Executive Summary

There is a critical need for increased training of the health workforce to meet future demands which acknowledges that health professionals need to have professional competencies, as well as skills in interprofessional practice. These skills are required to engage communities with increasingly complex health conditions and social contexts.

This project aimed to explore the current status of Western Australian clinical placement opportunities that potentially provided students with interprofessional learning experiences. The intention was to gather more specific qualitative information regarding interprofessional learning opportunities and how interprofessional placements could be framed in health organisations.

In the literature there are currently very few descriptions of student placements being integrated within services where teams are already engaging in interprofessional practices. It was hypothesised that this may have been because of two inter-related issues;

- Poor identification of exposure to interprofessional practice, and
- Assumptions of what constitutes interprofessional practice.

Exploration of nineteen Western Australian health and disability teams through interview, revealed that while there is scope for students to be exposed to interprofessional practices in a range of health services, these placements are under utilised as interprofessional learning opportunities. The findings of this project also suggest that there are a diverse range of placement types (or degrees of exposure to interprofessional practices) in different contexts that could have a cumulative impact on the development of interprofessional competencies. More explicit teaching and reflection on the interprofessional practices being demonstrated in a team’s approach to service delivery, the management practices, and the processes in place supporting teamwork, was needed in health service teams to better integrate interprofessional learning experiences in existing placements.

Recommendations

1. **Adoption of a broader definition of interprofessional placement in health and education sectors:**
   - that challenges prevailing assumptions about the components of an interprofessional placement;
   - by establishing interprofessional placements in health teams with students from single to multiple professions based on the needs and constraints of that health service team, and
   - by exploring models of placing students from professions not currently represented on a health team, with external profession specific supervision as needed.
2. Development of a collaborative approach to improve health professionals' access and capacity to deliver interprofessional learning activities in health and education sectors:
   - with a commitment by all supervisors to ensuring that all students understand the roles, responsibilities and the professional underpinnings of both their own profession and of other health disciplines,
   - by establishing common frameworks describing the diverse types of interprofessional practices which currently exist,
   - by providing training in interprofessional clinical supervision, and
   - by expanding resources and tools that support interprofessional learning e.g. SCIPE Reflection on Interprofessional Learning resource.

3. Establishment of benchmarks or guidelines for achieving interprofessional capabilities to be supported by education provider, Professional Associations and Accrediting Bodies:
   - with capacity for any placement to report on interprofessional learning experiences gained by a student,
   - preferably within the context of enhancing the interprofessional standards already in each professions competency standards,
   - with support for placements occurring in teams where interprofessional and work-ready skills may be the primary focus.

4. Greater acknowledgement and support for health sector teams providing interprofessional practices:
   - with recognition of the improved health outcomes achieved as a direct result of the interprofessional practices in place,
   - as learning forums for both students and other health professionals, and
   - with a focus on policies and processes that ensure the delivery of interprofessional practices using the most appropriate and efficient team approaches a client group needs.
2. Introduction

Background

Investment in increased training of health professionals is an essential workforce strategy, with health human resources described as being “in crisis” (pg. 12) by the World Health Organisation.1 However the need for increased training creates growing demand for clinical placements in an environment already under considerable service delivery pressures.2 At the same time future health workforce skill requirements have changed with recognition of the need for health workers to have professional competencies as well as skills in interprofessional practice to engage communities with increasingly complex health conditions and social contexts.2 1 It is considered vital to develop a health workforce with skills in working interprofessionally to reduce health system fragmentation and provide better services to the community.1

Profiling of clinical placements in Western Australia (WA) by HMA2 identified that while there is workforce interest in strengthening interprofessional learning there were challenges for the sector to support students developing interprofessional capabilities. The challenges listed included facility designs, health professionals working and being managed in ‘silos’ and clinicians not supporting interprofessional education of students.2

Purpose

The WA Clinical Training Network (WA CTN) facilitated a Communities of Interest (COI) engagement process to explore interprofessional learning opportunities with education providers and health service provider stakeholders.3 The facilitation process identified the need for shared benchmarks and standards for placements as part of the interprofessional education process in the health sector, and the need to review the grey and academic literature to determine the existence of these standards. An extensive literature review was being completed simultaneously to the COI process. These reviews were predominately focused on university sector interpretation and application of interprofessional education into university curricula. When this COI project commenced the initial requirements had been explored through these literature reviews (see Table 1). Literature review findings indicated that placements facilitating interprofessional learning had not been developed and explored sufficiently in the literature to provide benchmarks and standards at this time.

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3 AIM WA (2013) WA Clinical Training Network, Communities of Interest Final Report. University of Western Australia Business School
As a result, this COI project strategy was adjusted to explore the current status of Western Australian clinical placement opportunities that potentially provided students with interprofessional learning experiences. The intention was to gather more specific qualitative information regarding interprofessional learning opportunities and how interprofessional placements could be framed in health organisations.

**Current Status**

Interprofessional education focuses on preparing students of each health profession to work with other health professionals in the health workforce in a collaborative and effective manner in order to provide interprofessional practice or collaborative practice.

“For health workers to collaborate effectively and improve health outcomes, two or more from different professional backgrounds must first be provided with opportunities to learn about, from and with each other. This interprofessional education is essential to the development of a “collaborative practice-ready” health workforce, in which staff work together to provide comprehensive services in a wide range of health-care settings” (pg. 13) ¹

A framework describing a three phase developmental approach to interprofessional education has been used by Griffiths University to plan their curriculum for health professionals.⁴ The framework has phases from interprofessional education focusing on awareness of other health professions, up to education providing exposure to interprofessional teams (Table 2). This third developmental phase focuses on opportunities for students to engage in interprofessional practice within student placement situations. This project was particularly interested in exploring the phase three context further to determine information that could be used to guide and facilitate the planning and provision of these types of student experiences in the health sector.

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The most recent report by the Interprofessional Curriculum Renewal Consortium (ICRC)\(^5\) provided nine exemplars of interprofessional education activities but did not include an example of a purely phase three program. A National Audit of Australian Interprofessional Health Education\(^6\) reported that there were few examples of phase three interprofessional education activities outside of Western Australia. Examples of phase three programs described by Nicol\(^7\) were predominately in the context of interprofessional practice within created projects or services, often driven by the university sector in partnership with service providers, or in on-campus service models.

