Module 3B: Student Manual
Highlights

Interprofessional Practice Education in Clinical Settings: Immersion Learning Activities
Acknowledgements

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

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


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

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We welcome your feedback and comments to these materials. A revised manual will be developed in the Spring of 2011. Please send your comments to: IPE_initiative@umanitoba.ca

January, 2011
Opportunity knocks!

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

Are you ready for the challenge?

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

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

Toolkit overview

This is Module 3B of a 3 module toolkit:

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

Module 3B: IP Practice Education in Clinical Settings: ‘Immersion’

IP learning activities:

Student Manual
- Participating in an IP learning opportunity
- Manual overview

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

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

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

Interprofessional Practice Education in Clinical Settings
What is Collaborative Practice?

**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.

**Collaborative practice** 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.

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.

**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.
What is Person-Centred Care?

Patient-centred care means that the patient/client (and their family, if applicable) is at the centre of their own health care.

Patient-centred care involves listening to patients and families and engaging them as a member of the healthcare team when making care decisions.

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.

Patient-centred care 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.

What is...  

Patient-Centred Care

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.
What is Interprofessional Education? Why Learn Collaboration?

Interprofessional education:
* Is the process by which we train or educate practitioners to work collaboratively
* Changes how healthcare providers view themselves
* Is a complex process that requires us to look at learning differently
* Requires healthcare providers to practice in a way that allows for and accepts shared skills and knowledge
* Requires interaction between and among learners.

Healthcare providers who are good interprofessional, collaborative practitioners understand the importance of working together with colleagues and the patient/family to achieve the best health outcomes.

Interprofessional education helps healthcare providers work together and pool information. No one healthcare provider has all the answers.

What is... Interprofessional Education (IPE)

Benefits of interprofessional education include:
* Enhanced practice that improves the delivery of services and makes a positive impact on care
* Improved understanding of the knowledge and skills needed to work collaboratively
* A better and more enjoyable learning experience for participants
* Flexibility to implement in a variety of settings.
National Interprofessional Competency Framework

Goal: Interprofessional Collaboration

A partnership between a team of health providers and a client in a participatory, collaborative and coordinated approach to shared decision-making around health and social issues.
What does collaboration look like?

Collaboration is about valuing diversity, understanding others' values and beliefs, and creating a positive climate built on trust and respect. As an approach to practice, it focuses on how team members interact, learning how to become an effective collaborator is more complex than simply learning a set of tools or techniques. Effective collaboration is about valuing diversity, understanding others' values and beliefs, and creating a positive climate built on trust and respect.
Module 3B: Student Manual

Interprofessional Practice Education in Clinical Settings: Immersion Learning Activities
Participating in an IP learning opportunity

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

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

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

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

A calendar has been included in Appendix 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.
Manual Overview

This Manual has three parts:

**Part I – Common Essential Principles: Interprofessional (IP) Care Planning**
The creation of an IP care plan requires knowledge and skills in goal setting and an awareness of effective collaborative team functioning. The first section of this 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 leadership and decision making**, a negotiation of the differing perspectives/priorities of the various team members and patients. It requires an examination of one’s own uni-professional scope of practice, an **awareness of the roles and responsibilities** of other members of the health care team and flexibility. A healthy team is one that recognizes **conflict** as an inevitable consequence of members’ passion for patient care which should be welcomed, openly identified and used as a driver for positive change.

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

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

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

- Stated learning objectives
- A brief review of the IP competency domain
- An outline of the student activity
- An appendix listing descriptors for each competency domain to help the student visualize actions which either demonstrate (or fail to demonstrate) mastery of that IP competency. The appendix also includes tools and/or instruments to guide and stimulate students’ thinking as they observe and reflect on the collaborative behaviours of the IP team and that of their own and student teams’ behaviours.
PART I
COMMON ESSENTIAL PRINCIPLES FOR INTERPROFESSIONAL CARE PLANNING
Common Essential Principle #1: Setting Patient Care Goals

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

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

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

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

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

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1 “Interprofessional Education Geriatric Care (IEGC) Reference Guide to the Seven Core Competencies” with permission.
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.
APPENDIX
Helpful and Hindering Collaborative Behaviors
IP collaborative teaming requires mastery of the following competencies:²

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
- 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

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² British Columbia Competency Framework for Interprofessional Collaboration
Collaboration Audit\textsuperscript{3}

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.

