they could tell us what's going on. So I don't think we had that much confusion, but I can understand if everybody is new at the same timethere is going to be confusion. We also didn't know but I don't think it was that much confusionbecause there were others and then later on we had to explain to the new group what's going on. (40)

Prof. Clarke: But you suggested earlier on, if I understood correctly, that you would've suggested that this is actually part of your preparation before placement, that you all know at the same level what is expected of you when you are placed.

P2: Yes.

Prof. Clarke: And also how to behave in a community. As you have said the people were so kind to you, very welcoming and how do they expect you to be. Anything else? Then I want to thank you.

Appendix E: Formal study analysis / interviews A and B

FORMAL INTERVIEW A

INTRODUCTION

The formal study consisted of two separate interviews. The interviews are defined as interview A and interviwew B.

The participants during interviews A and B differed and the participant codes and profiles for each group are indicated with each interview.

Response numbers were allocated to each response and the responses linked to the themes andsub-themes during the data analysis and the discussions which were done.

PARTICIPANTS CODES AND PROFILE OF THE FORMAL STUDY

CODES:

1SH - Speech and Hearing students

2N- Nursing students

3M - Medical students

PARTICIPANTS PROFILEFORMAL INTERVIEW 1

Interprofessional group	participant totals(N=5)	Participant codes
Speech and Hearing therapy students	n 2	SH1 and SH2
Nursing students	n2	N1 and N2
Medical students	n1	M1

THEMES AND SUB-THEMES OF THE FORMAL STUDY (INTERVIEWS A and B)

Main theme	Sub-themes
A. Organisation	A.1 Rotation and student schedules A.2 People, Structure and Function A.3 Preparation prior to IPC / IPE
B. Perceptions and experiences related to interprofessional team structures prior to and following interprofessional collaboration (IPC) and interprofessional education (IPE)	B.1 Experiences and perceptions during IPC B.2 Prior experiences and perceptions B.3 Challenges B.4 CHW as a team member
C. Team cohesion – IPC and IPE at Avian Park	C.1 Referral practices C.2 Advantages of team cohesion C.3 The need for further IPC and IPE
D. Advantages of practices within the Re-engineering of PHC	D.1 Home visits D.2 Quality of home visit

FORMAL INTERVIEW A

PARTICIPANT RESPONSE	RESPONSE NUMBER
SH1:" *Dit was lekker gewees.Eerstens omdat jy, sê nou maar jy werk saam met 'n Fisio en jy weet nie eintlik wat hulle doen nie, so dan is dit nogals lekker om te sien wat hulle doen, om te weet as jy eendag moet verwys,om te weet waarnatoe om te verwys, so om te sien wat hulle doen, dit was nogals lekker gewees."*	1
SH1:" *Nee, nie spesifiek Fisio's nie. Ons het saam met mediese studente gewerk en Arbeidsterapeute en Dieetkundiges."*	2
SH1:"*Byvoorbeeld nou die dag het die Dieetkundiges vir ons 'n voordrag gedoen oor vitamine A en sulke goed en hoe hulle die babas meet en sulke goed en dit was nogals interessant, want ek het nie 'n idee gehad hoe om dit te doen nie, ek het nie geweet hulle doen dit nie.*	3

Hulle het al met ons kom praat, die Dieetkundiges, oor wat hulle doen, maar dit was nogals interessant gewees, dit is wat hulle doen, dat daar 'n spesifieke manier is wat en hoe hulle dit doen"	
SH1:" *Ek weet nie rêrig nie, Medies – ons het nie so baie met hulle te doen gekry nie. As ons uitgegaan het, het hulle ingekom. Ons was op 'n paar home visits saam met hulle gewees."*	4
SH1:" *Die home visits – ons was nog net twee keer daar gewees. Ons was een keer saam met 'n mediese student gewees. In 'n sin het ek gevoel, soos die Arbeidsterapeute en die Fisio's en die Spraak – ek dink ons het meer ervaring, of dis die idee wat ons gekry het, dat ons meer ervaring het, en veral soos die Verpleegsters ook, met home visits, in die sin van hulle het bietjie onseker voorgekom, nie onseker in die sin van wat om te doen nie, maar net oor hoe om die mense te benader in 'n huis, of dit was in die spesifieke geval, maar ek weet nie hoe die ander daaroor gevoel het nie, so dit was nogals interessant om te sien. Ek dink ons benader dit op 'n ander manier,ons praat meer met die mense, maar hulle is baie meer op die punt af en weet wat hulle wil hê, maar dit is hoe ons moet werk."*	5
SH1:"*Ons is maar partykeer meer gefokus op die omgewing ..."*	6
SH1:"*Ja, ek bedoel, ons is immers spraakterapeute."*	7
SH1:"*Ja, dit was 'n lekker ervaring. Ek dink net ek het by tye 'n bietjie weerloos gevoel in die gemeenskap. Mens weet, dis 'n normale gemeenskap, dis net omte loop daarnatoe, dalk was ek net bietjie meer op my senuwees met sulke goed. Maar dit het gehelp dat die community care workers daar was, hulle het mens baie meer op jou gemak gestel, hulle ken die mense en weet waarnatoe, maar dit was lekker gewees. "*	8
SH1:"*Ja, al was ons in 'n groep, was dit nog steeds so. Ek bedoel jy ry nie daarnatoe nie, so jy is afhanklik van die gemeenskap se goedgesindheid."*	9
SH2:"*As 'n meisie voel 'n mens maar outomaties bietjie meer weerloos as jy op jou eie stap, selfs al stap jy dan saam met ander meisies. Maar ek moet saamstem, ek dink nie mens besef in hierdie interdissiplinêre span, ons fokus so op die Fisioterapeut, OT, Arbeidsterapeut, dat ons nieagterkom hoe baie ons die community care worker nodig het totdat ons fisies met hulle werk nie. Voordat ek op Worcester gekom het, het ek nie verstaan van mense soos community care workers nie. Ek was nog glad nie op 'n home visit nie, ek was maar in die hospitaal op my vorige blok. So dit was vir my interessant, want mens het die mense*	10

nodig wat die omgewing ken, wat so half die mense ken. Mens voel maar dis 'n onbekende omgewing, mans het mos maar die tendency as hulle daar rondsit en meisies stap verby om goeters te sê, so dit bring vir mens 'n gevoel van veiligheid. So dit was 'n interessante ding gewees wat ek geleer het. "	
SH2:" *Hulle is ook die persone wat so half die span bymekaar hou in 'n sin, want hulle is konstant. Hulle is daar. Ons ander mense, die span self, verander die heeltyd, maar sy is heeltyd konstant daar, so sy weet wat aangaan, sy help almal."*	11
SH2:"*Outjies wat na skool op straat kuier, tieners, hulle is mos maar altyd 'n vreemde soort."*	12
SH2:" *Wat ek aan gedink het toe ons gepraat het oor die mediese spanlede, is dit was vir my persoonlik –die dokters werk met 'n persoon wanneer hulle akuut is en wat ek opgetel het,spesifiek op die home visit en so aan, is hulle is baiekeer gefrustreerd,want nou kom hulle in hierdie huislike omgewing, soos die meisie wat saam met ons gegaan het, en al wat sy eintlik wou gehad het is dat die man in 'n ambulans kom, by 'n hospitaal kom, dat iemand na sy vinger kan kyk, want dit is besig om septies te raak.Nou word daar van haar verwag om hierdie vorms in te vul en te praat oor hoe dit gaan met die kinders en eintlik al wat sy wil hê, is dat hy reggemaak moet word. Ek dink nie dit kom altyd, as mens in die gemeenskap werk by 'n kliniek soos Avianpark, kom dit nie so goed voor nie. As 'n mens nou nog bloed trek of net na die ore moet kyk, meer meganiese goed wil ek amper sê, is dit bietjie makliker, mens voel dat jy meer kan doen, maar ek dink sy't gevoel daar's 'n baie groot gaping tussen wat in die hospitaal gedoen word en wat by die huis of in die klinieke gedoen kan word. "*	13
SH2:"*Maar die frustrasie dat dit nie kan gebeur op daardie stadium nie."*	14
SH2: "*Soos ons Spraakterapeute of Arbeidsterapeute wat met rehab werk, ons verstaanlang prosesse. Jy kan 'n paar keer gaan, 'n paar keer met die persoon werk, jy kan daar in sy huis met hom werk meeste van die tyd. Mens hoef hom nie eers na die hospitaal toe te vat nie. So dit was hierdie spesifieke ervaring"*	15
SH2:"*Ek weet nie of ek so diep daaroor gedink het of dit iets vir my beteken het nie. Ek dink dit het wel vir my ook geleer van daardie tipe frustrasie, want ek mag dalk eendag ook 'n pasiënt teëkom wat ek baie graag net by 'n hospitaal wil uitkry, maar ek kan nie, want ek kan nie sy elektriese rolstoel vervoer nie, en ek weet hy het eintik hierdie tipe masjien of hierdie tipe ding nodig en ek kan dit nie by hom uitkry nie.*	16

