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PROJECT CLOSURE REPORT

Interprofessional Clinical Placements

June, 2010

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1. Project Overview

A briefing note on Interprofessional (IP) Education and Practice was presented to WRHA Senior Management on November 20, 2008. WRHA senior management supported the need to embrace IP Education and Practice across the care continuum and requested the Professional Advisory Committee (PAC) develop an action plan outlining key steps for implementation.

PAC hosted a leadership forum on IP education and collaborative patient centered care (IECPCP) on May 13, 2009. Participants at this forum agreed a key first step in advancing IP education and practice within the WRHA was to identify and further develop collaborative practice and learning environments.

A number of WRHA programs and sites volunteered to begin the process of becoming collaborative practice and learning environments .The University of Manitoba, through its Interprofessional Education initiative, also endorsed the concept of IP clinical placements involving multiple health and social faculties and schools.

Four clinical practice units associated with WRHA programs/sites were selected to act as pilot sites for this project which matched students from various faculties/schools with clinical preceptors as part of their traditional clinical placements. Students on these units participated in IP education and activities in addition to the traditional clinical placement learning outcomes. Three of the four site teams underwent team training focused on teamwork and collaboration prior to the placement of students with the team. The fourth site had prior participation in IP practice projects and declined additional training.

In addition, the project team partnered with University of Western to further test the Assessment of Interprofessional Team Collaboration Scale (AITCS). Preliminary results from the AITCS were used to develop the team specific workshop content for the three sites that participated in team training.

2. Project Goals, Objectives, and Timelines

Goals
To develop, deliver and evaluate a process for interprofessional (IP) student clinical placements within the WRHA.

Objectives
1. Develop processes to coordinate IP student placement at WRHA sites
2. Define roles and responsibilities of the IP site lead
3. Define site commitment requirements
4. Select IP self assessment tools to measure team collaboration
5. Conduct team self assessments using standardized tools
6. Identify IP training materials, learning modules and resources to address gaps identified in team self assessments
7. Facilitate team education through on-line learning modules and workshops
8. Facilitate the delivery of IP clinical placement learning modules
9. Evaluate project outcomes
10. Identify critical success factors to support future successful IP student Clinical Placement partnerships
11. Recommend future directions for a collaborative, sustainable model for IP student placements within the WRHA
12. Identify opportunities to incorporate IP learning modalities into the WRHA clinical education infrastructure.

Timelines

Project Initiation:	October 2009
Project Closure:	May 2010
Project Duration:	7 months

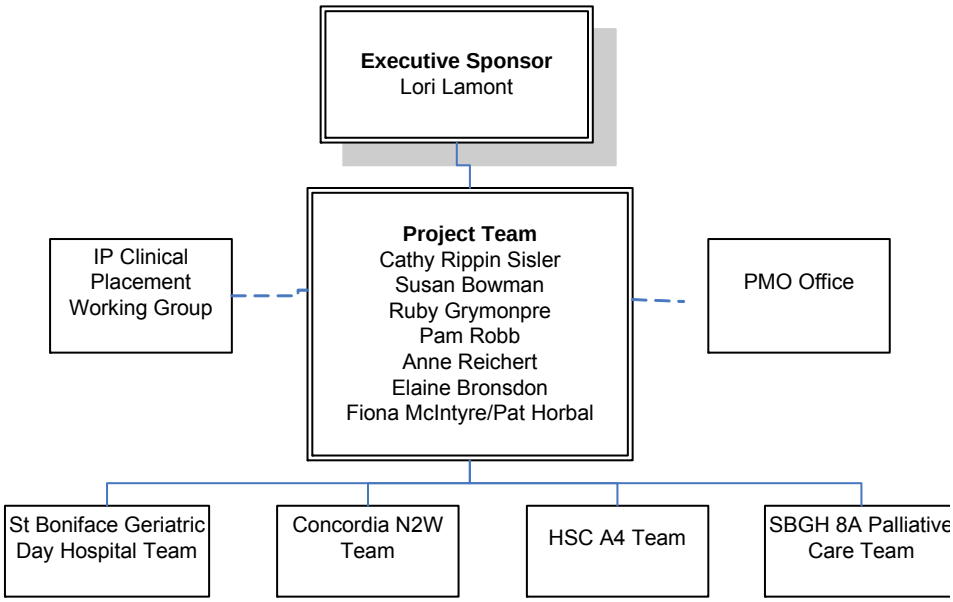
3. Project Expectations/Metrics

Outcomes	Metrics
Interprofessional student placements from U of M faculties/schools will be coordinated at WRHA sites	The 4 pilot sites will host an interprofessional team of students from U of M health faculties with representation from a minimum of three different faculties/schools
Student placements will incorporate 8 – 15 hours of interprofessional content/activities into the clinical placement	Site leads will schedule and track time each week dedicated to formal interprofessional activities with the student team
Teams at pilot sites will demonstrate growth in core competencies of interprofessional practice	Scores from self assessment tools will be evaluated and compared pre and post intervention
Recommendations for a model for future sustainability of interprofessional clinical placements will be developed	Evaluation of processes, lessons learned, communication strategies

4. Project Leadership and Resources

	Description
Executive Sponsor:	Lori Lamont, VP/CNO WRHA
Project Sponsor:	Cathy Rippin Sisler, Regional Director Clinical Education & Continuing Professional Development
Project Manager:	Susan Bowman
Project Team:	Ruby Grymonpre, Ann Reichert, Pam Robb, Elaine Bronsdon, Fiona McIntyre/Pat Horbal

Project organizational structure



5. Reflecting on Risks and Risk Response Plan

Risk Type	Risk Response and Commentary
Resource Risk	The partnership with University of Western deteriorated with respect to timely data analysis when they lost access to a research assistant. Access to an analyst from Manitoba Health resulted in access to preliminary site data in time to use for site workshops.

6. Reflecting on Communication Plan

Stakeholder Group	Method of Communication	Commentary on Success or Suggested Alternative Approaches
Project Team	Face to Face meetings Status Updates Email	Appropriate format for communication
Site Leads	Face to Face Meetings Team Meetings Email	The site lead position at one site was transitioned to another staff member part way through the project resulting in fragmented site and project communication. Role and responsibility documents were developed to assist with clarity of roles and responsibilities and allow for improved transitions.

Stakeholder Group	Method of Communication	Commentary on Success or Suggested Alternative Approaches
Site Teams	Site Lead - face to face - email Project Lead - information sessions - ward posters	The communication plan placed the responsibility of ensuring dissemination of information to the front line site teams and departments with the site lead. The project manager was available for information sessions to staff, but the site lead was responsible for identifying the site team and booking the sessions. In the larger pilot sites, this became an unwieldy task and led to varying messaging being received by the stakeholders on site. In future roll-outs, the communication plan should include a more detailed outline of the site stakeholders as there was differing interpretations by the site leads at pilot sites.
U of M Clinical Placement Committee	Face to Face Meetings – initially biweekly and transitioned to monthly	Appropriate format for communication
Students	Student information night	13 students attended an evening information session (42% of the students that had been identified by their faculties at that stage of the project).
	Faculty Representatives	Not all faculty representatives informed their students of the project goals/expectations. Terms of Reference were revised to emphasize the faculty role in engaging/informing students.
	Recruitment/Information material	Not all faculty representatives utilized recruitment/information material which resulted in different messaging to students related to their ability to “opt out”. Standardized communication methodology and consistent information dissemination among all faculties is essential for successful IP clinical placements.

7. Project Implementation Plan and Results

Project Overview:
The project was split into two phases.
Phase 1 sites included Concordia Hospital (CH) Acute Orthopedics N2W and Health Science Center (HSC) Internal Medicine Clinical Teaching Unit A4. IP student placements occurred on these units during January/February 2010.

Phase 2 sites included Saint Boniface General Hospital (SBGH) Palliative Care 8A and SBGH Geriatric Day Hospital. IP student placements occurred on these units in February/March 2010.

Each pilot site identified their team composition including both professional and non-professional staff. The teams completed 4 self assessment survey tools measuring team collaboration. Results of the surveys were analyzed and used to develop workshops based on the BC Framework of Collaboration (Appendix A). Workshop content covered the following topic areas: Interprofessional Partnerships and Understanding Roles and Responsibilities; Interprofessional Communication and Conflict Resolution; Patient/Family Centered Care and Shared Decision Making; and Interprofessional Care Planning.

Ethics/Site Impact Process:
Processes for Ethics review through WRHA, SBGH and University of Manitoba Health Research Ethics Board began in October 2009 along with site access requests and/or impact reviews at the pilot sites due to the research component of the project. Ethics approval and delivery of staff surveys for phase 1 sites occurred in December 2009; conditional approval for the SBGH phase 2 sites was received in January 2010, with final approval in February 2010.

Student Team Composition:
A total of 34 students from 9 different faculties were initially placed in interprofessional clinical placements across the four sites. 29 students remained actively involved for the duration of their clinical placements.

Concordia Hospital had 9 students representing the faculties of Occupational Therapy (OT), Respiratory Therapy (RT), Pharmacy, Social Work (SW), Nursing, and Clinical Nutrition.

HSC had 20 students placed on this unit with active involvement from 16 students from the faculties of SW, RT, Pharmacy, Clinical Nutrition and Dentistry.

SBGH Palliative Care had 3 students placed on this unit from Medicine, Nursing and SW. The SW student was part time (2 days per week) and dropped out of the project in the second week.

SBGH Geriatric Day Hospital had 6 students representing OT, Physiotherapy (PT), Clinical Psychology, SW, Medicine and Nursing.

8. Project Goals and Outcomes

1. Develop processes to coordinate IP student placements at WRHA sites.
   Outcome: Work is ongoing at the U of M Clinical Placement Working Group. The differing start dates, duration of clinical placements, number of days per week on site and shift schedules led to challenges at the pilot sites in organizing the student sessions. Placement lengths as short as 1 week for some faculties resulted in a constant turnover in student representation at the weekly IP student meetings and prevented a staged learning environment to build on the collaborative competencies of the student team. Required shift work and students who were placed for as few as 2 days per week on site, created challenges for inclusion of the entire student team at meetings.

2. Define roles and responsibilities of the IP site lead.
   Outcome: Complete. (Appendix B) The role description of the site facilitator was also redefined during the project. (Appendix C)

3. Define site commitment requirements.
   Outcome: Complete. (Appendix D)

4. Select IP self assessment tools to measure team collaboration.
   Outcome: Complete. The following tools were utilized:
   - Assessment of Interprofessional Team Collaboration Scale (AITCS) Appendix E
   - Attitudes Toward Health Care Teams (ATHCT) Appendix F
   - Interprofessional Socialization and Valuing Scale Appendix G
   - Collaboration and Satisfaction about Care Decisions Appendix H

5. Conduct team self assessments using standardized tools.
   Outcome: Complete. The self assessment tools were completed by teams at 2 intervals during the project. Preliminary data analysis was utilized to develop team workshops.

6. Identify IP training materials, learning modules and resources to address gaps identified in team self assessments.
   Outcome: Complete. PowerPoint and materials utilized are included in Appendix I

7. Facilitate team education through on-line learning modules and workshops.
   Outcome: Complete. Education consisted purely of workshops; utilization of on-line modules was not feasible for this project due to restrictive timelines and financial limitations. Teams were offered up to 8 hours of workshops on collaborative competencies. Several formats for delivery of workshop material was explored including lunch and learn sessions, 2 hour inservices, half or full day workshops; sites identified the format that best met the needs of the team.

   Site 1 (CH): 40 staff participated in 8 hours of workshops/education. The sessions were repeated on 4 days with a staggered schedule to accommodate the majority of team members at that site. Staff representation included Nursing, PT, OT, RT, Pharmacy, SW, Clinical Nutrition and Health Care Aides (HCA).

   Site 2 (HSC): A 2 hour format for workshops was chosen by the unit, but 4 out of 6 planned sessions were cancelled due to lack of registrants. Two sessions were run for a total of 4 staff members from PT, SW, Clinical Nutrition and Speech Language Pathology.
   Site 3 (SBGH Palliative Care): 42 staff participated in 8 hours of workshops/education. Sessions were repeated on 4 days in February with an additional session in April for staff that had been unable to attend the initial training. Staff representation included Nursing, Medicine, HCA's and SW.

   Site 4 (SBGH Geriatric Day Hospital): This site chose not to schedule any workshop or education sessions for the staff.

8. Facilitate the delivery of IP clinical placement learning modules.
   Outcome: Complete. A student manual was developed for use by the site facilitators with the student teams. The manual included an outline for student sessions, learning objectives and toolkit. (Appendix J)

9. Evaluate project outcomes.
   Outcome: Complete. Project evaluations were provided to students at the completion of their clinical placements as well as a follow-up email reminder. Evaluations were provided to site leads, preceptors and facilitators in addition to debriefing sessions. The evaluation forms are found in Appendix K; the analysis is in Appendix L.

10. Identify critical success factors to support future IP student clinical placement partnerships.
    Outcome: Refer to section 10 – Ongoing Work and Next Steps

11. Recommend future directions for a collaborative, sustainable model for IP student placements within the WRHA.
    Outcome: Refer to section 10 – Ongoing Work and Next Steps

12. Identify opportunities to incorporate IP learning modalities into the WRHA clinical education infrastructure.
    Outcome: Refer to section 10 – Ongoing Work and Next Steps

9. Project Learnings

WRHA

1. The project time line was chosen to take advantage of the greatest overlap of student placements among the University of Manitoba health faculties/schools rather than take into consideration the preparation or planning time required to accomplish the project deliverables. Selection and delegation of site facilitator roles by the site leads occurred in some cases only days before the arrival of students. Teams reported feeling ill prepared to carry out project activities. Future projects would benefit from the utilization of project management philosophies from the initial planning phase in order to develop enhanced site engagement and lay out reasonable time lines to achieve deliverables.

2. The process to obtain ethics and site access approval took anywhere from several weeks to months at the various sites. Future projects should build this time line into the project plan to prevent delays.

3. Site selection occurred at a very senior level of the site or program structure with front line managers and staff at 3 of the pilot sites reporting that they did not feel involved, engaged or informed about the decision making process; a feeling that this was an “add on” to already busy workload portfolios and caseloads was a common message at these sites which may have been addressed if there had been more time for site engagement at all levels of the organization prior to the project start. Site selection criteria and role descriptions that were developed in this project should be utilized in future projects to inform site/program executive of the commitment requirements necessary from the various levels of the organization.

4. Some of the pilot sites were hosting additional clinical placements during the project time lines, but the students were not assigned to the pilot units. A centralized, coordinated process for student placements at sites would facilitate IP student placement opportunities and encourage a model of student collaboration immediately in preparation for a more formalized student clinical placement model.

University of Manitoba

1. Many faculties had already assigned students to their placements prior to the project start; students were not assigned to the IP project based on their interest or engagement in the IP project format. Future IP placements should be planned with a time line that would allow the faculties to advertise and promote the IP Clinical Placement sites to the students prior to student assignment.

2. Information and recruitment material was developed for the University of Manitoba faculty representatives, but not all faculties used this material or were able to notify their students of the project prior to the start of the placements. Students that did not attend the information event were not as well informed of the expectations of the project and in

the case of some faculties, were led to believe that participation in the project was optional. Clear, consistent messaging and information dissemination across faculties is essential in the success of future IP Clinical placements. Terms of Reference for the IP Clinical Placement Working Group were redefined to provide better clarity for membership. (Appendix M)

3. Students were included in the project if any part of their clinical placement occurred at a pilot site during the predetermined project time lines for that site. Start and end times of student involvement varied due to staggered placement dates; student involvement ranged from placement duration of 1 – 5 weeks and site presence ranged from 2 – 5 days per week on the pilot units. General feedback from the student and preceptor evaluations and site debriefing meetings noted that students that were not on site full time struggled to participate as fully in the student shared care planning sessions and found the additional tasks more of a burden than the students that were on site 4 – 5 days per week. Facilitators reported greater difficulty in building on concepts of collaborative practice with the student teams with constant turnover of the student membership. Despite discussing strategies to involve all students in the weekly meetings, sites struggled to be fully inclusive when the student schedule included the real world barriers such as evenings or weekend shift work.

   The success of future IP clinical placements will require the U of M IP Clinical Placement Working Group representatives to continue to work together to share concepts and rationale regarding clinical placement practices. Creative alternatives to the current clinical placement timing and format must be explored; modifications should be made to the student manual to address the current reality of non-block/non-sequential placement format for many of the faculties. Individual faculty placement procedures were submitted by the faculty representatives and collated (Appendices N). Spreadsheets outlining these clinical placement processes (Appendix O) and scheduling for eligible student placements (Appendix P) are valuable resources that should be maintained and updated.

4. The project scope originally only included students from the 12 participating University of Manitoba health related schools/faculties. This resulted in a limited pool of students at some of the pilot sites and excluded some key disciplines from the project. The project scope was expanded during the project to accommodate clinical dietician interns who had already graduated from the U of M program but were placed in the WRHA pilot sites for their internships; in addition, U of M affiliated Social Work students from Collège de Saint-Boniface were included. Future roll-out of IP practice environments should consider wider inclusion of any health related schools/programs that place students within WRHA or RHA sites. Interest was expressed by other disciplines such as Spiritual Care and Rehabilitation Assistants.

10. Ongoing Work and Next Steps

1. Ongoing partnerships between WRHA and U of M are critical to ensure opportunities for IP student placements continue and grow.

2. Sustainability will only be achieved if sites participating in IP opportunities and future projects commit to become ongoing IP practice environments.

3. The stake holder groups should be expanded to include all post secondary institutions that place health related students within the WRHA environment.

4. Engagement and inclusion of students as a partner in development of IP clinical placements is highly recommended. The feedback from students was positive and echoed the importance of making this kind of placement mandatory for all students to experience.

5. Engagement of front line staff in the planning phases of IP placements is critical to a successful outcome and will require additional training for teams related to collaborative team competencies.

6. Creative opportunities for IP placements will need to be explored in partnership with the educational institutions. Feedback from debriefing sessions with pilot sites recommended developing focused IP opportunities outside of the traditional clinical placement model.

7. Centralized coordination of student placements at sites would allow for a critical mass of students to be identified on target units and encourage a model of student collaboration immediately in preparation for the more formalized IP student clinical placement model.

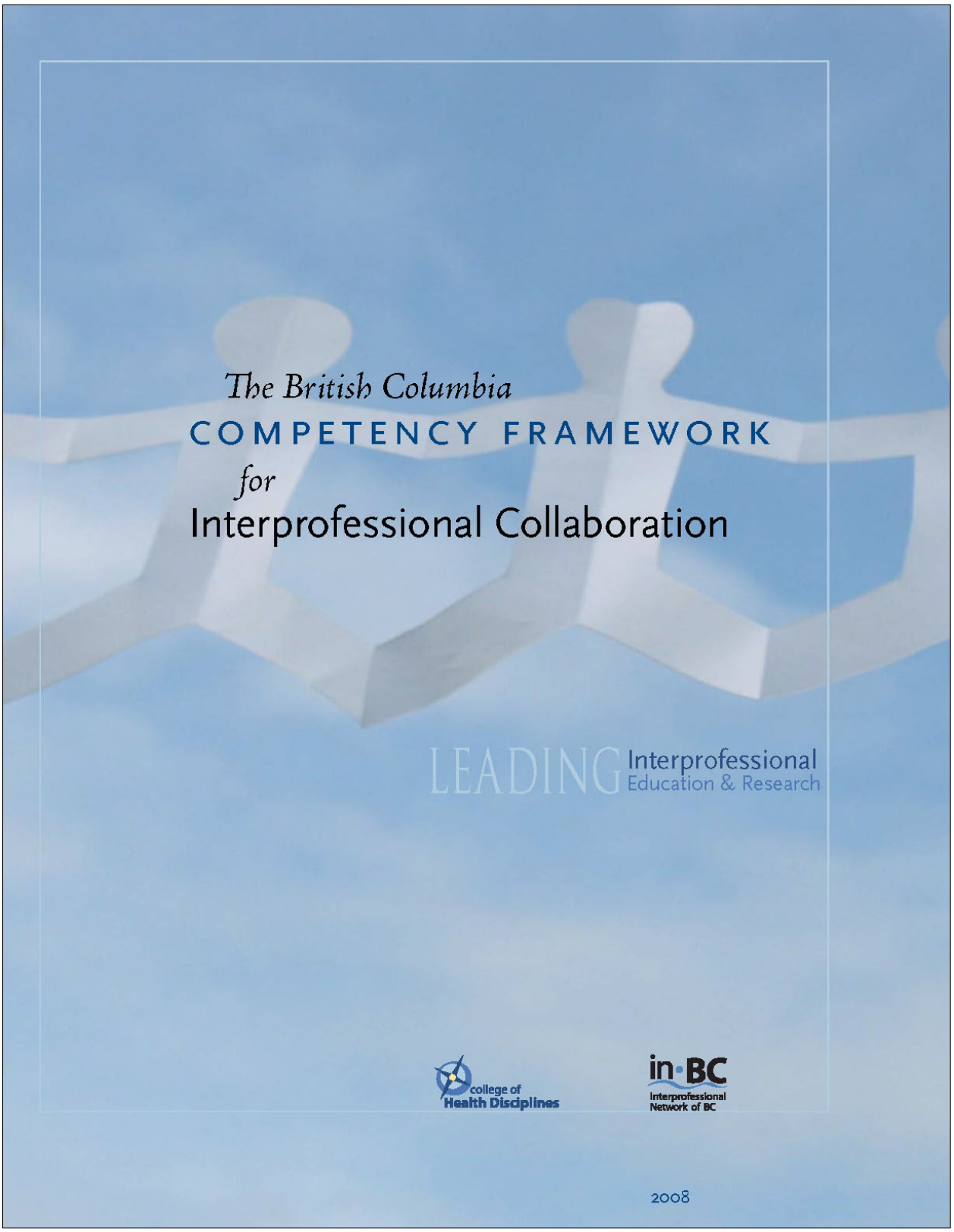
11. Project Closeout Signoff

Name	Role	Signature	Date
Lori Lamont	Executive Sponsor	**Original signatures on file with PMO**	
Cathy Rippin Sisler	Project Sponsor		
Susan Bowman	Project Manager		
Janet Bjornson	PMO Regional Director		

cc: Project Management Office

12. APPENDICIES

APPENDIX A



GLOSSARY OF TERMS

SHARED LANGUAGE

Patient/Client Where this term is used, it should be taken to mean anyone receiving care.

