Twelve tips to support healthcare teams to incorporate interprofessional education and collaborative practice into day-to-day workplace practices

Martelle Ford[1], Priya Martin[2] and Michael Sy[3]

Abstract: Despite a growing body of research into interprofessional education and collaborative practice (IPECP), practical strategies and initiatives are required to assist healthcare workers with implementation. Practical strategies and tips outlined in this paper can support healthcare teams to incorporate IPECP into day-to-day workplace practices. Beyond IPECP engagement, the proposed tips will assist with refining current workplace practices and processes to make them more collaborative, intentional, and streamlined at the point of care. Bearing in mind that there is no 'one size fits all' approach to IPECP, these tips have been developed to suit a variety of contexts and are able to be adapted and contextualised by healthcare workers and teams. These 12 tips would not only assist with the implementation of new ideas related to IPECP, but also influence sustainability considerations of these initiatives within healthcare settings.

Keywords: interprofessional education; collaborative practice; health settings

1. PhD Candidate, Rural Clinical School, Faculty of Medicine, The University of Queensland Toowoomba
2. Senior Research Fellow, Rural Clinical School, Faculty of Medicine, The University of Queensland, Toowoomba
3. Associate Professor, National Teacher Training Center for the Health Professions University of the Philippines Manila

Address for correspondence: Martelle.Ford@uq.edu.au

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Introduction

Healthcare teams working collaboratively have demonstrated enhanced patient care outcomes, and better patient satisfaction with the care provided (Wen & Schulman, 2014). In addition, collaborative working has been found to reduce stress and increase job satisfaction for healthcare workers (WHO; World Health Organisation, 2010). Interprofessional education (IPE), where students learn with, from and about each other (Örgütü, 2010; Reeves et al, 2013), is being increasingly incorporated into undergraduate curriculum internationally to produce healthcare workers who are trained to work collaboratively when they graduate (Naumann et al, 2021; Roberts & Forman, 2015; WHO, 2010). Broadly, IPE research suggests that learner, faculty and organisational factors are key elements for the planning and implementation of IPE in healthcare settings. To successfully implement IPE in healthcare settings these factors need to be view as interacting with each other (Reeves et al, 2007). Hill and colleagues (2019) have previously developed strategies to support healthcare workers to recognise the educational benefits of IPE and overcome barriers to implementation.

The importance of interprofessional education and collaborative practice (IPECP) in healthcare settings is being increasingly acknowledged (Khalili et al, 2019; WHO, 2010). IPECP involves multiple healthcare workers from different professional backgrounds providing comprehensive services by working with clients, their families, carers, and communities to deliver the highest quality of care across settings (WHO, 2010). While there is a growing body of IPECP research (Khalili et al, 2019), it will be valuable to build on emerging IPE and IPECP research to provide practical strategies for healthcare workers to implement and facilitate evidence-informed IPECP at the point of care. These practical tips and strategies will assist healthcare teams to incorporate IPECP into day-to-day workplace practices.

Evidence-practice gap is a well-acknowledged barrier to timely implementation of findings in practice, with some concerns that this gap could be widening (Joyce et al, 2009; Olsen et al, 2007). This issue, along with the impacts of the COVID-19 pandemic on collaboration (Weinsing et al, 2020), calls for practical information on what healthcare workers can do at the point of care to enhance IPECP. Practical IPECP implementation tips would provide healthcare organisations and teams ideas to not only develop IPECP strategies, but also create an impetus to evaluate, re-create, and refine, as necessary, current IPECP initiatives to improve their usage in

practice (WHO, 2010). To maximise IPECP outcomes there is a requirement for time, effort and planning by healthcare teams (Sargeant et al, 2008; Wilcock et al, 2009). In line with recommendations to advance IPECP (WHO, 2010), practical tips would help healthcare teams develop, evaluate and action IPECP processes and initiatives to improve healthcare outcomes.

The 12 tips presented in this paper have been developed to support facilitation of IPECP by healthcare workers across the continuum, including recent graduates, experienced learners, and clinical educators (student supervisors). New learners include trainees, new graduates, as well as experienced staff practising in their discipline for many years, who may not have formally learnt about IPECP in their undergraduate curriculum. These practical tips have been developed based on the literature and the collective experience of the authors who have championed IPECP implementation, teaching and research across several healthcare settings internationally. The term/abbreviation IPECP used throughout the article, includes both interprofessional education and interprofessional collaborative practice components.