So ek het bietjie van daardie frustrasie geleer."	
N1:" *Nursing. Ek kan nogals hierdie projek sien as iets wat kan voortgaan in die toekoms, want die verskillende spanne bymekaar, hoe hulle ge-collaborate het met mekaar, is vir my fantasties. Van die Nursing perspective af het ek eenkeer uitgegaan na 'n woning in Avianpark saam met Arbeidsterapeute en Fisio's. Dit was 'n gesin van elf gewees en dit was half 'n shack, half in 'n huis gebou. Die eerste ding wat ek opgetel het, was die omgewing. Soos jy inkom, kyk jy mos maar na alles – holistic moet jy mos maar alles approach. Ek kom toe agter dit was 'n follow-up. Ons kom bymekaar by die kliniek en dan gaan jy deur 'n paar lêers en dan kyk jy wat moet opgevolg word. Dan beweeg ons in groepe uit en in elke groep is 'n member van elke beroep en dan gaan julle na die wonings en julle kyk van julle perspective af. Van die Nursing perspective af het ek agtergekom daar is in die gesin van elf drie babas en nie een van hulle het Road to Health charts nie. Drie tieners het nie identiteitsboekies gehad nie. Die ma en die pa bly eenkant in die geboude gedeelte van die huis en die res bly in die ander gedeelte van die huis. Die omgewing was nie so vreeslik skoon nie, maar die oomblik toe ons daar aankom, toe begin hulle vinnig skoon te maak, hier kom die groep mense, hulle is mos nou vreemdelinge, ons mense is mos maar so. Wat ek eintlik wil sê, met die teruggaan kliniek toe bespreek ons wat ons ervaar het. Elkeen gee sy input. Ons besluit saam.Kan dit 'n referral wees na 'n Fisio toe, kan dit 'n referral wees kliniek toe of na SASSA toe? Maar waarna ek eintlik gekyk het, is hoe die span kan saamwerk aan een probleem, wat elkeen sy input kan gee. Soos sy gesê het, jy voel maar blootgestel in 'n gemeenskap wat jy nie ken nie, want dis mos nou vreemd, maar jy stap in doelgerig, want jy weet wat jy nou daar gaan doen. En julle kan nou maar stry, as jy daarvandaan kom en jy het iets vir iemand beteken, dis iets positief. Avianpark is nou net die regte plek om die projek mee aan te gaan vir die toekoms, want daar is verskriklik baie probleme daar. So ek het baie geleer, geleer hoe om met die multi-disciplinary team saam te werk en my input te kon gee – dit was vir my nice. "*	17
N1:" *Ek sou nie sê ek het so* blootgestel *gevoel soos wat sy byvoorbeeld gesê het nie. Dit was 'n vreemde omgewing, maar ek het rêrig nie blootgestel gevoel nie."*	18
N1:" *Nee, seker omdat ek ouerig is, kyk ek anders na dinge. Ek voel anders oor dinge en ek approach dinge anders."*	19
Prof. Clarke "*Dan het jy ook vir ons basies gesê dat dit vir jou 'n positiewe ervaring was"* *"en van Verpleging se kant af het jy ook gevoel jy kon 'n bydrae maak".*	20

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N1:"*Definitief.*"	
Prof. Clarke:"*Het ek dit reg opgesom? Is daar iets wat ek uitgelaat het, wat ek verkeerd verstaan het?*" **N1:**"*Die collaboration tussen die verskillende spanne.*" **Prof. Clarke:**"*Het jy gevoel dat die mense van die ander beroepe geluister het na jou?*" **N1:**"*Definitief, ons het eintlik by mekaar geleer.Sy het nog nooit gehoor van sekere goed wat ek van gehoor het nie. En jy vra ook: 'Wat is 'n Road to Health chart?' Wat is dit? Wat is dit? Op die ou end is dit meer 'n verduideliking as wat ons eintlik wou doen.*"	21a 21b (continuation of thought same Participant)
P1:"*Dan net iets van Fisioterapie. Dit was die eerste keer eintlik hierdie jaar wat ek rêrig in kontak gekom het in 'n interdissiplinêre span. Dit was vir my eintlik baie lekker om saam met al die ander mense te werk en dan leer jy ook so by mekaar. Maar ek dink mense verskil, so jy moet ook leer om aan te pas,want sekere groep mense, al wil jy dit nie glo nie, jy het jou traits, dan moet jy gewoond raak aan hoe mense dan is, net by hulle aanpas in die span.*"	22
M1:"*Ja, van Medies af, soos wat jy nou sê, om so half in 'n span saam te werk en 'n klomp verskillende persoonlikhede te hê, dit is nogal definitief 'n vaardigheid wat jy kan aanleer hoe om te werk. Wat ek ook nogal van gehou het, dit gee vir jou meer 'n perspektief van jou pasiënt se agtergrond, jy gaan in sy huis in, jy verstaan jou pasiënt baie beter, ek dink dit maak 'n groot verskil. Ek het definitief baie geleer omtrent die ander professies. Ek dink in Medies is ons baie probleem-geöriënteerd. Ons is baie, ek meen ons begin alles met 'n probleemstelling. Ek dink ons raak baie gefrustreerd as ons nie 'n probleem vind nie.Ek dink dit is eintlik tans my grootste frustrasie by Avianpark. Ek kom by die mense se huise aan en ek soek vir 'n fout en ek kry nie die fout nie en dit frustreer my.*"	23
Prof. Clarke: "*Maar die vaardighede van daardie soft skills, daardie persoonlikhede en verskillende beroepe wat hulle bydra, het vir jou waarde toegevoeg*" **M1:**"*Ja definitief, ek meen, as ek nie 'n probleem kan vind nie, dan help hulle my weer.*"	24
M1: "*Ja, dis definitief 'n groot ding daardie. Dit help jou om jou pasiënt beter te verstaan.*"	25
M1: "*Ja, mens kry 'n groot idee hoeveel mense bly op een perseel. Dit is eintlik vir my 'n groot ding. Ek het mense met krukke huis toe gestuur*	26