Family This term not only refers to the patient/client's relatives but anyone within their social network that may be affected by their care.

Interprofessional A professional's skills, knowledge and roles are adapted to fit in with other professions.[1]

Team For the purposes of this framework, this term is used to denote either: (a) a group of health professionals who work together around the care of a patient/client in an "informal" way; or (b) a collection of individuals who are interdependent in their tasks, who share responsibility for outcomes, who see themselves and who are seen by others as an intact social entity embedded into one or more larger social systems and who manage their relationships across organizational borders i.e. a "formalized" team.[2]

Collaboration A process that requires relationships and interactions between health professionals regardless of whether they are members of a formalized team or a less formal or virtual group of health professionals working together to provide comprehensive and continuous care to a patient/client.[3]

1 Finch J. (2000) 'Interprofessional education and teamworking: a view from the education providers'. British Medical Journal, 321: 1138-1140.
2 Cohen, S.G. and D.R. Bailey (1997). What makes teams work: Group effectiveness research from the shop floor to the executive suite. *Journal of Management*, 23(4), 238-290.
3 Canadian Health Services Research Foundation. Teamwork in Healthcare: Promoting effective teamwork in healthcare in Canada. www.chsrf.ca.

The British Columbia Competency Framework for Interprofessional Collaboration

The term competency is often used to describe the knowledge required to be able to perform a particular task. According to Norman[4], a competency is more than knowledge; it includes the understanding of knowledge, clinical, technical and communication skills, and the ability to problem-solve through the use of clinical judgment. According to the CanMEDS[5] competency framework, the development of a competency is the process of translating the core abilities involved in effective practice into educationally useful elements. However, despite recent attention to Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) there is no commonly agreed upon set of interprofessional competencies.

With the aim of developing a universally applicable interprofessional competency framework, the UBC College of Health Disciplines, using the Interprofessional Network of BC (In-BC) Guided Independent Fieldwork Study (GIFS) framework as a foundation, compared and contrasted 15 existing competency frameworks (see Appendix). By examining the consistencies, inconsistencies, overlap, discrepancies, and language among these frameworks, a 'Competency Framework for Interprofessional Collaboration' was developed.

The objective of this framework is to inform curriculum development for health and human service professionals throughout the continuum of learning. Many of the competencies in the framework build on generic competencies that are developed during discipline-specific learning. Ideally, practitioners who demonstrate both their own profession's specific and unique competencies and the interprofessional competencies will have the skills and knowledge necessary to provide patient/clients with optimal, integrated care. It is hoped that this framework will be used as an interprofessional competency framework by health and human service educators, practitioners and decision-makers throughout the province.

The *BC Competency Framework for Interprofessional Collaboration* is organized into three domains:

I. Interpersonal and Communication Skills
II. Patient-Centred and Family-Focused Care
III. Collaborative Practice
   A. Collaborative Decision-Making
   B. Roles and Responsibilities
   C. Team Functioning
   D. Continuous Quality Improvement

4 Norman GR: Assessing Clinical Competence. New York: Springer; 1985: pp 330-341.
5 CanMEDS (2005). The CanMEDS 2005 Physician Competency Framework. The Royal College of Physicians and Surgeons of Canada. http://rcpsc.medical.org/canmeds/CanMEDS2005/CanMEDS2005_e.pdf.

I. *Interpersonal & Communication Skills*

Consistently communicates sensitively in a responsive and responsible manner, demonstrating the interpersonal skills necessary for interprofessional collaboration.

Effectively expresses one's own knowledge and opinions to others involved in care:

* Demonstrates confidence and assertiveness to express one's views respectfully and with clarity;
* Employs language understood by all involved in care and explains discipline-specific terminology;
* Explains rationale for opinions;
* Evaluates effectiveness of communication and modifies accordingly.

Actively listens to the knowledge and opinions of other team members:

* Listens to and shows genuine interest in the perspectives and contributions of others;
* Is observant and respectful of non-verbal as well as verbal communication;
* Confirms that one understands all ideas and opinions expressed.

Uses information systems and technology to exchange relevant information among all professionals to improve care:

* Uses technology and other tools to keep others continuously updated;
* Is aware of and uses information resources from other professions;
* Plans and documents care on a shared health record.

II. *Patient-Centred & Family-Focused Care*

Through working with others, negotiates and provides optimal, integrated care by being respectful of and responsive to patient/client and family perspectives, needs, and values.

Involves the patient/client and family as partners in group decision-making processes:

* Actively encourages patient/clients and families to express their feelings and needs as part of an interprofessional team;
* Interacts with other professionals to consistently promote and support patient/client and family participation and autonomy;
* Promotes an environment of respect for the patient/client and family, fostering a feeling of comfort within the team;
* Ensures utilization of team communication strategies appropriate for the patient/client and their family;
* Fosters non-judgemental and inclusive attitudes by the team towards patient/clients and families;
* Shares options and healthcare information based upon team discussions with patient/clients and families to foster informed choice;
* Identifies patient/client's social determinants of health with the team and engages appropriate collaborators.

Ensures continuous integration of patient/clients and families into the team in order to maintain optimal, evolving care:

* Remains responsive to the changing needs of the patient/client and family as a member of the team;
* Strives to strengthen and build the relationship between the patient/client, family and all relevant care providers;
* Ensures that appropriate education and support is provided by the team for family members and others involved with the patient/client's care;
* Advocates self-care, disease prevention, and wellness as part of the team's mandate to promote a healthy lifestyle.

III. Collaborative Practice

Establishes and maintains effective working partnerships with other professionals, patient/clients, families, other teams, organizations, and individuals to achieve common goals.

The collaborative practice domain comprises four sub sections:

A. Collaborative Decision-Making (page 7)
B. Roles and Responsibilities (page 8)
C. Team Functioning (page 9)
D. Continuous Quality Improvement (page 10)

A. *Collaborative Decision-Making*

Establishes and maintains effective and healthy working partnerships with other professionals, whether or not a formalized team exists.

Establishes interdependent relationships with other health care providers:

* Negotiates ground rules to create a safe environment for collaboration;
* Respects others' contributions and work ethic;
* Is able to determine whom to involve depending on the needs of the patient/client

Shares decision-making with others:

* Establishes and focuses on common goals;
* Identifies patient/client-centred goals;
* Implements joint decisions once all options and evidence are provided and discussed.

Maintains professional conduct during interprofessional encounters:

* Develops, promotes and exercises non-judgemental and inclusive practice respecting other cultures, values and belief systems;
* Practices ethical behaviour in all professional activities;
* Displays integrity, honesty and social responsibility;
* Adheres to standards of practice (e.g. avoids conflicts of interest).

Resolves conflicts with others when disagreements arise related to opposing opinions, decisions or viewpoints:

* Understands issues that may contribute to the development of conflict;
* Acknowledges that conflict can be productive;
* Ensures conflicts are addressed before they become counterproductive;
* Uses mechanisms for conflict resolution if conflict escalates.

Maintains flexibility and adaptability when working with others:

* Re-evaluates one's own position in light of new information from others;
* Cooperates with others involved in care;
* Ensures that complexity, uncertainty and other stressful situations do not negatively affect relationships;
* Ensures that conflict does not affect the care of the patient/client and that the patient/client remains the central focus of the team.

B. *Roles and Responsibilities*

Consults, seeks advice and confers with other team members based on a clear understanding of everyone's capabilities, expertise and culture.

Has sufficient confidence in and knowledge of one's own discipline to work effectively with others in order to optimize patient/client care:

* Demonstrates ability to share discipline specific knowledge with other health care professionals;
* Negotiates actions with other health care professionals based on one's own role constraints and discipline specific ethical and legal practices;
* Shares one's professional culture and values to help others understand one's own point of view.

Has sufficient confidence in and knowledge of others' professions to work effectively with others in order to optimize patient/client care:

* Actively seeks out knowledge regarding others' scopes of practice;
* Understands how others' skills and knowledge compliment and may overlap with one's own;
* Negotiates actions with other health care professionals based on an understanding of other disciplinary role constraints, overlap of roles, and discipline specific ethical and legal practices;
* Respects others' professional culture and values in order to understand their frame of reference.

C. *Team Functioning*

Uses team building skills to negotiate, manage conflict, mediate between different interests and facilitate building of partnerships within a formalized team setting.

Maintains interdependent relationships with interprofessional team members:

* Fosters mutual trust and respect within the established interprofessional team;
* Shares responsibility for team actions;
* Ensures that good communication is maintained across settings and over time;
* Contributes to team cohesion by celebrating successes, acknowledging contributions, and supporting others during times of difficulty and crisis.

Has a critical understanding of interprofessional team structures, effective team functioning and knowledge of group dynamics:

* Is aware of the dynamic nature of teams and operates with flexibility;
* Identifies which team member will take the appropriate facilitator role in specific contexts;
* Understands that compromise may be necessary to reach consensus.

Reflects on team functioning in order to identify dysfunctional processes:

* Is aware of how one's feelings and behaviours affect other members of the team;
* Is aware that professional and cultural differences may produce misunderstanding;
* Is observant of inequalities and disrespect within the team and is able to diplomatically address these issues.

Facilitates interprofessional team meetings:

* Monitors and controls the team's balance between process and task;
* Keeps group focused on agreed upon goals;
* Mediates in conflict situations;
* Synthesizes and summarizes team interactions and decisions.

Can act as a representative linking the interprofessional team and outsiders:

* Conveys decisions made by the team to others;
* Relays outside information to the team;
* Knows what information is relevant to whom.

D. Continuous Quality Improvement (CQI)

Works with an interprofessional team to contribute to continuous improvement of the health care system, particularly in the area of patient/client safety by mitigating errors, increasing efficiency, and minimizing delays.

Critically evaluates policy and practice in the context of patient/client safety and shares one's own perspective with the interprofessional CQI team:

* Shows awareness of health care error and patient/client safety concepts;
* Objectively observes and criticizes one's own professional policies and practice;
* Applies experience of IP working to discussions regarding improvements to policy and practice.

Commitment to a just, non-blaming, non-punitive interprofessional CQI team culture:

* Acts on the assumption that errors are a result of system failure not individual fault;
* Objectively discusses and analyzes problems being addressed by the CQI team;
* Questions other professionals using non-blaming approaches that are conducive to learning when deviations from recommended or best practice occur.

Negotiates and tests interventions within the team to foster process and systems change:

* Demonstrates the ability to advocate for change;
* Brings innovation and creativity to the team;
* Advocates for policy change to ensure that recommended interventions are implemented and sustained.

APPENDIX

Existing Frameworks Compared & Contrasted

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APPENDIX B:

Interprofessional Clinical Placement – Role Descriptions

Site Lead Role

A project of this nature requires a site lead with excellent communication skills and a working knowledge of the site department managers and/or professional lead structure in order to develop a site team to disseminate information and coordinate student placement meetings.

Site Lead Responsibilities

1. Act as facility representative with the project team

2. Attend project team planning and de-briefing meetings

3. Act as, or designate, a facilitator for the student team (see separate roles/responsibilities for the facilitator).

4. Develop a site communication plan to ensure that information is shared with all key stakeholders. Stakeholders may include:
    1. Program Directors
       Program directors may be an excellent resource to assist in information dissemination and to assist in problem solving if issues arise with logistics or participation at the ward/unit level.
    2. Ward and department managers
       Manager understanding and engagement is essential in ensuring participation from all staff irrespective of their direct involvement with students. Manager "buy-in" is required in order to facilitate the front line staff availability and participation in any team meetings and/or training.
    3. Clinical placement coordinators
       Depending on the size and/or composition of the department, this may be the discipline manager, a front line staff member or a unique position. Inclusion of these individuals will ensure that the placement of students on the unit proceeds as planned and that student assignments are not modified without discussion.
    4. Front line staff
       This communication strategy may be two-fold in that front line staff may receive direct communication from their discipline specific manager, but should also receive information as part of the interprofessional (IP) team on the selected ward/unit.
    5. Preceptors/Supervisors/Faculty Advisors
       Any individuals that are responsible for overseeing and/or supervising the students should be included in the communication strategy. These individuals will be integral in ensuring that the students are available to meet with the student team and can assist the student with aligning the project goals with the goals and deliverables of the clinical placement. The facilitator will need to consult with these individuals in order to develop a meeting schedule for the student team.

5. Support and work with the facilitator(s) to develop a meeting schedule for students that maximizes student participation from all disciplines. This may involve some schedule adjustments if some of the student rotations involve evening or weekend shifts.

6. Coordinate workshop/education schedules for the project team front line staff. Workshop timing and length should be planned with input from all discipline leaders to ensure that all staff have an opportunity to be involved and engaged.

APPENDIX C:

Interprofessional Clinical Placement – Role Descriptions

Facilitator Role:

When choosing a facilitator, this individual should have:

- flexibility in their schedule to be able to meet with the student group a minimum of 3 times a week at times that are scheduled to maximize student participation
- knowledge of the ward and/or patient population to assist in both patient selection to maximize interprofessional (IP) involvement and to assist in facilitation around an IP patient care plan
- excellent communication skills
- good organizational skills
- an interest in working with students

Facilitator Duties:

1. Arrange a weekly schedule/lesson plan outlining which collaborative competency the students will focus on each week and identify a process for providing this schedule to the students and/or their preceptors.

   The student manual outlines targeted IP competencies, learning objectives and suggested activities that can be utilized with the student team to help develop an understanding of collaborative practice. Additional tools are available in the appendices to use as appropriate. Students should be encouraged to observe behaviours related to these competencies both within the student team and in the patient care team as a whole. The competencies include: Understanding Roles and responsibilities, Shared Decision Making, Interprofessional (IP) Communication, and Conflict Analysis and Management in addition to the essential principles of setting patient care goals and interprofessional care planning.

2. Confirm student schedules for each week and student availability.

   The different faculties have different start dates and durations of placements. A sample calendar, including start and end dates for the clinical placements of the various faculties, is included in the student manual. Some disciplines may have students that follow a rotation including evenings, nights or weekends so some schedule changes may have to be negotiated to try and make students available for the weekly meeting times. This negotiation of schedule adjustments may be a shared the responsibility with the site lead along with the specific discipline manager/clinical coordinator.

3. Set up 3 separate times to meet with the student team each week.

   These meetings may be planned with the various preceptors prior to student arrival. Don't forget that you may also have to book a room or organize a location that will be easily accessible for the students as well as accommodate the size of the group.

   - The purpose of the first meeting will be to assign the students a patient for all to assess and ensure that all students are aware of the targeted IP competency for the week. The facilitator should ensure that the students have adequate time to conduct their individual assessment prior to the shared care planning session. Once the students have been oriented to the expectations of the project, this meeting will be brief and may eventually be able to be done without a formal meeting time as long as a process is identified for the students to be assigned a common patient and ensure

they all have the schedule of weekly competencies. Please remember that email is not secure and cannot be used to communicate confidential information such as patient names or identifiers.

- The second meeting will be the IP Shared Care Planning session. During this session the facilitator will ensure that each student has an opportunity to present his/her uni-professional care plan/issues and ensure that the multiple perspectives of each member of the student team are being heard. Try to stimulate a bit of positive conflict as students negotiate how their identified priorities fit into the IP care plan for the patient. The student team and/or delegate should have an opportunity to present the completed care plan to the patient care team as a whole during a team meeting.

- The third meeting should be a 'debriefing' session. During this session, the facilitator will guide the students as they reflect on the previous week's activities. Behaviours related to the chosen collaborative competency for the week should be discussed, reflecting on the clinical team, student team and/or personal behaviours. The Appendices included in the Student Manual provide tools that will help with each competency.

  Please note that each practice environment will have its own culture and processes which may dictate when and how these meetings are organized. In a patient setting with a chronic and/or stable patient population, patients may be picked a week or two prior to give all disciplines ample opportunity to carry out their individual assessments; the timeline for an acute ward may be shortened accordingly to allow the students to present their care plan at a team meeting where their patient is discussed prior to discharge.

4. Arrange for the team to pick a patient that would be appropriate for the student team to assess.

   Each week the students should have a new patient to review. Take into consideration the composition of the team when choosing the patient; you may choose a different patient for a student team consisting of nursing, medicine and pharmacy compared to OT, PT and SW.

   The project work is to complement the goals of their clinical placement, so whenever possible, try to select a patient that would benefit from intervention from each of the disciplines represented in the student team; if there is a large student team, you may not be able to always pick a patient that will benefit from all of the disciplines represented, but in many cases, it is as valuable for the students to be able to identify when their particular expertise is not required for a particular patient as well as learn the roles of the other students with a different patient population.

5. Determine a process/time for the students to present the shared care plan at a team meeting and ensure that the team is familiar with the student goals so the whole team can support and model IP collaboration within the team.

APPENDIX D:

Interprofessional Clinical Practice – Site Selection Criteria

Commitment to interprofessional practice at all levels of the organization is essential for successful interprofessional collaboration to occur in the front line teams. Simply assigning staff to work together on a particular team or unit does not create an environment of interprofessional practice; skill sets related to collaborative competencies must be learned and commitment to change embraced by site and program executive, by unit and discipline managers and leaders, and by front line staff.

In order to develop and foster interprofessional collaborative practice and learning environments, sites must be prepared to commit to the following:

1. Assign an individual to collate information related to all student placements that are scheduled to occur on site. This will include the duration and overlap of students assigned to common wards or practice settings in the facility. A ward that is hosting a minimum of three students from different disciplines at the same time is an ideal opportunity to formalize an interprofessional student team.

2. Assign a site lead to coordinate meetings, workshop/training schedules and to develop and manage the communication plan

3. Assign/train a unit facilitator for shared care planning sessions

4. Commit funds as necessary to enable staff to participate in collaborative practice training/workshops

5. Ensure that there is both a “top down” and “bottom up” communication flow among all of the stakeholders

6. Commit to strong leadership support and active engagement; opting out by any one discipline is not considered acceptable and barriers should be identified and dealt with early on in the process

APPENDIX E:

Assessment of Interprofessional Team Collaboration Scale (AITCS)

The AITCS is a diagnostic instrument that is designed to measure the interprofessional collaboration among team members. It consists of 48 statements considered characteristic of interprofessional collaboration (how team works and acts). Scale items represent four rationally determined subscales thought to represent the key belief domains of AITCS. The subscales are: (1) Partnership—13 items, (2) Cooperation—15 items, (3) Coordination—5 items, and (4) Shared Decision Making—15 items.

Scoring AITCS

Respondents indicate their general level of agreement with items on a 5-point rating scale that ranges from (1) "Never" to (2) "Rarely" to (3) "Occasionally" to (4) "Most of the time" to (5) "Always". This scale produces scores from 48 to 240. It takes 10-15 minutes to complete.

Demographic Information

Please provide your birth date (dd/mm/yyyy): _____

Please check ☒ the category you belong to:

Gender: ☐ Male ☐ Female **Employment Status:** ☐ FT ☐ PT ☐ Casual

Educational Preparation

- ☐ Certificate
- ☐ Diploma
- ☐ Bachelor Degree
- ☐ Masters Degree
- ☐ Other (specify): _____

Please check one of the following discipline categories:

☐ Audiologist	☐ Physical Therapist (Physiotherapist)
☐ Clinical Kinesiologist	☐ Pharmacy
☐ Clinical Psychologist	☐ Paramedics
☐ Dental Assistant	☐ Physician (Medicine)
☐ Dentist	☐ Personal Support Worker
☐ Dietary Aid	☐ Speech Language Pathologist
☐ Dietitian (Nutritionist)	☐ Social Worker
☐ Imaging Technologist	☐ Spiritual/Pastoral Care
☐ Laboratory Technologist	☐ Recreational Therapist
☐ Nursing: Registered Nurse	☐ Respiratory Therapist
☐ Nursing: Licensed Practical Nurse	☐ Therapy Assistant
☐ Occupational Therapist	☐ Other (please specify) _____

Please indicate:

Years in practice (*since achieving license to practice*):_____; Years with your current team: _____

1

Assessment of Interprofessional Team Collaboration Scale

Instructions:

Note: Several terms are used for the person who is the recipient of health and social services. For the purpose of this assessment, the term 'patient' will be used. While acknowledging that other terms such as 'client' and 'consumer' are preferred in some disciplines.

Please read over each statement and circle the value which best reflects how you currently feel your team and you as a member of the team work or act.

1	2	3	4	5
Never	Rarely	Occasionally	Most of the time	Always

Section 1: PARTNERSHIP [1]

When we are working as a **team**[2] all of my team members…..

1	Apply a unique definition of ***Interprofessional collaborative practice*** to the practice setting	1 2 3 4 5
2	Share the power with each other	1 2 3 4 5
3	Encourage each other and patients and their families to use the knowledge and skills that each of us can bring in developing plans of care	1 2 3 4 5
4	Help and support each other	1 2 3 4 5
5	Have excellent communication among ourselves, our patients and their families	1 2 3 4 5
6	Respect and trust each other	1 2 3 4 5
7	Are open and honest with each other	1 2 3 4 5
8	Make changes to their functioning based on reflective reviews	1 2 3 4 5
9	Are protective regarding issues that can damage our team interests	1 2 3 4 5
10	Team members are held accountable for accepted tasks and responsibilities by each other	1 2 3 4 5
11	Establish agreements on goals for each patient we care for	1 2 3 4 5
12	All team members are committed to the goals set out by the team	1 2 3 4 5
13	Strive to achieve mutually satisfying resolution for differences of opinions	1 2 3 4 5

[1] Orchard & Curran "a partnership between a team of health professional and a client in a participatory, collaborative and coordinated approach to shared decision-making around health issues" (2003)

[2] A team can be defined as any interaction between one or more health professionals.

Section 2: COOPERATION

When we are working as a **team** all of my team members…..

