STORYAID.EU
IPE CONCEPT ANALYSIS

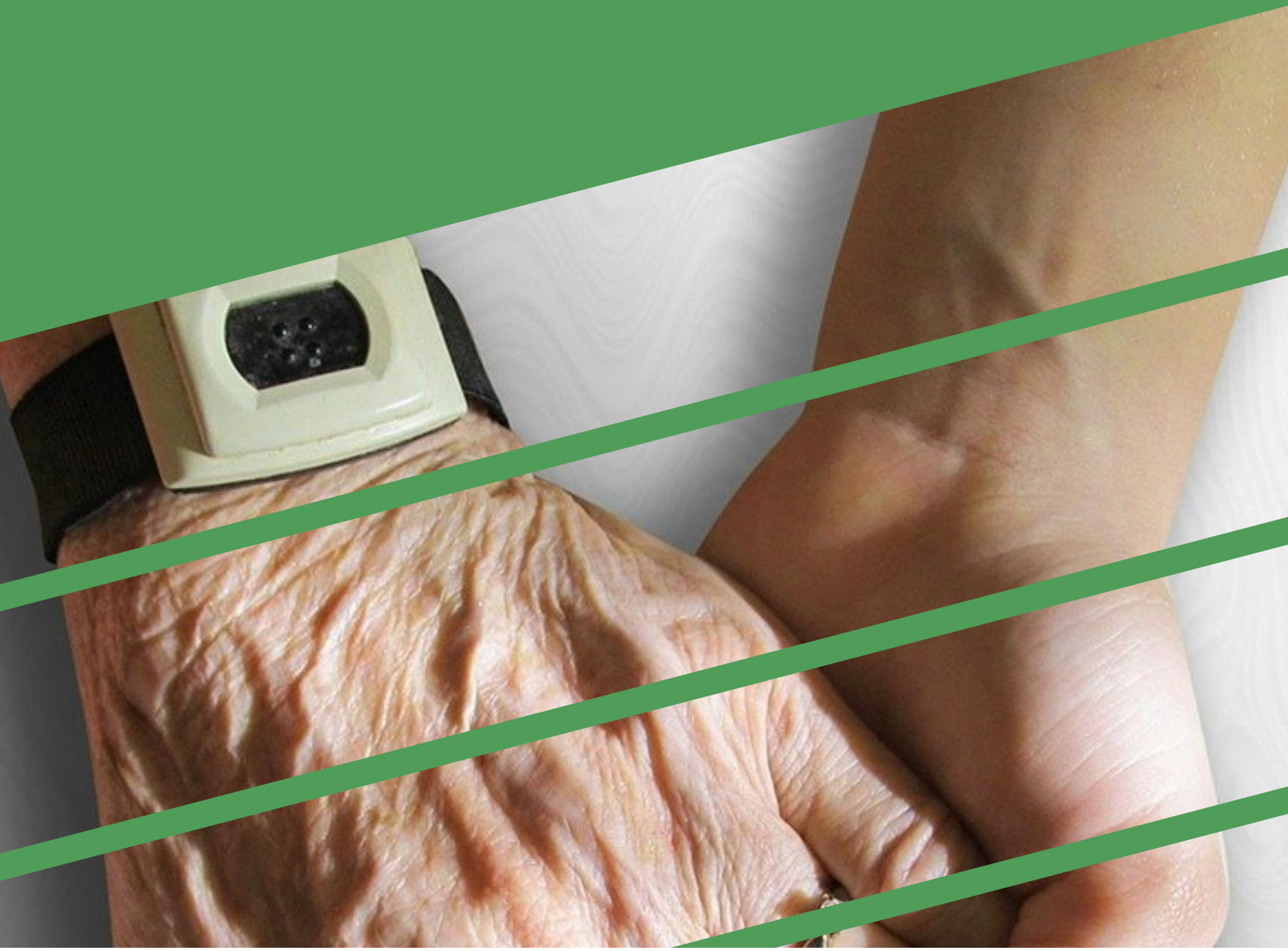
ERASMUS+ PROGRAMME

2014-2020

KEY ACTION 2: STRATEGIC PARTNERSHIP

HUMANIZING HEALTHCARE EDUCATION THROUGH THE USE OF STORYTELLING

AGREEMENT N°2019-1-ES01-KA203-065728



StoryAidEU
Humanizing Healthcare Education through the use of Storytelling
Medizinische Universität Graz
RGU ABERDEEN
WSEPiNM KIELCE
MTU
AGENFOR ITALIA
International Network for Health Workforce Education
Co-funded by the Erasmus+ Programme of the European Union