en gesien wat hulle alles moet oor beweeg met hulle krukke en hoekom dinge soos tuberkulose so maklik kan versprei, onder andere."	
M1: *"Ek dink tot dusver het dit die meeste van sosiale werkers opgelewer in 'n omgewing waar sosiale probleme groot is. Daar is baie mense wat bv nie ID-dokumente het nie en dan reël die sosiale werker dat die mense ID-dokumente kry. Of daar is ouer mense wat met 'n klomp klein kinders saamlewe wat dwelms gebruik, dan help die sosiale werker om daardie ouer kinders uit die huis uit te kry."*	27
SH2:"*Ek dink ook (Spraak) 'n punt wat baie Medies en Verpleging aangeraak het, was dit van perspektief,wat u nou gesê het van in die groep sit en daarna daaroor praat, en dan was dit interessant,bv sy het agtergekom die babas het nie Road to Health charts nie, en ek en die ander Spraakterapeut sou waarskynlik nou gekyk het hoe praat die ouma wat 'n beroerte gehad het, terwyl die Fisioterapeut sou gekyk het hoe mobiel is die ouma. So al daardie verskillende goed waarna verskillende mense kyk, dit gee vir mens 'n baie beter beeld van wat aangaan en wat dan daardie persoon se beperkinge is,maar ook die goed wat daardie persoon dan help. Die jong meisie wat ook in die huis bly wat die ouers noudalk nie 'n grant voor het nie, maar sy kan dan die ouma help in die dag en haar was, sy kan na die kindertjies kyk. So dit is baie interessant, elke ding waarna elke persoon kyk, en dan sit jy partykeer en dan dink jy, ek sou nou glad nie daaraan gedink het nie."*	28
SH2:"*Spraak – dit voel asof al die probleme word vinniger identifiseer en dit word vinniger behandel, want almal kyk gelyk daarna, as wanneer dit net jy is en jy moet verwys onmiddellik, dis net wat jy dink en jy sien dalk nie alles raak nie."*	29
S1:"*Daar is 'n goeie kans dat ek nie daarna sal kyk nie. Ek weet dis belangrik, maar ek is so gefokus op die spraak en dietaal en hoe die kind ontwikkel."*	30
N2:" *As ek vanVerpleegkunde af kyk, was ek baie skepties gewees aan die begin, want ek het nie geglo dit is studente nie.Ek het geglo ons Verpleging is al studente, julle is almal klaar geleerwat daar was. Net toe ons uitgaan, toe gooi hulle my aan die diepkant in en ek moes skryf. Toe het die mediese student daardie hele geografie, daardie blokkies-ding wat die familie voorstel. Toe dink ek 'wat is dit?'en toe het ek gevra dat ek dit kan teken en ek het nou van die voorbeeld af gewerk en die familie was regtig 'n groot familie gewees waar daar 'n ouma was, daar was 'n Spraakterapeut gewees, daar was 'n gewone Arbeids-terapeut gewees, die hele multi-disciplinary team was bymekaar gewees. So toe ons nou bymekaar sit, toe wil niemand praat nie en ek dink, dit is my eerste dag en ek is so nuuskierig, kom ek vra maar vrae.*	31

En ek begin vrae vra en ek dink toe ons geleer was om ook vrae te moet vra vir die kliënt om mos nou te kan antwoord, en ek onthou dit was die kleindogter gewees. Toe het die mediese student vir my gesê, 'Moet jy so baie praat?' en vrae vra, maar ek het geleer, as ek nou kyk van Verpleeg se kant af, jy moet belangstelling toon in die persoon sodat hulle gemaklik met jou kan raak en begin praat. Toe vra die een, ek kan nie meer onthou wat was sy gewees nie, toe sê sy vir my ek moet vir die persoon vra, want sy het na haar ouma gekyk wat 'n stroke gehad het, hulle was klaar besig gewees, dit was net follow-up gewees, die spraak het herstel, sy was met fisio besig gewees, sy't 'n loopraam gekry. Toe sê die mediese student hy het niks ommeer te doen nie, so hy gaan maar vir ons dophou. En toe het ons nou vir hom betrek en vir hom verduidelik dis waarna ons kyk, of hy nie goed kan link na waarna hy kan kyk nie, en hy het toe vir ons mooi verduidelik hoe hy die prentjie sien, en toe ons nou almal bymekaar sit, was dit heel interessant, toe ons bymekaar sit dat ons nie saam met ander mense wil werk nie. Toe was ons baie kwaad want dit was ons almal se laaste dag saam gewees. Ek het geleer, as jy nou kyk van jou persoonlike agtergrond af na ander mense toe, dan besef jy die lewe is nie regtig so maklik hierbuite nie, en as ek nou na 'n pasiënt in die hospitaal kyk, kyk ek net, kom die pasiënt nie van Avianpark af met so 'n agtergrond nie?Wat is die omstandighede by die huis waaruit die pasiënt kom? As ek vir 'n pasiënt sê, meneer, onthou nou, jy moet was – is daar water waarin die pasiënt kan was? Hoe beweeg die pasiënt, so dinge het vir my meer prakties geraak met daardie agtergrond, nie net gedink almal moet was nie."	
N2: "Ja, ek was teleurgesteld, ek wou weer gegaan het. Ek was die eerste een van die groep, so ek het hulle lekker aangesteek van die Verpleegkantaf, vir hulle vertel hoe lekker dit was, maar ek het nie vertel ons was daar in Smartytown en dit was baie rof in daardie gedeelte nie, so ons het letterlik mekaar se rûe gewatch. As die een loop, kyk die ander een rond, maar in die reis-opset was ons baie veilig gewees en ons het gery, ons het nie geloop nie."	32
N2:"Ja, en ek het gevoel elkeen is deel van die span. Toe ons maar begin gesels het, toe was dit nie van jy voel uit of jou inligting wat jy gee, is nie van belang nie. Ons het almals'n saamgevat."	33
Prof. Clarke:"En dan was dit vir jou 'n ervaring om te sien dat almal wat daar sit, is studente en nie Spraak en OT's nie?" *N2:"Ja, dit was vir my 'n skok gewees."*	34
Prof. Clarke:"En jy het gevoel hulle het dit waardeer?" *N2:"Ja, ek het so gevoel, want toe ons nou in die hospitaal mekaar*	35

raakloop, het jy die vrymoedigheid om vir die een te vra. Die een het miskien nou 'n tendon wat geskeur het en dan kom hulle en hulle sê die OT's moet nou soontoe gaan en dan wonder jy wat gaan jy nou doen, en dan verduidelik hulle vir jou, dis wat hulle fisies met die pasiënt gaan doen."	
N2:"Ja, so sê nou ons stap op doktersrondte. Ek werk in C3, die Ortopediese saal, en daar is twee firmas, dr Franken se firma en dr Basson se firma. As dit dr Franken se firma is, is ons almal baie bang, niemand wil praat nie. Toe het ons geleer as die een student antwoord en die ander een sy input gee, het Dokter nie so baie vrae om te vra nie. Maar toe het ons agterna gesê ons weet nie en sal ons vir mekaar vra. Sy wil graag weet hoe hanteer hy sekere wonde, veral as dit nou 'n totale heupvervanging was, dan vra hy ons vasvra en dan sien jy die ander een sukkel, want ons is van twee verskillende beroepe, so die een is miskien Medies en ek is nou by Verpleging. Nou ken ek die antwoord, dan fluister jy net die antwoord, dan sal Dokter sê 'ek soek julle nie weer saam nie', dan skei hy vir ons. Maar dit was lekker om vir mekaar te help en vir mekaar te kan vra, jy het die vrymoedigheid gehad."	36
SH1:" Ek dink ook nou net soos sy nou genoem het, dat jy in die span vir almal leer ken (van spraakterapie se kant af) en jy sou nie noodwendig na die tyd dan gaan julle en dan doen julle ander aktiwiteite ook saam, soos in die interdissiplinêre span, wat nie noodwendig die geval sou gewees het nie. Ek dink persoonlik ek is baie stil, ek hou van my space en so, maar ek het al so baie ander aktiwiteite gedoen saam met die Fisio's en die mediese studente en so, maar dit is omdat jy leer ken hulle in die werksopset en dan doen julle soos buitemuurse goed ook saam, en dis ook baie nice."	37
SH1:"Wat ek nie dink sou gewees het as jy nie daardie blootstelling gekry het nie."	38
M1:"Ek sou baie daarvan hou as die werk net bietjie meer georganiseerd kan wees. Ek voel dit is nie goed genoeg gestruktureerd nie. Ek sou baie gelukkiger wees as ons vooraf bietjie beter riglyne kan kry oor presies wat gedoen moet word in huise en waarvoor ons moet soek, want ek voel ons word net 'n bietjie in die diepkant ingegooi. Ek sou daarvan hou." *M1:"Ja, ek sal baie daarvan hou as iemand net saam met ons sit, hierdie is mevrou so-en-so, sy het 'n rukkie terug hierdie operasie gehad. Gaan net asb en evalueer vir hierdie en hierdie tipe dinge. Want op die stadium, ons stap net na 'n huis toe, ons weet nie wat om te verwag nie en baie van die tyd weet ons nie regtig wat ons heeltemal daar doen nie."*	39 a 39 b (*continuation of thought same* *participant*)