1	Include patients in setting goals for their care	1 2 3 4 5
2	The goals that team members agree upon are equally divided amongst the team	1 2 3 4 5
3	Team members frequently re-evaluate the effectiveness of their collaborative practices	1 2 3 4 5
4	Listen to the wishes of their patients when determining the process of care chosen by the team	1 2 3 4 5
5	Encourage and support open communication, including the patients during team meetings	1 2 3 4 5
6	Use and agree upon process to resolve conflicts	1 2 3 4 5
7	Feel satisfied with the outcome of conflict management	1 2 3 4 5
8	Understand the boundaries of what each other can do	1 2 3 4 5
9	Understand that there are shared knowledge and skills between health professions	1 2 3 4 5
10	Exhibit a high priority for gaining insight from patients about their wishes/desires	1 2 3 4 5
11	Create a cooperative atmosphere among the members when addressing patient situations	1 2 3 4 5
12	Complete tasks to contribute to the team's cohesiveness	1 2 3 4 5
13	Openly discuss each other professional roles	1 2 3 4 5
14	Feel comfortable challenging unfamiliar language used by other team members	1 2 3 4 5
15	Establish a sense of trust among the team members	1 2 3 4 5

Section 3: COORDINATION

1	Team members meet and discuss patient care on regular basis	1 2 3 4 5
2	There is support from the organization for teamwork	1 2 3 4 5
3	Team members coordinate health and social services (e.g. financial, occupation, housing, connections with community, spiritual) based upon patient care needs	1 2 3 4 5
4	Team members use a variety of communication means (e.g. written messages, email, electronic patient records, phone, informal discussion etc.)	1 2 3 4 5
5	There is consistent communication with team members to discuss patient care	1 2 3 4 5

Section 4: SHARED DECISION – MAKING

1	All members of our team are involved in goal setting for each patient	1 2 3 4 5
2	Listen to and consider other members' voice and opinions/views in regards to individual care plan process	1 2 3 4 5
3	The leader for the team varies depending on the needs of our patients	1 2 3 4 5
4	Select the leader for our team	1 2 3 4 5
5	Take the responsibility for care within their scope of practice	1 2 3 4 5
6	Team members openly support inclusion of the patient in their team meetings	1 2 3 4 5
7	Patients have the final decision on care plans	1 2 3 4 5
8	When care decisions are made, the leader strives for consensus on planned processes	1 2 3 4 5
9	Feel a sense of belonging to the group	1 2 3 4 5
10	Team members establish deadlines for steps and outcome markers in regards to patient care	1 2 3 4 5
11	Team members jointly agree to communicate plans for patient care	1 2 3 4 5
12	Team members consider alternative approaches to achieve shared goals	1 2 3 4 5
13	Encourage each other and patients and their families to use the knowledge and skills that each of us can bring in developing plans of care	1 2 3 4 5
14	The focus of teamwork is consistently the patient	1 2 3 4 5
15	Work with the patient and his/her relatives in adjusting care plans	1 2 3 4 5

Thank you for completion of this questionnaire!

APPENDIX F:

DOB (dd/mm/yyyy)_____

ATTITUDES TOWARD HEALTH CARE TEAMS (1)
(ATHCT)

Directions: Please answer the following questions by circling the number from 1 to 6 that most accurately reflects your opinion, with 1 meaning *"Strongly Disagree"* and 6 meaning *"Strongly Agree"*.

	Strongly Disagree	Disagree	Slightly disagree	Slightly Agree	Agree	Strongly Agree
1. Working in teams unnecessarily complicates things most of the time.	1	2	3	4	5	6
2. The team approach improves the quality of care to patients.	1	2	3	4	5	6
3. Team meetings foster communication among team members from different disciplines.	1	2	3	4	5	6
4. Physicians have the right to alter patient care plans developed by the team.	1	2	3	4	5	6
5. Patients receiving team care are more likely than other patients to be treated as whole person.	1	2	3	4	5	6
6. A team's primary purpose is to assist physicians in achieving treatment goals for patients.	1	2	3	4	5	6
7. Working on a team keeps most health professionals enthusiastic and interested in their jobs.	1	2	3	4	5	6
8. Patients are less satisfied with their care when it is provided by a team.	1	2	3	4	5	6
9. Developing a patient care plan with other team members avoids errors in delivering care.	1	2	3	4	5	6
10. When developing interdisciplinary patient care plans, much time is wasted translating jargon from other disciplines.	1	2	3	4	5	6
11. Health professionals working on teams are more responsive than others to the emotional and financial needs of patients.	1	2	3	4	5	6
12. Developing an interdisciplinary patient care plan is excessively time consuming.	1	2	3	4	5	6
13. The physician should not always have the final word in decisions made by health care teams.	1	2	3	4	5	6
14. The give and take among team members helps them make better patient care decisions.	1	2	3	4	5	6
15. In the most instances, the time required for team meetings could be better be spent in other ways.	1	2	3	4	5	6
16. The physician has the ultimate legal responsibility for decisions made by the team.	1	2	3	4	5	6
17. Hospital patients who receive team care are better prepared for discharge than other patients.	1	2	3	4	5	6
18. Physicians are natural team leaders.	1	2	3	4	5	6
19. The team approach makes the delivery of care more efficient.	1	2	3	4	5	6
20. The team approach permits health professionals to meet the needs of family caregivers as well as patients.	1	2	3	4	5	6
21. Having to report observations to the team helps team members better understand the work of other health professionals.	1	2	3	4	5	6

University Western Ontario

APPENDIX G:

Birth Date (dd/mm/yyyy): _____

Interprofessional Socialization and Valuing Scale

Introduction

This instrument is designed to help you explore your perceptions of what you have learned about working with professionals from other disciplines. Please complete the following questionnaire based on your own views of your experiences (through workshops, classes, or practice.

Please **indicate the degree to which you hold or display each of the beliefs, behaviours, and attitudes** that are described. You are asked to consider ***where you feel you are now.***

You are asked to respond to each statement using a 7-point scale with 1 meaning (Not at All) and 7 meaning (To a Very Great Extent). Please respond by circling the one number that you feel best fits your experience. If you feel the statement does not apply to you please use the zero value (0).

	To a Very Great Extent	To a Great Extent	To a Fairly Great Extent	To a Moderate Extent	To a Small Extent	To a Very Small Extent	Not at All	N/A
In the context of your workshop or clinical practice….								
1. I feel confident in taking on different roles in a team (i.e. leader, participant)	7	6	5	4	3	2	1	0
2. I am comfortable debating issues within a team	7	6	5	4	3	2	1	0
3. I more highly value open and honest communication with team members	7	6	5	4	3	2	1	0
4. I am able to listen to other members on a team	7	6	5	4	3	2	1	0
5. I have gained a better understanding of my own approach to care within an interprofessional team	7	6	5	4	3	2	1	0

	To a Very Great Extent	To a Great Extent	To a Fairly Great Extent	To a Moderate Extent	To a Small Extent	To a Very Small Extent	Not at All	N/A
In the context of your workshop or clinical practice….								
6. I am aware of my preconceived ideas when entering into team discussions	7	6	5	4	3	2	1	0
7. I have a better appreciation for using a common language across the health professionals in a team	7	6	5	4	3	2	1	0
8. I believe that interprofessional practice is a waste of time	7	6	5	4	3	2	1	0
9. I have gained an enhanced awareness of my own role on a team	7	6	5	4	3	2	1	0
10. I am able to share and exchange ideas in a team discussion	7	6	5	4	3	2	1	0
11. I have gained an enhanced perception of myself as someone who engages in interprofessional practice	7	6	5	4	3	2	1	0
12. I feel comfortable being the leader in a team situation	7	6	5	4	3	2	1	0
13. I feel comfortable in speaking out within the team when others are not keeping the best interests of the client in mind	7	6	5	4	3	2	1	0

	To a Very Great Extent	To a Great Extent	To a Fairly Great Extent	To a Moderate Extent	To a Small Extent	To a Very Small Extent	Not at All	N/A
At this point in time based on my participation in workshops and/ or clinical practice...								
14. I believe that the best decisions are made when members openly share their views and ideas	7	6	5	4	3	2	1	0
15. I see myself as preferring to work on an interprofessional team	7	6	5	4	3	2	1	0
16. I feel comfortable in describing my professional role to another team member	7	6	5	4	3	2	1	0
17. I have a better appreciation for the value in sharing research evidence across different health professional disciplines in a team	7	6	5	4	3	2	1	0
18. I believe that it is important to work as a team.	7	6	5	4	3	2	1	0
19. I am able to negotiate more openly with others within a team	7	6	5	4	3	2	1	0
20. I believe that interprofessional practice will give me the desire to remain in my profession	7	6	5	4	3	2	1	0

	To a Very Great Extent	To a Great Extent	To a Fairly Great Extent	To a Moderate Extent	To a Small Extent	To a Very Small Extent	Not at All	N/A
At this point in time based on my participation in workshops and/ or clinical practice...								
21. I have gained an enhanced awareness of roles of other professionals on a team	7	6	5	4	3	2	1	0
22. I have gained an appreciation for the importance of having the client and family as members of a team	7	6	5	4	3	2	1	0
23. I feel comfortable in being accountable for the responsibilities I have taken on	7	6	5	4	3	2	1	0
24. I am comfortable engaging in shared decision making with clients	7	6	5	4	3	2	1	0
25. I feel comfortable in accepting responsibility delegated to me within a team	7	6	5	4	3	2	1	0
26. I have gained a better understanding of the client's involvement in decision making around their care	7	6	5	4	3	2	1	0
27. I feel comfortable clarifying misconceptions with other members of the team about the role of someone in my profession	7	6	5	4	3	2	1	0
28. I have gained greater appreciation of the importance of a team approach	7	6	5	4	3	2	1	0

	To a Very Great Extent	To a Great Extent	To a Fairly Great Extent	To a Moderate Extent	To a Small Extent	To a Very Small Extent	Not at All	N/A
At this point in time due to my participation in workshops and/ or clinical practice...								
29. I feel able to act as a fully collaborative member of the team	7	6	5	4	3	2	1	0
30. I feel comfortable initiating discussions about sharing responsibility for client care	7	6	5	4	3	2	1	0
31. I believe that interprofessional practice is difficult to implement	7	6	5	4	3	2	1	0
32. I am comfortable in sharing decision making with other professionals on a team	7	6	5	4	3	2	1	0
33. I have gained more realistic expectations of other professionals on a team	7	6	5	4	3	2	1	0
34. I have gained an appreciation for the benefits in interprofessional team work	7	6	5	4	3	2	1	0

Please assist us in knowing information about you that will help in determining any relationships between previous experience/knowledge and interprofessional education.

1. My current designation would be: *please check in one box as to the group you belong to*

1.1 ☐ I am a student 1. 2 ☐ I am a Clinician 1.3 ☐ I am student with program practice experience

2. If you checked the box in 1.2 or 1.3 please answer the following: *Check all boxes that apply*

My program practice experience has included

2.1 ☐ Community agency care 2.2 ☐ Acute care 2.3 ☐ Out-patient care

2.4 ☐ Rehabilitative care 2.5 ☐ Home care 2.6 ☐ Family health team care

2.7 ☐ Other: Please describe _____

3. Have you participated in Interprofessional Education Workshops? ☐ YES ☐ NO

If you answered "YES" please identify how many you have attended:

3.1 ☐ 1 workshop 3.2 ☐ 2 workshops 3.3 ☐ 3 workshops

3.4 ☐ 4 workshops 3.5 ☐ 5 workshops 3.6 ☐ 6 workshops

3.7 ☐ 7 workshops 3.7 ☐ 8 workshops 3.9 ☐ more than 8 workshops

If you are a student please complete the question # 5 and if you are a clinician please complete the question # 6

5. I am a student in a health program and have participated in an Interprofessional Group practice placement:

☐ YES ☐ NO

If you responded "YES", please identify the number of placements you have experience with:

5.1 ☐ 1 placement on a team 5.2 ☐ 2 placements on teams

5.3 ☐ 3 placements on teams 5.7 ☐ 4 or more placements on teams

6. I am a health practitioner and have experience working on teams: ☐ YES ☐ NO

If you responded "YES" to question # 7, please complete the next section

The length of my experience in working on teams is:

6.1 ☐ 1-3 years 6.2 ☐ 4-6 years

6.3 ☐ 7-10 years 6.3 ☐ more than 10 years

7. The heath/social service practitioner group I either study or practice in/as is:

7.1 ☐ Audiology 7.2 ☐ Clinical Kinesiology 7.3 ☐ Dentistry

7.4 ☐ Dietetics 7.5 ☐ Medicine 7.6 ☐ Nursing (RN)

7.7 ☐ Nursing (RPN) 7.8 ☐ Occupational Therapy 7.9 ☐ Personal Care Worker

7.10 ☐ Physical Therapy

7.11 ☐ Pre-Professional Program: (Bachelor of Medical/Health Sciences, Kinesiology, Pre-Social Work)

7.12 ☐ Psychiatry 7.13 ☐ Psychology 7.14 ☐ Social work

7.15 ☐ Speech Language Pathology 7.16 ☐ Other: *Please state* _____

8. My gender is: ☐ Male ☐ Female

Thank you for taking the time to complete this instrument.

APPENDIX H:

BIRTH DATE (DD/MM/YYYY): _____

COLLABORATION AND SATISFACTION ABOUT CARE DECISIONS

Instructions: These questions are related to the **decisions about care** for patients made by an interdisciplinary team of care providers (i.e. physician, registered nurse, physical therapist, occupational therapist, speech-language pathologist, pharmacist and social worker). For each statement of question, please **circle** the number that best represents **your** response.

	Strongly Disagree					Strongly Agree
1. Interdisciplinary team members *planned together* to make the decisions about the care for patients.	1	2	3	4	5	6
2. Open Communication among interdisciplinary team members took place as the decisions were made for patients.	1	2	3	4	5	6
3.Decision-making responsibilities for patients were *shared* among interdisciplinary team members	1	2	3	4	5	6
4. Interdisciplinary team members *cooperated* in making these decisions.	1	2	3	4	5	6
5.In making these decisions, *interdisciplinary* concerns about patient needs were considered	1	2	3	4	5	6
6. Decision-making for patients was *coordinated* among interdisciplinary team members.	1	2	3	4	5	6

7. How much *collaboration* among interdisciplinary team members occurred in making decisions for patients?						
No Collaboration						Complete collaboration
1	2	3	4	5	6	7

8. How *satisfied* are you with the way decisions were made (i.e. with the *decision-making process,* not necessarily with the decision itself)?						
Not Satisfied						Very Satisfied
1	2	3	4	5	6	7

9. How *satisfied* are you with the decisions made for patients?						
Not Satisfied						Very Satisfied
1	2	3	4	5	6	7

Thank You for completing this questionnaire!

APPENDIX I

Interprofessional Partnerships

Understanding Roles and Responsibilities

1

Interprofessional Education occurs

When two or more professions learn with, from, and about each other in order to improve collaboration and the quality of care (CAIPE 1997, revised 2002)

Collaborative Practice

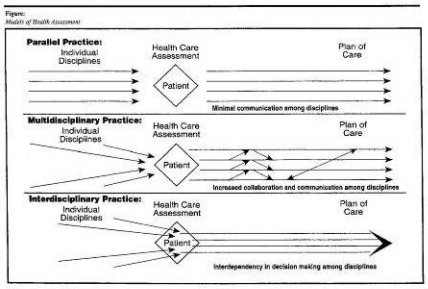
can positively impact current health issues such as:

- Wait times
- Healthy workplaces
- Health human resources
- Patient safety
- Rural and remote
- Chronic disease management
- Population health and wellness.

(CIHC, 2010)

2

The Nature of Collaboration



18 Journal of Physical Therapy Education Vol 15, No 2, Summer 2001

Benefits of collaborative practice include:

- Using appropriate language when speaking to other healthcare providers or patients/family
- Understanding that all healthcare providers contribute to the team or collaborative unit
- Showing respect and building trust among team members
- Introducing new members of the team in a way that is welcoming and gives them the information they need in order to be a contributing member
- Turning to colleagues for answers
- Supporting each other when mistakes are made, and celebrating together when success is achieved

(CIHC, 2010)

4

What are Our Challenges

- Silo approaches
- Respecting professional identities
- Logistical considerations
- Resistance to change
- Bridging learning and practice environments

5

Interprofessional Partnerships

"Health professionals must work interdependently in carrying out their roles and responsibilities....with an appreciation of each professions unique contributions to health care."

(O'Neil and the Pew Health Professions Commission, 1998)

6

Interprofessional Partnerships

Different health care professions have evolved under their own and society's historic forces and ongoing sociological processes.

7

Interprofessional Partnerships

- Each profession has struggled to define its identity, values, sphere of practice and role in patient care.
- This has led to each health care profession working within its own silo to ensure its members (its professionals) have common experiences, values, approaches to problem-solving and language for professional tools.

(Professional cultures as Barriers , Hall)

8

Interprofessional Partnerships

- Physicians are trained to assume responsibility for decisions.
- Chronic care, geriatrics, mental health and palliative care, however, are areas where patients' needs are so complex, interprofessional teams have become necessary to provide the full spectrum of care.

9

Interprofessional Partnerships

Interprofessional team members have areas of overlapping competencies and must share varying degrees of responsibilities.

This often leads to "role blurring" due to confusion as to where one's practice boundaries begin and end.

(Falk 1977) Mariano 1999)

10

Interprofessional Partnerships

Gaps:

Can impact on safety and quality of care

Overlaps or redundancies:

Can impact on access, efficient use of resources and consistencies among professionals

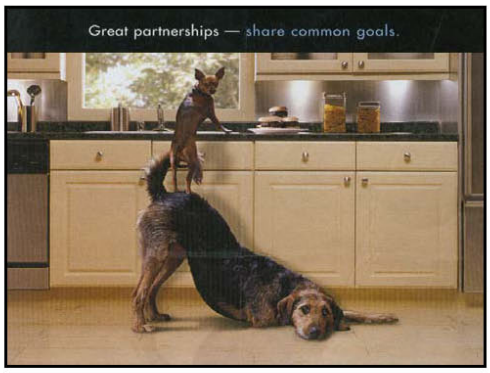
11

Interprofessional Partnerships

According to one physician the goal is to ensure:

"that everybody takes advantage of everybody else's **skill and strengths** so that the people we are trying to serve get the best kind of care and services that they can and that it is not withheld just because there are people concerned with overstepping **turf and boundaries**...working towards the same goal...work together collaboratively around problems that arise....we respect each other." (Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres)

12



Interprofessional Communication

Conflict Resolution

14

Interprofessional Communication

- Professions have different value systems instilled during the training process.
- Each of these professional values can create communication barriers between the professions.

15

Interprofessional Communication

New professionals begin their careers with interprofessional barriers of unfamiliar vocabulary, different approaches to problem-solving, and a lack of common understanding of issues and values.

Communication skills that are taught to students usually focus on interactions with patients and families from the perspective of his/her profession, not on communication across professions

16

Interprofessional Communication

A willingness to collaborate, trust, communicate with others and demonstrate respect are necessary for collaboration to work.

17

Interprofessional Communication

"Just putting people together to work does not necessarily produce effective teamwork."

Ryan, D. (2006). Tools for Facilitating Health Care Teamwork in *Multiprofessional Education in the Health Sciences*.

18

Interprofessional Communication

Every team needs a clear sense of purpose.

A clear sense of what our role is, ... for being mediators between the health centre and the community that we serve...

(Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres)

19

Interprofessional Communication requires:

- Developing trusting relationships
- Actively listening
- Communicating to ensure common understanding of care decisions
- Developing shared goals, shared care plans

20

Interprofessional Communication

Modes of communication include:

- Written
- Verbal
- Body language
- Unspoken understanding
- Cultural and Environmental cues

21

Interprofessional Communication

Successful interprofessional team functioning appears to be associated with efforts to ensure that staff are involved in critical decisions.

This does not always imply consensus.

(Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres)

22

Interprofessional Communication

"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?"

(Bill Cole, MS, MA. Founder and CEO Procoach Systems, Silicon Valley, California www.mentalgamecoach.com)

23

Conflict Resolution

"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..."

Brown, J.B., Bickford, J., Moss, K., & Gillis, L. (2007). What Makes a Team Work in a Community Health Centre?

24

Conflict Resolution

Sources of conflict:

- Poor communication
- Individual values, beliefs, personalities
- Philosophies of practice
- Modes/methods of practice
- Differing interests
- Scarce resources
- Power imbalance

25

Conflict Resolution

"if you acknowledge where the power lies. If it is brought out on the table and set forward, and say you know that you are all going to talk about this but the ultimate decisions going to be in so and so's hands....then people know what is going on and you know...that can be very liberating and people feel freer to express themselves."

(Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres)

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Strategies for Decision Making

(Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres)

- Unanimous
- One person decides
- Compromise
- Multi-voting
- Majority Voting
- Consensus

27

Conflict Resolution

Age, culture and gender all have an effect on how people engage in decision-making. Politeness, assertiveness and the importance of maintaining harmony in relationships vary by culture. (Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres)

28

Conflict Resolution

- Poor communication is one of the most pervasive barriers to conflict resolution.
- Communication between teams, sites and all levels of staff has become a challenge.

29

Conflict Resolution

Fatigue, stress and chaotic work environments can cause team members to retreat into their individual professional silos, where there is safety, clear limits, recognition of professional value and license to work autonomously.

30

Conflict Resolution

The demand for patient or client care and community involvement continues to grow and competes with meeting time,

yet,

not having the time to meet undermines the effectiveness of collaboration

31

Conflict Resolution

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.

(Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres)

32

Conflict Resolution

- Shared values are the result of listening, appreciating, building consensus and practicing conflict resolution.
- For people to understand the values and come to agree with them, they must participate in the process: unity is forged, not forced.

(Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres)

33

The following collaborative skills are essential for effective teamwork (Norsen et al., 1995):

- Cooperation
- Assertiveness
- Responsibility
- Communication
- Autonomy
- Coordination

34

Conflict Styles

Thomas, K.W. & Kilmann, R.K. (1974) *Conflict Mode Instrument. New York: XICOM.*

- Avoiding
- Accommodating
- Compromising
- Competing
- Collaborating

35

Patient/Family Centered Care

Shared Decision Making

36

Patient-Centred care

- means that the patient/client (and their family, if applicable) is at the centre of their own health care.
- involves listening to patients and families and engaging them as a member of the healthcare team when making care decisions.
- does not mean patients get exactly what they ask for, but rather that patients are working with their healthcare providers to determine health goals that are realistic and achievable.

CIHC 2010

37

Patient-Centred care

When the patient is at the centre, the healthcare system revolves around their needs rather than the needs of healthcare providers, fiscal pressures or space allocation.

CIHC 2010

38

Patient-Centred care:

- Requires a balance between the professional knowledge of care providers and the personal knowledge of the patient and their family
- Ensures the patient is listened to, valued and engaged in conversation and decision-making about their own health care needs
- Focuses on the patient's goals and the professional expertise of the team
- Adds the knowledge of all team members to the patient's self-knowledge and self-awareness.

CIHC 2010

39

Patient/Family Centered Care

Care plan goals belong to the patient

Are your patients considered a member of the team?

