Guidance for initiating and evaluating interprofessional education

The Interprofessional subcommittee, Faculty of Medical and Health Sciences, University of Auckland https://www.healthcareer.ac.nz/ipe/

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Contents

Abbreviations

ACLS	Advanced Cardiac Life Support
IPE	Interprofessional Education
RHIP	Rural Health Interprofessional Programme
WHO	World Health Organization

Background to interprofessional education

The World Health Organization (WHO) defines interprofessional education (IPE) as:

> *"When students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes."*[1]

Hence there are three levels of learning.[2]

1. ***About each other:*** Students gain knowledge and understanding about other disciplines, specialities and professions than their own, including scopes of practice, roles and responsibilities.
2. ***From each other****:* Students learn from students enrolled in other programmes or institutions as well as from practising health professionals. Their active participation and information exchange helps them to develop interprofessional knowledge and skills.
3. ***With each other****:* Students learn with students, practitioners, and professionals from other health professions at their own and/or other institutions, in hospital and community settings.

IPE can range from shared learning, where students from different disciplines enrol in a programme with a common curriculum and assessment, to full engagement where they learn collaboratively in a team environment with their own roles and responsibilities. Specific interprofessional learnings often centre around insight into a participant's own knowledge and roles in the context of teamwork, and the extent of the knowledge and roles of others they are working with. Ultimately, better functioning interprofessional teams will lead to better patient care.

Four key competencies of IPE have been identified:[2]

1. ***Values and ethics****:* Learn to work with people from other professions in a climate of mutual respect and shared values.
2. ***Roles and responsibilities*****:** Understand the roles and responsibilities of own and other professionals in assessing and addressing the healthcare needs of patients and populations.
3. ***Interprofessional communication*****:** Develop the ability to communicate responsively and responsibly with patients, families, communities, and professionals to support a team approach to healthcare.
4. ***Teamwork***: Learn to work in a team to provide patient-centred, safe, timely, efficient, effective, and equitable healthcare.

Development of IPE in your programme

It is important that IPE activities serve areas of grass roots needs, rather than being imposed from above. Engagement by students, and buy-in from academics and managers, will only happen if the activity serves real and meaningful areas of need (see the related document: Engagement in Interprofessional Education at the Faculty of Medical and Health Sciences, Available from: https://www.healthcareer.ac.nz/home/ipe/)

Where to start? IPE collaborations can grow from active networking – contacting colleagues by phone or email, and through staff meetings and conferences. Explore synergies and develop a collaborative interprofessional teaching team to break down disciplinary 'silos'. Considering potential obstacles early, such as conflicting timetables, resource needs, differing

curricular aims and education stage of the students in order that these can be resolved in a sustainable way.

What activity or learning situation is appropriate? The learning should be around an authentic topic or skill that is meaningful to learners who will be working together in practice in the real world. Look for synergies where uni-professional activities may be combined with little or no added cost. An example is University of Auckland medical and nursing students undergoing Advanced Cardiac Life Support (ACLS) training together.[3] Learning with and from each other enables participants to function better collectively as team players going forward, and the evaluation of the combined ACLS course highlights these valuable benefits. Another example, combining formal and informal elements of interprofessional learning, is the Interprofessional Workshops held at Counties Manukau Health, which involve 60-70 healthcare students from up to seven different professional disciplines who are all on clinical practicum at CMDHB at the same time.

Space and timing issues

Timing and time needed are important considerations. Students need to establish their own professional identities, as well as learning to collaborate with other professionals. The IPE activity itself may dictate the timing of when this can or should be introduced within the curriculum, and may differ between disciplines. For example, 5th year medical students train with 3rd year nursing, pharmacy and postgraduate dietetic students in the University of Auckland's Rural Health Interprofessional Programme (RHIP).[4]