ERASMUS+ PROGRAMME

2014-2020

KEY ACTION 2: STRATEGIC PARTNERSHIP AGREEMENT

N°2019-1-ES01-KA203-065728

STORYAID - HUMANIZING HEALTHCARE EDUCATION THROUGH THE USE OF STORYTELLING

Concept Analysis: IPE

July 2020

Contents

The aim of this paper is to develop a concept analysis which explores the concept of interprofessional education (IPE) in order to provide greater clarity within the context of the project *Humanizing Healthcare Education through the use of Storytelling* (StoryAid). The paper establishes an operational definition for the concept of IPE as it relates to the health care setting. A concept analysis is a strategy that allows one to examine the attributes or characteristics of a concept (Walker and Avant 2005 p 37). Concept analysis methodology is vital in order to gain scientific and conceptual clarity to guide research (Wilson 1963). A number of different concept analysis methodologies exist within the nursing science literature (Walker and Avant 1994, Morse 1995 and Chinn and Kramer (1995). According to Fitzpatrick and McCarthy (2016) the concept analysis method proposed by Walker and Avant (2005) is the most frequently used method within the healthcare sciences. Undertaking a concept analysis is important to clarify the meaning of IPE due to the concept being of central importance to the StoryAid project.

This paper outlines the concept analysis methodology developed by Walker and Avant (2011). Walker and Avant were the first to develop an 8-step model of concept analysis for HCP based on Wilson's work. The Walker and Avant (2011) framework is a step-by-step approach which gives rise to the defining attributes, antecedents and consequences of a concept which, in turn, provide an operational definition offering greater clarity of meaning. The authors suggest that concepts are categories of information that contain defining attributes and that concept analysis is the formal, linguistic exercise which enables the delineation of these defining characteristics or attributes. It includes the following steps: (1) selecting a concept; (2) determining the aim of analysis; (3) identifying all possible uses of the concept; (4) determining concept-defining attributes; (5) identifying a model case; (6) identifying a borderline case; (7) identifying antecedents and consequences of the concept; and (8) defining empirical referents of the concept.

Selecting a concept

According to Walker and Avant (2011) the first step is to select a concept. The concept should make some contribution to the development of the discipline and there should be some lack of clarity or consensus as to its meaning or use within the context in which it is to be explored. In the context of the StoryAid project, IPE is a key concept relating to health care professionals' ability to effectively work together, however the concept is used and defined in a range of ways so it requires greater conceptual clarity. The significance of IPE is extremely high since collaboration and highly integrated teamwork are essential to patient safety and quality of care (Olenick, Allen, Smego, 2010). When individuals of different professions learn together, the experience can change their attitudes, and reduce stereotypes between professions within the medical field. IPE is increasingly being recognized as a valuable tool of training health professionals to improve health care and patient outcomes.

Determining the aims of analysis

Once the concept is identified, the second step is to determine the aim of the analysis. The aim of this analysis is to explore the concept of interprofessional education (IPE) regarding its direct connection to humanism and storytelling. More specifically, the aim is to identify the attributes and characteristics of IPE and to develop an operational definition of IPE within the context of health workforce education that fits all disciplines, defines common goals.

Identifying all uses of the concept

With roots in the 1960s and 1970s, mostly across the United Kingdom (UK) and United States, the IPE movement became energized in the late 1980s through two reports by the World Health Organisation: *Continuing Education for Physicians* (1973) and *Learning Together to Work Together for Health* (1988). In the UK, IPE originated in numerous discrete initiatives, largely unknown to each other in various

fields of professional practice. Early IPE efforts were largely based on the premise that teamwork and collaboration not only help to better meet the needs of patients and clients, but also help to resolve tensions between professions working in close proximity to each other (Fransworth et al., 2015). Interprofessional education (IPE) was first conceived in 1973 by a WHO expert group in Geneva. WHO member states were then charged with implementing medical education IPE pilot projects and since then there has a been a rapid proliferation in the number of publications on the subject.

IPE has been defined as an andragogical, interactive, experiential learning and socialization process. It occurs when two or more members of a health care team (who participate in either patient assessment and/or management) learn with, from, and about each other as they collaboratively focus on patient-centered care and achieving optimal health outcomes (Olenick, Allen, Smego, 2010).

IPE reduces segmented education between health care professionals, thereby decreasing hierarchies, misperceptions and miscommunications between different professions. IPE legitimizes a holistic approach in which health care professionals recognize each another's contributions to patient care. The effective incorporation of IPE into health professional education curricula and practice settings has the potential to result in optimal patient-centred outcomes, due to effective and highly integrated teams facilitating and optimizing collaborative patient care and safety (Olenick, Allen, Smego, 2010).

Another aspect of IPE is that it supports people – including health professionals, health workers, students, residents, patients, families and communities – to learn together every day in order to enhance collaboration and improve health outcomes while reducing costs (National Center for Interprofessional Practice and Education, 2020).