40

41

Collaborative patient centered practice:

- is designed to promote the active participation of each discipline in patient care.
- enhances patient and family centered goals and values
- provides mechanisms for continuous communication among care givers
- optimizes staff participation in clinical decision making within and across disciplines
- fosters respect for disciplinary contributions of all professionals

Health Canada 2003

42

Collaborative Practice

- occurs when healthcare providers work with people from within their own profession, with people outside of their profession and with patients/clients and their families.
- requires a climate of trust and value, where healthcare providers can comfortably turn to each other to ask questions without worrying that they will be seen as unknowledgeable.

When healthcare providers are working collaboratively, they seek common goals and can analyze and address any problems that arise.

CIHC 2010

43

Patient/Family Centered Care

Collaboration is the most common descriptor of teamwork in healthcare, but are we truly collaborative…..

44

Key Principles of Collaboration

Sharing

- Responsibilities
- Planning, intervention and decision making
- Health care philosophy
- Professional perspectives

45

Key Principles of Collaboration

Partnership

- Two or more individuals
- Collegial-like relationship
- Open and honest communication
- Mutual trust and respect
- Each partner values the work and perspectives of others
- A common goal or set of shared goals

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Key Principles of Collaboration

Interdependency

- Mutual dependency
- Interdependent rather than autonomous
- Individual contribution is maximized
- Output of the whole becomes much larger than the sum of the inputs of the parts

47

Key Principles of Collaboration

Power

- Shared between team members
- Simultaneous empowerment of each participant whose power is recognized by all

48

Patient Centered Primary Care Collaborative

"Purchaser Guide" Released July, 2008

49

Patient/Family Centered Care

Can patients and families easily navigate through our processes?

50

Shared Decision Making

"the process of **interacting** with patients who **wish** to be involved in arriving at an **informed**, **values-based** choice among two or more medically reasonable alternatives"

(A. M. O'Connor et al.," Modifying Unwarranted Variations In Health Care: Shared Decision Making Using Patient Decision Aids" Health Affairs, October, 2004

51

Shared Decision Making

MEDICAL CARE
Volume 39, Number 3, pp 214–231
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Determining the Need for Hip and Knee Arthroplasty: The Role of Clinical Severity and Patients' Preferences

Gillian A. Hawker, MD, MSc,*†‡§ James G. Wright, MD, MPH,†‖
Peter C. Coyte, PhD, ¶** J. Ivan Williams, PhD,†† Bart Harvey, MD, PhD,‡
Richard Glazier, MD, MPH,†§‖ Annette Wilkins, BA,** and Elizabeth M. Badley, PhD†‡§

. . . Among those with severe arthritis, no more than 15% were definitely willing to undergo (joint replacement), emphasizing the importance of considering both patients' preference and surgical indications in evaluating need and appropriateness of rates of surgery

52

Interprofessional Care Planning

- A clear and recognizable idea or goal must serve as the focus for team members in order for teamwork to succeed.
- Each member must shift from his/her specific professional focus to one requiring understanding of another's observations and interpretations.

53

Interprofessional Care Planning

- A study by Leipzig et al. in 2002 surveyed 2nd year med students, nurse practitioner students and Master's level social work students .
- Most respondents felt that the interprofessional approach benefited patients and was a productive use of time.

54

Interprofessional Care Planning

- The majority of the medical residents (80%) believed the physician had the right to change the team's patient care plans without the consent of the team and had the final word on team decisions
- 35 – 40% of the nurses and social work students agreed with this viewpoint.

55

Interprofessional Care Planning

Collaborative practice must foster a status-equal basis between the various team members

56

15

Video clips courtesy of:

University of Toronto
Office of Interprofessional Education
Collaboration in Primary Care: A professional Development multi-Media Toolkit

University of Toronto
Office of Interprofessional Education
Carole Laurin: Reflections on Interprofessional Care

University of Toronto
Office of Interprofessional Education

Ice Breakers – Team Training

Fear in a Hat

Fear in a Hat is a teambuilding exercise that promotes unity and group cohesion. Individuals write their personal fears (anonymously) on sheets of paper which are then collected in a hat and read aloud. Each person tries to describe his or her understanding of the person's fear. This leads to good discussion centered on the fears.

For the purpose of the IP Clinical Placement Project, instead of a personal fear, write down a fear that a patient may feel or encounter when they come to hospital or are in the care of your team.

Required Items/Time:

This teambuilding exercise requires writing utensils, sheets of paper, and a hat. Allow about five minutes of writing time, plus one to two minutes per participant. The recommended group size is at least eight, but no larger than 20.

Setup for Fear in a Hat:

Distribute a sheet of paper and a writing utensil to each person. Instruct them to anonymously write a fear or worry that they have (or in our case, that they can imagine their patients having). Tell them to be as specific and as honest as possible. After everyone is done writing a fear/worry, collect each sheet into a large hat.

Running the Fear in a Hat Teambuilding Activity

Shuffle the sheets and pass out one per person. Take turns reading one fear aloud, and each reader should attempt to explain what the person who wrote the fear means. Do not allow any sort of comments on what the reader said. Simply listen and go on to the next reader.

After all fears have been read and elaborated, discuss as a whole group what some of the common fears were. This teambuilding exercise can easily lead to a discussion of a team contract, or goals that the group wishes to achieve.

LISTEN Word Game

This activity can be used as a team building exercise. Individuals are asked to find as many words that they can come up with using the letters from the word LISTEN. Participants are asked to work independently initially and then share their responses aloud with their group. Answers should be recorded and the number of words achieved individually compared with the result from the group. This may be used as a lead in to discussion around collaboration, team work and collective expertise.

Required Items/Time: Writing utensils, sheets of paper and white board or flip chart to record group responses. Allow about five minutes of time for individuals to come up with their list of words, plus an additional 10 minutes for sharing responses and compiling the group list.

Examples of possible words are outlined below:

1. I
2. Is
3. It
4. In
5. Isle
6. Lie
7. Lit
8. List
9. Lint
10. Lent
11. Lien
12. Lens
13. Sin
14. Sit
15. Set
16. Sent
17. Site
18. Silt
19. Slit
20. Stile
21. Stein
22. Silent
23. Tie
24. Tin
25. Tis
26. Ten
27. Tile
28. Tine
29. Tinsel
30. Net
31. Nest
32. Nit
33. Nil
34. Nile
35. Neil

People Bingo

Bingo is one of the most popular ice breakers because it's so easy to customize for your particular group and situation, and everyone knows how to play it.
Ideal Size - Up to 30. Divide larger groups.
Use For - Introductions in the classroom or at a meeting.
Time Needed – 15 - 20 minutes, depending on the size of the group.
Materials Needed - Bingo cards (customize your own as outlined below), pens/pencils

Instructions - If you know your participants, make a list of 25 interesting traits that describe different aspects of them, things like, "plays the bongos," "once lived in Sweden," "has a karate trophy," "has twins," "collects children's art," "has a tattoo."

If you don't know your participants, make a list of more general traits like "drinks tea instead of coffee", "loves the color orange," "has two cats," "drives a hybrid," "went on a cruise in the last year." You can make these easy or difficult depending on how much time you want the game to take. If you're making your own, bingo cards have five boxes across and five boxes down. B-I-N-G-O! A simple table in Word does the trick. Fill in the boxes on a master and make copies. Leave room for signatures.
When you're ready to play, give each participant a bingo card and a pen. Explain that the group has 10 - 15 minutes to mingle, introducing themselves, and finding people who match the traits on the card. They must put the person's name in the corresponding box or have the person sign the appropriate square. The first person to fill five boxes across or down yells BINGO! and the game is over. Ask participants to introduce themselves and share one of the interesting traits they learned about someone else.
Debriefing
Debrief by asking for volunteers to share how they feel differently about the others in the group now that they know a few things about them. When we take the time to get to know each other, barriers dissolve, people open up, and learning can take place.

People Bingo (sample cards)

Has blue Eyes	Likes Spicy Food	Is going on a cruise this year	Owns a dog	Drives a red car
Has a Tattoo	Got underwear for Christmas	Is a cat lover	Is left handed	Favorite color is blue
Speaks a second language	Has 2 children		Drinks Tea	Plays on a Sports team
Seeks computer advise from kids	Does not have a cell phone	Likes to clean	Wears socks to bed	Loves cottage country
Believes in Santa	Has been hospitalized in the last year	Has never used a rotary dial phone	Remembers “Father Knows Best”	Is a reality TV junkie

People Bingo (sample cards)

Has brown Eyes	Has travelled to both the east and west coasts	Made a New Year’s resolution	Owns a fish	Does not like dessert
Has a gym membership	Likes chick flicks	Is a dog lover	Belongs to a book club	Favorite color is red
Speaks a second language	Does not have children		Drinks Tea	Is a morning person
Owns a boat	Does not have a cell phone	Has never used an iPod	Loves to cook	Loves cottage country
Loves snow	Is going on a winter vacation	Has a library card for personal use	Has gone bungee jumping	Is a reality TV junkie

Stranded on a Mountain - the team building survival game

As well as being a fun exercise, this will also give team members the chance to see what type of role they naturally take within a group. This will help with deciding on roles. You could either do the activity with the whole group or split the groups into two smaller ones.

Explain the exercise like this:

After your small light aircraft crashes, your group, wearing casual clothing, is stranded on a forested mountain in appalling winter weather (snow covered, sub-freezing conditions), anything between 50 and 200 miles from civilization (you are not sure of your whereabouts, and radio contact was lost one hour before you crashed, so the search operation has no precise idea of your location either). The plane is about to burst into flames and you have a few moments to gather some items. Aside from the clothes you are wearing which does not include coats, you have no other items. It is possible that you may be within mobile phone signal range, but unlikely.

Your aim is to survive as a group until rescued. From the following list choose just ten items that you would take from the plane, after which it and everything inside is destroyed by fire.

First you have five minutes by yourself to consider and draw up your own individual list of what the team should have, without consulting with other members of the group. Keep this list after presenting it briefly to the group. Then you have 15 minutes as a group to discuss and agree a list on behalf of the group. Nominate a spokesperson and present this new list.

Afterwards, you can discuss with the team as a whole the benefits of discussion, teamwork, collective expertise, group communication skills, etc., in the team approach to compiling the list, compared to each individual working alone to establish a list.

List of items:

- Pack of 6 boxes x 50 matches
- Roll of polythene sheeting 3m x 2m
- 1 bottle of brandy
- 1 crate of bottled spring water (twelve litres in total)
- Small toolbox containing hammer, screwdriver set, adjustable wrench, hacksaw, large pen-knife
- Box of distress signal flares
- Small basic first-aid kit containing plasters, bandages, antiseptic ointment, small pair of scissors and pain-killer tablets
- Tri-band mobile phone with infrared port and battery half-charged
- Clockwork transistor radio
- Gallon container full of fresh water
- Box of 36 x 50gm chocolate bars
- Shovel
- Short hand-held axe
- Hand-gun with magazine of 20 rounds
- 20m of 200kg nylon rope
- Box of 24 x 20gm bags of peanuts
- Box of tissues
- Inflatable 4-person life-raft
- Compass.
- Large full Aerosol can of insect killer spray
- Small half-full aerosol can of air freshener spray
- Notebook and pencil
- Travelling games compendium containing chess, backgammon & draughts
- Sewing kit
- Whistle
- Torch with a set of spare batteries
- Box of 50 night-light 6hr candles
- Bag of 6 large blankets

APPENDIX J

putting the "i" in team

Manitoba interprofessional initiative

Towards Excellence in Interprofessional Practice and Education

STUDENT MANUAL

University of Manitoba

Winnipeg Regional Health Authority
Caring for Health

Office régional de la santé de Winnipeg
À l'écoute de notre santé

Prepared by Ruby Grymonpre (IPE Initiative) in collaboration with the IP Clinical Placement Working Group, in alphabetical order [Lorene Belows (Dental Hygiene), Susan Bowman (WRHA), Kelly Brink (Pharmacy), Doug Brothwell (Dentistry), Margaret-Anne Campbell-Rempel (Occupational Therapy), Mark Garrett (Physical Therapy), Sandra Gessler (Nursing), Florette Giasson (Social Work, St Boniface College), Tuula Heinonen (Social Work), Maxine Holmqvist (Clinical Health Psychology), Tara Petrychko (Medicine), Cathy Rippin-Sisler (WRHA), Kyle Turcotte (Kinesiology and Recreation Management), Andrew West (Respiratory Therapy)

The IP Clinical Placement Working Group agreed to adopt the British Columbia Competency Framework for Interprofessional Collaboration, with permission. Available as a pdf at: http://www.chd.ubc.ca/competency

Several of the instruments included in this manual were extracted from the document entitled: "Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres: Resources, Tips and Activities you can Use to Enhance Collaboration" and from the Institute of Interprofessional Health Science Education - McMaster University, with permission [approvals from McMaster pending]

Several concepts within this manual were adapted from the document entitled: "Interprofessional Education Geriatric Care (IEGC) Reference Guide to the Seven Core Competencies" with permission. Available as a pdf at: http://www.cihc.ca/library/

CIP tk

ISBN

What is Collaborative Patient-centred Practice?

Collaboration has been defined as:

> "An interprofessional process for communication and decision making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the client/patient care provided" and expanded to "collaboration is a process that requires relationship and interaction between health professionals… and varies depending on the complexity of health care needs and the numbers of professionals working to address those needs."[1] (p.39)

Collaborative patient-centred practice is a means to address complex and varied community and individual needs. In collaborative patient-centred practice there is an awareness of and respect for the differences and strengths of each member of the team, a trust and a willingness to collaborate and communicate. A challenge for collaborative practice is that each health profession comes from a different culture, differing values, beliefs, attitudes, and behaviours. Understanding these different professional cultures also fosters trust and conveys respect to members of the team. One perspective of collaboration is:

> "That everybody takes advantage of everybody else's skill and strengths so that the people we are trying to serve get the best kind of care and services that they can and that's not withheld just because there are people concerned with overstepping turf and boundaries…working towards the same goal…work together collaboratively around problems that arise…we respect each other.[1] [physician respondent](p. 39)

1 "Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres: Resources, Tips and Activities you can Use to Enhance Collaboration"

What are the benefits of Collaborative Patient-centred Practice?

Research suggests that when team members have knowledge not only of their own skills, but also the skills of other members of the health care team, and when these teams work together with the patient to decide on a course of treatment, patient outcomes are better, and the overall job satisfaction of health care providers is improved. The personal and professional benefits of participating in collaborative practice were described by one team member:

> "Wow, the interprofessional approach…how much I learned from that…from listening to people from another profession, from working with them, hearing their perspectives on things, piecing it together…I really felt that made me a much better practitioner, because I wasn't doing tunnel vision. I had a much broader scope. It also helped me have a much better understanding and respect for other professions and what they do and what they have to put up with.[1] [social worker respondent](p. 41)

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6

Towards Excellence
in Interprofessional Practice and Education

Introduction

The goal for this project 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 expected to create an 'IP care plan' versus their traditional uni-professional care plan.

IP student sessions will run weekly according to the following format. Each week students will be expected 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 student team mid-week to create a IP care plan.
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 I 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.

This Manual has four 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 manual 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 manual 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 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 manual has four units, each corresponding to one of the following four IP competency learning domains.

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

Each unit follows a similar format: learning objectives, a brief review of the IP competency domain and an activity. In addition to developing knowledge, skills, attitudes and behaviours around the common essential principles and the delivery patient-centred care, each week, students are encouraged to focus on at least one of the four additional learning domains.

Part IV – Appendices

Most units also refer students to an Appendix containing instruments or tools to guide students as they observe their IP clinical team mentors' behaviours around a particular competency domain and as they reflect on their own and that of their student teams' behaviours.

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Towards Excellence
in Interprofessional Practice and Education

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[2]

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.

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

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.

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 II 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 III 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.

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Towards Excellence
in Interprofessional Practice and Education

PART II

Philosophical Underpinning: Patient-centred & Family-focused Care

Philosophical Underpinning: Patient-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[3]

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

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

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 IV 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.

PART III

Targeted IP Competencies: Roles & Responsibilities

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[4]

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

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

often leads to conflict or 'turf wars' and underutilization of the skills and knowledge of many members of the health care team.

Activity

Appendix V 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

Shared 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 workforce 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 VI 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

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[5]

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,

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

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 VII 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

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."[6]

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.

6 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 November 9, 2009)

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)

- 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)

- 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)

Conflict Management Strategies[7,8]

- 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

7 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).

8 Ajemian, 199318; Grant, Finnochio, and the California Primary Care Consortium Subcommittee on Interdisciplinary Collaborative Teams in Primary Care, 199519; University of Colorado Health Science Center, 199520

Activity

Appendix VIII 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:

- Observe and assess the conflict management behaviours of your IP team mentors.
- As you participate in the IP care planning session, reflect and improve upon your own and your IP student team's conflict management behaviors

APPENDIX I

Calendar

January, 2010 – Block I

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	4 Dent, Clin Hlth Psych, OT, RT, Pharm, Med IV start	5 SW starts (Tues & Wed only)	6 Nursing, starts	7	8 Dent end Hygiene pm only	9
10	11 Dent start Kin starts	12	13	14	15 Dent end Hygiene pm only	16
17	18 Dent start	19	20	21	22 Dent Hygiene pm only	23
24	25 Dent start	26	27	28	29 Dent end Hygiene pm only	30
31						

February, 2010 – Block I

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1 Dent start	2	3 Med III starts	4	5 Dent end Hygiene pm only	6
7	8 Dent start	9	10	11	12 Pharm ends Dent end	13
14	15	16 Med III ends	17	18	19	20
21	22	23	24	25	26 OT ends	27
28					SW ends Apr 30 Kin ends April 9 RT ends June 21	

February, 2010 – Block II

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15 Clin Hlth Psych, Kin, RT, SW, Nursing continue Med IV starts	16	17 Med III starts	18	19	20
21	22 Dent start Pharmacy starts	23	24	25	26 Dent end OT ends Med IV ends	27
28						

March, 2010 – Block II

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1 Dent start PT starts	2	3	4	5 Dent end	6
7	8 Dent start Med IV start	9	10	11	12 Dent end	13
14	15 Dent start	16	17	18	19 Dent end	20
21	22 Dent start	23	24	25	26 Dent end PT ends Nursing ends Med IV ends	27
28	29 Dent start	30 Med III ends	31			

April, 2010

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2 Dent ends Pharmacy ends	3
4	5 Dentistry starts	6	7	8	9 Dentistry ends Kinesiology ends	10
11	12 Dentistry starts SW ends	13	14	15	16 Dentistry ends	17
18	19 Dentistry starts	20	21	22	23 Dentistry ends	24
25	26 Dentistry starts	27	28	29	30 Dentistry ends SW ends RT continues June 21	

APPENDIX II

Helpful & Hindering Collaborative Behaviors

IP collaborative teaming requires mastery of the following competencies:[9]

Maintains interdependent relationships with interprofessional team members

- Fosters mutual trust and respect within the established IP team
- Shares responsibility for team actions
- Ensures that good communication is maintained across settings and over time
- Contributes to team cohesion by celebrating successes, acknowledging contributions, and supporting others during times of difficulty and crisis

Has a critical understanding of IP team structures, effective team functioning and knowledge of group dynamics

- Is aware of the dynamic nature of teams and operates with flexibility
- Identifies which team member will take the appropriate facilitator role in specific contexts
- Understands that compromise may be necessary to reach consensus

Reflects on team functioning in order to identify dysfunctional processes

- Is aware of how one's feelings and behaviours affect other members of the team
- Is aware that professional and cultural differences may produce misunderstanding

9 British Columbia Competency Framework for Interprofessional Collaboration

- Is observant of inequalities and disrespect within the team and is able to diplomatically address these issues

Facilitates IP team meetings

- Monitors and controls the team's balance between process and task
- Keeps group focused on agreed upon goals
- Mediates in conflict situations
- Synthesizes and summarizes team interactions and decisions

Can act as a representative linking the IP team and outsiders

- Conveys decisions made by the team to others
- Relays outside information to the team
- Knows what information is relevant to whom

Collaboration Audit[10]

Rate the extent to which you agree or disagree with each statement that describes the actions of people in your team, teams or organization. Use the following scale to indicate your level of agreement or disagreement.
There are 5 questions per page for ease of photocopying

Strongly Agree	5
Agree	4
Neither Agree Or Disagree	3
Disagree	2
Strongly Disagree	1

In this team, people …

_____ 1. Act in a trustworthy and trusting manner.

_____ 2. Ask others for help and assistance when needed.

_____ 3. Treat others with dignity and respect.

_____ 4. Talk openly about feelings.

_____ 5. Listen attentively to the opinions of others.

_____ 6. Express clarity about the group's goals.

10 "Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres: Resources, Tips and Activities you can Use to Enhance Collaboration" p.46

_____ 7. Make personal sacrifices to meet a larger group goal.

_____ 8. Can rely on each other.

_____ 9. Pitch in to help when others are busy and running around.

_____ 10. Give credit to others for their contribution.

_____ 11. Interact with each other on a regular basis.

_____ 12. Treat every relationship as it will last for a lifetime, even if it won't.

_____ 13. Make it their business to introduce their colleagues to people who can help them succeed.

_____14. Freely pass along information that might be helpful to others.

_____ 15. Relate well to people of diverse backgrounds and interests.

Team Effectiveness Survey [11]

Instructions: Please give your candid opinion of this team by rating its characteristics on the seven-point scale shown below. Circle the appropriate number on each scale to represent your evaluation. Do not put your name on this. Return the survey in the envelope provided.

1. Goal Clarity

Are goals and objectives clearly understood and accepted by all members?

1	2	3	4	5	6	7
Goals and objectives are not known, understood or accepted						Goals and objectives are clear and accepted

2. Participation

Is everyone involved and heard during group discussions or is there a "tyranny of a minority"?

1	2	3	4	5	6	7
A few people tend to dominate						Everyone is active and has a say

3. Consultation

Are team members consulted on matters concerning them?

1	2	3	4	5	6	7
We are seldom consulted						Team members are always consulted

4. Decision Making

Is the group both objective and effective at making decisions?

1	2	3	4	5	6	7
The team is ineffective at reaching decisions						The team is very effective at reaching decisions

5. Roles and Responsibilities

When action is planned, are clear assignments made and accepted?

1	2	3	4	5	6	7
Roles are poorly defined						Roles are clearly defined

11 "Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres: Resources, Tips and Activities you can Use to Enhance Collaboration" (p. 10-12)

6. Procedures

Does the team have clear rules, methods and procedures to guide it? Are there agreed-upon methods for problem-solving?

