Module 3B: Student Manual

Interprofessional Practice Education in Clinical Settings: Immersion Learning Activities

Winnipeg Regional Health Authority
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The Fact Sheets: 'What is Collaborative Practice?' 'What is Person-Centred Care?' 'What is Interprofessional Education' and the CIHC National Competency Framework were reproduced, with permission, from the Canadian Interprofessional Health Collaborative. www.cihc.ca

Several of the instruments included in this manual were extracted from the document: Gillis L, Hoffman K, Moss K, Boyko J, Davies L, Ring L. "Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres: Resources, Tips and Activities you can Use to Enhance Collaboration". Association of Ontario Health Centres. April 2007 with permission. Available as a pdf at: http://www.aohc.org/aohc/index.aspx?CategoryID=24&lang=en-CA

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Several concepts within this manual were adapted from the documents entitled: "Interprofessional Education Geriatric Care (IEGC) Reference Guide to the Seven Core Competencies" and the "Interprofessional Education in Clinical Settings: A Facilitators Guide". Winnipeg, MB. (2008) Adapted with permission. Available as a pdf at: http://www.cihc.ca/library/

We welcome your feedback and comments to these materials. A revised manual will be developed in the Fall of 2012. Please send your comments to: IPE_initiative@umanitoba.ca

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Opportunity knocks!

You are doing your fieldwork or placement at an institution that is committed to advancing interprofessional education and collaborative person-centred care. As teams transition to collaborative environments they become aware that IP collaboration is more than simply effective communication or exchange of ideas. It is maximizing the knowledge and skills of its members to create new ideas and address complex issues. IP collaboration is more than cooperation or 'playing nice in the sandbox'. On a foundation of respect and trust, IP collaboration seeks diverse opinions and welcomes sparks of dissent. As you experience a collaborative environment you will learn that how teams interact is one of the most critical elements to delivering highest quality care.

Are you ready for the challenge?

Your traditional fieldwork or placement provides a 'real world' environment for you to further develop your unique discipline specific knowledge, skills and attitudes. As you participate in interprofessional learning activities outlined in this module you will be challenged to add a new dimension to your learning, outside of your professional silo and your singular contributions.
You will learn about, with and from other health professionals. You will gain a better understanding of your professional skills and those of other members of the health team and appreciate areas of overlap. You will quickly learn that when teams work collaboratively with patients to help them decide on their plan for health maintenance or illness management, health outcomes for patients are improved and health providers are more satisfied with their work.

Seize the opportunity! You are a pioneer, shaping the health services delivery model of the future!

Toolkit overview

Introduction

- What is collaborative practice?
- What is person-centered care?
- What is interprofessional education (IPE)?
- Why learn collaboration?
- What does collaboration look like?

This is Module 3B of a 3 module toolkit:
Student Manual: 'Immersion' IP learning activities

- Participating in an IP learning Opportunity
- Module overview

Part I – Common Essential Principles for Interprofessional Care Planning
- Setting Patient Care Goals
- Interprofessional (IP) Care Planning

Part II – Philosophical Underpinning:
- Person- and Family-Centred Care

Part III – Targeted IP Competencies
- Unit 1: Understanding Roles and Responsibilities
- Unit 2: Shared Leadership and Decision Making
- Unit 3: IP Communication
- Unit 4: Conflict Analysis and Management

Appendices

Participating in an IP learning opportunity

The goal for these learning opportunities is for health and social care students to begin to develop the necessary knowledge, attitudes, skills, and behaviours to be effective members and leaders within an interprofessional (IP) collaborative patient centred team. Students will participate in their traditional clinical placement and will be expected to develop care plans for clients/patients as usual…the only difference being that other health & social care students will be 'working up' the same client. Each week, the IP student team will be asked to create an 'IP care plan' versus their traditional uni-professional care plan.