N1: *"Van die Nursing af – ek sal saam met hom stem, want eintlik moet die carersvoor jy uitgaan vir jou oorgee, dit is die profiel van die pasiënt of die kliënt,dit is 'n follow-up of dit is 'n first visit, ons gaan hierna kyk en ons gaan daarna kyk, dit is 'n bestaande probleem. Sodat as jy daar kom, kan dit eintlik beter gedoen word. Jy gaan mos dan nou spesifiek nadaardie persoon se probleem kyk van die verskillende velde af en dit kan gouer gedoen word. Jy kan dan ten minste twee besoeke doen in plaas van een."*	40
SH1:"Omdat die groepe ruil elke tweede week, daar's gedurig nuwe spanne en elke keer dan moet jy ingelig worden along the way verloor ons inligting."	41
M1:"Ag, ek het al baie keer daar aangekom en dan is dit iemand wat eintlik geen probleme het nie, alles is reeds uitgesorteer, dan kom ek daar aan en dan is dit letterlik, kom ons haal die persoon van die tuisbesoeke af. Dit het al twee keer met my gebeur."	42
SH1:"Of van Spraak se kant af,ons het al eenkeer daar aangekom en dan die eintlike probleem, die kind wat die eintlike probleem is, is nie meer daar nie, hy's by die ma. Ons moet nog steeds met die ouma en almal praat, maar ek voel net op die oomblik is dit nie eintlik 'n probleem nie, maar dis 'n opvolg. Ons wil eintlik – dis bietjie frustrerend."	43
SH1:"Van Spraak se kant af sou ek sê, ek wil nou nie vir die community care workers meer werk maak in 'n sin nie, maar as hulle dalk net voordat ons weer gaan, partykeer is die opvolgbesoeke oor twee weke of later, dalk net voor dit weer gaan seker maak, net 'n vinnige inloer en hoor of daar nog 'n probleem is en seker maak wat die adres is. "	44
SH1:"Ja, om te hoor of dit rêrig 'n probleem is en om te sê nee, dis nie nodig dat 'n mediese student saamkom nie. Daar's baie ander probleme wat hulle beter kan hanteer.Hierso is spesifiek 'n Spraakterapeut en 'n Fisioterapeut nodig, want dit help nie ons gaan na 'n persoon toe wie se been geamputeer is nie. Ek as Spraakterapeut kan niks daar doen nie. Vat eerder 'n Fisio en 'n Arbeidsterapeut saam, maar stuur my eerder na 'n ander huis toe waar ek meer nodig gaan wees."	45
SH2:" Dit gebeur wel met Spraak dat ons ... Elke dissipline het pasiënte wat hulle moet sien op die tuisbesoeke en 'n mens kom dan nie altyd by almal uit nie.Ek dink dis 'n baie groot administrasieprobleem, as daar dalk 'n effens beter liasseerstelsel was, goed gemerk, almal moet hulle goed daarin sit. 'n Community care worker of een persoon elke dag gaan kyk dat almal hulle goed teruggesit het, dat dit onder die persoon se naam alfabeties geliasseer is sodat die volgende mense wat kom,	46

kan sien, o hier's dit, en dat mens nie oor ses maande kom, o, ons het nou hierdie persoon se file gekry, gaan doen hulle gou hierdie Donderdag op 'n tuisbesoek, wanneer daar eintlik ander mense was waarop mens kon fokus wat jy sê nou maartwee weke terug gesien het, wat dan moontlik sou kon voorkom dat die vinger septies raak."	
M1:"*Ag, mens moet verstaan, die mediese studente doen 'n huisbesoek elke vier weke en intussen het ons baie ander akademiese verpligtinge en so aan. Op die stadium is ons nie heeltemal ge-'gear' nie en ek is baie onseker. Ek weet nie wat van my verwag word om daar te doen nie. "*	47
M1:"*Ja, ek dink so 'n program het geweldige potensiaal. As dit reg gedoen word, kan dit baie goed werk".*	48
SH2:"*En die interdissiplinêre groep, van Spraak se kant af, het ook groot implikasies vir die toekoms, want ek dink, nee, ek dink nie, ek weet, dit help ons om mekaar beter te verstaan. Soos wat nou net ook al genoem is, dit begin dalk in Avianpark, maar dit skuif hospitaal toe. Ons is nou almal studente, maar eendag as ons werk, dan is dit ook iets, want almal het daardie respek vir mekaar aangeleer en almal het geleer dat elkeen waardevol is en ek hoop dit sal dan maak dat mense minder geneig is om sommer net goed van 'n dissipline te verwagwat hulle nie heeltemal so vinnig dalk kan doen of op daardie oomblik kan doen nie. Net daardie basiese 'Ek verstaan jy het ook baie werk, ek verstaan dit wat jy doen, ek weet bietjie van jou scope of practice'.Want ek dink ons kry maar in ons opleiding self baie min daarmee te doen. Wat weet ek tog eintlik van wat 'n mediese student doen? Ek sit in my klasse en ek spandeer my vier jaar om net deur al my werk te kom om my goed te leer, so die tyd wat ek kan afstaan aan, wat is nou eintlik wat hulle moet doen of wat is nou eintlik wat die Verpleegsters moet doen of wat is wat die Arbeidsterapeute moet doen, is baie minder, en dis maar vir almal so. "*	49
SH1:"*Maar tog is dit ook lekker. Party van ons se tyd is baie kort of baie lank maar ons oorvleuel so perfek dat daar altyd mense is wat weet wat om te doen, wat mekaar kan help. So die Fisio's is sê nou maar nou nuut en die Spraakterapeute is nou al daar vir 'n paar weke en hulle neem net so oor by mekaar."*	50

FORMAL INTERVIEW   B

INTRODUCTION

Interview B consisted only of the physiotherapy students. The interview took place at the Eros school in Athlone and conducted by Professor Marina Clarke as in interview A.

The same basic conditions applied as for formal interview A.

PARTICIPANTS CODES AND PROFILE OF THE FORMAL STUDY B

CODE:

4P - Physiotherapy

PARTICIPANTS PROFILEFORMAL INTERVIEW 1

Interprofessional group	participant totals(N=2)	Participant codes
Physiotherapy	n 2	P1 and P2

FORMAL STUDY INTERVIEW B

PARTICIPANT RESPONSE	RESPONSE NUMBER
P1:"We went with a team of medical students and other students. I thought it was really interesting, I learned a lot from the other students, how they interacted with the patients and their role in it. I think it was interesting because us as Physios, I don't think they realised what our role was and in a way we did our bit and they were surprised at what we did.So it was nice, because we all learned from each other and what each role was, because often we think we know but we don't really know."	1

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P1:"*Well, we only went with the medical students, not the Speech or the OTs because they weren't around then, but theirs was medical related. In a way they didn't communicate, they didn't make the patient feel open to talking as they were just asking straight medical questions and the Physios were much more interactive and much more physical with the patients, so I think they learnt quite a lot from us as well to interact. With the stroke patients we would teach them how to go from sitting to standing and I think the medical students didn't realise we did that, so we showed them our little treatment, which was nice.*"	**2**
P1:"*Yes, but at the same time the patients would say which medication they were on and then the medical students realised that some of those medications were clashing against each other which could cause further problems. So they delved into that part whereas I was obviously clueless of that.* "	**3**
P2:"*Yes. I think in class they always tell us about the multidisciplinary team and you know of it but you never realise what it entitles, because we went with the medical students, the dieticians, the speech therapists. In my case we were all together, and the social workers as well, and it was so nice and you hear your patient has this wrong and that wrong, and you think: How am I going to solve this? And you realise, it's actually not my problem. It is my problem but I don't have to solve it. And then it was so nice to know you can actually get the best for your patientby referring him to somebody else who knows what's going on.* "	**4**
P2:"*There's just some things you can't change for your patients. Like my one patient, she hadlike ... and I said, sorry, I can't do anything about it. I can get somebody ... she said, 'really, can you do that?' and I said yes, I will get somebody, and problem solved. Well, not solved, but they're working on it.*"	**5**