1	2	3	4	5	6	7
There is little structure and we lack procedures						The team has clear rules and procedures

7. Communications

Are communications between members open and honest? Do members listen actively?

1	2	3	4	5	6	7
Communications are not open; not enough listening						Communications are open; people listen to each other

8. Confronting Difficulties

Are difficult or uncomfortable issues openly worked through or are conflicts avoided? Are conflicts worked through?

1	2	3	4	5	6	7
Difficulties are avoided; little direct conflict management						Problems are attacked openly and directly

9. Openness & Trust

Are team members open in their transactions? Are there hidden agendas? Do members feel free to be candid?

1	2	3	4	5	6	7
Individuals are guarded and hide motives						Everyone is open and speaks freely

10. Commitment

How committed are team members to deadlines, meetings and other team activities?

1	2	3	4	5	6	7
Deadlines and commitments often missed						Total commitment

11. Support

Do members pull for each other? What happens when one person makes a mistake? Do members help each other?

1	2	3	4	5	6	7
Little evidence of support						Lots of support

12. Risk Taking

Do individuals feel that they can try new things, risk failure? Does the team encourage risk?

1	2	3	4	5	6	7

Little support for risk — Lots of support for risk

13. Atmosphere

Is the team atmosphere informal, comfortable and relaxed?

1	2	3	4	5	6	7

The team spirit is tense — The team is comfortable and relaxed

14. Leadership

Are leadership roles shared, or do the same people dominate and control?

1	2	3	4	5	6	7

A few people dominate — Leadership is shared

15. Evaluation

Does the team routinely stop and evaluate how it's doing in order to improve?

1	2	3	4	5	6	7

We never evaluate — We routinely evaluate

16. Meetings

Are meetings orderly, well planned and productive?

1	2	3	4	5	6	7

Waste of time — Couldn't be better

17. Fun

Is there an "esprit de corps", or sense of fun, on this team?

1	2	3	4	5	6	7

Humbug! — We have fun

Meeting Effectiveness Survey[12]

Please give your candid opinions of the meeting you attended as part of this team. Rate each characteristic of the meetings by circling the number that applies.

1. Meeting Objectives

Are the objectives set out in advance of the meeting?

1	2	3	4	5	6	7
Objectives are seldom set out in advance						Objectives are always set out in advance

2. Communication

Are agendas circulated to all members in advance of the meeting?

1	2	3	4	5	6	7
Agendas are rarely circulated in advance						Agendas are always circulated in advance

3. Start Times

Do meetings start on time?

1	2	3	4	5	6	7
Meetings hardly ever start on time						Meetings always start on time

4. Time Limits

Are there time limits for each agenda item?

1	2	3	4	5	6	7
We do not set time limits						Time limits are set for each item

5. Meeting Review

Are action items brought forward from the previous meeting?

1	2	3	4	5	6	7
Items are seldom brought forward						Items are always brought forward

12 "Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres: Resources, Tips and Activities you can Use to Enhance Collaboration" (p. 79-82)

6. Warm up

Is there a meeting warm up to hear from all members?

1	2	3	4	5	6	7
We seldom use a meeting warm up						We often use a meeting warm up

7. Role Clarity

Are roles (timekeeper, scribe, facilitator) made clear?

1	2	3	4	5	6	7
Roles are not defined						Roles are always clearly defined

8. Setting

Is there a quiet place for the meeting with ample work space, flipcharts and AV support?

1	2	3	4	5	6	7
The meeting place is not well suited						The meeting place is very good

9. Process

Is there clarity before each topic as to how that item will be managed?

1	2	3	4	5	6	7
There is rarely any planning on process						There is always clarity on process

10. Preparation

Does everyone come prepared and ready to make decisions?

1	2	3	4	5	6	7
We are often unprepared						We are generally prepared

11. Interruptions

Are meetings disrupted due to people leaving, phones ringing, pagers beeping, etc?

1	2	3	4	5	6	7
There are constant interruptions						We control interruptions

12. Participation

Are all members fully exchanging views, taking responsibility for actions and follow up?

1	2	3	4	5	6	7
People hold back and do not take ownership						Everyone offers ideas and takes action

13. Leadership

Does one person make all the decisions or is there a sharing of authority?

1	2	3	4	5	6	7
The manager holds the chair and makes most decisions						Authority is shared

14. Pace

How would you rate the pace of the meeting?

1	2	3	4	5	6	7
Poor						Just right

15. Tracking

Do meetings stay on track and follow the agenda?

1	2	3	4	5	6	7
Meetings often stray off track						Meetings usually stay on track

16. Record Keeping

Are quality minutes kept and circulated?

1	2	3	4	5	6	7
Rarely kept and circulated						Always kept and circulated

17. Listening

Do members practice active listening?

1	2	3	4	5	6	7
We don't listen closely to each other						Everyone listens actively to each other

18. Conflict Management

Are differences of opinion suppressed or is conflict effectively used?

1	2	3	4	5	6	7
Conflict isn't very effectively used						Conflict is effectively exploited for new ideas

19. Decision Making

Does the group generally make good decisions at our meetings?

1	2	3	4	5	6	7
We tend to make poor decisions						We tend to make good decisions

20. Closure

Do we tend to end topics before getting into new ones?

1	2	3	4	5	6	7
We often start a new topic before closing another				We close each topic before moving on		

Team Communication Observation Guide[13]

SET THE STAGE	COMMENTS
• Greet and introduce each other • Clarify roles • Demonstrate interest and respect	

NEGOTIATE AGENDA	COMMENTS
• Perspective of each team member is taken into account • Establish reason for meeting e.g. issues, priorities, timelines • Establish team roles e.g. chair, recorder	

ESTABLISH COMMON GOALS/PLANS	COMMENTS
• Input from all team members is ensured • Various techniques are used to clarify statements • Identify, confirm and priorize problem list • Check mutual understanding of subsequent interventions • Reach agreement on next steps eg. information and resources needed, how it will be obtained and by whom	

13 Team Communication Observation Guide, Interprofessional Education Program, Faculty of Health Sciences, McMaster University (2005), Unpublished

DEMONSTRATE RESPECT FOR OTHER TEAM MEMBERS/BUILD RELATIONSHIPS	COMMENTS
• Demonstrate appropriate verbal and nonverbal behaviour e.g. tone, pace, eye contact, posture, facial expression • Express understanding and willingness to help and share opinions • Deal sensitively with each other's concerns • Acknowledge accomplishments / progress / challenges • Members listen attentively e.g. do not interrupt	

DEMONSTRATE CLIENT-CENTRED FOCUS	COMMENTS
• Maintain respectful language (verbal and nonverbal) when discussing clients and in the presence of clients • Attend to all information and direct contact by expressing caring, concern and empathy • Ensure client involvement is appropriate e.g. client's knowledge/ interest/expectations/goals/ values/culture • Modify treatment/prevention plans to meet client(s) needs	

MAKE TEAM DECISIONS	COMMENTS
• Team members share responsibility for actions of the team as a group • Understanding and acceptance of the plan is checked • Team members demonstrate ability to give and receive feedback e.g. feedback is focused on behaviour not personality traits, feedback is focused on exploration of alternatives and is descriptive not judgmental • Effective strategies are used to resolve conflict e.g. outside consultant • Meetings are closed by summarizing progress and next steps	

APPENDIX III

Interprofessional Care Planning

Interprofessional Care Plan

Client identifier: _____

Patient Issue(s) [in order of priority]	Planned Intervention(s) [Who, What]	Desired Outcome(s) [Goal – SMART]	Timeline [When]	Follow-up [progress]

APPENDIX IV

Patient-centred & Family-focused Care

Patient and family centred care involves mastery of the following competencies:[14]

Involves the patient /client and family as partners in group decision –making processes

- Actively encourages patients and families to express their feelings and needs as part of an interprofessional team
- Interacts with other professionals to consistently promote and support patient/client and family participation and autonomy
- Promotes an environment of respect for the patient/client and family fostering a feeling of comfort within the team
- Ensures utilization of team communication strategies appropriate for the patient/client and their family
- Fosters non-judgemental and inclusive attitudes by the team towards patient/clients and families
- Shares options and healthcare information based on upon team discussions with patient/clients and families to foster informed choice
- Identifies patient/client's social determinants of health with the team and engages appropriate collaborators

Ensures continuous integration of patient/clients and families into the team in order to maintain optimal, evolving care:

- Remains responsive to the changing needs of the patient/client and family as a member of the team
- Strives to strengthen and build the relationship between the patient/client, family and all relevant care providers
- Ensures that appropriate education and support is provided by the team for family members and others involved with the patient/client's care
- Advocates self-care, disease prevention, and wellness as part of the team's mandate to promote a healthy lifestyle

14 British Columbia Competency Framework for Interprofessional Collaboration

Kalamazoo Observation Guide

Effective Communication[15]

DATE _____ INTERVIEW/SCENARIO _____

Builds Relationship	Comments
• Greets and shows interest in patient as a person • Uses words that show care and concern throughout the interview • Uses tone, pace, eye contact, and posture that show care and concern	
Opens Discussion	**Comments**
• Allows patient to complete opening statement without interruption • Asks "Is there anything else?" to elicit full set of concerns • Explains and/or negotiates an agenda for the visit	
Gathers Information	**Comments**
• Begins with patient's story using open-ended questions (e.g. "tell me about…") • Clarifies details as necessary with more specific "yes/no" questions • Summarizes and gives patient opportunity to correct or add information • Transitions effectively to additional questions	

15 Adapted by Carl deLottinville (2006) from Essential Elements of Communication in Medical Encounters: The Kalamazoo Consensus Statement. Participants in the Bayer-Fetzer Conference on Physician-Patient Communication in Medical Education. *Academic Medicine*, 2001; 76:390-393

Understands Patient's Perspective	Comments
• Asks about life events, circumstances, other people that might affect health • Elicits patient's beliefs, concerns and expectations about illness and treatment • Responds explicitly to patient's statements about ideas and feeling	
Shares Information	Comments
• Assesses patient's understanding of problem and desire for more information • Explains using words that patient can understand • Asks if patient has any questions	
Reaches Agreement	Comments
• Includes patient in choices and decisions to the extent he/she desires • Checks for mutual understanding of diagnostic and/or treatment plans • Asks about patient's ability to follow diagnostic and/or treatment plans • Identifies additional resources as appropriate	
Provides Closure	Comments
• Asks if patient has questions, concerns or other issues • Summarizes • Clarifies follow-up or contact information • Acknowledges patient and closes interview	

ADDITIONAL COMMENTS:

APPENDIX V

Roles & Responsibilites

IP collaborative team members who understand and value the unique roles and responsibilities of various members of the health care team will demonstrate the following competencies:[16]

Has sufficient confidence in and knowledge of one's own discipline to work effectively with others in order to optimize patient/client care:

- Demonstrates ability to share discipline specific knowledge with other health care professionals
- Negotiates actions with other health care professionals based on one's own role constraints and discipline specific ethical and legal practices
- Shares one's professional culture and values to help others understand one's own point of view

Has sufficient confidence in and knowledge of others' professions to work effectively with others in order to optimize patient/client care:

- Actively seeks out knowledge regarding others' scopes of practice
- Understands how others' skills and knowledge compliment and may overlap with one's own
- Negotiates actions with other health care professionals based on an understanding of other disciplinary role constraints, overlap of roles and discipline specific ethical and legal practices
- Respects others' professional culture and values in order to understand their frame of reference

16 British Columbia Competency Framework for Interprofessional Collaboration

Diversity of Values, Beliefs and Strengths Handout[17]

The following questions relate to your work as a member of your profession, discipline or area of work.

1. My professional training and education and/or background prepared me well for…

2. My profession, discipline or area of work places a high value on…

3. My profession, discipline or area of work encourages me to…

4. The strengths of my profession, discipline or area of work are…

5. What I like most about my profession, discipline or area of work is…

17 "Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres: Resources, Tips and Activities you can Use to Enhance Collaboration" (p. 45)

Profession Name:
What do we do? (Some clear statement of the main purpose of the profession. This can include indications of the scope of practice):
Why do we do what we do? (Main Elements of this Professional Philosophy):
Who do we work with? (Suggestions of the main client/patient groups with whom we work):
Where do we work? (Examples of typical work environments for this profession):
What are the unique features of this profession's practice? (This is the place to highlight the special inputs that your profession can add to any team process):
What else is helpful to know? (Use this space to provide special insights and information that will help others understand more about your profession and your role):

Profession Role Template Interprofessional Education Program, Faculty of Health Sciences, McMaster University (2005), Unpublished

APPENDIX VI

Shared Decision-making

IP decision making requires mastery of the following competencies:[18]

- Establishes interdependent relationships with other health care providers
  - Negotiates ground rules to create a safe environment for collaboration
  - Respects others' contributions and work ethic
  - Is able to determine whom to involve depending on the needs of the patient/client
- Shares decision-making with others
  - Establishes and focuses on common goals
  - Identifies patient/client-centred goals
  - Implements joint decisions once all options and evidence are provided and discussed
- Maintains professional conduct during IP encounters
  - Develops, promotes and exercises non-judgemental and inclusive practice respecting other cultures, values and belief systems
  - Practices ethical behaviour in all professional activities
  - Displays integrity, honesty and social responsibility
  - Adheres to standards of practice (e.g. avoids conflicts of interest)

18 British Columbia Competency Framework for Interprofessional Collaboration

Six Decision Making Processes[19]

#1 Unanimous - This happens occasionally when there is solution that is favoured by everyone and 100% agreement seems to be automatic. Unanimous decisions are usually made quickly. They are fairly rare and often occur in connection with trivial or simple issues.

#2 One person decides - This is a decision that the group decides to refer to one person to make on behalf of the group. A common misconception among teams is that every decision needs to be made by the whole group. In fact, one person decisions can be a fast and more efficient way to make group decisions. The quality of any one person decision can be raised considerably if the person making the decision gets advice and input from other group members before deciding.

#3 Compromise - A negotiated approach when there are two or more distinct options and members are strongly polarized (neither side is willing to accept the solution put forward by the other side). A middle position is created that incorporates issues from both sides. Everyone wins a few of their favourite points but also loses a few items they liked. The outcome is something that no one is totally satisfied with. In compromises, no one feels that they got what they wanted so the emotional reaction is often, "It's not really what I wanted but I am going to have to live with it".

#4 Multi-voting - This is a priority setting tool that is useful in making decisions when the group has a range of options before them and ranks the options based on a set of pre established criteria. Dot-motcracy is an example of multi-voting.

#5 Majority Voting - Involves asking people to choose the option they favour once clear options have been identified. Usual methods are a show of hands or secret ballot. The quality of the voting is always

19 "Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres: Resources, Tips and Activities you can Use to Enhance Collaboration" (p. 55)

enhanced if there is good discussion to share ideas before the vote is taken.

#6 Consensus - Involves everyone clearly understanding the situation or problem to be decided, analyzing all of the relevant facts together and then jointly developing solutions that represent the whole groups' best thinking about the optimal decision. Consensus is characterized by a lot of listening, healthy debates and testing of options resulting in a decision which everyone says, "I can live with it".

Advantages/Disadvantages of the Various Decision-Making Processes[20]

METHOD	ADVANTAGES	DISADVANTAGES	WHEN TO USE
Unanimous	Fast, easy, everyone is happy, unites the group	Too fast, perhaps the issue actually needed more discussion and debate	OK when discussion isn't vital on trivial or simple matters
One person decides	Can be fast, accountability is clearly spelled out	Can divide the group if the person deciding doesn't consult and makes a decision that others cannot live with. Lack both the buy-in and the synergy of a group decision	When the issue is unimportant or small, when there is a clear expert in the group who can make the decision, when only one person has the information and is unable to share it, when one person is solely accountable for the outcome
Compromise	Lots of discussion, creates a solution from seemingly very different options	Negotiating can be adversarial if people are pushing their point of view and there are power imbalances, this approach can divide the group, everyone wins but everyone also loses	Compromise is often the only alternative when faced with a strongly polarized group and when there are two options proposed, neither of which is acceptable to everyone

20 "Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres: Resources, Tips and Activities you can Use to Enhance Collaboration" (p. 56-57)

METHOD	ADVANTAGES	DISADVANTAGES	WHEN TO USE
Multi-Voting	Systematic, objective, democratic, non-competitive, reduces power imbalances, everyone wins somewhat, a fast way of sorting out a complex set of options	Often associated with limited discussion and understanding of options, forces choices that may not be satisfactory for people, real priorities may not have surfaced	When there is a long list of alternatives or items to choose from or when applying a set of criteria to potions identifies the best course of action
Majority Voting	Fast, high quality if used after thorough analysis, creates a clear decision	Can be too fast and low in quality if people vote their personal feelings without the benefit of each other's thoughts, creates winner and loser, hence can divide the group, the show of hands method puts people under pressure to conform	When there are two distinct possibilities and one or the other must be chosen, to decide items where a division in the group is acceptable. When consensus has been attempted and can't be reached. When un acknowledge power imbalances could prevent a consensus process
Consensus	A collaborative effort that unites the group, high involvement, systematic, objective, fact driven, builds buy in and high commitment to the outcome	Time consuming, low quality if done without the proper data collection or if members have poor group skills. Power relations can affect the outcome if not explicit	He most effective decision making process for important decisions where the ideas of the whole group are needed and buy in from all members is essential. The importance of the decision being made must be worth the time it takes to complete the consensus process properly

Behaviours That Help/Hinder Decision Making[21]

HELPFUL BEHAVIOURS	HINDERING BEHAVIOURS
Listening to others' ideas politely even when you disagree	Interrupting people to promote your personal views
Paraphrasing the main points made by another person to acknowledge their ideas	Not acknowledging the ideas that others have put on the table
Praising others' ideas or giving useful feedback	Criticizing or putting down others' ideas
Building on others' ideas	Pushing your ideas while ignoring others' input
Asking others to critique your ideas and accepting feedback	Getting defensive when your ideas are analyzed
Being open to accepting alternative course of action	Staying stuck on your ideas and blocking suggestions for alternatives
Dealing with facts	Basing arguments on feelings
Staying calm and friendly toward colleagues	Getting overly emotional; showing hostility in the face or any disagreement
Being open about your reservations and concerns	Keeping objections to yourself.

21 "Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres: Resources, Tips and Activities you can Use to Enhance Collaboration" (p. 58)

APPENDIX VII

Interprofessional Communication

IP collaborative teaming requires mastery of the following competencies:[22]

- Effectively expresses one's own knowledge and opinions to others involved in care
  - Demonstrates confidence and assertiveness to express one's views respectfully and with clarity
  - Employs language understood by all involved in care and explains discipline-specific terminology
  - Explains rationale for opinions
  - Evaluates effectiveness of communication and modifies accordingly
- Actively listens to the knowledge and opinions of other team members
  - Listens to and shows genuine interest in the perspectives and contributions of others
  - Is observant and respectful of non-verbal as well as verbal communications
  - Confirms that one understands all ideas and opinions expressed
- Uses information systems and technology to exchange relevant information among all professionals to improve care
  - Uses technology and other tools to keep others continuously updated
  - Is aware of an uses information resources from other professions
  - Plans and documents care on a shared health record

22 British Columbia Competency Framework for Interprofessional Collaboration

APPENDIX VIII

Conflict Anaylsis & Management

Conflict avoidance and management requires mastery of the following competencies:[23]

- Resolves conflicts with others when disagreements arise related to opposing opinion, decisions viewpoints
  - Understands issues that may contribute to the development of conflict
  - Acknowledges that conflict can be productive
  - Ensures conflicts are addressed before they become counterproductive
  - Uses mechanism for conflict resolution if conflict escalates
- Maintains flexibility and adaptability when working with others
  - Re-evaluates one's own position in light of new information from others
  - Cooperates with others involved in care
  - Ensures that complexity, uncertainty and other stressful situations do not negatively affect relationships
  - Ensures that conflict does not affect the care of the patient/client and that the patient/client remains the central focus of the team

23 British Columbia Competency Framework for Interprofessional Collaboration

Conflict Management Styles Handout[24]

Avoiding

Is hoping the problem will go away and not addressing the conflict. There is no attention to one's own needs or those of the other. Avoiding might be letting an issue go, being diplomatic or simply withdrawing from a threatening situation. This tool is effective when time, place or personal health make it inadvisable to pursue discussion.

Accommodating

Is meeting the concerns and needs of the other person and not addressing your own needs. This is giving in or yielding to the other person's views. This style is used when you want to work co-operatively with the other person without trying to assert your own concerns.

Compromising

Is looking for a mutually acceptable solution which somewhat satisfies both parties. You give up something, they give up something in order to come up with a solution you both can agree to. A compromise approach may work when you and the other person both want the same thing and you know you both can't have it.

24 "Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres: Resources, Tips and Activities you can Use to Enhance Collaboration" (p. 70)

Competing

Is a strong style where the individual uses their power or control of the resources to assert his or her own needs. Competing can mean trying to win, getting your own way, and is used when there is no concern for the other person's interests. The style is helpful when an important principle or need is at stake.

Collaborating

Is working toward solutions that satisfy the needs and concerns of both parties. This takes time to look at the all the issues and interests you both have which are behind the original positions. This approach combines the search for new alternatives and creating solutions that end in a "win-win" situation.

Personal Conflict Management Styles[25]

1. Describe the conflict management style you most frequently use at work.

2. Describe the conflict management style you most frequently use at home.

3. Describe the conflict management style you usually use with friends.

4. Describe a conflict management style that tends to irritate you. Why?

5. Describe a conflict management style that you admire in others. Why?

25 "Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres: Resources, Tips and Activities you can Use to Enhance Collaboration" (p. 71)

Conflict Analysis Tool[26]

If you do not have the opportunity to observe conflict in the clinical setting, the following scenarios have been provided for conflict analysis. Discuss your views with other members of your IP student team during the weekly debrief.

1. List all the factors that are contributing to the conflict.

2. Who is involved? Directly or indirectly?

3. What is the effect of the conflict on people? On the work?

4. What are the interests of each of the parties (Concerns, Hopes, Expectations, Fears, Beliefs, Assumptions, Priorities)?