There were few descriptions of integration of student placements within services where teams are already engaging in interprofessional practices or providing interprofessional learning opportunities. Potentially, phase three interprofessional education opportunities are not being identified because of two related issues:

- Poor identification of exposure to interprofessional practice, and
- Assumptions of what constitutes interprofessional practice.

**Poor identification of exposure to interprofessional practice**

Stakeholders who were interviewed as part of the WA CTN placement profiling report (HMA, 2013) identified that there were limited interprofessional education opportunities in current placements. However the same report documented that discipline representatives from aboriginal health, audiology, occupational therapy, physiotherapy, podiatry, psychology, and social work expressed the sentiment that students would be “exposed to multidisciplinary aspects of health care” (pg. 68)\(^5\) while on placements. These representatives seemed to distinguish between the informal nature of an experiential opportunity in a profession specific placement, compared to placements specifically labelled as an interprofessional placement.

In the Western Australia audit of interprofessional education programs, Nicol\(^7\) states “at present different health professionals see patients/clients separately and typically do not communicate between themselves about patient/client care” (pg. 23). While the report acknowledges there are “situations where professions work well together” (pg. 23)\(^7\), there remained a sense in the document that students may be unlikely to experience collaborative care practices in health service placements.

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\(^6\) Interprofessional Curriculum Renewal Consortium, Australia (2013) Interprofessional Education: a National Audit

\(^7\) Nicol (2013) Interprofessional Education for Health Professionals in Western Australia: Perspectives and Activity, University of Technology, Sydney
Several reports describe health professionals as not actively engaging with interprofessional education and not adopting interprofessional practices because of a perceived lack of evidence for engaging in interprofessional practice. However, evolving models of care in a number of areas such as primary health, mental health, chronic conditions, and rehabilitation, guide service provision with values and approaches that align with the definition of interprofessional practice.

Assumptions of what constitutes IPP

There is a common design of interprofessional education activities where students learn with students of other health professions. These designs have flowed into the development of interprofessional placement experiences where the hosting health service provider requires students representing two or more different professions to be placed together at the same time. For example, the HMA report identified that a challenge to interprofessional education in WA was that the “facility designs of hospitals do not easily accommodate groups of students” (pg. 69), with the implication that several students needed to be on placement at any one time. Nicol considered that a major barrier to placements supporting interprofessional learning is the difficulty coordinating “students from different schools and unit programs to be available at the same times” (pg. 51).

However, there are concessions that solitary student placements could still have an interprofessional learning component. Nicol’s report included an example of a medical school placement acknowledging that while it did “not often include formal learning from other students” (pg. 42) because it was occurring in a rural context where “health professionals necessarily work closely together…IPP is perceived to be occurring already” (pg. 42). Despite this concession, there appears to be a limited exploration of the learning a student can gain through a placement where all of the professions represented in a health service team are demonstrating interprofessional practices.

Similarly, there is a lack of clarity around how much interprofessional learning is needed to develop a student’s interprofessional competencies. While many interprofessional education programs are described in recent reports, there remains little specification of the amount of time students needed to be exposed to different health professions and to interprofessional practices. There remains significant variation in the length of time, quality and frequency of interprofessional education activities.

Project Aims

This project aimed to gather a sample of health service teams or clinics recognised as providing a level of interprofessional practice. An interview with a representative from each of these teams was undertaken to determine opportunities and potential barriers to embedding interprofessional learning through clinical placements in the health sector.

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9 National Practice Standards for Mental Health 2013
Interviews aimed to explore whether there was a need for guidelines or standards as to when and how a health-based placement could contribute to a student’s interprofessional learning. Ideally, these guidelines would assist health professionals to recognise interprofessional practice learning opportunities that could be offered within or in addition to current clinical placements for students.

**Project Methodology**

The project was steered by a small working group consisting of representatives from acute care, rehabilitation and mental health. The working group established the methodology undertaken and reviewed all documentation.

A call for participation in the interviews with the project officer was emailed through the WA CTN distribution list. Examples of teams were specifically sought from health services that may not currently be providing student placements and those services that only offer occasional student placements (e.g. for one single discipline represented in the team or services that have only one student per year). Figure 1 was included in the call for participants, to encourage teams who were collaborating regardless of the formality or manner of collaboration they engaged in. The quality of interprofessional practice within the teams or clinics was based on the team’s judgment and provision of examples.

**Figure 1 Framework for Interprofessional Practice / Collaborative Practice**

<table>
<thead>
<tr>
<th>Moments of Collaboration*</th>
<th>Teamwork *</th>
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<tbody>
<tr>
<td></td>
<td>(can’t happen without collaboration)</td>
</tr>
</tbody>
</table>

*where collaboration occurs at sufficient frequency and quality on this continuum, the services can provide an interprofessional learning experience

Teams who identified with the call for expressions of interest were asked to contact the project officer and interview times were then negotiated. *Team* was used as the umbrella term and describes a core group of professionals (and clients) that delivered a particular health service or clinic.

Representatives of each team were interviewed by phone using a set of common questions. The project officer, who was a health professional with over twenty years of experience working in teams and facilitating teamwork across rural and metropolitan sites and in primary health to tertiary care settings, conducted all interviews. The project officer initiated prompts for further information as required during the interviews. The interview format was designed following a synthesis of current literature exploring types of interprofessional education activities and elements of interprofessional practice. Specific to student placements, the interview explored common content from interprofessional capability or competency frameworks to explore what learning opportunities existed.

Overall, interviews aimed to gather a consistent and clear sample of core elements of team practices and student placement opportunities for comparative purposes and to build up a ‘bank’ of interprofessional practice examples. Case studies were documented using the framework and the written summary reviewed for accuracy by each team.
During the interviews and as part of the active analysis process the project officer identified some commonalities emerging as the variable determinants of teams. These variables formed the developmental framework depicted in Figure 2. Interview findings were further analysed according to key trends and themes. These themes are outlined with suggestions for further actions and investigations required.

**Figure 2. Team (interprofessional practice) Framework**

3. Project Results

**Interviews**

Nineteen Western Australian teams responded to the call for participation with one to two representatives of each team participating in an interview. Interviews lasted between 30 to 60 minutes for each team. Interviews often became an interactive dialogue between the project officer and the team representative as teams requested how they could develop their placement as an interprofessional learning experience for students.