IP student sessions are designed to run weekly according to the format outlined below. That being said, site leads and/or facilitators are encouraged to modify the format as required for their particular context and based on student availability.

Each week (timeframe may vary) students wiil be asked to:

1. Attend a 30 minutes 'setting directions' facilitated session early in the week. During this session the IP facilitator will have identified a patient who has agreed to serve as the 'patient of the week'. The group must also decide on one or two of the four IP competency domains that will be the focus of their IP learning for the week.
2. Observe the behaviours of the clinical team mentors around common essential principles, patient centred care and at least one targeted IP competency domain(s).
3. Conduct their uni-professional assessments for that patient.
4. Meet with the IP facilitator and IP student team mid-week to create a IP care plan (1 hour).
5. Reflect on individual and student team's behaviours around the IP competency domain(s).
6. Present the IP shared care plan to their clinical team mentors.
7. Meet with the IP facilitator towards the end of the week for a 30 minute 'debriefing' session. This debriefing will allow students to discuss their observations, reflections and learnings over the previous week.

A calendar has been included in Appendix 7 for the students to arrange convenient times to meet with their IP facilitator, their IP student team, and to arrange a time for their IP case presentation.

Module Overview

This Module has three parts:

Part I –Common Essential Principles: Interprofessional (IP) Care Planning

The creation of an IP care plan requires knowledge and skills in goal setting and an awareness of effective collaborative team functioning. The first section of this module outlines common essential principles to guide students as they participate in the weekly IP care planning sessions.

Part II – Patient and Family-Centred Care

A critical philosophical underpinning to the delivery of health and social care is active, sincere engagement of patients and their families. During patient assessments students must learn to listen to the patient and, when negotiating goals during the IP care planning session, involve the patient and family as partners in the shared decision making process. This section of the module sensitizes the student to behaviours that facilitate patient and family centred care.

Part III – Targeted IP Collaborative Behaviours

Creating an IP care plan requires a variety of additional IP collaborative competencies. Each member of the team requires **IP communication skills.** Team processes should involve **shared leadership and decision making,** a negotiation of the differing perspectives/priorities of the various team members and patients. It requires an examination of one's own uni-professional scope of practice, an **awareness of the roles and responsibilities** of other members of the health care team and flexibility. A healthy team is one that recognizes **conflict** as an inevitable consequence of members' passion for patient care which should be welcomed, openly identified and used as a driver for positive change.
This section of the module has four units, each corresponding to one of the following four IP competency learning domains.

- Understanding Roles and Responsibilities
- Shared Leadership and Decision Making
- IP Communication Skills
- Conflict Analysis and Management

In addition to developing knowledge, skills, attitudes and behaviours around the common essential principles and the delivery patient-centred care outlined in Parts I and II, each week, students are encouraged to focus on at least one of the four additional learning domains.

Module Overview cont.

Each unit follows a similar format:

- Stated learning objectives
- A brief review of the IP competency domain
- An outline of the student activity
- Within each unit are links to the relevant Appendices. Each appendix lists descriptors for each competency domain to help the student visualize actions which either demonstrate (or fail to demonstrate) mastery of that IP competency. The appendix also includes tools and/or instruments to guide and stimulate students' thinking as they observe and reflect on the collaborative behaviours of the IP team and that of their own and student teams' behaviours.

PART I
COMMON ESSENTIAL PRINCIPLES FOR INTERPROFESSIONAL CARE PLANNING

Common Essential Principle #1: Setting Patient Care Goals

Learning Objectives

1. Understand the purpose and process of setting patient care goals
2. Be able to state a well designed goal using the SMART format
3. Begin to develop the skills required to create an IP patient centred care plan

Setting Patient Care Goals[1]

Setting patient care goals is a core function of clinical teams. Individualized patient goals can help to break down a hard-to-measure outcome into several more manageable outcomes. Goals link the recommended interventions to desired outcomes, help the IP team focus on priority issues and can be used to assess patient progress and to alter plans as necessary.