5. What conflict styles are being used?

6. What conflict styles might be more appropriate?

7. List all the possible ways that this conflict might be resolved.

26 "Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres: Resources, Tips and Activities you can Use to Enhance Collaboration" (p. 72)

Conflict Case Scenarios[27]

Scenario 1

A social worker was asked to do something for the team leader in very little time. The work was completed in the time specified. The team leader then returned it with a 'post it' attached that said: 'Please re-do, there are many pieces missing.' The pieces were, in fact, not missing. The social worker went back and asked the team leader for

a few minutes to chat at the team leader's convenience. The response was: 'It's not a good time but sit down anyways'; he proceeded to tell the social worker how disappointed he was with the work that she had done. When the social worker tried to point out that the missing pieces were on the reverse side of the page, she felt unheard. The team leader proceeded to highlight additional errors. His body language continued to be dismissive and there was no appreciation for the work that had been done in the short timeline.

Scenario 2

Several people in one particular position at a CHC were hired and then left over the course of a year. Staff noticed this turnover and started talking among themselves about whether these individuals were getting fired and what they must have done. There was a sense of foreboding lingering around the CHC. Gossip started and staff started talking behind each other's backs about who was next. People felt under threat and less able to speak their minds.

27 "Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres: Resources, Tips and Activities you can Use to Enhance Collaboration" (p. 73)

Scenario 3

A team in a small Community Health Centre is made up of a variety of disciplines. Staff feel that people are treated equally, except for one particular situation. There is a high incidence of diabetes in the community and the centre has developed an education program to address this. The health promoter, the dietician, the nurse practitioner and the physician all had a role to play in the workshop. But it seemed that the time of the physician and nurse practitioner was more valuable. The health promoter and dietician were the ones who had to do all the advertising, room set up, getting refreshments ready and cleaning up after the workshop. The physician and the nurse practitioner came in for a few minutes and presented their part of the workshop and then left. The routine tasks are not something the physician and nurse practitioner volunteer to do, nor are they directly asked to help with.

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APPENDIX K

PRECEPTOR EVALUATION: POST-EXPERIENCE

Feedback on the Experience:

For each statement, please circle the number that most accurately reflects your feelings about the IP Clinical Placement Project. This information will be used to evaluate and improve the overall content and format of the project. Your feedback is important to us and it would be greatly appreciated if you would provide answers to all of the questions. Please remember that all information you provide is confidential, and will be reported in group format based on feedback from a number of preceptors (individual responses will not be identified); please answer as honestly as possible.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	No respons
Content:						
The teaming competencies are important for health and social care professionals.	1	2	3	4	5	
The educational content focused on the important aspects of interprofessional (IP) teaming.	1	2	3	4	5	
The educational content is relevant to health care practice in the setting that I practice	1	2	3	4	5	
Student Educational Format:						
The IP Clinical Placement Project, as a whole, was well organized	1	2	3	4	5	
The overall format (interactive, learning in context) was conducive to learning	1	2	3	4	5	
The amount of time provided to cover the educational content was appropriate	1	2	3	4	5	
The workload for the student required by the educational component was excessive.	1	2	3	4	5	
The 'setting directions' session was a useful way to inform students of expectations for the upcoming week.	1	2	3	4	5	
The 'debriefing' session was a useful way for students to reflect on and reinforce their learning over the week	1	2	3	4	5	
The IP care planning session was an excellent format to learn interprofessional team competencies	1	2	3	4	5	
Facilitator/Preceptor Role:						
The IP Clinical Placement Project was a burden to my existing workload.	1	2	3	4	5	
I had some say about how the IP Clinical Placement Project was implemented on my unit	1	2	3	4	5	
I am a valuable member of my site team	1	2	3	4	5	
Overall Experience:						
This experience is important for students from ALL health care disciplines	1	2	3	4	5	
I would recommend this experience to future students	1	2	3	4	5	
Overall, I found the IP Clinical Placement Project to be well organized	1	2	3	4	5	

Jan 21, 2010

…….Continued on back side……

If you indicated ‘Strongly Disagree’ to any question (or conversely ‘Strongly Agree’ to a negatively worded question), please indicate which question and provide an explanation:

_____

_____

_____

_____

What did you particularly like about this experience?

_____

_____

_____

_____

What suggestions do you have to improve the content and/or format of the IP Clinical Placement Project for future students?

_____

_____

_____

_____

Additional comments?

_____

_____

_____

STUDENT EVALUATION: POST-EXPERIENCE

Feedback on the Experience:

For each statement, please circle the number that most accurately reflects your feelings about the IP Clinical Placement Project. This information will be used to evaluate and improve the overall content and format of the project. Your feedback is important to us and it would be greatly appreciated if you would provide answers to all of the questions. Please remember that all information you provide is confidential, and will be reported in group format based on feedback from a number of students (individual responses will not be identified); please answer as honestly as possible.

	Strongly Disagre	Disagre e	Neutral	Agree	Strongly Agree
Content:					
The teaming competencies presented are important for health care professionals.	1	2	3	4	5
The educational content focused on the important aspects of interprofessional (IP) teaming.	1	2	3	4	5
The educational content is relevant to my future practice	1	2	3	4	5
I will use *at least some* of the information provided in my future practice	1	2	3	4	5
I will use *a great deal* of the information provided in my future practice	1	2	3	4	5
The educational content met the learning objectives stated in each unit of the student manual	1	2	3	4	5
The Appendices to the manual were a relevant part of the training	1	2	3	4	5
Educational Format:					
The IP Clinical Placement Project, as a whole, was well organized	1	2	3	4	5
The overall format (interactive, in context) was conducive to my learning	1	2	3	4	5
There was not enough time to interact with team members during group sessions	1	2	3	4	5
The amount of time provided to cover the educational content was appropriate	1	2	3	4	5
The clinical site in which the training took place was conducive to my learning	1	2	3	4	5
The workload required by the educational component was excessive	1	2	3	4	5
The opening 'setting directions' session helped me understand expectations of the week	1	2	3	4	5
The closing 'debriefing' session helped me reflect and reinforce what I learned over the week	1	2	3	4	5
The IP care planning session was an excellent format to learn interprofessional team competencies	1	2	3	4	5
About the Facilitators/Preceptors:					
The facilitators/preceptors were knowledgeable in the area of interprofessional teaming	1	2	3	4	5
The facilitators/preceptors were organized and presented the material clearly	1	2	3	4	5
The facilitators/preceptors encouraged student feedback	1	2	3	4	5
During each group session, I felt comfortable contributing to the discussion	1	2	3	4	5

Jan 21, 2010

……..Continued on back side……..

Overall Experience:	**SD**	**D**	**N**	**A**	**SA**
This experience was a valuable part of my education	1	2	3	4	5
This experience is important for all health care disciplines	1	2	3	4	5
I would recommend this experience to other students	1	2	3	4	5
My interest in working on this particular unit ___surgery___(specify) has increased as a result of this experience	1	2	3	4	5
I have gained an overall understanding of what a healthy interprofessional collaborative team looks like	1	2	3	4	5
The IP Clinical Placement Project provided me with a strong skill base in interprofessional teaming	1	2	3	4	5

If you indicated 'Strongly Disagree' to any question (or conversely 'Strongly Agree' to a negatively worded question), please indicate which question and provide an explanation:

_____
_____
_____
_____

What did you particularly like about this experience?

_____
_____

What suggestions do you have to improve the content and/or format of the IP Clinical Placement Project for future students?

_____
_____
_____

Additional comments?

_____
_____
_____
_____

Thank you for completing this evaluation form!

APPENDIX L

Winnipeg Regional Health Authority
Research and Evaluation

Office régional de la santé de Winnipeg
Recherche et évaluation

Inter-Professional Clinical Placement Project

Student and Preceptor Post-Experience

June 2010

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Research Associate

Analysis provided by:
Winnipeg Regional Health Authority
Research & Evaluation Unit
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Background

The WRHA Research and Evaluation Unit was asked to analyze the survey forms received from students and preceptors who underwent an Inter-Professional Clinical Placement Project (IPCPP) experience. The purpose of the survey was to summarize student and preceptor reflections on the IPCPP experience. The student and preceptor survey forms consisted of 26 student and 16 preceptor five point Likert scale (strongly disagree to strongly agree) items along with four open ended questions.

Analysis of this evaluation is divided into two parts: students post project experience and preceptors post project experience.

Students Post – Inter Professional Clinical Placement Experience

QUANTITATIVE ANALYSIS

In total, 29 students participated in the IPCPP at four (4) different sites. Thirteen (13) of these students completed the survey forms (response rate: 45%). To maintain anonymity of the respondents' identity, the total number of respondents per site is not being reported. Due to human error some students received preceptor survey forms instead of student survey forms. Two of the survey forms returned by students were preceptor survey forms. These two student responses were included only if the item was worded the same as the one in the student survey form.

Educational Content: This component consisted of seven items with each item to be rated on a 1-to-5 Likert response scale.

1. The teaming competencies presented are important for health care professionals (N=13)

A mean of 4.46 indicates agreement with the statement. Ninety-two percent (92 %) of the student respondents agreed or strongly agreed that the teaming competencies presented are important for health care professionals; 8% were neutral.

2. ***The educational content focused on the important aspects of inter-professional teaming (N=13)***

A mean of 4.15 indicates agreement with the statement. Ninety-two percent (92 %) of student respondents agreed or strongly agreed that the educational content focused on the important aspects of inter-professional teaming; 8% were neutral.

3. The education content is relevant to my future practice (N=13)

A mean of 4.23 indicates agreement with the statement. Ninety-two percent (92 %) of student respondents agreed or strongly agreed that the educational content is relevant to their future practice; 8 % were neutral.

4. I will use at least some of the information provided in my future practice (N=11)

A mean of 4.2 indicates agreement with the statement. All (100%) student respondents indicated that they will use at least some of the information in their future practice.

5. I will use a great deal of the information provided in my future practice (N=11)

The mean is 3.45 to this statement with 9% disagreeing, 36% being neutral and 55% agreeing that they will use a great deal of the information in their future practice. The mean may be correct because respondents were exposed to IPCPP for the first time and other factors such as, organization and communication influenced their response to this statement. When comparing this statement with the previous statement (no. 4) it is possible that, in future, the majority of students may agree/strongly agree with this statement that they will use the information a great deal if the project is re-implemented after incorporating suggestions provided in the narratives to this survey.

6. The educational content met the learning objectives stated in each unit of the student manual (N=11)

A mean score of 2.9 indicates a neutral opinion overall. Nine percent of student respondents did not respond to this statement; 9% disagreed, 46% were neutral, and only 36% agreed that the educational content met the learning objectives as stated in each unit of the student manual.

7. The Appendices to the manual were a relevant part of the training (N=11)

A mean score of 3.36 indicates a neutral opinion. Eighteen percent of student respondents either strongly disagreed or disagreed with the statement; 27% were neutral and 55% either agreed or strongly agreed that the appendices to the manual were a relevant part of the training.

Summary
In sum, the **content** of the IPCP experience scored a mean of 3.86 with a standard deviation of 0.95. It appears that to a large extent students agree that educational content is important and relevant and also that they will use the information to some extent in their future practice. However, non response, disagreement, and neutral response to statements such as, using a great deal of information, education content meeting the learning objectives, and appendices to the manual being relevant indicate that respondents are expecting modifications and improvements in the project.

Educational Format: This component consisted of 9 items with each item to be rated on a 1-to-5 Likert response scale.

1. The IP Clinical Placement Project, as a whole, was well organized (N=13)
A mean score of 2.69 indicates a somewhat neutral opinion overall. Fifty four percent (54%) of the student respondents strongly disagreed or disagreed with this statement and it is also reflected in the student narratives (see qualitative analysis section, p-8). Twenty three percent (23%) were neutral and 23% of the respondents agreed or strongly agreed that the IPCPP, as a whole, was well organized.

2. The overall format (interactive, in a practice context) was conducive to my learning (N=13)
A mean score of 3.84 indicates agreement with the statement. Of the student respondents, 8% disagreed, 23% were neutral, and 69% either agreed or strongly agreed that the overall format was conducive to their learning.

3. There was not enough time to interact with team members during the group session (N=11)
A mean score of 2.81 indicates a neutral opinion overall. Of the student respondents, 46% disagreed, 27% were neutral, and 27% agreed that there was not enough time to interact with team members during the group discussion.

4. The amount of time provided to cover the educational content was appropriate (N=13)
A mean score of 3.61 indicates some agreement with the statement. Twenty three percent (23%) of the respondents either disagreed or strongly disagreed that the amount of time provided to cover the education content was appropriate. In contrast, 77% agreed or strongly agreed that the amount of time provided to cover the educational content was appropriate.

5. The clinical site in which the training work took place was conducive to my learning (N=11)
A mean score of 3.9 indicates agreement with the statement. Eighty-two percent (82%) of student respondents either agreed or strongly agreed that the clinical site in which the training work took place was conducive to their learning. The remaining 18% were either neutral to or disagreed with the statement.

6. The workload required by the education component was excessive (N=13)
A mean score of 2.0 indicates disagreement with the statement. Ninety-two percent (92 %) of the student respondents disagreed or strongly disagreed that the work required by the educational component was excessive. Only 8% were neutral to this statement.

7. The opening 'setting directions' session helped me understand expectations of the week (N=13)
Responses were widely distributed from strongly disagree to strongly agree. A mean score of 2.69 indicates somewhat neutral response. However, 15% did not respond to this item and wrote 'NA' adjacent to it and 23% strongly disagreed or disagreed to this item and this opinion was reflected in open ended question responses; 23% were neutral and 39% either agreed or strongly agreed that the opening 'setting directions' session helped them to understand expectations of the week.

8. The closing 'debriefing' session helped me reflect and reinforce what I learned over the week (N=13)
A mean score of 2.3 indicates that students either disagreed or did not understand what was being asked of the respondents. 23% offered no response, 18% disagreed, 38% were neutral, and 23% agreed that the closing 'debriefing' session helped them to reflect and reinforce what they learned over the week.

9. The IP care planning session was an excellent format to learn inter-professional team competencies (N=13)
A mean score of 3.76 indicates agreement that the IP care planning session was an excellent format to learn inter-professional team competencies of the respondents. Of the student respondents, 8% disagreed, 23% were neutral, and 69% either agreed or strongly agreed that the IP care planning session was an excellent format in which to learn inter-professional team competences.

Summary
Overall, the **educational format** of the IPCP experience has an average score of 3.06 with a standard deviation of 1.10. It appeared that there were quite a few organizational and implementation issues which influenced students' response to this component. It also appeared that students encountered some problems with the opening and closing sessions and they were not sure how to respond to these statements in this regard. Some either responded with 'NA'/'?' or non response. On a positive note, it appears that the majority of the students did not feel that workload was excessive. Further, they also felt that time to interact with team members and time provided to cover the educational content was enough and appropriate.

About the Facilitators/Preceptors: This component consisted of 4 items with each item to be rated on a 1-to-5 Likert response scale.

1. The facilitators/preceptors were knowledgeable in the area of inter-professional teaming (N=11)
A mean score of 4.27 indicate agreement with the statement. Ninety-one percent (91%) of the student respondents either agreed or strongly agreed that the facilitators/preceptors were knowledgeable in the area of inter-professional teaming. The remaining 9% of students were neutral to this statement.

2. The facilitators/preceptors were organized and presented the material clearly (N=11)
A mean score of 3.9 indicates agreement with this statement. Nine percent (9%) of respondents disagreed, 18% were neutral, and 73% of the student respondents either agreed or strongly agreed that the facilitators/preceptors were organized and presented the material clearly.

3. The facilitators/preceptors encouraged student feedback (N=11)
A mean score of 4.09 indicates agreement with the statement. Eighteen percent (18%) of the respondents either strongly disagreed or disagreed; 82% of the student respondents either agreed or strongly agreed that the facilitators/preceptors encouraged student feedback.

4. During each group session, I felt comfortable contributing to the discussion (N=11)
A mean score of 4.36 indicates agreement with the statement. Ninety-one percent (91 %) of the student respondents either agreed or strongly agreed that during each group session they felt comfortable contributing to the discussion; 9% of respondents were neutral to this statement.

Summary
In sum, the component **about the facilitators/preceptors** of IPCPP experience scored a mean of 4.15 and standard deviation of 0.93. The majority of the student respondents agreed that facilitators/preceptors were knowledgeable and well organized and also that they encouraged student feedback. Respondents also indicated that facilitators/preceptors provided a favourable environment wherein they felt comfortable in contributing to the discussions.

Overall Experience: This component consisted of six items with each item to be rated on a 1-to-5 Likert response scale.

1. This experience was a valuable part of my education (N=11)
A mean score of 3.9 indicates agreement with the statement. Seventy-three (73%) of respondents agreed or strongly agreed that the experience was a valuable part of their education; 27 % were neutral to this statement.

2. This experience is important for all health care disciplines (N=13)
A mean score of 4.3 indicates agreement with the statement. Fifteen percent (15%) of the student respondents were neutral and 85% either agreed or strongly agreed that this experience is important for all health care disciplines.

3. I would recommend this experience to other students (N=13)
A mean score of 3.76 indicates agreement with this statement. Of the student respondents 15% disagreed, 15% were neutral and 70% of respondents either agreed or strongly agreed that they would recommend this experience to other students.

4. My interest in working on this particular unit___(specify) has increased as a result of this experience (N=11)
Nine out of 11 students responded to this question and seven out of 11 specified the unit they worked in. A mean score of 2.27 indicates disagreement with the statement. The response to this item was widely distributed: 36.5%

either disagreed or strongly disagreed, 18% were neutral, 18% did not respond, and 27.5% of the respondents agreed that their interest in working on specified unit has increased as a result of IPCPP experience.

5. I have gained an overall understanding of what a healthy inter-professional collaborative team looks like (N=11)
A mean score of 4.0 indicates agreement with the statement. Although 18% of the respondents disagreed, 9% were neutral, and 73% either agreed or strongly agreed that they have gained an overall understanding of what a healthy inter-professional collaborative team looks like.

6. The IP Clinical Placement Project provided me with a strong skill base in inter-professional teaming (N=11)
A mean score of 3.45 indicates some agreement with the statement. Eight percent (18%) of the respondents disagreed, 27% were neutral, and 55% of them either agreed or strongly agreed that the IPCPP provided them with a strong skill base in inter-professional teaming.

Summary
On the whole, **overall IPCP experience** scored an average of 3.64 and standard deviation 1.19. The majority of the student respondents felt that the experience was valuable and important for **ALL** health care disciplines. Similarly, the majority of the respondents' also indicated that they had gained an overall understanding of what a healthy inter-professional collaborative team looks like and that they will recommend this experience to other students. However, to a large extent IPCP experience did not increase students' interest in working on specified unit and moderately provided them with a somewhat strong skill base in inter-professional teaming.

QUALITATIVE ANALYSIS

To assist students to reflect upon their IPCPP experience, four open ended questions were asked on the survey. Table 1 presents the number of students who either responded to the given question or not.

Table 1

Open Ended Question	Response (YES)	Response (NO)
If you indicated 'Strongly Disagree' to any question (or conversely 'strongly Agree' to a negatively worded question), please indicate which question and provide an explanation	6	7
What did you particularly like about this experience?	11	2
What suggestions do you have to improve the content and/or format of the IP Clinical Placement Project for future students?	10	3
Additional comments?	6	7

Overall, students felt that the IPCPP has the potential to enhance patient centered care. The majority of students identified issues with organization, planning, and communication. Further, the majority provided suggestions on how to move forward with the project. Similarly, 85% of the students responded to the question about what they particularly liked about their experience. It appears that even though students experienced hurdles, they really like the initiative and felt that it is valuable to collaborate with other disciplines to provide patient centered care. Some students pointed out that there is lack of equality among the students resulting in the creation to a hierarchy when inter-professional practice is about reducing those same hierarchies.

Project Potential

"It [IPCPP] is an important aspect of healthcare and all students should have the opportunity to learn and experience this type of practice in a hospital setting

"*I think that this [IPCPP] is a wonderful initiative and an important issue. I imagine it will be an even more meaningful experience for students in the future when some of the 'bugs' are worked out"*

What did you particularly like about this experience?

"I really enjoyed that we got to meet with the other students and get to know what their roles are in the hospital. Without this inter-professional education I would not have had the opportunity to get to know and understand what the others do"

"Collaborating with other students of different disciplines and having feedback from the whole interdisciplinary team at rounds. I feel like the interdisciplinary experience was extremely valuable to me"

"My facilitator pointed out many group dynamics that I had not seen. Also, working out care plans with others for patients was very useful"

"It gave me the opportunity to learn what other health professions can contribute to a person staying in the hospital"

Identified Issues

"The organizational/last minute changes of facilitator made it difficult to get the full experience"

"Unfortunately I did not receive [the] (de)briefing session prior to beginning the project or[the] consent to be a part of the project. I did not understand the desired end points of the study but agree that multidisciplinary approaches are important to patient care"

"Although the manual was wonderful the practice of meeting in a group broke down. Because of lack of commitment/understanding of the project by some students/staff which [this] led to students to withdraw from the project"

"More organization in that it came at a time when people were just returning from their holidays and there appeared to be a lack of communication between the coordinators"

"As someone who just "parachuted in" for one week I think that it would have been better to have joined in a later week. The first week seemed disorganized and adding me as a component likely made it more difficult for the organizer and they couldn't continue

Suggestions:

"Better organization, communication, and explanation"

"Plan for more students to be involved from more health care professions. Also, having a follow up session on patient to go over if goals were being achieved"

"Try to have a patient that involves all areas"

"The meeting at the beginning to explain the project should have included a description of the kind of team skills/behaviours we were trying to achieve with this project"

Point to be noted – Lack of equality

"Students who were supposed to participate, but did not should not have been given the option to not participate if they did not want to. It is unfair to expect students who did not have that opportunity to participate when there were students from faculties who felt there was too much work involved and so did not participate as the option they were given was to not participate if they felt they could not. Some students were not given this option, creating a ***lack of equality among the students*** *and also* ***creating a hierarchy when inter-professional practice is about reducing those hierarchies****"*

(Preceptors also felt same: "*I think there should not be the option to be there or not. This is not how normal placements work"*)

Preceptor Post – Inter Professional Clinical Placement Experience

QUALITIATIVE ANALYSIS

In total, 19 preceptors participated in the IPCPP at 4 different sites. Fifteen of these preceptors completed the survey forms (response rate: 79%). To maintain anonymity of the respondents' identity, the total number of respondents per site is not being reported.

Content: This component consisted of three items with each item to be rated on a 1-to-5 Likert response scale.

1. The teaming competencies are important for health and social care professionals (N=15)

A mean score of 4.45 indicates strong agreement with this statement. All (100%) the preceptors either agreed or strongly agreed that the team competencies are important for health and social care professionals.