Teams participating in the interviews were public health providers operating in hospital and community settings, health providers operating in the non-government sector and private sector were approached but declined to participate. The participating teams identified the following as catchment areas for their health service:

- Statewide (4)
- Metropolitan Perth (7)
- Rural and Remote (8)

Clinical areas serviced by the teams included:

- Aged Care
- Mental Health
- Maternity
- Complex and chronic conditions
- Disability services
- Paediatric
- Rehabilitation
- Acute care
- Disadvantaged/ complex social issues/ Alcohol and Drugs
Professions represented on the teams included:
- Occupational Therapy (OT) = 16 (e.g. OT was represented on 16 of the 19 teams)
- Social Work (SW) = 14
- Physiotherapy (PT) = 12
- Nursing (N) (including Midwifery/ Child Health Nurse (CHN) =12
- Speech Pathology (SP) =10
- Medicine (Med) = 10 (from a range of specialties and ranging from residents to senior specialists dependent on the team)
- Clinical Psychology (CP) = 6
- Dietetics = 3

Teams also included Allied Health Assistants, Aboriginal Health Workers, Mental Health Officers, Audiologists, Pharmacists, Chaplains, Podiatrists and Pathologists.

There was a diverse configuration of professions represented on different teams with the smallest teams comprised of 3 core professional groups (for example Med, SW, CP) and the largest consisting of 7 professional groups (for example Med, SP, OT, PT, SW, CP and Audiologist).

All teams were described as having a degree of collaboration with other professional groups that were either part of the same service (but not consistent members of the team) or of external agencies.

Terminology used by teams to describe their service varied between multidisciplinary and interprofessional and interdisciplinary. However, all identified with the concept of a team that worked together to achieve the best outcomes with the client.

**Student Participation**

Two teams were University coordinated interprofessional student placements where continuous rotations of students occurred throughout the year and students of more than one health profession have overlapping placements. These programs fulfilled a student led (student directly managing service provision) format.

A third team had experienced this combined profession student format when funded as an interprofessional practice placement. However, with the loss of Commonwealth funding, specifically accommodation funding for a rural student clinical placement, had been unable to have their offers for placement filled by the universities for the frequency and variety of students needed to sustain the model.

Of the remaining 16 teams, all but one team were described as having had at least one student on placement in the past two years and 14 teams were reported to have had students from more than one profession in the year. While several of these teams frequently had overlaps of students from different professional groups, these were considered ‘unplanned’ or opportunistic. When overlap occurred some programs combined the students on learning experiences or observation sessions together.

Teams also identified occasions when students from a profession not represented on the team engaged with the team as a learning experience e.g. medical students involved in an emergency department were exposed to the care coordination teams and their role in
decision making for patient admission or discharge. Teams indicated that they had scope
to offer a clinical placement to students from health professions not represented on their
team. They identified this as an opportunity to supplement their service provision (e.g.
pharmacy student potential participating in sub-acute rehabilitation), as well as offer a
learning experience or opportunity for students to gain exposure to difficult to engage
communities or Aboriginal and Torres Strait Islander (ATSI) communities.

Team Approach

Interviewees were asked which of the following descriptors best applied to how the health
professionals on the team provided services;

**Coordination:** Team members talk and provide each other with necessary information

**Cooperation:** Team members negotiate and plan to minimize duplication/ensure resource
efficiency

**Collaboration:** Team members interact, negotiate and jointly work with other team
members.\(^\text{12}\)

Fifteen (15) of the teams felt that the **collaboration** description best described the key
approach of their team. However, 12 teams considered that all three team approaches
were applied according to the particular needs of the clients. Teams described that the
three team approaches were in operation at any one time as a ‘sliding scale’ depending on
the needs, complexity and circumstances of the client.

“we cross all three depending on the needs of the client” Team 5

Decision-making around which of the three approaches was needed by a client was often
described by interviewees as continual monitoring of a client’s progression, a careful
allocation of resource intensity by a coordinator or manager.

“the coordinator is aware if someone has been seen a few times and is not moving, we
may send in someone new with a fresh pair of eyes” Team 19

Three interviewees reported that the focus of their team was at a level of complexity that
collaboration was essential for nearly every client/ family group.

“for support and the complexity we have to have dual medical and psychosocial services –
we have two heads on everyone” Team 13

An interviewee describing a rural health service reported different teams within their larger
service ‘team’ that tended to align to different descriptors (with varying team approaches
used within the smaller teams dependent upon specific client needs). For example, a
feeding difficulties clinic reported requiring more collaborative effort for a greater proportion
of the clients while a fracture clinic at the same service operated predominately at the
coordination level, aligning appointments and sharing critical information.

The final 2 teams identified most strongly with the cooperation description only.

“it’s mostly informal.. plan who will see them that term” Team 16

\(^\text{12}\) Adapted from World Health Organisation (2010) Framework for Action on Interprofessional Education &
Collaborative Practice, Health Professions Network Nursing & Midwifery Chair, Geneva
Team Management

Interviewees were asked to provide descriptions of the type of quality management system in place at the service to support interprofessional practices, with interviewees asked to indicate which best described their current circumstances.

**Type One** – a spirit of cooperation that is personally driven
**Type Two** – proactive processes and agreements although informal (not strategically planned)
**Type Three** – systematic process and written agreements supporting teamwork

Interviewees from 15 teams felt that they had systematic planning processes and written agreements that supported the interprofessional practices in place. They provided examples of orientation packages, documented program delivery guidelines and clinical guidelines that emphasised collaboration as the operational context. In particular, a strong orientation package (some used for both new staff and for student clinical placements) were considered critical to ‘set the scene’ of the practices in place for the team. Most of these teams indicated they met not just for clinical purposes but also at least annually to review how the team was functioning and establish quality improvement targets.

Four teams considered that they had more informal processes in place or felt that their teamwork practices were currently under development. No teams identified with type one which is most likely a reflection of the process of ‘self selection’ that occurred as part of the project methodology (i.e. teams responded to a call for expressions of interest). This process of self selection has meant that teams with stronger processes in place supporting their interprofessional practices tended to respond to the call for participants.