The purpose of IPE is to prepare the students of health professions for Interprofessional Practice (IPP) by teaching collaborative practice competencies within the context of Interprofessional Teams. Collaborative practice competencies (knowledge, attitudes, and behaviour) must be integrated into the curricula of health professions. These collaborative practices can have a highly significant impact due to effective health care teams being a key factor for improving patient safety and the quality of patient-centered care (Kilner, Sheppard, 2010).

Defining attributes

The fourth step involves defining the critical attributes within the specific context of the StoryAid project. The defining attributes of a concept are described as the characteristics that consistently appear in the manner with which it is used (Walker and Avant 2005). The defining attributes of IPE identified in the literature review are: (i) active involvement; (ii) experiential learning and socialisation; (iii) anagogical experiences, and (iv) collaborative, patient-centered care. The first is that IPE includes *active involvement* (interactional) by two or more members of a health care team who participate in either patient assessment and/or management.

The second is that IPE is an *experiential learning and socialization process*. IPE involves a process where participants learn with, from, and about one another, both within and across disciplines, via the experience itself.

The third attribute is that IPE involves *anagogical experiences*. This means that IPE involves processes whereby knowledge and values are shared between participants in a non-hierarchical and decentred manner.

The final attribute of IPE is that it promotes *collaborative patient-centred* care that strives for optimal health outcomes that are *not driven by content or subject matter*. A wide range of professionals can participate in IPE, such as nurses (including nurse practitioners or nurses with advanced degrees),

doctors, pharmacists, social workers, nutritionists, physical therapists, occupational therapists, counsellors, physician assistants, dentists, emergency medical personnel including paramedics, radiology professionals, and respiratory care professionals. Any medical or allied health professional that engages in patient assessment, care, and/or management may be included in IPE.

Definition

In light of the above, IPE can be defined in the following manner:

Interprofessional education is defined as developing healthcare students to learn with, from and about each other to teach them to work collaboratively in practice, resulting in improved patient care.

Identify a model case

The fifth step involves constructing a model case to include all the defined attributes of a concept. A model case encompasses all the defining attributes of a concept and is a pure exemplar of the case (Walker and Avant, 2011). The following is a model case which includes the defining attributes of IPE. A model case can be incorporated into training due to it triggering a social reflection of an experience that demonstrates key andragogic principles – learner centeredness, motivation and readiness to learn. Using a model case to encourage a reflection experience enables students to learn from one another as they have acquired similar knowledge and need to practice similar skills (Leggat, 2007).
In this IPE activity, groups of different health profession students participate in a problem-based learning case scenario. Prior to the day of the IPE exercise, students are given information on the disease featured in the activity, and its relevant treatment from both their professional perspective as well as from a multi-professional perspective. The rationale for this is that students can focus on interprofessional interactions instead of exclusively focusing on knowledge of disease. Thus, the exercise becomes process-focused rather than content-focused. The distinguishing feature of this IPE exercise is that each group of learners assumes the role of a health professional other than their own health profession role. Assigned roles are determined randomly; for example, pharmacy students assume the role of a nurse, medical students assume the role of a pharmacist, and nurse students assume the role of a doctor (Thistlethwaite, Moran, 2010).

Model Case

An ambulance crew transferred a homeless gentleman to the Emergency Department following a head injury. The gentleman was dressed in torn clothes and smelled of stale tobacco. The paramedics informed the nurse in the Emergency Department that this gentleman may be dangerous. The nurse started to examine the patient without informing him, as he was sleeping. The patient woke up and started to stand up on the stretcher. The nurse asked him to sit back down and relax. The patient continuously tried to stand up, eventually pushing the nurse and pulling out a knife. The nurse started shouting in fear ,"He has a knife! he has a knife!". A physician arrived on the scene to assist her ***(active involvement)****; he calmly walked over to the patient and said, "I can see you are scared but you are in hospital and we are here to care for you as you have a head injury"* ***(andragogic /non-hierarchical and decentred experiences)****. The patient calmed down and started to speak with the physician. The physician discovered that the patient had spent two months on the street after an economic crisis. He was separated from his wife and left homeless. During his time on the streets, he had been mugged and abused. He was anxious, fearful, and distrusting of other people* ***(an experiential learning and socialization process)****. The emergency team arranged for him to shower and eat a meal* ***(collaborative patient-centred care).*** *He was also referred to a social worker. The patient started to co-operate, and everyone found him interesting to speak to* ***(knowledge and value sharing process).*** *The gentleman was eventually discharged. Within six months the gentleman came back to the Emergency Department to thank the staff for listening to him and showing empathy towards him. He was not recognizable as*

*he was dressed in a suit and clean-shaven (**a process where participants learn with, from, and about one another and the patient).***

Contrary Case

A contrary case is a clear example of "not the concept" (Walker and Avant 2011).