Tip 1 – Invest in IPECP champions

IPECP champions are needed in healthcare services to advocate for and implement IPECP initiatives (McNeil et al, 2015; Spencer et al, 2015). It is recommended that healthcare services invest in multiple IPECP champions, particularly in rural settings, to account for high staff turnover rates (Martin et al, 2021a). When a IPECP champion leaves their role, identifying and upskilling a replacement champion takes time. This gap could affect the continued implementation of IPECP at a site with detrimental impacts on team collaboration, shared decision making and client-centred care. The investment of multiple IPECP champions would also support teams made up of part-time staff.

Multiple IPEP champions would further enable the opportunity to orientate new healthcare workers into the team. The champion can facilitate IPECP onboarding of new team members by asking reflective questions such as:

- Can you reflect on why healthcare workers need to collaborate?
- How have you collaborated with other healthcare workers outside of

your discipline, in previous roles?
- How do you think you could incorporate collaborative practice into your role here?

Targeted questioning enables new team members to consider ways in which they can work collaboratively within the current team. Such orientation would also allow champions to provide new team members information on site-specific access to IPECP resources (Tip 6), existing IPECP initiatives and resulting outcomes. An IPECP champion model, as described, would help with the sustainability of IPECP in healthcare services as multiple people would be responsible for driving IPECP initiatives. This also enhances timely access for staff to an IPECP champion for urgent matters.

Tip 2 – Develop awareness of team structure, process, and roles

IPECP is not exclusive to teams that have an interprofessional model of service delivery. All teams, irrespective of whether they utilise a multi-disciplinary, interprofessional, transdisciplinary or another model of care, can incorporate elements of IPECP in their education and care delivery processes. In a recent Australian interview study, it was found that team members within the same teams had different perceptions about the model of care their respective teams employed (Martin et al, 2021a). Such issues can be mitigated by explicit discussions during team meetings and planning days on the model of care the team uses and, if applicable, the model of care the team aspires to work towards. By doing this, all members of the team can be unified on how their team currently works and the direction they are headed in. Teams can undertake shared activities such as mapping roles within the team to understand ways in which one team member interacts with another in order to facilitate the progress of the team as a whole. Belbin's team role inventory and taxonomy is one strategy that can assist teams with this activity (Belbin, 2012). Another team development intervention to establish ground rules and clarify expectations is through the use of a team charter which can improve communication, support, cohesion and job satisfaction among team members (Aaron et al, 2014; Shuffler et al, 2018).

Tip 3 – Adopt and use shared language

While language is a system that helps healthcare workers understand their own roles, shared language encourages collaborative practice between healthcare workers from multiple disciplines and backgrounds (Cahn, 2017; Stühlinger et al, 2019). The importance of adopting and implementing shared language for healthcare workers is multi-faceted. Shared language between healthcare workers has been found to help circumvent errors that may occur from miscommunication (Pamplin et al, 2011). Stühlinger and colleagues (2019), in a study of 197 healthcare workers found that shared language was associated with better interprofessional practice and higher quality patient care. The use of shared language allows healthcare workers from various disciplines to engage in shared decision making, to enhance client-centred outcomes. Shared language should be the foundation of IPECP initiatives and needs to be continually developed to ensure ongoing sustainability (Cragg et al, 2013).

Shared language can be discussed while orienting new staff members to the team (Tip 1). New team members can be educated on:

- The importance of shared language for collaborative practice
- The shared language and terminology that has been implemented at the local site.
- It would be helpful to provide new team members examples of how shared language and terminology has resulted in positive client-centred outcomes, plus examples of where it may have improved collaborative practice within and across teams.