Team Processes

Interviewees provided many examples of the processes that were in place that supported collaborative practices. These included;

- one point of referral contact or one written referral document into the team,
- case management/ key worker service provision models,
- client intake triage processes,
- patient/ client focused management plan,
- shared/ joint assessments of client,
- use of client centred collaborative assessment tools e.g. Scale of Assessment of Family Enjoyment in Routines (SAFER),
- shared/ joint responsibility for delivery of health services,
- client group sessions facilitated by the team,
- regular team meetings/ information sharing sessions,
- start of the day planning / collaboration sessions,
- single format discharge or outcome reporting,

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tools to support interprofessional learning of team members e.g. self directed learning packages, regular in-services delivered by a scheduled professional to the rest of team, newsletters.

Several teams described information sharing contexts where the combined skills, knowledge and experience of the team as a whole was engaged for the purpose of problem solving of complex issues. This team based problem solving approach was used even where the whole team was not necessarily involved directly with a particular client. Interviewees described a sense of a large team collaborating for the benefit of each client with direct health service delivery led (efficiently) by a critical few.

“a meeting where the team collaborate even if not seeing the client and everyone gets to have input” Team 5

“we all have different insights … it’s wrapped around care as a group with the woman at the centre” Team 14

Collaborative tools and clinical guidelines were consistently described as elements of the team that supported and maintained both a consistent level of collaboration and the patient/ client centric focus of the team. Patient/ client centred practices were considered the core of most of the teams.

“it (key worker model) has reduced the frenetic feeling that everyone has to get their bit in…the professionals focus on the parent’s priority” Team 15

“a room is allocated to the parents…professionals visit them” Team 2

Team Learning

Interviewees were asked to reflect on the elements of collaborative practice and teamwork a student would be exposed to during a placement with the team. Responses were analysed as an example against the Implementation Framework for Interprofessional Learning at Griffith University threshold learning outcomes14 to reflect on the capacity for current health service teams to provide interprofessional learning experiences. This framework was selected as it focuses particularly on setting minimum learning standards for students grounded in the Rogers, Chan & Buys three-phase developmental model.4 5

Table 3 Interviewee responses aligned with the Griffith University Minimum Learning Outcomes for IPL

<table>
<thead>
<tr>
<th>Griffith University Minimum Learning Outcomes for interprofessional practice</th>
<th>Opportunities for students to be exposed to learning content in surveyed teams</th>
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<tbody>
<tr>
<td>Articulate purposes for IPP</td>
<td>Keeping the team focused on the purpose of the service was considered critical, with interviewees describing how they continually reflected and reviewed as a team to ensure decisions were meeting the team’s purpose.</td>
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| **Work effectively in a team** | Teams interviewed had a range of both formal and informal processes in place to optimise the team working effectively. Orientation was considered critical with many teams having shadowing work processes to fully and gradually embed a new staff member (or student) into the team work culture and methods.

> “a team member chairs the coordination of the program for a year and then they act as the deputy chair to help out the new chairperson” Team 4 |

| **Describe barriers to IPP and strategies to overcome** | Interviewees were clear on how they had to overcome barriers to IPP such as lack of co-location with other members, and services being delivered ‘out on the road’.

They also reported students commenting on how their ‘design’ was markedly different to other experiences because the teams had actively changed structures and processes to overcome barriers. |

| **Health professions literacy (own profession)** | All teams surveyed offered scope for students to see their profession in interprofessional contexts where skills sets such as flexibility, clinical decision making and clinical judgments based on past experiences were critical rather than reliance on the use of formal assessments and therapy tools. |

| **Health professions literacy (other professions)** | A range of experiences were available in different teams for students to experience and appreciate other professional’s roles including:

- clinical discussion meetings
- team professional development tools (e.g. Emergency Department Care Coordination Learning package)
- joint visits or observation opportunities in clinic or in the community

> “learn how to ‘talk about’ other professionals when you are the key worker” Team 15

> “spend a day with all disciplines to see their role” Team 18

> “becomes clear to see who does what” Team 14 |
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Recognise and challenge stereotypes</strong></td>
<td>Certain teams offered considerable scope for students to observe and reflect on stereotypes and how misperceptions can influence clinical decisions. Teams working with families from disadvantaged backgrounds, refugees, aboriginal communities and people affected by drugs and alcohol could provide rich experiences with people living in complex situations that may challenge and expand student appreciation of these contexts.</td>
</tr>
<tr>
<td><strong>Express options appropriately</strong></td>
<td>As above certain teams provide a rich environment for exposing students to the many strategies and communication skills required to provide options that support client / patient decision making. &quot;they need to learn that just because someone is nodding their head ..it doesn’t always mean they agree… or understand them&quot; Team 18</td>
</tr>
<tr>
<td><strong>Listen effectively</strong></td>
<td>All teams reported the communication skills were critical and listening to the patient/ client to understand their point of view was essential.</td>
</tr>
<tr>
<td><strong>Synthesise input to reach consensus on optimal care and support</strong></td>
<td>Most teams identified that a core group of clients/ patients required high level discussion, sensitive planning and continual reflection on intervention. There was variation in the amount or frequency of these types of situations depending on the team’s focus (ranging from the majority for specialised teams to approximately 50-70% of a team’s clinical ‘workload’ e.g. client numbers were not necessarily high but the level of collaboration needed took up a large proportion of the professional’s time). &quot;every call and every case is shared...different points of view help” Team 13</td>
</tr>
<tr>
<td><strong>Reflect critically and creatively on IPP performance</strong></td>
<td>Most interviewees identified this as a gap in their current approach to student placements in that they rarely facilitated explicit reflection on elements of IPP the student was experiencing when working in the team.</td>
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### Barriers to Team Based Student Placements

Interviewees were asked what were the barriers to having students embedded within the team. Barriers clustered around four main themes:

- Supervision Capacity
- Clinical Load
- Infrastructure
- Allocation
**Supervision Capacity**

Teams reported barriers specific to having inadequate staffing levels or fluctuating staffing particularly with systemic impacts of job freezes, perceived impacts of activity based funding models and ‘project only’ status of some teams. Limits to team members’ experience and skills in supervision or having adequate time to support students at risk or having difficulty was identified as a barrier.