Well-stated goals describe an outcome. Although a key responsibility of the team is in depth assessment of problem areas, it is not adequate for this assessment process to form the goal. For example, in someone with depression, a goal of "assess cognition" would not be adequate. Rather the team needs to reflect on what is the purpose of the assessment e.g. educate pt/family on problem areas OR establish diagnosis OR start pharmacotherapy.

A well designed goal should be SMART. SMART Goals are:

- **Specific**: The focus of the goal should be narrow and pertain specifically to the patient being discussed
- **Measurable**: The goal should be quantifiable or described in such a way that the team can be certain if the goal was achieved. For example "BP controlled" as a goal is open to interpretation but BP systolic <160 is quantifiable
- **Achievable**: The clinical assessment should guide the team in determining what an achievable goal would be for the given situation. For example if the patient is a life-long binge drinker with no desire to stop then abstinence from alcohol is not an achievable outcome. On the other hand, making sure his/her family is aware of the resources available to them and counselling him/her on alcohol reduction/cessation are achievable outcomes.
- **Reliable**: Two or more clinicians assessing the same individual on the same outcome should be able to agree on whether the outcome has been achieved. Two clinicians may not agree on whether exercise tolerance improved "significantly" but can both agree that the 6 minute walk improved more than 50 meters.
- **Time-limited:** Experienced clinicians should be able to identify approximately how long they will need to work with an individual to achieve the identified goals. This is an important step for patients and their families. They want some understanding at the beginning of the rehabilitation process of what they can expect and what they are committing to.

1 "Interprofessional Education Geriatric Care (IEGC) Reference Guide to the Seven Core Competencies" with permission.

Common Essential Principle #2: Interprofessional Care Planning

Learning Objectives

1. Become aware of interprofessional (IP) collaborative team behaviours that either facilitate or hinder IP care planning
2. Through observation of your team mentors as they create IP care plans, be able to recognize helpful or hindering collaborative team behaviours.
3. As you participate in weekly IP student care planning sessions, reflect and improve upon your own and your IP student team's collaborative behaviours.

Interprofessional Care Planning

For the purposes of this exercise, an interprofessional (IP) care plan is a documented plan that identifies and prioritizes patient issues, interventions, goals and timelines for follow-up after consideration has been given to the varying perspectives of each member of the health and social care team, including the patient. IP care planning that takes advantage of the multiple perspectives, knowledge and skills of its team members (including the patient) will lead to superior outcomes.

Different health and social care professions may come to the care planning session with different documentation formats, underscoring the unique and varying perspectives and contributions of each team member. The: Subjective, Objective, Assessment, Plan (SOAP); Assessment, Plan, Intervention, Evaluation (APIE); Data, Assessment, Plan (DAP); or Data, Assessment, Recommendation, Plan (DARP) are but a few of the care plan formats used across professions and/or within institutions. IP care planning requires each clinician to re-evaluate their own (uni-professional) treatment goals and place them in the broader context of the treatment environment, patient wishes, as well as the goals of other members of the interprofessional (IP) team.

Activity

IP care planning requires team members to have mastered a range of collaborative competencies. Appendix 3 contains competencies, tools and instruments that will help you visualize helpful and hindering collaborative behaviours. Use these tools as a guide to stimulate your thinking as you observe, participate and reflect on IP care planning sessions.

Each week:

(1) Work with your IP facilitator to identify a 'patient of the week'.
(2) Create your uni-professional patient-centred care plan and goals for the patient.
(3) Meet with your IP student team to negotiate an IP care plan for the patient. Use (or adapt) the IP Care Plan format included in Appendix 6 to document your IP care plan.
(4) Observe and assess the effectiveness of the collaborative teaming behaviours of your IP team mentors.
(5) As you participate in IP student care planning sessions, reflect and improve upon your own and your IP student team's collaborative behaviours.