2. The educational content focused on the important aspects of the inter-professional (IP) teaming (N=15)
A mean score of 4.0 indicates agreement with the statement. Twenty percent (20%) of the preceptor respondents were neutral and 80% of them either agreed or strongly agreed that the educational content focused on the important aspects of inter-professional meeting.

3. The educational content is relevant to health care practice in the setting that I practice (N=15)
A mean score of 4.0 indicates agreement with the statement. Of the preceptor respondents, 26.5% were neutral and 73.5% either agreed or strongly agreed that the educational content is relevant to health care practice in the setting that they practice.

Summary
In sum, the component of the survey called **content** scored a mean of 4.15 with a standard deviation of 0.67. It appears that the majority of preceptor respondents felt that team competencies are important for health and social care professionals. Further, they also felt that the educational content is relevant in their practice setting and also that it is focused on the important aspects of inter-professional teaming.

Student Educational Format: This component consisted of seven items with each item to be rated on a 1-to-5 Likert response scale.

1. The IP clinical Placement Project, as a whole was well organized (N=15)
A mean score of 2.4 indicates disagreement with the statement. Of the preceptor respondents, 53% either strongly disagreed or disagreed that the IPCPP, as a whole was well organized; This also reflected in the preceptor narratives (see qualitative analysis section, p-13). Of the remaining respondents 40% were neutral and only 7% agreed that IPCPP, as a whole, was well organized. It appears organizers need to plan in advance and focus to a large extent on how they organize and implement the inter-professional clinical placements.

2. The overall format (interactive, learning in context) was conducive to learning (N=15)
A mean score of 3.4 indicates a neutral opinion towards this statement. Of the preceptor respondents, 13% disagreed, 40 % were neutral and 47% either agreed or strongly agreed that the overall format was conducive to learning. It appears there is a need for improvement in the format for future implementation of the project.

3. The amount of time provided to cover the educational content was appropriate (N=15)
A mean score of 2.9 indicates a neutral opinion to this statement. Of the preceptor respondents, 33% of the preceptor respondents disagreed, 47% were neutral and 20% either agreed or strongly agreed that the amount of time provided to cover the educational content was appropriate. It appears that factors such as organization and communication influenced the response to this statement. As a result majority of them were neutral followed by disagreement.

4. The workload for the student required by the educational component was excessive (N=15)
A mean score of 2.06 indicates disagreement with this statement. Eight-three percent (83%) of the preceptor respondents either disagreed or strongly disagreed that the student workload required by the educational component was excessive; 27% were neutral. It appears that the educational component may not need much change for future implementation of IPCPP as preceptor respondents found that it was not excessive.

5. The 'setting directions' session was a useful way to inform students of expectations for the upcoming week (N=15)
A mean score of 3.2 indicates a neutral opinion about this statement. Of the preceptor respondents, 13% did not respond to the statement and some placed a question mark adjacent to this statement (perhaps indicating they didn't know or may be they did not facilitate the session); 14% disagreed, 33% were neutral and 40% agreed that the 'setting directions' session was a useful way to inform students of expectations for the upcoming week.

6. The closing 'debriefing' session was a useful way for students to reflect on and reinforce their learning over the week (N=15)
A mean score of 3.26 indicates a neutral opinion about this statement. However, 60% of the preceptor respondents agreed that the 'debriefing' session was a useful way for students to reflect on and reinforce their learning over the week; 7% did not respond and placed question mark adjacent to the statement, 7% strongly disagree, and 26% were neutral to above statement.

7. The IP care planning session was an excellent format to learn inter-professional team competencies (N=15)
The response to this statement was widely distributed. A mean score of 3.2 indicates a neutral opinion overall: 13% of respondents offered no response, 7% disagreed, 20 % were neutral, and 60% either agreed or strongly agreed that the IP care planning session was an excellent format to learn inter-professional team competencies.

Summary
Overall, the **student educational format** component of IPCPP experience scored a mean of 2.92 with a standard deviation of 1.12. To a large extent preceptors felt that the IPCPP was not well organized. This appears to have negatively influenced some preceptor respondents' perceptions about the 'setting directions' session, the 'debriefing' session, and 'viewing IP care planning sessions as an excellent format to learn IP team competencies'. On the other hand, the majority of preceptor respondents perceived that the overall format was conducive to learning, that the amount of time provided was appropriate, and that the workload for the students ***was not*** excessive.

Facilitator/Preceptor Role: This component consisted of three items with each item to be rated on a 1-to-5 Likert response scale.

1. The IP Clinical Placement project was a burden to my existing workload (N=15)
A mean score of 2.53 indicates a somewhat neutral opinion to this statement. However, a distribution of responses indicates that 46.5% either disagreed or strongly disagreed that IPCPP was a burden to their existing workload. 40% were neutral and 13.5% agreed that the IPCPP was a burden to their existing workload. One participant made a note ***"but a welcome one"*** and indicated that he/she likes the initiative. Therefore, it appears that in the future organizers of IPCPP need to assess/redistribute preceptors' workload in order to reduce the perceived burden and increase preceptor involvement.

2. I had some say about how the IPCPP was implemented on mu unit (N=15)
The responses to this statement are widely distributed. A mean score of 2.46 indicates a neutral opinion. Of the preceptor respondents, 13% did not respond, 40% either disagreed or strongly disagreed, 20% were neutral, and 27% either agreed or strongly agreed that they has some say about how the IPCPP was implemented on their unit.

3. I am a valuable member of my site team (N= 15)
A mean score of 3.6 indicates overall agreement with the statement. Of the preceptor respondents, 7% offered no response, 7% disagreed, 13% were neutral, and 73% either agreed or strongly agreed that they are valuable members of their site team.

Summary
In sum, the component on **facilitator/preceptor role** scored a mean 2.86 with a standard deviation of 1.3. To a large extent the preceptor respondents did not perceive the IPCPP as a burden to their existing workload. Further, they felt that they are valuable members of their site team which helps to carry out the project.

Overall Experience: This component consisted of three items with each item to be rated on a 1-to-5 Likert response scale.

1. This experience is important for students from ALL health care disciplines (N=15)
A mean score of 4.13 indicates agreement with this statement. Seventy-nine percent (79%) of respondents either agreed or strongly agreed that the experience is important for students from ALL health care disciplines; 21% either disagreed or were neutral to the above statement.

2. I would recommend this experience to future students (N=15)
A mean score of 3.93 indicates agreement with the statement. Fourteen percent (14%) disagreed, 20% were neutral, and 66% of respondents either agreed or strongly agreed that they would recommend this experience to future students.

3. Overall, I found the IP Clinical Placement Project to be well organized (N=15)
A mean score of 2.46 indicates a somewhat neutral opinion to this statement. Of the preceptor respondents, 53.5% either disagreed or strongly disagreed that they found the IPCPP to be well organized; 33% were neutral and 13.5% agreed with the above statement.

Summary
In sum, the **overall IPCPP experience** scored 3.51 with a standard deviation of 1.35. It appears that although preceptor respondents felt that IPCPP was not well organized, they seem to consider this experience to be important for students from ALL health care disciplines and they would recommend this experience to future students.

QUALITATIVE ANALYSIS

To assist preceptors to reflect upon their IPCPP experience, four open ended questions were asked on the survey. Table 2 presents the number of preceptors who either responded to the given question or not.

Table 2

Open Ended Question	Response (YES)	Response (NO)
If you indicated 'Strongly Disagree' to any question (or conversely 'strongly Agree' to a negatively worded question), please indicate which question and provide an explanation	8	7
What did you particularly like about this experience?	12	3
What suggestions do you have to improve the content and/or format of the IP Clinical Placement Project for future students?	10	5
Additional comments?	9	6

Overall, preceptor respondents felt that the IPCPP has a very high potential to enhance patient centered care. The majority of respondents identified issues with organization, planning, and communication of IPCPP. Further, the majority of respondents provided suggestions regarding how to move forward with the IPCPP. Similarly, the majority of the preceptors responded to the question about what they particularly liked about their experience. It appears that even though preceptors experienced hurdles, they really like the initiative and felt that it is valuable for students to collaborate with other disciplines to provide patient centered care. Some preceptors mentioned that they felt that students should not be given an option to choose or not to choose inter-professional clinical placement experience. Further, some also felt medicine and nursing disciplines are essential for these placements to work and they were not represented adequately in the IPCPP.

Project Potential:

"Tremendous potential if not sabotaged"

"This experience is important for students from all health care disciplines. I think this is an area that needs to be shown to students. Overall health care workers can do better"

"The concept is important for all disciplines, however would be better if everyone is on the same placement schedule"

Areas to work on – Organization and Communication

"I feel this was disorganized for a few reasons. I was asked to facilitate a session approximately one week prior. Then [I] was not given [any] clear direction or explanation or outline of what to present and/or how. The inconsistency of the students and scheduling, I feel reflects poorly on the facility. As a whole it really challenged our professionalism in this manner"

"The lack of organization and communication from our site was a significant issue. The way it was organized with multiple people leading sessions did not work well"

"It seems that at my site, the project seemed to be implemented quite quickly and I think that not all team members were aware that it was happening"

"I wasn't told what my role of field work educator had to do with the project and ultimately had nothing to do with the project"

Emphasis on:

"Medicine and nursing student did not participate. They are essential for this program to work"

"Cohesive teams produce high quality, decisions and create a re-assuming context for families and patients regarding care. Medical and nursing do not have well developed skills for teaming. They need to participate and develop skills"

Suggestions:

"I feel there needs to be a single person who is the co-coordinator and who runs the sessions so that there is an organized and consistent approach. I feel there needs to be one organizer for all areas and it should not be piecemealed. I think there should not be the option to be there or not. This not how normal placements work"

"Lesson plan (1 page) and goals for each week of ICP project. More interactive vs. didactic education for health care providers"

"Students should have the opportunity to team one week or two <u>before</u> they are asked to perform on a team"

"More general information regarding the project should have been provided to the whole team"

"I think there should not be the option to be there or not. This is not how normal placements work"

What did you particularly like about this experience?

Collaboration Related:

"[I liked] the sharing of our different skills and how we can better support each others goals. Also, I liked the focus on including patient and family. An area we seem to forget about"

"I love that we are finally teaching IP collaboration at a student level and attempting ALL disciplines to invest. However, I think more marketing/selling of the program is required to get more key players to see the benefit of investing in the process" [this quote also implies way to go forward and suggestion]

Student Related:

"The enthusiasm of young learners and their willingness to be collaborative"

"Good chance for students to interact, develop team work and learn what each other's roles and scope of practice are"

"Students got to learn the role of other professions and they learned to interact as a team"

"I liked the students working together and learning other disciplines perspectives. I think they will be better able to question colleagues and have open safe dialogues"

Student Manual Related:

"Work book helpful"

"The manual could be improved upon"

Conclusion

In total, 29 students and 19 preceptors participated in the IPCPP at four (4) different sites. Thirteen (13) students and fifteen (15) preceptors completed the survey forms. The majority of the respondents agreed that the IPCP experience is important and valuable for students from ***All health care disciplines***. They also felt that the overall format was conducive to students learning and that the educational component was appropriate and not excessive. However, most of the respondents pointed to organization, planning and communication issues. In sum, the majority of the respondents are of the opinion that, if issues related to organization, planning and communication are overcome then this project has tremendous potential to enhance patient centered care. Further, medicine and nursing disciplines ***must*** participate and participation ***should not*** be optional in inter-professional clinical placement.

APPENDIX M

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IP CLINICAL PLACEMENT WORKING GROUP
Terms of Reference

Purpose

The purpose of the IP Clinical Placement Working Group is to develop sustainable interprofessional (IP) clinical placement opportunities for eligible students enrolled in participating health care and social services professional programs.

Responsibilities

- To map out the clinical placement[1] schedules for eligible students[2] across participating health & social professional programs, to identify areas of overlap, and to determine potential time intervals for IP clinical placements to occur.
- Grounded in adult and experiential learning theories, to develop learning opportunities for students within their IP clinical placements. Learning objectives should be aligned with the IP Curriculum Blueprint[3] and address collaborative knowledge, skills, attitudes and behaviors.
- To develop a common assessment framework for students across multiple professions participating in IP clinical placements
- To raise awareness and interest of students regarding collaborative person engaged practice and to ensure informed recruitment of and consistent messaging to students participating in IP clinical placement opportunities
- To identify and work with the appropriate clinical site contacts[4] from each participating Collaborative Practice and Learning Environment[5] (CP&LE) to ensure coordinated placement of students from the participating programs
- To work towards a streamlined process within the University of MB for the placement of eligible students at a growing number of CP&LE.

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[1] Clinical Placements refer to courses that offer 'real world' patient/client centred health care/social services learning opportunities for students. Also known as Clinical Practica, Clinical Rotations, Clerkship Rotations, Externships, Experiential Learning, and Fieldwork. It is recognized that clinical placements can occur within primary or tertiary care sites.

[2] In the early stages of this project the focus will be on creating IP Clinical Placement opportunities for 'senior' students (as determined by each faculty): e.g. 4th year dentistry, medicine, pharmacy, nursing students, 3rd year physical and respiratory therapy, social work, and nursing students and 2nd year dental hygiene and occupational therapy students.

[3] Guided by the CIHC Collaborative Competency and the BC Competency Frameworks, the UofMB IP Curriculum Blueprint outlines the learning objectives that must be addressed across a learning continuum (exposure, immersion, mastery) in order to achieve a range of IP collaborative competencies

[4] The appropriate clinical site contact varies by professional program and clinical sites by may include preceptors, unit managers, facility &/or department placement coordinators, department managers, professional leads

[5] Collaborative Practice and Learning Environments are those environments that possess the necessary collaborative attitudes, knowledge, skills and behaviors and are prepared to mentor IP teams of students from health care professional faculties.

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- To advocate for a growing number of collaborative practice and learning environments (CP&LEs) within Manitoba who are willing to serve as IP Clinical Placement sites.
- To partner with WRHA to develop measures & criteria for universities & clinical teams to use when determining the appropriateness of a specific site for interprofessional student placements
- To ensure ongoing evaluation of any IP Clinical Placement session developed
- To communicate activities of the Working Group to respective IPE Liaison Advisory Committee members, curriculum committees and other faculty, as appropriate.

Leadership & Membership

The IP Clinical Placement Working Group consists of one chair (a Working Group member volunteering for the position), the clinical placement coordinators of the participating health care & social services programs or their designates, appointed members from the Winnipeg Regional Health Authorities and other representatives as appropriate and approved by the IPE Coordinator.

Accountability

The IP Clinical Placement Working Group is accountable to the University of Manitoba IPE Liaison Advisory and IPE Steering Committees

Support to Working Group

The IPE Initiative Office Assistant will provide administrative support (booking rooms, preparing & distributing meeting agendas and minutes). The IPE Coordinator will network/collaborate with relevant partners (such as MB Health, the Regional Health Authorities, and the Interprofessional Continuing Professional Development Network) to promote/support a growing number of CP&LEs within Manitoba.

Term

August 2009 ongoing

Frequency

Meetings will be scheduled monthly with additional meetings arranged on an ad hoc basis at the call of the chair. Documents will be stored at the IPE Initiative office and posted on the IPE Initiative website (once developed).

Workplan updated: May 27.10

APPENDIX N

Clinical Placement Process for Clinical Health Psychology (CHP)

The CHP program trains residents, who are in full-time clinical placements 12 months of the year. A new class is admitted each September, and placements start on the first working day of September.

There are five content streams that residents apply to. The program has 7 residents at any given time, and may also have post-doctoral students.

Adult Stream (2 residents)
Child and Adolescent Stream (2 residents)
Neuropsychology and Rehabilitation Stream (1 resident)
Rural Stream (1 resident)
Northern Stream – Flin Flon, Thompson or Dauphin (1 resident)

Each stream consists of two six-month Major Rotations. Residents also spend one half day per week in Minor Rotations.

For residents in the Adult and Child and Adolescent Streams, the first six months of the year is based either at HSC or SBGH (switch after 6 months). While in these settings, residents contribute to and participate on a number of health care teams on an ad hoc basis (e.g., cardiac care, inpatient psychiatric assessment, child mental health, etc.). Neuropsychology residents are based at HSC, but may also work with geriatric neuropsychology at Deer Lodge and with rehabilitation neuropsychology at Riverview. Rural residents spend their first 6 months in Winnipeg, and are usually based out of SBGH. For the second six month, they work in the Interlake region (based out of Selkirk). Northern Stream residents are typically based out of Deer Lodge (Operational Stress Injury Clinic) for the first six months, and then are based in a Northern community (Flin Flon, Dauphin or Thompson) for the second six months. It is very likely that as IP sites are identified, there will be opportunities for psychology to participate.

Residents choose their own minor rotations shortly after arriving in Winnipeg (typically, October). There is a wide range of options that residents may select from in a number of different sites. There is some flexibility in the program, and it may be possible that one minor rotation could have an IP focus in the future. In the meantime, as further IP sites are developed, we will look for ways to highlight this in the descriptions of existing minor rotations.

Clinical Placement Process Faculty of Kinesiology and Recreation Management

Supervised Fieldwork Experience Program:

- Our program commenced in 1981 as a mandatory component of our Recreation Studies Degree Program (now Recreation Management and Community Development)
- Program is optional for our Recreation Management and Community Development degree and Kinesiology degree students as a result of our curriculum review
- Fieldwork Placements take place primarily in the fall term (entire term); placements have been done in winter and summer.
- Visits to organizations to meet with student, supervisor and fieldwork coordinator are scheduled during the placement.
- Evaluations are done in the middle and at the end of the fieldwork experience by both student and supervisor.
- Experiential plans and reflections are required by each of our students prior to and during fieldwork experience.
- Students are responsible to fulfill 455 hours during the term – this works out to 35 hours per week.
- Honorariums can be provided to our students up to a maximum of tuition for the term. Honorariums are not mandatory and are expected to range from in kind items to a $500 -$1800 provision.
- The student is required to receive payment for job related expenses from the agency. These will include room and board allowance for positions outside of Winnipeg, and travel and other expenses (parking) that are fieldwork experience related.

Clinical Placement Process for Medicine

The tracks of rotations are preset. We place the students in their groups (the group number corresponds to the track number) normally by the end of March. We will be holding a session with the current med 2 students in February for them to submit their preferred choice of group/track. We run an organized lottery system that will assign the students to a group/track based on all student responses and what is best for the overall class. With 112 med 2 students currently, by the end of March we will have them organized into eight groups of 14 students each.

The various departments (i,e the individual rotations) are then sent a listing of the group/track breakdown in early March and they are responsible for the detailed hospital placements and preceptors. The preceptor is not always known in advance. The majority of departments try to work a minimum of 2 periods in advance. Some departments do full scheduling prior to August (i.e. OG, MD and SG).

While this is going on our Med 3 students transitioning into Med 4 begin setting up their electives. This process begins early and normally the majority of elective placements for the Oct to Dec period are know by September and the elective placements for January and then later in February and March will be know by the end of December.

Each department/rotation has a clerkship director and at least one assistant. There is also a Clerkship Coordinator that oversees the complete clerkship and also an Electives Coordinator who oversees the complete elective process.

Terminology:

- Clinical Placements are referred to as Rotations, and the time span is referred to as Periods. Overall it is referred to as the Clerkship Rotation Schedule.
- The rotations are overseen by the department (i.e. Psychiatry rotations overseen by the Dept of Psychiatry)
- UGME office and personnel are responsible for scheduling on a macro level with the departmental personnel (clerkship directors and program assistants) responsible for the micro scheduling the hospital/unit level.
- Students are divided into eight groups and each group is assigned a track of rotations to complete in the order given. They must pass the rotation as well as the examination and/or assignment (Multiple Specialty Rotation and the Family/Community Medicine rotations do not have examinations)
- Electives are mandatory, and the students are able to apply for an elective of their choice either here at the U of Manitoba or to an external medical school.

Student Placement Process for Second Year OT Students at University of Manitoba

Developed for the U of M IP Clinical Placement Working Group
By: Margaret Anne Campbell-Rempel Academic
Fieldwork Coordinator Occupational Therapy Department

Fieldwork Placement Terminology and Individuals Involved:
Fieldwork Placement- This is the clinical placement /experience. Students are placed with an Occupational Therapist. This therapist is responsible for setting up the placement, the education and supervision of the student, and completing the student evaluation. Students must be supervised by a registered OT for the fieldwork to be recognized. Therapists may supervise one student, "share a student" (jointly supervise with another therapist), or may supervise 2 students at one time. In some situations supervising therapists are "offsite" or not physically located in the same area as the student.

Process for obtaining placements: The OT fieldwork program at U of M sends a "call for offers" or "placement request" to the OT managers, clinical service leaders, professional leaders or individual therapists. These requests are generally e-mailed. Only 2 sites currently use HSPnet. Requests are sent out twice yearly**.** The June request covers both of the fieldwork placements completed in year one of the MOT program, and the Intermediate 2 (January/February) placement in year two. We ask to receive responses to this June request in July/August. The second request is sent out in January and covers the final (advanced) 6 week placement for second year MOT students. We ask for responses to be sent back to the program by March. (The process of these 2 requests are further discussed under placement timeframes and process below)

Once received by a site the requests are then circulated to therapists who indicate when they will supervise a student. Therapists make these decisions based on a multitude of factors, including the best fit between their service and the student level, other students who may be present in the environment, systems issues like changes in programs, changes in personnel, and personal issues like holidays. Some sites expect each therapist to offer AT LEAST one placement/year.

In some situations therapists do not have an OT supervisor or manager. Often in these cases the request is sent directly to the therapist. Sometimes there is coordination through a staff OT in an organization, in other situations each individual deals with us directly. Community therapists tend to work especially independently.

Academic Fieldwork Coordinator (AFC): Faculty member responsible for coordinating all 4 fieldwork placements within the Masters of Occupational Therapy program (MOT program).

Outreach Developers: Faculty members who work alongside the AFC to develop fieldwork opportunities and support fieldwork educators for MOT students.

Placement Time frames & Process:
Final year OT students have 2 placement times in their second year:

- **Intermediate 2 Fieldwork** is 8 weeks long and starts the first week of January. It finishes at the end of February or beginning of March depending upon the year.
- **Advanced Fieldwork** is 6 weeks long. Dates are flexible across July, August and into the first 2 weeks of September. Fieldwork dates vary based on the timeframes offered by sites.

Intermediate 2 Fieldwork

- We request offers by sending out a request in June, and asking the offers be returned to us by July or August.