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P2: *"What I also saw with the medical students is that they ask the questions and yes/no, and then they go on. With us we ask what do you want to do, what can you do? What do **you** want? It's not like I can give you this and I can do that. The one thing I also realised when we walked in there is that you must ask the patient what do they know about physio, because we ask them, 'do you know why I'm here?' and they say 'no'. But if you tell them I can help you with this and this and this, then they are more open to you. I also found you can't go in there and ask them questions. You have to become, not their friend, but you have to ask them how is their home situation, and then they'd say, oh, there's drugs, and I learnt a lot more about how to ask questions, especially if there's a team of people coming in and they ask questions, they don't really like it.I learnt a lot."*	**<u>6</u>**
P1: *"Another thing I learned was the team work. Often we feel the medical students should take over the interview for some reason, then for us to step up and give our part, just to get everyone in the team to say their part, because they often feel oh, their part's not relevant or during an interview they mustn't say anything. It actually taught us to step up and say our part."*	**<u>7</u>**
P2: *"I had a really nice time. It's the first time that I actually got to deal with them. It's the first time ever we experienced that, like when you're in the hospital the doctor gives you the order and you go. But here you can actually sit and ask why do you say that? Why do you want to do that? Why did you ask him that? Why did you throw those many patients together?"*	**<u>8</u>**
P2: *" Or any other health professional. Why did you tell them to do this? It's not like you read it in a letter, the patient is doing this and this or they can't eat this or they mustn't do this. OK, I can see this, but why? That was nice to actually have the opportunity to talk to somebody about it and then you think, maybe I can change this or incorporate this."*	**<u>9</u>**

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P2:"Yes, and even between, we were four Physios there, but two worked together and I didn't even with my colleague tell her, why did you say that. I don't need to agree with you, just tell me how did you get there? Now we worked together, not like I have my patient and you have your patient but there we have the same patient, then we can actually discuss it and say why do you want to do that or what do you think of that. That was also a nice experience."	**<u>10</u>**
P2:" Oh definitely. What do you do? Do you just massage the whole day? No, I'm done with massage. You can actually take something stupid like getting them to sit or stand. It's something you just do but you don't realise people can't do it, and if they can't do that they can't get out and they can't move. They have an idea but they don't know specifics, so it was nice for them as well. They will also know, oh this patient can't do this, so maybe they need a Physio	**<u>11</u>**
P2: Yes, we did. One morning we had a Speech therapist who presented a talk about what do we do in the field. We do this and this test and we had to look in each other's ears and we had to do tests and that was quite nice. So now we know more what they do.".	**<u>12</u>**
P2:"And it was nice that iswas us students talking to another group of students. It wasn't the lecturer *Telling us that is what you can do. You felt comfortable talking to them, they were friends, So it was a nice environment to learn in"*	**<u>13</u>**
P2:" I wouldn't say friends but I was comfortable with them. I would talk to them about patients if there was something I wanted to know, but not that we became best friends. But we had a good relationship."	**<u>14</u>**
P2:" And in the hostel you also become friends. Sometimes we had supper together. "	**<u>15</u>**

P1:"*And also the Speech therapists. What I learned, we did our home visits with the Speech therapists and we were trying to get the patient from lying to sit, and that was our main focus and that was all I was thinking about. Then it* *was the Speech therapist's treatment and he was teaching the patient to name a pen or a toothbrush, because the patient didn't know that this was a pen and that was a toothbrush, so they were teaching him that. And I thought to myself what's the point of him sitting by himself if hedoesn't know what a toothbrush is. Everything was so blurred. It was a simple concept, but I thought that he can't even name things or speak.*"	**16**
P1:" *When I watched their treatment I actually thought that their treatment was more important than mine*"	**17**
P1:" *Yes. Another thing about Avian Park is that I sometimes felt it was a bit disorganised, like each profession didn't know what they were supposed to do, because we were the first group there. Everyone was a bit lost, we didn't even have the OTs and Speech therapists but it sounds as though it became more organised, but it felt like with us we didn't quite know what was expected of us. So I think in the beginning of the year it might be nice to have a big lecture or talk or something to say exactly what was expected and how to ask the questions and each person must speak up otherwise they will not get a turn. Just something each time with new students. I don't know how you guys felt, if you were a bit lost. It took a long time to get used to the system and all the information. It would be helpful.*"	**18**
P1:" *It was, yes. Maybe if each discipline had their own questions to ask or something, because sometimes people didn't say anything. But I think they didn't know what to do.*" **P1:**"*Yes, and the confusion. Even if there were notices up in Avian Park saying who's going, where they're going, what car are they going in,*	**19 a** **19 b**

because all that takes so much time, which limited our time with the patients. "	Conituation of thought- same participant
P1:"We went with the community care workerwho took us to the homes, and we would sit in the home and have a discussion with the head of the home or whoever was at home, and we would discuss and ask questions."	**20**
P1:" I think there's nothing that can prepare you for that, because you walk into a home and it's quite shocking sometimes. It opens your eyes quite a bit. "	**21**
P1:"For me it wasn't so bad, because I've been to Transkei a few times, so I was expecting that sort of thing, whereas I think for the other students it might have been more of an experience. To me it was okay. I found the families so welcoming and friendly, I thought they might be like 'who are these people, these professionals walking into my house?' I thought they might be a bit nervous but they were so welcoming. I think that was surprising to me. Some of them gave us hugs and welcome to our home and offer you food and that was very welcoming. "	**22**
P2:"I think it was nice to see the patient in their house, to see what they have in their house. Because you ask them, 'do you have a step?' Sometimes it's only a few centimetres, not really a step. Or you get there and you see, like we had a lady and she had a medicine cabinet or something and she couldn't open it because it was too high up. So we just put a string in the door so she could pull it, that we had thought of ourselves, otherwise she would've struggled for the rest of her life. It's something simple. You wouldn't be able to change that if you can't see it. And I saw a lady who had a hip replacement and she was so negative because she said she needs to lie in bed for the next six weeks. So I said you can sit, I'll just adjust your chair for you and you can sit, and she just cried – she was so happy. She didn't expect that. And if I saw her in hospital, I wouldn't have*	**23**

known that."	
P2:" I felt well, this is just an adjusted chair, it's something stupid, and she was going wow, she was so happy about it. So I was thinking I can actually make a difference and I didn't even have to do something big."	**<u>24</u>**
P2":I was really happy about it. It was nice to do something nice for somebody.And to know they really appreciate it."	**<u>25</u>**
P2:" And it's something simple like adjusting a chair."	**<u>26</u>**
P1:"We ask the patients in the hospital, do you have a wheelchair-friendly house, is your bathroom inside or outside, just go through the list you have to ask, all these steps. Then you go to their home and you see no bathroom. And you have to ask, where's your bathroom, oh, it's just outside, and I looked and I ask where outside, and he says over there, and it was far and it was gravel and he was in a wheelchair. And I realised this is actually the main problem in this situation and I realised it's not the hospital, where outside, how's the ground, and understand where and how. And then I realised this is the main problem,	**<u>27</u>**