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<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Neither Agree Or Disagree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
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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.

_____ 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.

\textsuperscript{3} “Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres: Resources, Tips and Activities you can Use to Enhance Collaboration” p.46
Team Effectiveness Survey

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

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

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4 “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)
7. Communications
Are communications between members open and honest? Do members listen actively?

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<tbody>
<tr>
<td></td>
<td>Communications are not open; not enough listening</td>
<td>Communications are open; people listen to each other</td>
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8. Confronting Difficulties
Are difficult or uncomfortable issues openly worked through or are conflicts avoided? Are conflicts worked through?

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<tr>
<td></td>
<td>Difficulties are avoided; little direct conflict management</td>
<td>Problems are attacked openly and directly</td>
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9. Openness & Trust
Are team members open in their transactions? Are there hidden agendas? Do members feel free to be candid?

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<tbody>
<tr>
<td></td>
<td>Individuals are guarded and hide motives</td>
<td>Everyone is open and speaks freely</td>
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10. Commitment
How committed are team members to deadlines, meetings and other team activities?

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<tr>
<td></td>
<td>Deadlines and commitments often missed</td>
<td>Total commitment</td>
<td></td>
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11. Support
Do members pull for each other? What happens when one person makes a mistake? Do members help each other?

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<td></td>
<td>Little evidence of support</td>
<td>Lots of support</td>
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12. Risk Taking
Do individuals feel that they can try new things, risk failure? Does the team encourage risk?

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<tbody>
<tr>
<td></td>
<td>Little support for risk</td>
<td>Lots of support for risk</td>
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Team Effectiveness Survey cont.

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

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

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

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5 “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)
Meeting Effectiveness Survey cont.

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 stay on track
Meetings usually stray off 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
SET THE STAGE

• Greet and introduce each other
• Clarify roles
• Demonstrate interest and respect

NEGOTIATE AGENDA

• 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

• Input from all team members is ensured
• Various techniques are used to clarify statements
• Identify, confirm and prioritize problem list
• Check mutual understanding of subsequent interventions
• Reach agreement on next steps e.g. information and resources needed, how it will be obtained and by whom

Team Communication Observation Guide: Permission Pending
DEMONSTRATE RESPECT FOR OTHER TEAM MEMBERS/BUILD RELATIONSHIPS
• 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
• 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
• 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
INTERPROFESSIONAL CARE PLANNING
Interprofessional Care Plan

Client identifier: __________________________________________

<table>
<thead>
<tr>
<th>Patient Issue(s) [in order of priority]</th>
<th>Planned Intervention(s) [Who, What]</th>
<th>Desired Outcome(s) [Goal – SMART]</th>
<th>Timeline [When]</th>
<th>Follow-up [progress]</th>
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Philosophical Underpinning: Person Centred and Family Focused Care

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

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

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

Activity

Appendix 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.

7 “Interprofessional Education Geriatric Care (IEGC) Reference Guide to the Seven Core Competencies” with permission.
APPENDIX
PERSON CENTRED AND FAMILY FOCUSED CARE
Patient and family centred care involves mastery of the following competencies:  

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 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

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8 British Columbia Competency Framework for Interprofessional Collaboration
# Communication Skills Assessment

## RANZCOG Assessment of Communication Skills

Kalamazoo Essential Elements Communication Checklist (adapted)

<table>
<thead>
<tr>
<th>Trainee’s Name:</th>
<th>Supervisor’s Name:</th>
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<tbody>
<tr>
<td>(Please print.)</td>
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### A. Builds a Relationship (includes the following):
- 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

(Please tick the appropriate box.)

<table>
<thead>
<tr>
<th>1 Poor</th>
<th>2 Fair</th>
<th>3 Good</th>
<th>4 Very Good</th>
<th>5 Excellent</th>
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### B. Opens the Discussion (includes the following):
- 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

(Please tick the appropriate box.)