Despite these capacity restrictions almost all teams reported an interest in providing students with exposure to their models of care. Some felt these restrictions would mean they would have to limit how many students they could take and only focus on health professions integral to their team (rather than a broader cohort of health professions).

**Clinical Load**

A major concern for teams was around the capacity to offer a suitable, safe and adequate clinical experience for students in the team context. Barriers included fluctuating levels of suitable clients, fluctuating clinical requirements during student placement periods.

“challenge to find a caseload for a student” Team 14

“would they see enough?” Team 4

“one off exposure” Team 2

“may not see the whole process” Team 15

The complexity of the client group was also perceived as a barrier for students in terms of the skills, knowledge and experiences needed to provide services. Team processes relied on extensive clinical experiences and/or the need for rapid decision making e.g. drop-in clinics, informal assessments with ATSI families. Interviewees reported limitations on how ‘hands on’ students could be and reflected that there would need to be a degree of shadowing rather than direct management of clients.

“complex nature of the clients” Team 4

“seniors only due to the complexity and the need for a professional with confidence and solid experience” Team 13

Similarly, there were barriers around which clients could be allocated to students based on assessed safety risks, potential risks to losing client engagement and how often client/families could be asked to engage in student programs.

“need processes to make the student safe” Team 14

“has risks for the engagement of some families” Team 7

“have to be careful about the amount the family has been used for a student” Team 15
**Infrastructure**

Barriers common to most student clinical placement programs included the lack of physical space for both service provision and hosting student placements in rural areas. Physical space restrictions were perceived as an obstacle based on assumed need to take more than one student at a time, but also just a reflection of the lack of suitable physical space for current service provision.

> 'overwhelming already as part of a busy medical clinic’ Team 14

Those teams with extensive travel requirements (e.g. where all services were provided as home or community visits) reported issues around students not being able to use cars to provide these services.

**Allocation Planning**

While two team programs were targeted interprofessional placements and therefore allocated students in this capacity, the other teams had variable methods of being allocated a student. Some student placements were part of a broader profession specific placement. This may mean that students participated in the team programs because they had been allocated to the particular professional involved in that team. Alternatively, the team was allocated as a ‘rotation’ experience. Varying requirements around planning and allocation of students does impact on the team’s overall capacity to anticipate and coordinate student placements.

> “there are differences in departments ‘way’ of taking students’ Team 4

> “part of a broader placement“ Team 2

Many teams reported that allocation of students by universities was variable so that even when requested by health services, students were not necessarily allocated. Interest in having students participate in some teams was felt to not have been supported by university schools.

The requirement for placement offers to be made well in advance limited some team programs being able to respond to these requests due to an inability to predict staffing capacity or even program existence in the case of some team programs that were still not considered core business.

**Form of Placement Assessment**

Representatives of the teams were asked what types of assessments they completed for student placements (where applicable) and what they perceived would best suit their placement.
Table 3 Continuum of Placement Assessment Options

<table>
<thead>
<tr>
<th>Profession specific</th>
<th>Profession specific with targeting of the Interprofessional elements</th>
<th>Profession specific and an Interprofessional capability tool</th>
<th>Interprofessional capability tool only</th>
</tr>
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</table>

Students were being assessed on a profession specific competency tool for all except one university partner program where students were assessed using an interprofessional capability framework only. One other profession within a team was able to use an interprofessional capability framework in lieu of a profession specific tool (Occupational Therapy).

Interviewees expressed limited awareness of interprofessional capability tools. However, 6 teams indicated that they could potentially assess a student specifically on an interprofessional capability tool particularly where there was perceived to be a limited capacity to provide access to profession-specific clinical competencies for a student. As part of a broader department rotation these teams could offer options for intensive interprofessional capability experiences to complement more clinically specific services.

Interviewees also indicated there was considerable scope to enhance the explicit discussion of interprofessional practice capabilities and experiences to support student interprofessional learning. There was a need for more explicit reflection of interprofessional competencies when the profession specific tools that were being used.

“IP competencies need to be clearly represented in each of the professional competency standards” Team 17
4. Discussion

Opportunities for students to be exposed to interprofessional practices exist in a range of health service settings.

This small survey of Western Australian health and disability sector teams has indicated that a variety of team environments are available for students to gain exposure to interprofessional practices. Teams identified as providing interprofessional practices represent most of the major health care settings including emergency, acute care, rehabilitation, aged care, mental health, paediatric and disability services. In particular, teams were identifiable in all health care settings currently considered critical for enhanced student placements including primary care, mental health and rural and remote contexts.

Teams were engaged in a number of interprofessional approaches that ranged on a continuum from simple coordination of services across multiple professionals, through to cooperation between professionals and finally collaboration among multiple professionals for the most complex of the client groups (Figure 3). Application of the range of team approaches within teams reflected an important interprofessional competency, that of a clinical judgment in relation to which of the health professionals are needed and how health professionals are to be engaged (e.g. direct or indirect) in order to support the achievement of client outcomes. In applying this interprofessional competency, the clinician must also consider various factors relating to the efficient use of staffing resources.

Figure 3. Client Driven Teamwork

Team management, of the majority of teams in this survey, had a degree of formality that supported long-term collaborative practices and was sufficiently sustainable in order to withstand employee turnover, as well as industry pressures and changes. These teams engaged in quality improvement practices which target the functioning of the team such as annual planning meetings, team reviews and collaborative projects such as team orientation package development or self-directed learning packages.

Team management, of all other teams surveyed, had informal agreements or guidelines that supported the team’s interprofessional practices. This survey indicates that there is capacity for further networking and collaboration aiming to strengthen systematic
processes that facilitate interprofessional practices - both for the teams participating in this survey and for other teams operating in the same health care settings.

It appeared that there were some critical drivers that facilitated certain health settings to establish service delivery teams with good interprofessional practices. One potential driver is a high level of complexity of client needs in the target client group. Interviewees estimated that a minimum of 60-70% of the target client group needed more than one health professional to be involved with them at any one time. A minimum of three health professionals appeared essential to form the core ‘team’.