Even when an obviously great idea has been discovered, getting the students involved together in the same place and the same time can be a substantial and often underestimated challenge. Firstly, an appropriate space must be found which can be problematic. Secondly, scheduling a suitable time that is agreeable to the different participant groups can also be very difficult given often inflexible timetables. Appointing someone who is supportive of IPE to be responsible for timetable negotiation can be extremely helpful in achieving a successful outcome. An alternative approach to resolving these difficulties that may be appropriate for certain IPE activities is to makes them a virtual opportunity which can be completed asynchronously by students, thereby avoiding space and timing constraints. Such an approach was taken recently at the University of Auckland using a virtual patient simulator.[5]

Learning approaches

IPE activities can be face-to-face (synchronous) or during collaborative online learning (synchronous or asynchronous). Students learn with others from a different programme or with practitioners representing different professions from their own.[2] Examples of the types of approaches that can be used include simulations (e.g. ACLS or the Virtual Patient Project above), working together on clinical rotations, working on a joint project (for example, design a health promotion programme or resource incorporating the different professional perspectives), clinical observations, case discussions, video-conference discussions and online or chatroom discussion forums.

Learning may occur outside of the prescribed or formal activities, such as during breaks through informal social interactions, so it is good to schedule these in. It is also important to consider the possibility of informal interprofessional learning, as well as that occurring during formally delivered activities, when evaluating such IPE initiatives. Learning is

inseparable from the context in which it occurs.[6] For example, in the RHIP programme, students from a range of disciplines live together in a house for five weeks, and have many opportunities to learn about each other's values, roles and responsibilities within the healthcare team beyond the formal learning sessions.

Whatever the approach employed, students need to simultaneously develop their own sense of professional identity, while learning to work with others and collaborate in interprofessional teams.

Sustainability of IPE programmes

People: While having an IPE champion may be key to developing an IPE programme and getting it off the ground, it is risky for an IPE activity to be reliant on such people in the longer term. When a single champion leaves, or moves on to other things, the activity may die. Embedding IPE activities into the wider curriculum of the schools and departments which offer such courses is essential for their long term survival.

Scalability: When an IPE activity becomes embedded and widely recognised as important, often more disciplines may want to be involved. While this is excellent on many grounds, it brings its own challenges in terms of the scalability of the activity. Factors that need to be considered are how large an activity can become without beginning to lose some of its genuineness and ensuring that the activity is relevant and authentic for learners from all participating disciplines. Growth may also present problems in terms of space and venues to house the activity and added complexity of coordinating more timetables from different programmes. Increasing size of an activity also bring increasing costs.

Evaluation of IPE Activities

As in all teaching, evaluation is a critically important part of establishing and maintaining the quality of what is being taught. Determining the purpose of the evaluation and the approach to be used is vital. Evaluation of an IPE activity is likely to be a multifaceted process, and should consider whether formal learning outcomes are being achieved, but should also consider informal aspects of learning. Consideration should be given to what the evaluation is aiming to provide; whether it is formative to gather data to improve an IPE activity, or whether it is summative to ascertain the final impact of an IPE activity on students abilities or for publication (an example evaluation form and participant feedback form are including in Appendix 1 and 2).[7] Validated rating scales that yield quantitative data on participants' attitudes towards working together in interprofessional teams can also be used (for example the Readiness for Interprofessional Learning Scale or RIPLS, as used during evaluation of the ACLS course mentioned previously).[3] Demonstrating the effective translation of skills learnt during the IPE activity to the participant's clinical workplace is the ultimate goal of IPE and should be considered in an evaluation process, but determining this directly can be difficult given time delays and confounding factors.

The evaluation needs to be linked to the intended learning outcomes for the IPE activity. Careful consideration to the questions to be asked is essential as they will drive the methodology used and provide direction to the type of evaluation design to be selected. Depending on the focus of the evaluation, designs can be quantitative, qualitative or a combination of both. If the aim of the evaluation is to disseminate information about the IPE

activity in scholarly publications then approval from a relevant ethics committee is recommended early in the development of the evaluation.