PART II
PHILOSOPHICAL UNDERPINNING PERSON- AND FAMILY-CENTRED CARE

Philosophical Underpinning: Person Centred and Family Focused Care

Learning Objectives

1. Become aware of helpful and hindering patient centred and family focused care team behaviours
2. Through observation of your team mentors as they create IP care plans, recognize helpful or hindering patient and family-centred care team behaviours.
3. As you participate in weekly IP student care planning sessions, reflect and improve upon your own and your IP student team's patient and family centred care behaviours

Patient Centred and Family Focused Care[1]

Care plan goals belong to the patient and must be congruent with the patient's expressed values and expectations. This requires clinicians to spend time in their assessment actively encouraging patients and families to express their opinions, social circumstances and belief system. Communication should be open, non-judgemental and respectful and patients/families should feel like they are an integral part of the team in a supportive environment.

At times patients and/or family depend on the clinical team to guide them on specific and achievable outcomes especially for those decisions requiring clinical expertise and knowledge of diagnosis and treatment options. There are times when the clinical team identifies a problem area which the patient/family has not considered/does not consider a priority. A negotiation then follows between the patient/family and the team as to whether to address this area. If there are issues of patient safety e.g. driving ability, financial abuse, the team members may have professional, legal or ethical duties which require them to address this area even if the patient/family are not in agreement.

Activity

Appendix 5 entitled Supporting Person and Family – Centered Health and Wellness contains competencies, tools and instruments that will help you visualize helpful and hindering patient centred and family focused behaviours. Use these tools as a guide to stimulate your thinking as you observe, participate and reflect on IP care planning sessions.

Each week:

1. Observe and assess the effectiveness of the patient and family-centred care behaviours of your IP team mentors.
2. As you participate in IP student care planning sessions, reflect and improve upon your own and your IP student team's patient centred and family focused behaviors.

1 "Interprofessional Education Geriatric Care (IEGC) Reference Guide to the Seven Core Competencies" with permission.

PART III
TARGETED IP COMPETENCIES

TARGETED IP COMPETENCIES
UNDERSTANDING ROLES AND RESPONSIBILITIES

Learning Objectives:

1. During an IP shared care planning session, be able to articulate your professional role in the care of patients.
2. Recognize the roles and scopes of practice of other members of the IP collaborative team and identify areas of responsibility overlap.
3. During an IP shared care planning session negotiate responsibilities/actions based on role constraints, overlap and/or discipline-specific legal/ethical practice standards.

Roles and Responsibilities[1]

It is important for all team members to be aware of the different roles of each discipline on a team, to learn about their individual perspectives on & responsibilities for patient care and to recognize and value the potential for role overlap. Team members need to understand each other and respect the roles played by each professional. Only when team members are aware of the values and philosophies of other disciplines can they fully understand the roles of those disciplines and know who and how to ask for advice. Team members with professional competence, who recognize the limitations of their own professional knowledge and who respect and trust the unique and complementary knowledge of other disciplines, are integral to an effective team.

A lack of appreciation between health care professionals is one of the root causes leading to inadequate communication, a lack of trust and respect between team members, and inevitably situations of team conflict. Further, role ambiguity and poor understanding of role overlap often leads to conflict or 'turf wars' and underutilization of the skills and knowledge of many members of the health care team.

Activity:

Appendix 1 Instruments contains competencies, tools and instruments that will help you visualize behaviours which either demonstrate (or fail to demonstrate) an understanding of the roles and responsibilities of members within the IP collaborative team. Use these tools as a guide to stimulate your thinking as you observe, participate and reflect on IP care planning sessions.

This week:

1. Observe and assess the behaviours of your IP team mentors which either demonstrate or fail to demonstrate an understanding of the roles & responsibilities of members within their team.
2. As you participate in the IP care planning session, reflect and improve upon your own and your IP student team's behaviors as they relate to understanding roles and responsibilities.