236

how are we going to solve it. You think much broader. And also the wheelchair-friendly house, the one man was lying in bed near the wheelchair. But he couldn't get from his bed outside because the kitchen was so narrow, he couldn't fit through. That was the main problem, so I had to ask the son to move the kitchen counter, so that he could get the wheelchair through and he could then eventually, so it's that simple, and now I understand."	
P2:"*I was giving a pain class and I said we all experience pain and my one patient laughed at me and said, 'my sweetheart, you've never experienced pain'.She could see I was privileged and she was suffering. For me I realised I mustn't try to pretend I can relate because there are times you really can't. And that taught me a lot. Often we say, oh we all go through this and meanwhile I had no idea of what's actually going on in their lives, so that taught me quite a lot.*"	**28**
P1:" *Yes. I did learn from the patients all the time. You also learn how they deal with their situation like it wasn't us going in and saying you must do this and this, but rather how do you do this, what is the easiest way? We also ask questions like do you understand your condition, what do you understand this to mean, or what do you think is wrong with you? Then you get their perspective which is totally different.*"	**29**
P1:"*Their way is usually better than our way.*"	**30**
P2:" *I had a lady, she had, I think, osteoporosis in her spine and the doctor told her your spine is busy breaking and she was petrified. She didn't want to move because she says she knows if her spine breaks she will be a paraplegic. She eventually was in so much pain and everything. I thought, actually you're fine, you must just talk to them, and explain to them,what do you know about your condition? She said but the doctor told her her spine was breaking, good-bye. And I said, yes, but you could still move, because we gave her exercises the first week and we asked her are you*	**31**

doing it, and she said no. And we asked her why didn't you do it? We want to help you here, even if you're so scared to move. And then she did her exercises and she became so much better. You must just ask them what do they know. For us, because we know it, we expect other people to know it, too. That really brought me down, realising they don't know it. "	
P2:"That day I also realised that my actual treatment for the day is not exercise, it's actually just education. That's what my job was for the day. We never think about it, we always go, 'Talk exercise'. That's what we want to do. You can't do it, it's not going to work. "	**32**
P1:"And we became a psychologist for one session. It was a session, and even if I'm not, I have to be here in order to get wherever we wanted to. "	**33**
P1:" I think we had to play another role which made us understand better, what was more important, was it the exercises or the education?"	**34**
P1:" I just like the personal part, like we went and spoke to the Speech therapist about the patient instead of writing a referral letter. We spoke to them and then we got feedback afterwards from them and said how did it go and then they told us about it. And there's the OT who said there's this patient who needed help and there's much more talking about it, whereas at Tygerberg Hospital you write a letter and then you never hear about the patient again.So that is nice, you got the feedback about the patient as well."	**35**
P2:" We also sometimes had the opportunity, if this was my patient but he needed speech therapy, I could attend the speech therapy session and then they would talk and you would think 'I never asked him that' or 'maybe I should also try that' and you discover something new from the patient that was quite helpful. Maybe I should teach him to sit more uprightor do this better or help him with that. It is nice to see that and	**36**

afterwards you could discuss, why did you do that? If I do this for him, do you think it would help you?"	
P1: *"Same thing with the man who was trying to sit and say pen, the Speech therapist realised that better posture will make him speak better, so they have to sit him up."*	**37**
P1:" *We tried to do education at Avian Park, activities in classes, have the community come in and give them class. But also lack of communication. We tried to advertise on the radio and do everything we could, use word of mouth to see if people would come and listen to the talk, but there was a lack of people coming to listen to the talk. So I don't know what we could have done to improve that. But I think that is one of the main health promotion things that would've been good."*	**38**
P1: *"I don't know. They didn't want to leave their homes and come. It was far for them to walk, to come for a little lesson. I don't think the lesson gave them enough. Some were very motivated to come. I think it's just a new project, it needs to be developed and hope more people will come as time went. That was one very important thing.Then we discovered we should maybe do the talk where all the patients were waiting anyway for their medication. There was a lot of people waiting at one stage, so we just did our talk, which was great, and they heard it anyway."*	**39**
P2:" *Yes, I think the organisation part, because I was in the second group, so by the time we got there the other professions had been there, so they could tell us what's going on. So I don't think we had that much confusion, but I can understand if everybody is new at the same timethere is going to be confusion. We also didn't know but I don't think it was that much confusionbecause there were others and then later on we had to explain to the new group what's going on."*	**40**

Appendix F: Ethical Approval

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

Approved with Stipulations
New Application

28-Jan-2013
THEUNISSEN, Anna Luttig

Dear Ms Anna THEUNISSEN,

The **New Application** received on **04-Dec-2012**, was reviewed by members of **Health Research Ethics Committee 2** via Expedited review procedures on **22-Jan-2013**.

Please note the following information about your approved research protocol:
The Stipulations of your ethics approval are as follows:

1. Please correct the following typing/spelling errors:
Informed consent section
posses to possess
inlcude to include

Please remember to use your **protocol number** (**S12/12/317**) on any documents or correspondence with the HREC concerning your research protocol.
Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the
conduct of your research and the consent process.

After Ethical Review:
Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired.
The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for anexternal audit.

Translation of the consent document to the language applicable to the study participants should be submitted.
Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239
The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code ofFederal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the SouthAfrican Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Departmentof Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department ofHealth (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981).

Researchthat will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval canbe obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and documents please visit: www.sun.ac.za/rds
If you have any questions or need further assistance, please contact the HREC office at 0219389207.
Ethics Refernce #: S12/12/317

Title: Interprofessional collaboration within interprofessional Education context in rural health care in South Africa: Student
experiences and Perceptions

Protocol Approval Period: **28-Jan-2013** -**28-Jan-2014**
Included Documents:
Application Form
Consent Form

AppendixG: Surmepi

Stellenbosch University Rural Medical Education Partnership Initiative

7 February 2013

Dear Mrs. Theunissen

CONFIRMATION OF AWARD: SURMEPI GRANT

This letter serves to confirm that you have been awarded a SURMEPI grant for Master's studies for the period February 2013 – December 2014. Congratulations!

The award comprises two annual payments of R30 000 each. Payment for year two will be subject to you demonstrating satisfactory progress and meeting the requirements as set out in the accompanying 'SURMEPI Grant acceptance' document which you are required to complete and return to Ms Suzaan Sutherland (ssutherland@sun.ac.za) before **28 February 2013**. Kindly note that no transfer of funds can take place before we are in receipt of this signed document and your relevant cost centre details.

During the year SURMEPI also offers a series of mentorship and postgraduate support activities which you are encouraged to participate in. The sessions for Master's Grantees will take place on the following days:
4 March 14:00 - 15:30
6 May 12:30 - 14:00
30 July 12:30 - 14:00
20 Sept 12:30 - 14:00

In addition, we will be hosting a special colloquium for all SURMEPI grantees on Tuesday, 11 June 2013 from 9:00 – 13:00. You will be receiving more information about these events in due course, but please diarise the dates in the meantime.

Kindly contact Prof Susan van Schalkwyk (scvs@sun.ac.za) should you have any enquiries with regard to this grant.

We wish you all the best for your studies.

Yours sincerely

Prof J Nachega
Principal Investigator: SURMEPI
cc: Prof S van Schalkwyk
Attachment:
SURMEPI Grant acceptance document

Prof M de Villiers
Principal Investigator: SURMEPI

Appendix H: Participant information leaflet and consent form

TITLE OF THE RESEARCH PROJECT:

The exploration of the experiences and perceptions of health and Allied Health Care students regarding interprofessional collaboration and education in a rural clinical setting in South Africa

REFERENCE NUMBER:

PRINCIPAL INVESTIGATOR: Annalie Theunissen 16910419

annalie.theunissen@gmail.com

ADDRESS: P/A   Private Bag 3113 / "Western Cape College of Nursing"

Worcester

6849

CONTACT NUMBER: 0722736505

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff or doctor any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee (HREC) at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

PURPOSE OF THE STUDY

To explore the experiences and perceptions of students regarding interprofessional collaboration and education amongst students in a rural healthcare context in South Africa.

PROCEDURES

- The research will take place at the same venue where you are working at the community project.
- Two persons from each dicipline will be included who will purposively apprached to attend in the research focus group interview.
- The interview will be taped and transcribed.
- All participant will receive a code that will enhance the protection of identity and confidentiality.
- There will be no intervention take will take place.
- Participation is voluntary and may be terminated at any time.

Why have you been invited to participate?

- You are an expert related to this topic and you posses valuable information that could influence interprofessional education and collaboration in the future. The valuable information will contribute to future effective curriculum development.