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<thead>
<tr>
<th>1 Poor</th>
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### C. Gathers Information (includes the following):
- Begins with patient’s story using open-ended questions (e.g."tell me about...")
- Clarifies details as necessary with more specific or "yes/no" questions
- Summarizes and gives patient opportunity to correct or add information
- Transitions effectively to additional questions

(Please tick the appropriate box.)

<table>
<thead>
<tr>
<th>1 Poor</th>
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### D. Understands the Patient’s Perspective (includes the following):
- 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 feelings

(Please tick the appropriate box.)

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<thead>
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<th>1 Poor</th>
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<th>4 Very Good</th>
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### E. Shares Information (includes the following):
- Assesses patient’s understanding of problem and desire for more information
- Explains using words that patient can understand
- Asks if patient has any questions

(Please tick the appropriate box.)

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<th>1 Poor</th>
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### F. Reaches Agreement (IF new/changed plan) (includes the following):
- Includes patient in choices and decisions to the extent s/he desires
- Checks for mutual understanding of diagnostic and/or treatment plans
- Asks about patients ability to follow diagnostic and/or treatment plans
- Identifies additional resources as appropriate

(Please tick the appropriate box.)

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<th>1 Poor</th>
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### G. Provides Closure (includes the following):
- Asks if patient has questions, concerns or other issues
- Summarizes
- Clarifies follow-up or contact arrangements
- Acknowledges patient and closes interview

(Please tick the appropriate box.)

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<tr>
<th>Summary of Feedback:</th>
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<tbody>
<tr>
<td>State what was done well during the consultation observed:</td>
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<tr>
<td>State what areas could be improved upon:</td>
<td></td>
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<tr>
<td>State whether any additional strategies should be implemented: (eg further training in communication, language or speech)</td>
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<tr>
<td>Does the trainee need any further assessment of their communication skills?</td>
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</tbody>
</table>
| ☐ Yes, areas for improvement identified.  
  Further assessment advised | ☐ Satisfactory  
  No further assessment advised |
| Date of further assessment __________ | Return to normal mid and end of term assessment |
| I have discussed the content of this assessment with my supervisor: | I have discussed the content of this assessment with the trainee: |
| Trainee’s name: | Supervisors name: |
| Trainee’s signature: | Supervisors signature: |
| Date: | Date: |

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

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

Activity:
Appendix 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. 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:

9 “Interprofessional Education Geriatric Care (IEGC) Reference Guide to the Seven Core Competencies” with permission.
10 British Columbia Competency Framework for Interprofessional Collaboration
APPENDIX
UNDERSTANDING ROLES AND RESPONSIBILITIES
Understanding Roles and Responsibilities

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:

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

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11 British Columbia Competency Framework for Interprofessional Collaboration
Diversity of Values, Beliefs and Strengths Handout\textsuperscript{12}

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 …

\textsuperscript{12} “Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres: Resources, Tips and Activities you can Use to Enhance Collaboration” (p. 45)
<table>
<thead>
<tr>
<th>Professional Roles Template</th>
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<tbody>
<tr>
<td>Profession Name:</td>
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<tr>
<td>What do we do?</td>
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<td>(Some clear statement of</td>
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<td>the main purpose of the</td>
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<td>profession. This can</td>
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<td>include indications of the</td>
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<td>scope of practice):</td>
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<tr>
<td>Why do we do what we do?</td>
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<td>(Main Elements of this</td>
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<td>Professional Philosophy):</td>
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<tr>
<td>Who do we work with?</td>
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<td>(Suggestions of the main</td>
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<td>client/patient groups with</td>
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<td>whom we work):</td>
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<tr>
<td>Where do we work?</td>
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<td>(Examples of typical work</td>
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<td>environments for this</td>
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<td>profession):</td>
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<td>What are the unique features of this profession's practice?</td>
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<td>highlight the special</td>
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<td>inputs that your profession can add to any team process):</td>
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<td>What else is helpful to</td>
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<td>know?</td>
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<td>(Use this space to provide</td>
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<td>special insights and</td>
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<td>information that will</td>
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<td>help others understand</td>
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<td>more about your profession</td>
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<td>and your role):</td>
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Profession Role Template Interprofessional Education Program, Faculty of Health Sciences, McMaster University (2005), Unpublished
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.