- These offers are then posted for student review,
- Students provide the academic fieldwork coordinator with their preferences.
- The AFC then matches students based on student preference, and profile requirements.
- The goal is to have matches completed in mid November. (This varies depending upon when we have sufficient placements to provide the list to the students).

Advanced Fieldwork

- Requests for Advanced Fieldwork placements are sent out in January with a return deadline of March.
- Again the offers are distributed for student review.
- The students then submit preference lists to the Academic Fieldwork Coordinator,
- Matches are completed by the AFC based on student preference and profile requirements
- The goal is to complete this process by early to mid May.
- Final placement dates may not be finalized from some settings until early June.

Clinical Placement Process for Faculty of Pharmacy Placements

Nancy Kleiman

Overview of the program:

- SPEP 1 – 1st year: 42 hours of community service learning, and 8 hours shadowing in each a community and 2 hours in hospital pharmacy. This occurs during the entire academic year (September until April).
- SPEP 2 – 2nd year: 80 hours (40 hours in each a community and hospital pharmacy) (2 – 1 week blocks) after the end of the academic year (1st 2 weeks in May)
- SPEP 3 – 3rd year: 160 hours (80 hours/2weeks in each a community and hospital pharmacy) after the academic year (the month of April)
- SPEP 4 – 4th year – 480 hours (6 weeks in 2 different practice settings) 3 – 6 week blocks starting November - April each year. Students have 9 weeks of classes starting in Sept then the rest of their final year they are out on placement. 2 of the 3 blocks are SPEP, the other is a 7 week elective (separate course).

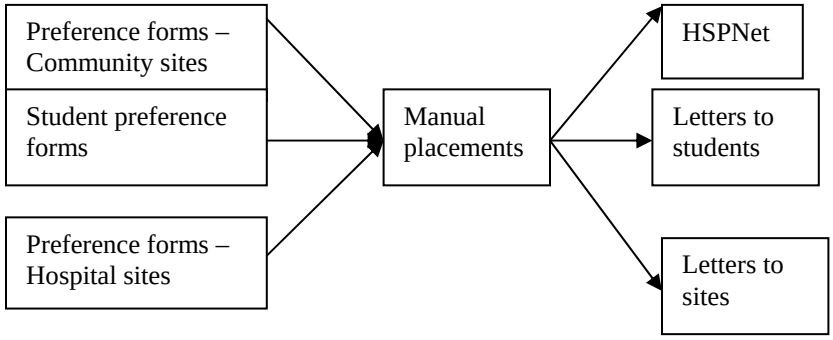
Roles and Responsibilities of Placement co-ordinators:

- Responsible for contacting sites to determine placements, maintaining site data and entering information in various databases and HSPNet
- Responsible for placement of students in all years of the program
- Preparation of manuals, maintaining website information, ensuring that pre-rotation preparations are done (WRHA routine practice requirements, all students have WRHA cards, all students have PHIA cards, all consent forms are completed and Immunization for all students are completed
- Responsible for ensuring that student is accomplishing requirements during rotation
- Act as a liaison between the faculty, the preceptor and the student
- Act as an information source for preceptors when required (workshops, clarifications etc)
- Responsible for documentation at the end of the rotation ensuring that student has completed all requirements of the program and have passed the program

Procedure for placements:

- Students are given preference forms listing the top 5 sites they would like to go to. Generally over 90% of students get placed at one of those sites on their list. We also ask them what their previous pharmacy experience is.
- Community sites are recruited in the summer and indicate which blocks they would prefer to take students. The students are then matched, beginning in the fall, to community sites manually based on preferences, work experience and site suitability. Most community sites have been visited by one of the SPEP co-ordinators and this information is kept along with the site specific information in Filemaker for reference.
- ***HSP Net*** – we signed on fall of 2009. We have utilized this program for placements within WRHA and will continue to do so, adding more sites as they become available. Currently we are sent, via email, the number of sites that WRHA will offer us and these are then inputted into HSPNet during the summer. Other hospital sites (St Boniface, Cancer Care and rural sites) are contacted and fill out a preference form that is then added to the list of sites taking students. The students are matched manually in the fall and this information is then inputted into HSPNet. Sites not using HSPNet are sent a letter indicating which students are going to their site and in which block they will be there.

We have not used it for the community placements as none of the sites use HSPNet to date.



Department of Physical Therapy
Clinical Education Process

Submitted by Mark Garrett
May 11, 2010

Background
The following information regarding the physiotherapy clinical placement allocation process pertains to the existing entry-level bachelors program. The department is currently seeking to transition to an entry-level professional masters degree credential, which will result in changes to the clinical placement process in terms of types, dates and duration. These changes will not impact the final year placements for several years.

Terminology
- *Academic Coordinator of Clinical Education (ACCE):* the student placement coordinator at the U of M.
- *Centre Coordinator of Clinical Education (CCCE):* the student placement coordinator at each receiving site.
- *Clinical Instructor (CI):* the placement supervisor. Students can have one or multiple CIs for the one placement. One CI can have up to 4 students simultaneously.
- *Clinical Placement:* the basic unit of fieldwork experience for the student.
- *Clinical Sites:* the various facilities where the placements occur.

Number of "Eligible" Placements
Two types of placements occur in the final year of the program: "neuro/geriatrics" placements and "internships". Both of these would be suitable for the IPE initiative. Each final year student undertakes two neuro/geriatrics placements and one internship.

- The neuro placement caseload includes clients with diagnoses such as stroke, TBI, Parkinson's disease, MS, spinal cord injury, cerebral palsy, etc.
- The geriatrics placement caseload tends to involve older clients with multisystem health problems and who are located in a wide variety of health care environments, including general medicine wards, ortho rehab, day hospital, long term care, community care, GPAT and PRIME.
- The internship is an "elective" style of placement, so can be undertaken in a very wide variety of environments. Over the past few years, most students chose to complete their internships in private practices.

Duration of Placements
- The neuro/geriatrics placements are 4 weeks in length, and are arranged in 4 back-to-back time slots from March to June inclusive.
- The internship is 8 weeks in length, and occurs in one of 3 overlapping time slots from May to August inclusive.

Dates for Planning Student Placements
- *October:* The ACCE sends the "Call for Offers" for the neuro/geri placements and internships to the CCCEs at the clinical sites. Two sites are currently piloting HSPnet for the placement process; the remainder utilize a traditional paper-based system.
- *November:* CCCEs return their offers to the ACCE.
- *January:* The ACCE presents the offers to the students. The students submit their preferred combinations of neuro/geri and internship placement time slots to the ACCE. The ACCE assigns each student a particular time slot combination. The students then submit their

preferred sites from the offers list to the ACCE. The ACCE assigns placements to each student.

- *Late January:* The ACCE informs the sites regarding their student assignment for the neuro/geriatrics placements.
- *Early February:* The ACCE informs the sites regarding their student assignment for the interships.

General Comments/Restrictions/Unique Situations

Of the two neuro/geriatrics placements each student undertakes, one must be significantly neurologically-based. There is considerable latitude regarding the second placement, which may facilitate our ability to be involved in IPE placements in a variety of settings.

The “elective” style internship lends itself to IPE initiatives in a variety of settings.

Clinical Placement Process for Social Work

The field placement process for the Faculty of Social Work is as follows:

Students in the 3 year program have two field experiences, in their second and final year of the program, consisting of 2 days a week throughout the entire academic year for a total of 28 weeks in field per year. Students indicate their preferences to the field Coordinator as to where they would like to complete their field experience. This step is done during the month of March and student résumés are sent out to Agencies at the end of March and beginning of April. The students are invited to interviews and are informed of their acceptance by May to end of June for a start date of September. Students can also find their own placement if they wish to do so. They would inform the field coordinator of their choice and administrative tasks would be completed by the field coordinator. If there is a field breakdown in the field placement, a new Agency is located.

Students in the 2 year concentrated program have one intense field experiences, consisting of 4 days a week throughout the entire academic year for a total of 28 weeks in field per year. Students indicate their preferences to the field Coordinator as to where they would like to complete their field experience. This step is done during the month of March and student résumés are sent out to Agencies at the end of March and beginning of April. The students are invited to interviews and are informed of their acceptance by May to end of June for a start date of September. Students can also find their own placement if they wish to do so. They would inform the field coordinator of their choice and administrative duties would be completed by the field coordinator. If there is a field breakdown in the field placement, a new Agency is located.

University of Manitoba, Faculty of Nursing

Clinical Placement Process
Year Four, Senior Practicum
NURS 4290

The Senior Practicum course is the final course in the Four Year Degree program of the Faculty of Nursing. From an academic perspective it fulfills the following purposes: it is the final consolidation experience; the capstone course of the four year program; it is the final point of quality assurance and evaluation for senior students; and it is a bridging experience to professional practice.

The Practicum consists of 12 weeks of full time practice in a clinical site, selected by the student, while "buddied" with a practicing nurse who serves as a preceptor working closely with the student and assisting in the evaluation the students' performance. The Practicum is offered 3 times per year, in the Fall, Winter and Summer terms. The placement process for all 3 terms is identical except for the dates involved.

Dates	Activity/Process Steps	Key People	Associated Terminology
Prep starts: September (for **Winter term**), January(for **Summer term**) and May (for **Fall term**)	Information sessions– introduces students to the practicum, provides guidelines for selecting a practice site, assignment and evaluation information	Course Leader	Course Leader: full time faculty
Throughout Sept and Oct (for Winter) Jan and Feb (for Summer) April and May (for Fall)	Students meet with course leader, as needed, to discuss their requests Students requesting specialty areas are screened	Course leader	
November (for Winter T) Feb (for Summer T) May (for Fall T)	Placements finalized, entered into HSPnet , confirmations returned and posted	Course leader & FON Placement Assistant, Receiving Site Coordinators	HSPnet: electronic placement communication system

October February May	Faculty advisors assigned- 4 -12 st/each Faculty advisor orientation	Course Leader Faculty advisors	Fac Advisor: Full time or sessional faculty who follow students progress closely and serve as resource for preceptors
Dates	Activity/Process Steps	Key People	Associated Terminology
November March/April May/June	Faculty advisors meet with student groups	Faculty advisors	
November/Dec March/April May/June	Students tour placement site, meet with unit managers and preceptors prior to placement	Unit or program managers and preceptors	
December May August	Preceptor workshop	Course leader and workshop facilitator	
Late November or early December May June	Student Information Session – mandatory session to provide information about national exam, application process and initial registration with provincial regulatory body (CRNM)	Course leader and CRNM representative	
Placement Starts: Early September Early January Early May	Practicum starts	Preceptor Fac Advisor	
Sept – Nov Jan – March May - July	On-going monitoring student progress	Faculty advisor & Course leader	
Placement Concludes: Early December Early April End of July	Practicum ends – grades assigned and eligibility for national exam determined	Course leader	

APPENDIX O:

Student Fieldwork Placements

Faculty	Terminology	# blocked times for placement	# required placements per student	Duration of placement	Faculty coordinator	Site coordinator?	HSPnet?	Dates for assigning students	Confirmation date	Students involved in selection	Placement start	Comments/Restrictions
Social Work - 3 yr program	field experience	1 block: 2d/wk	1	28 wks/block	Field coordinator	Agency	No	March	May/June	Yes	September	
Social Work - 2 yr program	intense field exp.	1 block: 4d/wk	1	28 wks/block	Field coordinator	Agency	No	March	May/June	Yes	September	
Social Work - summer field	intense field exp.	1 block: 4d/wk	1	13 wks/block	Field coordinator	Agency	No	March	April	Yes	May-Aug	summer placement from beg. May -beg. Aug
Pharmacy - year 3	SPEP	2 blocks	2	2 wks/block	Placement	preceptor or	Yes	September	September	Yes	April	1 block in community; 1 block in hospital
Pharmacy - year 4	clinical placement	3 blocks	2	6 wks/block	Coordinator	WRHA contact	Yes	September	September	Yes	November	HSPnet for WRHA sites only
Medicine - Med III	rotations/periods/	8 periods	8	6 wks/period	Clerkship/Electives	clerkship	No	February	March	Yes	September	Clerkship Coordinator oversees complete clerkship;
Medicine - Med IV	clerkships/electives	3 periods	3	6 wks/period	Program Admin.	director &	No		Sept & Dec	Yes	October	Electives Coordinator oversees electives process
						assistant						
Nursing	senior practicum	3 blocks	1	12 wks/block	Course leader	site	Yes	September	November	Yes	January	Faculty advisors assigned 4-12 students each
	faculty advisors				placement assistant	coordinator		January	February	Yes	May	
								May	May	Yes	September	
Clinical Health Psychology	placements/	Major: 2 blocks	2	6 mos/block			No			Yes	September	7 students apply & assigned to 1 of 5 'major' streams
	content streams	Minor: 1/2 d/wk	1	12 mos/block			No		October	Yes		0.5 d/week can be spent on 'minor' stream
Occupational Therapy	fieldwork placement	Intermed2:1block	1	8 wks/block	Academic field-	therapist	only 2	June	November	Yes	January	call for offers' 'placement request' to managers
		Advanced:1block	1	6 wks/block	work coordinator	manager/leader	sites	January	May	Yes	Summer	clinical service/ professional leaders
Kinesiology	fieldwork placement	1 block	1	13 wks/block	Fieldwork Coord	Supervisor	No	March	March	Yes	September	Supervised Fieldwork Experience Program
KIN - Athletic Therapy	Clinic Practicum	6-12 hrs/wk	1 to 2/term	13 wks	Clinical Coordinator	Clinical Supervisor	No	Jul.=fall term;Sept.=winter term	Aug.=fall term; Nov. = winter term	Yes	Sept.=Fall; Jan=winter	Supervised Clinical Practicum Course
	Clinical Block Practicum		1	5 wks/block	Course Instructor	Clinical Supervisor	No	March	April	Yes	May	Supervised Clinical Block Practicum Course
Physiotherapy	clinical placement	4 blocks	2	4 weeks	Academic Coord of	Centre Coord of	only 2 sites	November	January	Yes	March	Neuro/geriatric placement
	internship	3 blocks	1	8 weeks	Clinical Education	Clinical Education	only 2 sites	November	February	Yes	May	Internship can be in a wide range of clinical areas
Dentistry	externships	39 blocks	1	1-2 wks/block	Doug Brothwell	Clinic Dentist	No	March	Aug & Dec	No	September	Limited to current externship sites- DeerLodge, Access Downtown, HSC
Dental Hygiene	externships	2: 5d/wkx 1 wk	2	?12weeks?	Externship Coord	Supervisor	No	May	May/June	No	September	26 students & 16 clinic weeks. Only Deer Lodge & HAC
	rotation	6: 1/2d/wkx2wks	6	other footnote								offer one week block placements. The other placements
		1: 1d/wk x 2wks	1	says 16? I see 9?								vary in duration and frequency depending on the weekday
Respiratory Therapy		39 blocks		1 wk/block - Conc			No				September	Blocks run Mon-Thurs
				2 mos/block HSC/St.B								
Clinical Nutrition												

APPENDIX P:

Clinical Placement Schedules for Senior Undergraduate/Graduate Health/Social Care Professional Students

	2010																
	September				October				November					December			
	6	13	20	27	4	11	18	25	1	8	15	22	29	6	13	20	27
Medicine 3rd year				29	X	X	X	X	X	9							
Medicine 3rd year										10	X	X	X	X	X	21	
Medicine 4th year					4	E	E	E	E	E	E	E	E	E	E	23	
Nursing		13	X	X	X	X	X	X	X	X	X	X	29				
Occupational Therapy																	
Pharmacy										8	X	X	X	X	17		
Physical Therapy																	
Physical Therapy																	
Physical Therapy																	
Respiratory Therapy	30	M-Th			M-Th			M-Th			M-Th						
Respiratory Therapy			M-Th			M-Th			M-Th			M-Th					
Respiratory Therapy				M-Th			M-Th			M-Th			M-Th	10			
Clinical Health Psychology	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Dentistry	6	M-F	M-F	M-F	M-F	M-F	M-F	M-F	M-F	M-F	M-F	M-F	M-F	6			
Dental Hygiene	6	X	X	X	X	X	X	X	X	X	X	X	X	6			
Human Ecology																	
Kinesiology Rec Managemer		X	X	X	X	X	X	X	X	X	X	X	X	X			
Social Work																	

April 28.10 draft

Clinical Placement Schedules for Senior Undergraduate/Graduate Health/Social Care Professional Students

	2011																
	January					February				March				April			
	3	10	17	24	31	7	14	21	28	7	14	21	28	4	11	18	25
Medicine 3rd year																	
Medicine 3rd year	5	X	X	X	X	X	15										
Medicine 3rd year							16	X	X	X	X	X	29				
Medicine 3rd year													30	X	X	X	X
Medicine 3rd year																	
Medicine 3rd year																	
Medicine 4th year	3	E	21				14	X	X	X	X	X	28				
Nursing	3	X	X	X	X	X	X	X	X	X	X	25					
Occupational Therapy	3	X	X	X	X	X	X	25									
Pharmacy	3	X	X	X	X	11		21	X	X	X	X	1				
Physical Therapy									28	X	X	25		4	X	X	29
Physical Therapy																	
Physical Therapy																	
Physical Therapy																	
Respiratory Therapy	3	M-Th			M-Th			M-Th			M-Th			M-Th			M-Th
Respiratory Therapy			M-Th			M-Th			M-Th			M-Th			M-Th		
Respiratory Therapy				M-Th			M-Th			M-Th			M-Th			M-Th	
Clinical Health Psychology																	
Dentistry		M-F	M-F	M-F	M-F	M-F	M-F	M-F	M-F	M-F	M-F	M-F	M-F	M-F	M-F	M-F	M-F
Dental Hygiene																	
Human Ecology																	
Kinesiology Rec Managemen																	
Social Work																	

April 28.10 draft

Clinical Placement Schedules for Senior Undergraduate/Graduate Health/Social Care Professional Students

	2011																		
	May					June				July				August					
	2	9	16	23	30	6	13	20	27	4	11	18	25	1	8	15	22	29	
Medicine 3rd year																			
Medicine 3rd year																			
Medicine 3rd year	X	10																	
Medicine 3rd year		11	X	X	X	X	X	21											
Medicine 3rd year								22	X	X	X	X	X	2					
Medicine 3rd year																17	X	X	
Medicine 4th year																			
Nursing									27	X	X	X	X	X	X	X	X	X	
Occupational Therapy																			
Pharmacy																			
Physical Therapy	2	X	X	27	30	X	X	24											
Physical Therapy	2	X	X	X	X	X	X	24											
Physical Therapy					30	X	X	X	X	X	X	22							
Physical Therapy									27	X	X	X	X	X	X	19			
Respiratory Therapy			M-Th			M-Th													
Respiratory Therapy	M-Th			M-Th			M-Th												
Respiratory Therapy		M-Th			M-Th			24											
Clinical Health Psychology																			
Dentistry	M-F	M-F	M-F	M-F	M-F	M-F	M-F												
Dental Hygiene																			
Human Ecology																			
Kinesiology Rec Managemer																			
Social Work																			

Footnotes

Clinical Placements' refer to courses that offer 'real world' patient/client centred health/social care learning opportunities for students. Also known as 'Clinical Practicums', 'Experiential Learning', 'Fieldwork' 'Externship'. For the purposes of this pilot project, preference should be given to clinical placement courses that are mandatory, engage students at WRHA practice sites, and are a minimum of 4 weeks (sequential) in duration.

Senior students' refer to those students in the final year of study of their respective program (e.g. 4th year medicine, pharmacy, dentistry, nursing, social work; 3rd year physical and respiratory, 2nd year occupational therapy, 'residents' in clinical health psychology).

Undergraduate' for medicine, nursing, pharmacy, physical therapy, respiratory therapy, kinesiology & recreation management, human ecology, social work

Graduate' for occupational therapy and Clinical Health Psychology

Medicine: 3rd year 8 x 6 week placements – not available April 4 – 17, 2010

Medicine: 4th year electives (approximately 21 weeks) – not available first 2 weeks of February and all of April

Nursing : 12 week blocks

Occupational Therapy: Intermediate 2 placement (2nd year) Jan – Feb (OT7600); Advanced Placement (2nd year – final placement) Jun-Sept (OT7800). This occurs in 6 week blocks at any time through out this time frame.

Physical Therapy: 3rd year placements - neuro/geriatrics placements are 4x4 weeks from Feb 28-June 24; final internships are 3x8 weeks from May 2-June 24, May 30-July 22 & June 27-Aug 19.

Respiratory: Rotations run Monday – Thursday between Aug 30, 2010 – Dec 30, 2010 and Jan 3 – June 24, 2011. Concordia Hospital rotations are 1 week in length, involving 1 student each week, with a different student participating every week. As there are approximately 16 students in RT, there will be weeks within the blocked time at Concordia where there are no students. HSC and St. Boniface rotations also run Monday – Thursday but are typically 2 months in length. There may be 2-3 students assigned to each site for these longer rotations.

Clinical Health Psychology – graduate (residents).

Dentistry: 4th year dental student externships start in September and continue throughout the entire academic year. Rotation duration depends on the site. Sites for the 2011R academic year will be: Access Downtown: 2-weeks; SMILE: 2 weeks; Deer Lodge: 1 week; Riverview: 1 week; HSC: 1 week

Dental Hygiene: Externships for 2nd year students run between September 6 – December, 2010 and Jan 4 – April 29, 2011. Placements include the following sites: Deer Lodge Centre, Siloam Mission, Mount Carmel Clinic, Children's Hospital, and Diabetes Education Clinic, Graduate Orthodontics, Health Action Centre, Hoffer & Lipkin (prosthodontists), private practice visit.. There are 26 students and 16 clinic weeks. Only Deer Lodge and Health Action Centre offer one week block placements. The other placements vary in duration and frequency depending on the weekday. For example Monday morning there may be 24 students in the Faculty of Dentistry clinic with 2 students on rotation, Tuesday afternoons there may be 14 students in clinic with 12 students at 7 different sites, etc

Human Ecology: Human Nutritional Sciences program; elective course commencing in September and running through to April. 3 hours per week; could modify schedule somewhat to accommodate a block placement – depending on when their classes are scheduled; 3rd year students apply in April for their 4th year practicum commencing in September.

Social Work: 3rd year field placements – every student's placement days differ depending upon when their classes are scheduled. Regular students are in field 2 d/wk (normally M & Tues); concentrated students are in field 4 d/wk. There are no hospital sites, it would be an elective. Summer sStudents attend 'field' four days a