CP&LE Environmental Checklist

for Evidence of Structures and Processes Supporting Interprofessional Education and Collaborative Practice at Community Settings

May 17, 2010

Indicators (note examples and supporting data for ratings on a separate page)	Frequency				Quality			
	0	1	2	3	0	1	2	3
Educational Strategies								
1. Site has regular IP placements (i.e., students from various disciplines have learning activities together with a focus on IP/collaborative competencies).								
2. Site offers IP education training fostering collaboration (e.g. simulation, IP case studies).								
3. Site measures student satisfaction/experience with the IP practice placements.								
4. They monitor student interest in employment on the unit after graduation.								
5. They provide training for staff to mentor students from different disciplines.								
6. They provide orientation to all new staff regarding collaborative practice.								
Practice Setting								
Communication								
7. They have hand-off reports (e.g. to update patient status) between providers that care for the same client.								
8. They have case conferences with participation/contributions from all providers.								
Interprofessional Conflict								
9. They use a process to resolve disagreements among professionals from different disciplines.								
10. Staff members feel comfortable expressing their opinions and raising issues at staff meetings.								
Client/Family-Centred Care								
11. They use a process (e.g., orientation to the program, family meetings, regular updates) to make families feel part of the team.								
12. They provide a family-friendly environment (e.g., place to relax or visit, flexible meeting hours).								
13. They use a process to respond to client emergencies quickly and by the appropriate provider.								
14. Staff referrals to other agencies ensure access to the appropriate providers for clients								
15. Staff members are well informed about each client's history (e.g., client doesn't have to repeat story to each provider).								
16. They have a process for linking the client back into the community, to the right provider.								
Collaborative Leadership								
17. They develop care plans for every client with input from appropriate providers.								
18. They share decision-making about client assignments and client care (evidenced in note books,								

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reflections, meeting notes, care plans).								
19. They have regular IP meetings attended by all providers to address practice issues.								
20. They use a process for sharing knowledge and experiences on "best practices" in collaboration among the IP team.								
Team Functioning								
21. Providers display trust towards their colleagues (e.g. can be assigned together on a client, no turf wars)								
22. They coordinate client care to cover staff (on breaks, vacation, illness).								
23. Students are purposefully integrated into the health care team.								
24. Allied health and other disciplines are purposefully integrated into the team.								
25. They have a process to support ongoing dialogue and negotiation around provider roles.								
26. Staff treat each other as equal members of the team.								
27. Staff have discussions on the shared values and common purpose of the team.								
Role Clarity								
28. Providers are clear about their own roles.								
29. Providers are clear about the roles of other professions.								
Organizational Level								
30. They use policies and procedures related to IP education.								
31. They use policies and procedures related collaborative practice.								
32. Staff performance evaluations include aspects of collaborative practice.								
33. Leadership consistently and visibly supports IP education and collaborative practice (reward collaborative practice or student mentoring, allows time for continuing education)								
34. They use job descriptions that clearly outline competencies and expectations for collaborative practice.								
35. They allocate quality resources to promote collaborative practice (e.g. designated educators, continuing education funds, in-services).								
36. They intentionally create a staff mix that is interprofessional and aligned with client needs.								
37. They monitor staff engagement in collaborative practice.								
38. They created space to facilitate collaboration (e.g. office shared by allied health and nursing, shared assessment room).								

Collaboration Observation Rating Scheme
March 18, 2010

In order to quantify progress toward IPE and collaboration and also to assess the quality of the intervention, the following matrix is proposed for rating evidence of processes supporting interprofessional education and collaborative practice in clinical settings. Most questions may only be answered by following up with prompts on the frequency or the quality.

	0	1	2	3
Frequency • a formalized, agreed upon process in place • a process consistently used on a regular basis by all IP team members (regular IP rounds, regular application of policies, regular student placements, regular monitoring of student satisfaction)	None observed or reported	**Low** 1. there is a formal process in place but it is not used 2. there is some process being used by some providers but it is neither formalized nor consistent	**Medium** 1. there is a formalized process in place and being used, but not consistently or not by all IP members	**High** 1. there is a formalized process in place that is consistently used all (most) IP members
Quality 1. intentional focus on IP 2. participation of multiple disciplines (e. g. rounds) 3. use of high quality tools (for example to monitor student satisfaction) 4. high complexity of an IP activity; active rather than passive (e.g. student develop IP shared care plan vs. shadowing another professional) 5. complexity/meaningfulness of information that is communicated	None observed or reported	**Low** 1. mainly discipline-specific focus with few IP elements 2. occasional participation of IP members 3. assessment tool is not standardized 4. low complexity/ passive activity (e.g. shadowing) 5. shared information is very basic	**Medium** 1. IP focus but quality can be improved 2. Participation of IP members but some key players are missing 3. standardized tool used 4. medium complexity/ medium level of participation (e.g. IP rounds) 5. shared information considers some provider/patient needs	**High** 1. High IP quality 2. All key IP team members are participating 3. standardized tool used and regular follow-up on the results 4. high complexity/ active participation (e.g. shared care plan) 5. shared information considers complex patient/provider needs

Increased ratings indicate increased effect/structure/process/consistency/quality