The teams involved in this study tended to have strong overarching models of care frameworks that team members had embraced and operationalised in areas of mental health, disability, rehabilitation and aged care. However, there was also a sense of strong leadership and purpose for achieving team targets described by Interviewees, the majority of whom held key positions in the team as manager, coordinator or chairperson.

**Opportunities for interprofessional learning are under-utilised currently in the health sector**

There was evidence that students were participating in a number of team models where they were exposed to interprofessional practices, however there were minimal explicit interprofessional learning activities being conducted in these placements (except on placements labelled, either currently or in the past, as interprofessional). This gap between exposure to interprofessional practices and active reflection on those experiences or observations currently limits the role these teams play in the delivery of interprofessional education. Students were self-identifying differences between other placement experiences and the ‘team’ placement, but interviewees openly reflected that this was an aspect they could be facilitating more while the students were on placement.

There appeared to be capacity to increase interprofessional learning activities within current team contexts by expansion of existing resources. Interviewees and stakeholders identified a number of resources with potential scope to be used more universally with adaptations, including student reflection tools (e.g. Subacute Care InterProfessional Education (SCiPE) Reflection on Interprofessional Learning) and self-directed learning packages (e.g. SCIPE training modules; Emergency Care Coordination Learning Package). In particular, orientation packages were either being developed or refined by many teams. These packages were often used for both new health professionals and students, or adapted for students, and were considered critical tools to establish interprofessional practices and the culture of the team.

The assumption, identified at the start of this project, that an interprofessional learning experience needed to have more than one student, appears to have restricted teams considering placements as an interprofessional experience. There is a need to facilitate a broader consideration of interprofessional placement opportunities away from a pure student-to-student learning environment to include more diverse opportunities for learning by a student embedded within a team of other health professionals. Importantly, the emerging placement models of students participating in a team where their profession was under or not represented (with external supervisory support) invite scope for both expanding placement varieties and complementing needed health services (e.g. pharmacy students addressing an inadequate pharmacy access by participating in rehabilitation or aged care teams). There is a need to investigate and deliver the most appropriate
supports to facilitate the interprofessional learning of a single profession student within a team delivering interprofessional practices.

In addition, many teams indicated that they had simultaneously placed students from different professions due to overlaps in university placement schedules, thereby meeting the current common assumption of interprofessional student placements. However, it was generally considered that these overlaps were opportunistic and could not be considered an interprofessional placement because they were unable to be planned and coordinated sufficiently.

For teams identifying as an interprofessional placement, problems were also reported in relation to coordinating placement scheduling of student from multiple professions, i.e. student overlaps not being aligned with each other or consistent. Interviewees indicated a high variance in the duration of scheduled overlap time between students of different professions and also in the duration of time students of different professions spent with each team. This high level of variance is also reported in the literature describing interprofessional placements.¹¹

It is also noteworthy that teams participating in the survey reported limited awareness of interprofessional competency frameworks or models (e.g. Interprofessional Capability Assessment Tool¹⁴; Griffiths IDEAS¹⁴) that could be used for student assessment or to facilitate interprofessional learning by any student on placement in the team. It could be considered that some of the teams are operationalising examples of interprofessional practices reflected by these tools.

**Interprofessional learning experiences will vary dependent on the context of the team.**

The project findings suggest that students could achieve varying levels of interprofessional education, even where the placement meets the criteria described within the Rogers et al⁴ third phase of interprofessional placement context. The team contexts described in interviews highlighted both barriers and potential scope for interprofessional learning that divided placements potentially as either observational (reflective learning) opportunities or active opportunities.

For instance, there are teams where students experience active engagement in processes that develop their interprofessional practice capabilities such as;

- Clinical planning meetings with or without client involvement
- Holistic assessment protocols e.g. Subacute Rehabilitation tool, SAFER
- Key worker/Coordinator roles
- Integrated processes e.g. coordinated notes, central appointments
- Planning/improvement meetings to enhance the team functioning

In some of these teams, students can also engage in activities specific to their professional requirements sufficiently to allow assessment of both profession-specific competencies and interprofessional capabilities. In other teams, however, there may be restrictions on the amount of profession specific activities able to be delivered by the student so that clinical competency assessment may not be feasible. In this instance the placement may target a student’s direct delivery of interprofessional competencies only.
Alternatively, health service teams exist that are well placed to provide observational opportunities for students where clinical skill levels are beyond that typically able to be offered to students, but where the level of collaborative practice is extensive and intensively engaged. Many of these teams offer observational opportunities rich in cultural, sociological and psychological diversity compared to other student placements. They may not be currently being used extensively as student placements because of either the complexity or risks of the client groups or the restrictions on specific professional experiences that can be offered to students. However, they offer scope as exemplars of both collaborative practice and exploration of cultural biases and mental model mindsets essential for interprofessional learning.

Figure 4. Potential Placement Types

Barriers to hosting student placements described by interviewees in this study were similar to more general reports on student placement difficulties in the health sector. Supervision capacity, clinical workloads and the physical infrastructure of the team environment were commonly identified as student placement barriers. However, issues identified in this study around how teams were allocated students highlights some more unique constraints for placing students in interprofessional practice contexts.

One type of team captured in this study could be considered a ‘stand alone’ team in that they were distinct from any other profession specific department and had internal lines of management. Some of these teams reported a perceived lack of interest or uptake of student placement opportunities. These teams considered that this lack of uptake was due to the risk of students not gaining adequate profession specific experiences.

A second type of team existed where the professional (or some of the professionals) on the team were allocated from a larger profession specific health service or hospital department. In this context, issues arose where one profession in the team coordinated students directly with the university, other professions were allocated students as a
‘rotation’ coming through the hospital departments student placement program. Different hospital departments also appeared to vary in the level of interest and method of undertaking student placements. This created an additional complexity, with teams not always able to specifically request and plan team student placements, and therefore needing to respond to opportunities on a more ad hoc basis.

Stronger integration of interprofessional capabilities in each professional competency standard is emerging as a key recommendation of reports focused on curriculum re-designs for interprofessional education. This would support an increased variety of placement opportunities that could contribute to a student’s overall competency set, with scope for a placement to emphasise certain competencies such as the interprofessional practice skill sets.