Tip 4 – Engage with peers

IPECP can be enhanced when teams work with a shared understanding of purpose and direction (Harrod et al, 2016; Soemantri et al, 2019). Therefore, peer engagement can be an important tool to facilitate IPECP sustainability. Peer engagement can be implemented in flexible ways that best suit the given team. Firstly, depending on site logistics, having teams co-located can support team peer engagement (Martin et al, 2021a). This could be achieved through a shared office space, or through having team offices located proximally. Furthermore, co-location allows access to other

healthcare workers (Martin et al, 2021a). Timely access to colleagues can result in client matters being resolved quickly. Access to other healthcare workers, via incidental conversations, can reduce the need for emails and scheduled meetings. Co-location can also provide an opportunity to better understand the roles of other team members.

Other ideas for peer engagement initiatives include:

- Reflective exercises at case conferences (Kim et al, 2010)
- Implementation of team initiatives such as team charter (Tip 2)
- Targeted IPECP professional development and follow-up (Martin et al, 2021a)
- Attending IPECP seminars/ webinars and sharing lessons learned with team members who could not attend (Martin et al, 2021a).
- Multiple IPECP champions working together (Tip 1)
- IPECP professional sharing days (Kim et al, 2010)
- Peer-assisted learning for staff
- Peer buddying (from other disciplines) to develop IPECP initiatives that promote collaborative practice between disciplines (Tip 5)
- Collaborative learning (such as, journal club with an IPECP focus)

The key to successful peer engagement is advance scheduling. For example, reflective exercises at case conferences or other IPECP activities incorporated into team case conferences, require allocation of time to the meeting agenda. IPECP peer engagement activities also require IPECP champions to plan and schedule rostered time for them to take place. Having multiple IPECP champions (Tip 1) will not only make this a less time-demanding task, but it would also promote peer engagement between IPECP champions.

Tip 5 – Connect with IPECP support persons

Buddies, peers, supervisors, and mentors can be useful vehicles in supporting healthcare workers in their roles. If they are IPECP champions and/or trained in and passionate about IPECP, they may be able to play a role in the development of IPECP skills, capabilities and knowledge in the healthcare worker receiving support. The COVID-19 pandemic has seen the use of 'Battle Buddies' to provide psychological support to frontline

healthcare workers battling the pandemic (Albott et al, 2020). Buddy systems have also been successfully used to offer emotional support to injured workers (Kosny et al, 2013). Near-peer mentoring has been shown to promote professional and personal development of medical students in their transition year (Akinla et al, 2018). Other professional support mechanisms such as clinical supervision and mentoring have functions of support and professional development (Martin et al, 2021b). All these professional support measures could be explored to determine their role, if any, in upskilling and engaging in IPECP. Should a suitable support person not be available within the immediate team, options outside the immediate team can be explored. Whatever the professional support mechanism, there will always be an opportunity to incorporate a learning goal or two on IPECP.

Tip 6 – Utilise IPECP tools and online resources

Learners and teachers who are new to IPECP may find IPECP concepts, principles, and practices overwhelming and therefore confusing. While IPECP resource availability is not an issue at present, being aware of accessing these resources and tools may be challenging. Today, IPECP resources and tools are not only accessible in university libraries but are also retrievable from several open access websites. Table 1. provides a non-exhaustive list of examples of commonly accessed IPECP resource sites.

The prerequisite of utilising sound and current IPECP tools and resources for practice, teaching, and learning is being able to locate and access them. As a starting point, assistance could be sought from librarians or IPECP champions to collect an initial pool of resources. It is important to not only consume these resources but to also contribute to improving these tools and resources. Ways to do this would not only be through formal research, but also through attending webinars, conferences, and Global Cafes (Filies et al, 2016) to discuss and debate about the resource or tool and through sharing experiences via social media as appropriate (Twitter, Facebook, LinkedIn and the like) (Cain & Chretien, 2013).

Table 1
Commonly accessed IPECP resource sites

IPECP resource sites	
NexusIPE Website (American Interprofessional Health Collaborative)	Provides access to different IPECP assessment tools, materials, and evidence synthesis; https://nexusipe.org
Interprofessional.Global Website (IPG)	Provides resources, news, and updates about the IPECP activities worldwide; contains contacts of IPECP champions globally; https://interprofessional.global/reports/
CAIPE Website (CAIPE UK)	Provides e-book and journal resources on IPECP; https://www.caipe.org/resources
Arizona State University – CAIPER (Centre for Advancing interprofessional Practice, Education and research) website	e-learning modules; https://ipe.asu.edu/caiper-interprofessional design%E2%84%A0-elearning-modules
Australian and New Zealand Interprofessional education and practice resource repository website	Provides news on conferences and events, journal resources and professional directory; https://nexusipe.org/informing/resource-center/anzahpe
Te Pou – Interprofessional practice and education in mental health and addiction services (New Zealand) website	Provides practice resources; https://www.tepou.co.nz /initiatives/interprofessional-practice-and-education-in-mental-health-and-addiction-services
Alberta Health Services website: provides a collaborative practice guide	https://www.albertahealthservices.ca/assets/careers/ahs-careers-stu-supporting-interprofessional-placements.pdf