Will you benefit from taking part in this research?

- No direct benefits.

Your responsibilities will inlcude:

- Your only responsibility will include you willing and honestparticipation.

Remuneration

- There are no remuneration or other personal advantages other that the knowledge that you will contribute to education in the future.

Are there in risks involved in your taking part in this research?

There are not risks involved for the participants of the society

If you do not agree to take part, what alternatives do you have?

- Participation is voluntary and there will be no negative consequences should you exercise your right to refuse.

Who will have access to your medical records? N/A

What will happen in the unlikely event of some form injury occurring as a direct result of your taking part in this research study? N/A

Will you be paid to take part in this study and are there any costs involved? N/A

Is there anything else that you should know or do? N/A

- You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed.

Declaration by participant

By signing below, I …………………………………..…………. agree to take part in a research study entitled *(insert title of study)*.

I declare that:
- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ....….......……………. on (*date*) …………...……….. 2009.

Signature of participant   Signature of witness

Declaration by investigator

I *(name)* ………………………………………..……… declare that:

- I explained the information in this document to …………………………………..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use a interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) ....….......……………. on (*date*) …………...……….. 2009.

Signature of investigator   Signature of witness

Declaration by interpreter

I *(name)* ………………………………………..……… declare that:

- I assisted the investigator (*name*) ……………………….………………. to explain the information in this document to (*name of participant*) ……………..…………………………….. using the language medium of Afrikaans/Xhosa.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) ....….......…………….. on (*date*) …………...………………..

Signature of interpreter   Signature   of   witness

AppendixI: Deelnemerinligtingsblad en toestemmingsvorm

TITEL VAN DIE NAVORSINGSPROJEK:

Studente ondervindinge en persepsies aangaande interproffesionele samewerking in die konteks van interproffesionele leer binne landelike gesondheidsorg in Suid Afrika

VERWYSINGSNOMMER:

HOOFNAVORSER: Annalie Theunissen 16910419

ADRES: P/A Privaatsak 3113 / "Western Cape College of Nursing"

   Worcester

   6849

annalie.theunissen@gmail.com

KONTAKNOMMER: 0722736505

U word genooi om deel te neem aan 'n navorsingsprojek.   Lees asseblief hierdie inligtingsblad op u tyd deur aangesien die detail van die navorsingsprojek daarin verduidelik word.   Indien daar enige deel van die navorsingsprojek is wat u nie ten volle verstaan nie, is u welkom om die navorsingspersoneel of dokter daaroor uit te vra.   Dit is baie belangrik dat u ten volle moet verstaan wat die navorsingsprojek behels en hoe u daarby betrokke kan wees.   U deelname is ook volkome vrywillig en dit staan u vry om deelname te weier.   U sal op geen wyse hoegenaamd negatief beïnvloed word indien u sou weier om deel te neem

nie. U mag ook te eniger tyd aan die navorsingsprojek onttrek, selfs al het u ingestem om deel te neem.

Hierdie navorsingsprojek is deur die Gesondheidsnavorsingsetiekkomitee (GNEK) van die Universiteit Stellenbosch goedgekeur en sal uitgevoer word volgens die etiese riglyne en beginsels van die Internasionale Verklaring van Helsinki en die Etiese Riglyne vir Navorsing van die Mediese Navorsingsraad (MNR).

Wat behels hierdie navorsingsprojek?

- Die navorsing sal plaasvind op dieselfde plek waar u gemeenskap praktiese ondervinding van jou studies plaasvind.
- Twee persone van elke disipline binne gesondheidsorg, wat teenwoording is by die praktiese ondervinding, sal genader word om aan die navorsing deel te neem.
- Die doel van die navorsing is om wetenskaplike inligting te verkry wat verband sal hou met u persoonlike persepsies en onderrig ondervindinge tydens interprofessionele leer binne die plattelande konteks in Suid Afrika.
- Individue sal doelgerig genader word en 'n keuse gegun word om deel te neem aan die navorsing. Deelname is geheelemal vrywillig.
- Die navorsing sal in die vorm van gesprekvoering plaasvind wat op band vasgelê sal word.
- Daar sal geen ingrepe tydens die gesprekvoering plaasvind nie.

Waarom is u genooi om deel te neem?

- U word genooi om deel te neem omdat u oor kosbare inligting beskik wat sal bydra tot toekomtige effektiewe onderrig en kurrikulum ontwikkeling.

Wat sal u verantwoordelikhede wees?

- U sal self geen verantwoordelikheid dra nie behalwe om net so openlik en eerlik as moontlik te wees en u unieke instette te lewer.

Sal u voordeel trek deur deel te neem aan hierdie navorsingsprojek?

- Daar is geen persoonlike vergoeding of direkte voordeel wat getrek kan word uit hierdie deelname nie.

Is daar enige risiko's verbonde aan u deelname aan hierdie navorsingsprojek?

- Daar is geen risiko's verbonde aan die navorsing nie. Dit is slegs 'n gesprek wat sal plaasvind en u privaatheid en anonimiteit sal te alle tye beskerm word. Die inligting

sal slegs binne die navorsing gebruik word en slegs die hoofnavorser sal toegang tot identifiserende besonderhede hê.

- **U kan die** Gesondheidsnavorsingsetiek administrasie **kontak by 021-938 9207 indien u enige bekommernis of klagte het.**

Verklaring deur deelnemer

Met die ondertekening van hierdie dokument onderneem ek, ……..................……….....……...……..………….., om deel te neem aan 'n navorsingsprojek getiteld (*Titel van navorsingsprojek).*

Ek verklaar dat:

- Ek hierdie inligtings- en toestemmingsvorm gelees het of aan my laat voorlees het en dat dit in 'n taal geskryf is waarin ek vaardig en gemaklik mee is.
- Ek geleentheid gehad het om vrae te stel en dat al my vrae bevredigend beantwoord is.
- Ek verstaan dat deelname aan hierdie navorsingsprojek **vrywillig** is en dat daar geen druk op my geplaas is om deel te neem nie.
- Ek te eniger tyd aan die navorsingsprojek mag onttrek en dat ek nie op enige wyse daardeur benadeel sal word nie.
- Ek gevra mag word om van die navorsingsprojek te onttrek voordat dit afgehandel is indien die studiedokter of navorser van oordeel is dat dit in my beste belang is, of indien ek nie die ooreengekome navorsingsplan volg nie.

Geteken te *(plek)* ....………….. op *(datum)* …………...………….. 2005.

Handtekening van deelnemer   Handtekening van getuie

Verklaring deur navorser

Ek *(naam)* …………………………………...……………… verklaar dat:

- Ek die inligting in hierdie dokument verduidelik het aan ……………………...………..
- Ek hom/haar aangemoedig het om vrae te vra en voldoende tyd gebruik het om dit te beantwoord.
- Ek tevrede is dat hy/sy al die aspekte van die navorsingsprojek soos hierbo bespreek, voldoende verstaan.

- Ek 'n tolk gebruik het/nie 'n tolk gebruik het nie. (*Indien 'n tolk gebruik is, moet die tolk die onderstaande verklaring teken.*)

Geteken te *(plek)* ....…………….. op *(datum)* …………....……….. 2005.

Handtekening van navorder   Handtekening van getuie

Verklaring deur tolk

Ek *(naam)* ……………………………..…………… verklaar dat:
- Ek die navorser *(naam)* ………...............................…………………. bygestaan het om die inligting in hierdie dokument in Afrikaans/Xhosa aan *(naam van deelnemer)* …………………………….......................... te verduidelik.
- Ons hom/haar aangemoedig het om vrae te vra en voldoende tyd gebruik het om dit te beantwoord.
- Ek 'n feitelik korrekte weergawe oorgedra het van wat aan my vertel is.
- Ek tevrede is dat die deelnemer die inhoud van hierdie dokument ten volle verstaan en dat al sy/haar vrae bevredigend beantwoord is.

Geteken te *(plek)* ....…………….. op *(datum)* …………....……….. 2005.