5. Recommendations

1. Adoption of a broader definition of interprofessional placement in health and education sectors:
   • that challenges prevailing assumptions about the components of an interprofessional placement,
   • by establishing interprofessional placements in health teams with students from single to multiple professions based on the needs and constraints of that health service team, and
   • by exploring models of placing students from professions not currently represented on a health team, with external profession specific supervision as needed.

2. Development of a collaborative approach to improve health professionals’ access and capacity to deliver interprofessional learning activities in health and education sectors:
   • with a commitment by all supervisors to ensuring that all students understand the roles, responsibilities and the professional underpinnings of both their own profession and of other health disciplines.
   • by establishing common frameworks describing the diverse types of interprofessional practices which currently exist,
   • by providing training in interprofessional clinical supervision, and
   • by expanding resources and tools that support interprofessional learning e.g. SCIPE Reflection on Interprofessional Learning resource.

3. Establishment of benchmarks or guidelines for achieving interprofessional capabilities to be supported by education providers, Professional Associations and Accrediting Bodies:
   • with capacity for any placement to report on interprofessional learning experiences gained by a student,
   • preferably within the context of enhancing the interprofessional standards already in each professions competency standards,
   • with support for placements occurring in teams where interprofessional and work-ready skills may be the primary focus.
4. Greater acknowledgement and support for health sector teams providing interprofessional practices:
   - with recognition of the improved health outcomes achieved as a direct result of the interprofessional practices in place,
   - as learning forums for both students and other health professionals, and
   - with a focus on policies and processes that to ensure the delivery of interprofessional practices using the most appropriate and efficient team approaches a client group needs.
Appendix A: Current Literature Reviews

The Interprofessional Curriculum Renewal Consortium, Australia (2014), Curriculum Renewal for Interprofessional Education in Health. Canberra

This is the final report for an Office for Learning and Teaching funded study following on for a 2009 report and 2011 report. It also includes extensive data from the HWA national audit and the WA study of IPE activities. Five recommendations are made to enhance national leadership, coordinate the building of IPE curricula, include IPP standards in all accreditation of health professional requirements, increase research and develop a repository of information and knowledge.

The report suggests a need for IPP to not be solely conceptualized as teamwork but as a manner of practice e.g. WHO example of collaborative practice, essential for all forms of service delivery (e.g. professional collaborating with the client). Additionally a broader view of IPE is encouraged as an educational approach for building collaborative competencies. Overall the report focuses heavily on curricula changes and describes:

- Competency Frameworks for measuring/ assessing IP competency/ capabilities – 6 examples are reviewed.
- IP Competencies that are represented across all current professional standards including:
  - communicating,
  - operating in scope of own practice and knowing when to refer to others,
  - collaborating,
  - working well in a team,
  - IPP for service delivery.
- Methods for teaching and assessing IPE – reviewing five different Curriculum Frameworks, with acknowledgement the as placement experiences are just one of many different IPE approaches and indicating “practice based IPE opportunities provide authentic but often resource intensive experiences”.
- Evaluation deficits and difficulties with reflection on new methods and approaches to evaluation including “realist evaluation”.
- Nine case studies with thematic analysis – no case studies include practice based IPE.

Interprofessional Curriculum Renewal Consortium, Australia (2013)
Interprofessional Education: a National Audit

This project audited Australian IPE activities for HWA. It formed part of a suite of studies (Curriculum renewal project (not reviewed in this document) and the WA IPE project (Nicol, 2013, below). A detailed summary of the history of IPE in the Australian context, and internationally is provided.

Twenty-six participants from different universities reported on approximately 83 specific IPE activities. Seven recommendations were made as key areas for development and national capacity building of IPE in university curricula. Recommendations are made around national leadership, collaborations, common language, core competencies, accreditation standards, CPD requirements and building capacity and knowledge.

The report provides more detailed analysis of the reported IPE activities in the following areas:

- learning outcomes and competencies
Future modelling of scenarios is provided projecting how IPE could look in three different trajectories:

- more of the same
- building on innovation and exemplars
- a curriculum paradigm shift.

**Nicol (2013) Interprofessional Education for Health Professionals in Western Australia: Perspectives and Activity, University of Technology, Sydney**

This report was WA Department of Health funded and aimed to identify and analyse existing interprofessional health education activity in WA. Interviews with 28 key informants were conducted and a review of IPE activities across Curtin, Edith Cowan, Notre Dame and UWA. The 4D Model of Curriculum development was used to present information:

- Dimension 1: Future needs of health care practice,
- Dimension 2: Capabilities,
- Dimension 3: Teaching, learning and assessment,
- Dimension 4: Delivery in institutions.

Specifically under dimensions 2 and 4 they reported that:

- no evidence that introduction of IPE into universities had had any direct effect on health sector workforce practices and the capacity of students to impact on graduation;
  - “there was disagreement about whether graduates with IPE experience would affect IPP in the workplace in future, or be absorbed into existing uni-professional culture and practice”
- many health professionals supported IPE but would not activity engage with it, with fear of role substitution and lack of evidence for IPP.

Within Dimension 3 clinical placements were seen as important but requiring coordination, resolution of organisational culture differences, consistency of external funding, effective planning and good preparation of all participants.

Training of supervisors in IPE and provision of discipline specific supervision concurrently were found to be important for placement success. An issue was raised of difficulties of balancing/ forming appropriate student groupings to be the IPE ‘team’.

Case studies are outlined for IPE activities at each university and multi-organisational activates ranging from single lectures, to clinical placements.

Future issues outlined in the report including:

- funding,
- accreditation and registration bodies,
- agreement across educators in universities,
- changing requirements in health services delivery.
As the follow up report to Dunstan et al (2011), below) this report outlines international commitments to IPE in terms of policy and policy drivers, then addressed the Australian commitment including policy and university responses in terms of IPE/IPL/IPP activity in Australia. It outlines impacts of the changing context of Higher Education in Australia.

The report reviews the literature around developing IPE curriculum frameworks and models, theory and practical requirements of IPE. It highlights the extensive and variable range of competencies, assessment approaches and pedagogical constructs associated with IPE.

Evidence for impact/ effectiveness of IPE is acknowledged as an extensive body of descriptive evaluation mostly limited to the level of participant satisfaction.


This report was the first release of a broader L-TIPP project (released as Nisbet, 2011, as above) as a proposal for adjusting the education and training experiences to improve interprofessional health practice.