Tip 7 – Create new IPECP opportunities

Following team development activities (Tip 2), teams can investigate what new IPECP opportunities they would like to pursue to sustain the momentum. Some examples of successful IPECP initiatives implemented in health services are highlighted below. A Primary Care Team in the

Republic of Ireland developed monthly educational meetings to provide team members with ongoing IPECP activities. These meetings were client-centred, attended by healthcare workers from different disciplines, and focused on the management of dementia, motor neuron disease and adolescent mental health (Foley, 2012). Evaluation of these sessions after three months was overwhelmingly positive (Foley, 2012). Northampton General Hospital in the United Kingdom implemented an interprofessional module with all medical and healthcare disciplines, on aspects of daily routine management, record keeping, medicine management, and handling equipment. This was developed and successfully delivered by trained facilitators from different discipline backgrounds (Jeffrey, 2012). In Australia, Martin and colleagues (2016) developed and implemented a structured six-month new graduate interprofessional learning program in a regional health service setting. Evaluation of this program indicated a positive effect on participant attitudes, beliefs, and behaviours, regarding interprofessional practice (Martin et al, 2016). All new IPECP initiatives will benefit from an evaluation plan developed at the outset of program implementation (CAIPE, 2013).

Tip 8 – Undertake continuing professional development with follow-up actions

Continuing professional development (CPD) is part and parcel of being a healthcare worker not only because it is mandatory but also because it can positively impact patient care (Mlambo et al, 2021). Examples of CPD activities in IPECP include participating in webinars, conferences, and training. More intensive CPD activities involve completing a master's or doctoral research project related to IPECP. For those new to IPECP, it is not imperative to pursue one's idea right away. A good starting point is to attend a webinar and take reflective notes. The next step can be voicing a question or reflection at an open forum. Subsequently, submitting an abstract to a local conference, Global Cafés hosted by a university, or a virtual conference, can be considered. Conferences facilitate the exchange of resources and ideas, foster a sense of community, and develop a person's professional identity (Rimmer & Floyd, 2020). Conference presentations can take various forms of presenting ideas, research, and/or stories. Depending on one's preference, an oral presentation, an informal short

story-telling format, a poster, or an interactive workshop could be chosen.

Following a CPD activity, participants may be asked to provide an experiential evaluation of the event attended. CPD doesn't stop there but continues by pursuing follow-up actions. In every presentation, regardless of the delivery format, it is worthwhile to engage via answering questions, receiving constructive feedback, or connecting with potential collaborators. Email addresses or social media handles can be shared before leaving the conference or online room to signal one's openness to discuss and collaborate in the future. From here, one can set actionable goals, short-term or long-term, to further knowledge and practices in IPECP.

Tip 9 – Maximise efficiencies through technology

The purpose of technology is to make things easier for humans. Maximising technology makes IPECP more accessible, efficient, and practice friendly. While the use of technology in IPECP is not a novel idea, for someone new to IPECP, it can be challenging to understand a new concept (i.e., IPECP) and learn how to use technology to understand the new concept at the same time (Sy et al, 2021). In this article, we consider technology as the use of computers to activate software and applications to facilitate learning and practice in the health and social care disciplines.