Handtekening van tolk   Handtekening van getuie

AppendixJ: Pilot interview as pre-test.

<u>**Semi – structured Interview Guide:**</u> Interprofessional Student Respondent Group

<table>
<tr><td>

THE EXPLORATION OF THE EXPERIENCES AND PERCEPTIONS OF HEALTH AND ALLIED HEALTH CARE STUDENTS REGARDING INTERPROFESSIONAL COLLABORATION AND EDUCATION IN A RURAL CLINICAL SETTING IN SOUTH AFRICA

</td></tr>
<tr><td>

Nature of Interprofessional student group

Instruction: Please indicate the respondent group by indicating with a [x] which group is participating.

<u>The group will consist of students from the following disciplines:</u>

1	Physiotherapy	P
2	Medicine	M
3	Speech and Hearing	SH
4	Dietetics	D
5	Social work	S
6	Nursing	N
7	Occupational Therapy	OT

</td></tr>
<tr><td>

Date of interview:

</td></tr>
<tr><td>

Time of interview:

</td></tr>
<tr><td>

Interview venue:

</td></tr>
<tr><td>

Interviewer:

</td></tr>
<tr><td>

Field worker:

</td></tr>
</table>

Number of participants:

<u>Brief description of Research Project</u>

In response to the demand for quality community health care, the University of Stellenbosch, Department of Health Sciences has implemented an Interprofessional education project. The latter is taking place in an underserved area of previously disadvantaged people in South Africa. The research will focus experiences and perceptions of the students related to IPC and IPE.

<u>Research Purpose</u>

To explore the experiences and perceptions of health and allied health care students regarding Interprofessional collaboration and education amongst students in a rural healthcare context in South Africa during their clinical placement.

<u>Question 1</u>

What were you initial expectations regarding IPC within the IPC clinical programmes before you all started working together as an intern professional group in the clinical field? Tell me about it.

<u>Question2</u>

Were your expectations regarding IPC met within the time that you all worked together in the rural project? Tell me more about it?

<u>Question 3</u>

What was your personal experience of IPC within the rural context after completion of the program?

<u>Question4</u>

How did you perceive IPE within the program in the rural health care setting?

<u>4.1 Regarding the project</u>

<u>4.2 Regarding the peer teaching during the program</u>

<u>Question 5</u>

Do you think there are limitations within the IPC programmes and what are the limitations if any? Motivate your answer.

<u>Question6</u>

How did the exposure to the IPC project influence your perceptions of IPE?

<u>Question 7</u>

What suggestions do you have regarding IPC within the IPE program

Prompts

- Influence on professional development

- Influence on personal development

Please know that your privacy and anonymity will be maintained and protected at all times.

Thank you for your participation.

AppendixK: Semi-structured interview guide

FORMAL STUDY: FOCUS GROUP INTERVIEW. (As adjusted)

<table>
<tr><td colspan="3">**THE EXPLORATION OF THE EXPERIENCES AND PERCEPTIONS OF HEALTH AND ALLIED HEALTH CARE STUDENTS REGARDING INTERPROFESSIONAL COLLABORATION AND EDUCATION IN A RURAL CLINICAL SETTING IN SOUTH AFRICA**</td></tr>
<tr><td colspan="3">**Nature of Interprofessional student group**

Instruction: Please indicate the respondent group by indicating with a [x] which group is participating.

The group will consist of students from the following disciplines:

<table>
<tr><td>1</td><td>Physiotherapy</td><td>P</td></tr>
<tr><td>2</td><td>Medicine</td><td>M</td></tr>
<tr><td>3</td><td>Speech and Hearing</td><td>SH</td></tr>
<tr><td>4</td><td>Dietetics</td><td>D</td></tr>
<tr><td>5</td><td>Social work</td><td>S</td></tr>
<tr><td>6</td><td>Nursing</td><td>N</td></tr>
<tr><td>7</td><td>Occupational Therapy</td><td>OT</td></tr>
</table>
</td></tr>
<tr><td colspan="3">**Date of interview:**</td></tr>
<tr><td colspan="3">**Time of interview:**</td></tr>
<tr><td colspan="3">**Interview venue:**</td></tr>
<tr><td colspan="3">**Interviewer:**</td></tr>
<tr><td colspan="3">**Field worker:**</td></tr>
<tr><td colspan="3">**Number of participants:**</td></tr>
</table>

OPENING QUESTION:

You were involved with other health and allied health care students in interprofessional collaboration and education activities in Avian Park.

Tell me how you experienced these interprofessional activities as part of your clinical placement in Avian Park.

PROBES:

- Experience as part of the interprofessional team
- Experience of interprofessional collaboration activities
- Experience of interprofessional education activities

AppendixL: Declaration Language Editor

Jeanne Santovito Language Editing
24 Fuchsia Road
Wellway Park East
Durbanville
7550
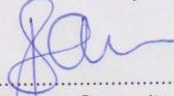
19 November 2013

To Whom it May Concern

Dear Sir/ Madam

Language Editing Confirmation

This letter serves to confirm that I, Jeanne Santovito, the undersigned, have proofread and edited the Abstract and Chapters 1-5 of the following document for language correctness. This was completed and returned to Anna Luttig (Annalie) Theunissen on the 19 November 2013.

Thesis: AN EXPLORATION OF THE EXPERIENCES AND PERCEPTIONS OF HEALTH AND ALLIED HEALTH CARE STUDENTS REGARDING INTERPROFESSIONAL COLLABORATION AND EDUCATION IN A RURAL CLINICAL SETTING IN SOUTH AFRICA.

Author: **Anna Luttig Theunissen.**

Yours faithfully

....
Jeanne Santovito
084-8822004
021-9751544
jeanneh@telkomsa.net

LONA'S LANGUAGE SERVICES

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* *Academic Manuscript Preparation*
* *Archival Research*
* *Transcriptions from Archived Documents*

Member: South African Translators' Institute (SATI)

3 Beroma Crescent
Beroma
Bellville 7530

11 February 2014

TO WHOM IT MAY CONCERN

This letter serves to confirm that the undersigned

ILLONA ALTHAEA MEYER

has proof-read and edited the document contained herein for language correctness.

(Ms IA Meyer)

SIGNED

Email: illona@toptutoring.co.za   Tel: 27 21 9514257   Cell: 27 78 264 8484   Fax: 0865148540
3 Beroma Crescent Beroma Bellville 7530

ApendixM: Declaration Technical Formatter

To whom it may concern

This letter serves as confirmation that I, Lize Vorster, performed the technical formatting of Anna Luttig Theunissen's thesis. Technical formatting entails complying with the USB technical requirements.

Yours sincerely

Lize Vorster
Language Practitioner

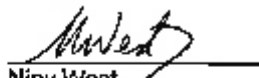# Appendix N: Declaration

Typist

<div style="text-align:center">

Tik 4 Taal
Tik & Vortaling / Typing & Translation
Redigering / Editing / CVs
Kwaliteit werk / Quality work
Billike pryse / Excellent rates
Tel 023 – 3470373 / 0826671383
Niny West

</div>

TO WHOM IT MAY CONCERN

Annalie Theunissen first approached me to assist her with the transcription of audio interviews for her thesis on 4 March 2013. I transcribed the Pilot interview as well as the Formal study for her, which was finalised on 27 June 2013.

I would like to wish her every success upon the completion of this very demanding assignment.

Kind regards

Niny West
0826671383

AppendixO: Declaration Dr. S. Snyman (IPOP)

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28 November 2013

TO WHOM IT MAY CONCERN

Dear Sir/Madam

RESEARCH: MS AL THEUNISSEN

I confirm that it was agreed that Ms A L Theunissen (Student number: 16910419), pending ethical clearance, could do research in Avian Park, Worcester as part of her study, *An exploration of the experiences and perceptions of health and allied health care students regarding interprofessional collaboration and education in a rural clinical setting in South Africa.*

Kind regards

DR STEFANUS SNYMAN
MBChB; MPhil (Health ScEd); DOM
Manager: Interprofessional Education & Practice (IPEP) | Service-learning
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