The report sets out the need for IPE in the context of health systems needing reform as a result of:

- community expectations for greater partnering in health care decision making,
- workforce shortages,
- increasing chronic illness and life style diseases needing complex response.

Four health reforms are identified:

- improve systems of governances, accountability and funding,
- increase responsiveness to demographic and geographic circumstance,
- new models of IP and team based care,
- establishing a health workforce with both professional and interprofessional capabilities.

Section two provides an historical overview of IPE acknowledging these date back to the 1970s. The report outlines key requirements and issues for IPE based on a national consultation process. The report calls for stronger partnerships between health and education where more extensive and sustained collaboration is needed.

A forecast of national building of IPE capacity and capability was made and tested in consultation with final areas of development called for:

- informing and resourcing curriculum development,
- embedding IPP as a core health professional practice standard, including in registration and accreditation processes,
- research to support and inform development,
- knowledge management systems for improved collaboration.
This document provides a model of integrating education and health systems, acknowledging the need for IPE preparing current and future health workforce to be ‘practice-ready’ to work within collaborative practice health services.

Interprofessional health care teams are described as having the following characteristics in the document:
- an understanding of how to optimize the skills of their members,
- to share case management, and
- provide better health services to patients and the community.

Mechanisms to shape IPE are identified as either educator requirements (academic staff training, university commitment) or curriculum requirements (program content, objectives, contextual learning).

Mechanisms to shape collaborative practices in health include:
- institutional support (protocols, shared resources, supportive management practices),
- working culture (communication, conflict resolution policies, shared decision making processes),
- environmental (space design, location).

The Framework focuses on the concept of collaborative practices defined as health care that “occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings”. (p13)

Internationally there is evidence of the benefits of collaborative practice (See Annex 7 for systematic reviews) across acute and primary care settings.

Evidence for IPE indicates that it is more effective when adult learning principles are used, learning methods reflect real world practice and with interaction between students. (Annex 6).

A key differentiation is made between coordinated teams, communicating across colleagues and collaborative practice – with the first two characteristics considered to lay the foundation for collaboration. Collaborative practice is emphasized as teams engaging in problem solving of complex or emerging problems, where new levels of shared understanding and creativity can be arrived at as a result of the collaboration. The Framework emphasizes systems building on what is currently available.
Appendix B Interview Format: Current Health Interprofessional Practice

Team Name/ Description:
What clinical area or health condition is the team working on?
Who are the core health professionals on the team (consistently /regular)
Additional health professionals when required:
Number of Team Members:
How consistent are the team members (e.g. shift workers/ staff turnover)
What do you consider critical to the teamwork? What is it that makes the team work as an IPP team?

Benefits of Teamwork - What does the team achieve by working interprofessionally?
Checklist:
- Peer support and job satisfaction
- Greater role clarity
- Safety of client/patient by team commitment to detection of gaps or errors in care
- Maximization of limited resources
- Reduced service duplication
- Reduced process duplication (e.g. Referrals)
- Continuity of clinical care
- Problem solving for complex client/ patients
- Collaborative decision making with the client/patient
- Other:

The WHO report on IPE and collaborative practice describes three descriptors of team operation – which description(s) does the team align with?

<table>
<thead>
<tr>
<th>Coordination</th>
<th>Cooperation</th>
<th>Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team members talk and provide each other with necessary information</td>
<td>Team members negotiate and plan to minimize duplication/ ensure resource efficiency</td>
<td>Team members interact, negotiate and jointly work with other team members.</td>
</tr>
<tr>
<td>Exchange of information or messages Team rapport Ease of access to information needed by all team members</td>
<td>Assisting each other to provide clinical services/ care.</td>
<td>Team focus on complex health problems and use their diverse points of view to create solutions.</td>
</tr>
</tbody>
</table>

In terms of the type of quality management (in Vyt (2008)) in place to support teamwork – which of the following types of team processes describes your team?
<table>
<thead>
<tr>
<th>Type One</th>
<th>Type two</th>
<th>Type three</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality is bound to personal aspects and can be variable, according to the persons working in the team</td>
<td>Professionals think proactively in terms of processes and agreements are made, albeit on an informal basis.</td>
<td>Health care workers work together on a systematic basis.</td>
</tr>
</tbody>
</table>

Does the direction of the team/unit explicitly stimulate interdisciplinary cooperation?
Are most colleagues willing to work together across disciplines?
Do most colleagues engage spontaneously in consulting and cooperating with other disciplines?

Are there persons who are especially skilled in coaching teams?
Are task descriptions written out in relation to other disciplines?
Do the working groups have clear goals in organizing meetings?

Is there a specific input of all disciplines that should be involved in projects and in meetings?
Do all professionals have the skills to engage and work efficiently in team meetings?
Are working documents in the unit structured and filled out in a way that it enhances efficient interprofessional communication?

Have there been students on clinical placement who have been exposed to the team’s way of working in the past 2 years?

<table>
<thead>
<tr>
<th>No students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student from one profession only (e.g. nursing students)</td>
</tr>
<tr>
<td>Students from more than one profession but with no overlap in students placement timetables</td>
</tr>
<tr>
<td>Students from more than one profession and with some to frequent overlap with other students.</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

If a student were to be on a clinical placement with the team what elements of IPP would they be exposed to?

<p>| Consensus/ decision making processes |
| Conflict resolution strategies/ policies |
| Facilities or a built environment that support teamwork |
| Use of processes and IT to support critical communication across team members |
| Regular meetings for clinical care |
| Model of team leadership and coordination |
| Strategies to support new members to be part of the team |
| Engagement with a team broader than health professionals e.g. other agencies involved in team regularly |</p>
<table>
<thead>
<tr>
<th>Culture and value of teamwork or efforts to improve/ develop the culture and value of teamwork</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reflection on teamwork and how well the team is functioning (e.g. meeting to develop the team)</td>
</tr>
<tr>
<td>Other:</td>
</tr>
</tbody>
</table>

What barriers are there to having a student on placement with the ‘team’?
What level of evaluation of the IPE could be used in the team?
Profession - Profession and IPP tool – IPP tool only
Is there a member of the team who exemplifies/ leads IP practice? How?