In IPECP, technology is often used to assist learning and working together across disciplines in an efficient way. There are two types of technology, low and high technology. Low technology or 'low-tech' refers to simple, often mechanical technology, that makes human life simpler. Examples of low tech IPECP aids used are visual schedules, team planners, easel paper, adhesive cards, marker pens, and stickers among others. High technology or 'high tech' refers to advanced and complex technology that is considered to be the latest in the market. Examples of high-tech aids used in IPECP include anything that uses computers to produce sound, videos, and multisensorial experiences (such as vibration alert). In IPE (education) specifically, high tech aids can include live streaming, podcasting, mobile applications, video games, virtual reality, learning management systems, online collaboration spaces, among others. In interprofessional collaborative practice, electronic medical records embedded in a computer system and the use of collaborative writing processors can be considered

high tech. Video conferencing tools can be used both to facilitate IPE and interprofessional collaborative practice. For IPE, video conferencing has the ability to 'share screen' to engage classes through games or collaborative writing, to divide the class in breakout rooms to discuss a case, and to send chat messages to all or specific people to interact virtually. It can also play a role in interprofessional collaborative practice where healthcare workers can easily meet with their clients to plan care interventions and options.

Tip 10 – Use client feedback and satisfaction surveys

Client feedback and satisfaction surveys are vital in IPECP, given the integral role of clients in health and social care teams. The client perspective is a valuable tool to allow for the refinement of IPECP delivery and to ensure effective and safe healthcare delivery by teams. It also demonstrates to clients, the importance of their experiences, to ensure that healthcare services are responsive to ensure best client-centred care. Without client feedback and satisfaction surveys, healthcare services are unable to measure the impact of IPECP on client outcomes. Client feedback can capture critical details on the effectiveness of shared medical decision-making and client care, as well as the level of collaboration they have witnessed in that team. Findings from client feedback and satisfaction surveys can also inform future IPECP research directions (Morgan et al, 2020).

Tip 11 – Consider documenting and sharing stories of IPECP

Narratives and stories may have a positive influence when used as an inspiration or 'empowerment' tool to stimulate policy making and advocacy campaigns in the health sector (Fadlallah et al, 2019). Policies enable implementation and sustainability of IPECP principles. Commonly, evidence extracted from empirical research is used to frame policies in health since stories are perceived to possess low rigour, and reliability. However, literature is increasingly supportive of the role of narratives for public policy (Fadlallah et al, 2019; Schlaufer, 2018). In fact, there is already a toolkit created by Jankowski and Baker (2019) on how to build

a narrative via evidence-based storytelling to aid policy making. In other words, oral histories, books, images, comics, short films, and other media can be used to form a narrative about the impact of IPECP, which can then be shared with colleagues (Tip 9).

Tip 12 – Embed IPECP in student placement models

IPECP can be facilitated across a variety of student placements ranging from a single student on placement to a group of students participating in a structured model of IPECP placement (Martin & Sy, 2021). Some examples of structured IPECP placement models available in the literature are highlighted here. The Rural Interprofessional Education and Supervision (RIPES) model (Martin et al, 2021c), was developed and implemented in rural Australia, where teams of students from two or more disciplines undertook placement with a given work unit, overlapping by a period of at least five weeks. Students participated in targeted IPECP activities (for example, weekly IPECP tutorials, work shadowing, joint IPECP project, joint client sessions), while also fulfilling their discipline-specific clinical placement requirements (Martin 2022; Martin et al, 2021c). The Rural Interprofessional Education (RIPE) project was implemented in rural Victoria (Australia) where students from predominantly nursing and medicine, undertook interprofessional learning placements (Stone, 2006). Other examples of IPECP incorporated into structured student placements are outlined by the Centre for the Advancement of Interprofessional Education (CAIPE, 2013). Coordinating structured IPECP models can be resource-intensive (Martin et al, 2021c) and hence other strategies are necessary to incorporate IPECP with all available student placement models (Martin & Sy, 2021).

Conclusion

Implementation of IPECP initiatives require organisational support (WHO, 2010), research effort and planning (Sargeant et al, 2008). These practical tips outlined in this paper can provide healthcare teams and workers ideas to adapt and contextualise IPECP initiatives and promote

collaborative, intentional, streamlined processes at the point of care. These tips have been developed, to align with recommendations to advance IPECP (WHO, 2010), and to support the facilitation of IPECP for healthcare workers across the continuum including recent graduates, experienced learners, and clinical educators, to improve healthcare outcomes. Furthermore, these tips can contribute to bridging the evidence-practice gap related to implementation of IPECP initiatives within healthcare settings.

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