When a number of different disciplines or organisations become involved in an IPE programme, evaluation of the IPE activity needs to be a collaborative process with IPE team members. Consideration needs to be given to what is being evaluated and why, the time and resources available for collecting and analysing the data and a process for disseminating the findings of the evaluation. An example of such an evaluation was recently conducted for an IPE activity run at the University of Auckland involving dietitian and speech-language therapy students and which incorporated formal and informal learning outcomes.[8 9]

Each discipline may already have established assessments required for their specific learning outcomes, and in such cases students may have different assessments and assignments to complete, in accordance with their own programmes. If only a sub-group of students from a cohort are involved in the IPE programme, they may not be required to undertake additional summative assessments relating to the IPE activities.

Conclusion

This document is presented to assist programmes in the development and implementation of IPE initiatives. It is expected that the document will be revised over time to include guidance for the evaluation and improvement of IPE activities. The goal is to promote improved health outcomes for the New Zealand population.

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Appendix 1 – An example rubric for evaluating an IPE activity

Rubric Template

		Minimal (score = 1)	Developing (score = 2)	Competent (score = 3)	Mastery (score = 4)
1	**Interprofessional collaboration**	No evidence of establishing collaborative relationships, sharing information, integration of information from others	Some evidence of establishing collaborative relationships, sharing information, integration of information from others	Good evidence of establishing collaborative relationships, sharing information, integration of information from others	Substantial evidence of establishing collaborative relationships, sharing information, integration of information from others
2	**Client & family centred care**	No evidence of information sharing or involving client/ family in decision-making	Some evidence of information sharing or involving client/ family in decision-making	Good evidence of information sharing or involving client/ family in decision-making	Substantial evidence of information sharing or involving client/ family in decision-making
3	**Roles & responsibilities**	Does not describe own role and responsibilities with the team/ client/ family. Does not demonstrate understanding of own scope of practice and of others.	Some reference to own role and responsibilities with the team/ client/ family. Some demonstration of understanding of own scope of practice and of others.	Good reference to own role and responsibilities with the team/ client/ family. Good demonstrate understanding of own scope of practice and of others.	Evidence of thorough understanding of own role and responsibilities with the team/ client/ family. Evidence of thorough understanding of own scope of practice and of others.
4	**Clinical Procedural Tasks**	Does not identify any of the reasonable clinical tasks	Identifies some of the reasonable clinical tasks	Identifies most of the reasonable clinical tasks	All reasonable clinical tasks identified
5	**Clinical reasoning**	No evidence of aspects of clinical reasoning model and EBP practice	Evidence of some aspects of clinical reasoning model and EBP practice	Evidence of most aspects of clinical reasoning model and EBP practice	Evidence of all aspects of clinical reasoning model and EBP practice

Appendix 2 – An example of a participant feedback form for and IPE activity

Creative Futures – Interprofessional Professional Student Feedback Form

The following competencies relate to interprofessional collaborative practice:

- **Role Clarification** – understanding of own role and role of others and use this knowledge to meet client goals.
- **Team Functioning** – demonstrate understanding of team dynamics to ensure interprofessional team work.
- **Client/Whānau/Community Centred Care** – seek out, integrate and value the client/whānau wishes and aspirations.
- **Interprofessional Communication** – utilise a range of communication skills to enable collaborative practice – both spoken and written, formal and informal.
- **Interprofessional Conflict Resolution** – demonstrate knowledge and use of conflict resolution skills with whole team (including client/whanau/educators).
- **Collaborative Leadership** – demonstrate knowledge and use of collaborative leadership skills in working together to implement and evaluate services which improve health and well-being outcomes.
- **Collaborative Reasoning** – demonstrates skills in critical thinking and collaborative reasoning with team (including client) and demonstrate evidence behind ideas/plan.
- **Collaborative Learning –** demonstrates a positive attitude to collaborative learning, shown by, awareness of own learning style, taking the initiative to read/learn/reflect, sharing learning with others and supporting the learning of others through feedback.

(Adapted from the Canadian National Interprofessional Competency Framework and the Speech Pathology Australia COMPASS®)

Areas that are developing well:

Areas to focus on next week:

Signed: _____