1 "Interprofessional Education Geriatric Care (IEGC) Reference Guide to the Seven Core Competencies" with permission.

TARGETED IP COMPETENCIES
SHARED LEADERSHIP AND DECISION MAKING

Learning Objectives:

1. Gain knowledge about the variety of decision-making methods available including their respective advantages and disadvantages.
2. Develop skill in recognizing behaviours that help and that hinder effective decision making in teams

Shared Decision Making:

Collaborative reflection and decision making that takes advantage of the multiple perspectives, knowledge and skills of members of the interprofessional health and social care team will lead to superior outcomes. Team morale is also increased when decision making processes are explicit and transparent and value the knowledge and skills of each team member. Dissatisfaction in the work-force occurs when members feel their voices are not being heard, when opinions are not valued or respected, and when power determines decision making authority.

It is important for the team to be aware of their decision making processes and the behaviours that either help or hinder decision making.

Activity

Appendix 2 entitled Shared Leadership and Decision Making contains competencies, tools and instruments that will help you visualize helpful and hindering decision making behaviours. Use these tools as a guide to stimulate your thinking as you observe, participate and reflect on IP care planning sessions.

This week:

(1) Observe and assess the decision making behaviours of your IP team mentors.

(2) As you participate in the IP care planning session, reflect and improve upon your own and your IP student team's shared decision making behaviors

TARGETED IP COMPETENCIES

INTERPROFESSIONAL COMMUNICATION

Learning Objectives

1. Become aware of helpful and less helpful interprofessional (IP) communication behaviours
2. Through observation, be able to critique/describe IP communication between your IP team mentors
3. As you participate in the weekly IP shared care planning sessions to reflect on and improve your own and your IP student team communication behaviours

Interprofessional Communication:[1]

Effective communication is an essential characteristic of a highly functioning IP team. Communication in health care teams is especially important for: providing and receiving constructive feedback, developing trusting relationships with clients and team members, evaluating new ideas based on the merit of the idea, and developing an integrated care plan.

Although verbal communication between health care team members is the most obvious mode of communication, it is not the only communication style that exists. Highly effective strategies for communication among individuals and teams include but are not limited to: body language (facial expressions, gestures and body positioning), unspoken understandings between team members and or patients, as well as cultural and environmental cues.

This unit assumes that you already are aware of basic communication skills (active listening, questioning, paraphrasing, validating, reframing, reflecting, summarizing, closed and open ended questions, minimal leads and accurate verbal following, repetition, confrontation and honest labelling, integrating). The focus of the following exercise is to address the common pitfalls in communication between interprofessional team members and in interactions with the patient and family.

Activity

Appendix 3 entitled IP Communication contains competencies, tools and instruments that will help you visualize helpful and hindering IP communication behaviours. Use these tools as a guide to stimulate your thinking as you observe, participate and reflect on IP care planning sessions.

This week:

(1) Observe and assess the IP communication behaviours of your IP team mentors.
(2) As you participate in the IP care planning session, reflect and improve upon your own and your IP student team's IP communication behaviors

1 "Interprofessional Education Geriatric Care (IEGC) Reference Guide to the Seven Core Competencies" with permission.

TARGETED IP COMPETENCIES
CONFLICT ANALYSIS & MANAGEMENT

"Wouldn't it be nice if all the members of a team treated each other respectfully at all times, agreed on everything, knew and accepted their roles from the outset, had no conflict and no stress? That's a world most of us will never live in. In reality, after a team has its honeymoon period at the outset, the often untidy process of storming through the gritty details of leadership, purpose, traction, speed, roles, rules and regulations and all other housekeeping issues rears its head. This is part of the normal, unavoidable series of stages that all teams encounter.[1]"

Learning Objectives

1. Become more knowledgeable about the types and sources of conflict.
2. Increase knowledge of the range of conflict styles that people use.
3. Develop the ability to identify a variety of conflict management strategies.
4. Increase skills in analyzing conflict and considering options for management.
5. Develop the ability to explore a variety of conflict management strategies.

Potential Sources of Conflict:

- Individual values, beliefs, learned experiences, personalities
- Philosophies of practice. Each professional has its own values/beliefs/attitudes /customs/ behaviours/diverse professional perspectives
- Differences in modes/methods of practice

"…they may not understand each other's role well, so you might have a perception that this person does not appreciate what I do...when it's really not that...you know the person doesn't quite understand what you do." (p. 61 [2])

- power imbalance

"I believe that this is an egalitarian environment where we all have equal say and equal value of opinion, so therefore I think that I can make a difference, but then when it gets played out, a lot of times, that is not the case. So, I think there are power imbalances here that are not acknowledged and are therefore hidden and masked." (p. 60 [2])

- Poor communication
- Scarce resources (money, time, staffing, space)
- Organizational or professional change that poses a threat
- Differing interests (concerns, hopes, expectations, priorities, fears)

"Conflict resolution is always challenging… We all tend to shy away from conflict and sometimes conflict is good. Because it means that something is wrong and there needs to be change. So I think that a healthy team is sometimes gonna experience conflict... I think people just learning that conflict is a natural occurrence and not holding grudges." (p. 60 [2])

1 Bill Cole, MS, MA. Founder and CEO. Procoach Systems, Slicon Valley, California www.mentalgamecoach.com/Programs/MentalGameOfTeamBuilding.html. http://www.mentalgamecoach.com/articles/ReduceTeamConflict.html (accessed October 05, 2011)

2 Building Better Teams: A toolkit for strengthening teamwork in community health centers: Resources, tips and activities you can use to enhance collaboration, Reproduced with permission from The Association of Ontario Health Centers, Canada

Conflict Management Strategies:[1],[2]

- Welcome the existence of the conflict, bring it into the open, and use it as potential for change.
- Separate the person from the problem in an effort to diffuse the emotional component of the conflict by showing respect, listening carefully, and giving all parties an opportunity to express views.
- Clarify the nature of the problem as seen by both parties. Is this the real problem?
- Deal with one problem at a time, beginning with the easier issues.
- Listen with understanding (interest) rather than evaluation. Use the communication skills of listening, reflecting, and clarifying.
- Attack data, facts, assumptions, and conclusions but not individuals (e.g., "I disagree with your assumptions").
- Brainstorm about possible solutions.
- Use objective criteria when possible.
- Invent new solutions where both parties gain.
- Implement the plan.
- Evaluate and review the problem-solving process after implementing the plan.
- Identify areas of agreement. Focus on common interests not positions

Activity

Appendix 4 entitled Conflict Analysis and Management contains competencies, tools and instruments that will help you understand how to analyze and manage conflict. Use these tools as a guide to stimulate your thinking as you observe, participate and reflect on IP care planning sessions.

This week:
(1) Observe and assess the conflict management behaviours of your IP team mentors.
(2) As you participate in the IP care planning session, reflect and improve upon your own and your IP student team's conflict management behaviors

1 The following discussion on conflict resolution strategies has been extracted from The GITT Core Curriculum Topic: 3 (Hyer, K., Flaherty, E., Fairchild, S., Bottrell, M., Mezey, M., Fulmer, T., et al. (Eds). (2003). *Geriatric Interdisciplinary Team Training: The GITT Kit, 2nd Edition.* New York: John A. Hartford Foundation, Inc. p. 8).

2 Ajemian,I. (1993). The interdisciplinary team. In D.Doyle, G. Hanks, Q.MacDonald (Eds.), Oxford Textbook of Palliative Medicine. 17-19. New York: Oxford University Press.
Grant, R.W., & Finocchio,L.J.(1995). California primary care consortium subcommittee on interdisciplinary collaborative teams in primary care. A model curriculum & resource guide. San Francisco: Pew Health Professions.