An ambulance crew transferred a homeless gentleman to the Emergency Department following a head injury. The gentleman was dressed in torn clothes and smelled of stale tobacco. The paramedics informed the nurse in the Emergency Department that this gentleman may be dangerous. The nurse started to examine the patient without informing him as he was sleeping. The patient woke up and started to stand up on the stretcher. The nurse asked him to sit back down and relax. The patient continuously tried to stand up, eventually pushing the nurse and pulling out a knife. The nurse started shouting in fear "He has a knife! He has a knife!". None of the supporting health care workers were in the area to aid the nurse. Eventually the nurse was able to calm the man on her own. The nurse discovered that the patient had spent two months on the street after an economic crisis. He was separated from his wife and left homeless. During his time on the streets, he had been mugged and abused. He was anxious, fearful, and distrustful of other people. The nurse was aware that this man needed a collaborative care plan but knew that the other staff were not able to support with this case due to being exclusively focused on their designated tasks. The nurse continued to care for the man alone and finally referred him to a social worker when he was no longer in the nurse's care.

This contrary case demonstrates an absence of IPE as it contains none of its four attributes. The patient was cared for entirely by the nurse, who experienced no team support which meant she was unable to provide high quality comprehensive care.

Identify antecedents and consequences

The identification of antecedents and consequences is the seventh step in the Walker and Avant framework. These are useful to highlight the social context in which the concept would be used, and to reinforce the key attributes of a concept (Walker and Avant 2011).

Antecedents

Antecedents are defined as those events or incidents that must occur prior to the occurrence of the concept (Walker and Avant 2005). Processes required to generate effective IPE include cognitive processes, reflective processes, problem-solving, critical thinking, the development of trust relationships, and the fostering of curiosity. Interprofessional learning components consist of experiential learning (where knowledge is created through experiences), and social learning (where learning is a social activity) (Bridges, 2011).

Consequences

Consequence is defined by the Online Dictionary (2020) as the effect, result, or outcome of something occurring earlier therefore it is the outcome of the concept. Due to IPE involving students from several healthcare professions learning and working together, it has shown to have a positive impact on teamwork in daily health care practice and is recommended for training programs of healthcare professionals (Thistlethwaite, Moran, 2010). Several advantages of IPE have been reported which include increased mutual respect and trust between different health professions, improved understanding of professional roles and responsibilities, more effective communication, increased job satisfaction, and positive impact on patient outcomes (e.g. decrease in patients' length of hospital stay and reduced number of medical errors) (Freeth, et al. 2005).

Defining empirical referents

The eighth and final step in the process of concept analysis is the identification of empirical referents, which involves individuals being able to measure or identify the concept. Empirical referents are classes or categories of actual phenomena that by their existence or presence demonstrate the occurrence of the concept itself (Walker and Avant 2011). Evaluation of interprofessional learning is evidenced by a change in knowledge, attitudes, behaviours, beliefs, and/or skills. Since the focus of IPE is on interaction rather than specific content, this means that evaluating whether interprofessional learning has occurred can take place through assessing reflection, journals, or concept maps. Evaluating whether particular competencies have been achieved would also provide evidence of effective interprofessional learning.

Conclusion

IPE training is a key competence that students across all healthcare professions should gain in the course of their studies in order to foster greater understanding of other healthcare professions and to develop collaborative practice and teamwork which they can practice once enter the workforce. IPE is a concept which has multiple definitions and uses throughout the healthcare literature. This paper presents a preliminary exploration of the concept and IPE is depicted through an array of attributes. This concept analysis paper has identified four defining attributes that constitute the concept of IPE, presented examples of model and contrary cases of IPE in a healthcare setting, outlined the antecedents and consequences of IPE, and listed empirical referents for IPE. It is hoped these can collectively provide a useful resource for healthcare professionals to identify, measure, and practice IPE in their work.

References

Barr, H et al. (2005). Effective interprofessional education: assumption, argument and evidence. Oxford, Blackwell Publishing.

Billings, D.M., Halstead J.A. (2009). Teaching in Nursing: A Guide for Faculty. St. Louis, MO: Saunders. 3.

Bridges, D.R., Davidson R.A., Odegard, PS, Maki I.V., Tomkowiak J. (2011). Interprofessional Collaboration: Three Best Practice Models of Interprofessional Education. Med Educ Online.

Brush, B.L., Kirk K., Gultekin L., Baiardi J.M. (2011). Overcoming: a concept analysis. Nurs Forum,46(3),160-168.

Fransworth, T., Seikel T., Daniel Hudock., Holst J. (2015). History and Development of Interprofessional Education. Phonet and Audiol.

Freeth, D., Hammick, S., Reeves, I., Koppel, B. (2005). Effective Interprofessional Education: Development, Delivery and Evaluation. Blackwell Publishing Ltd.

Herrmann, G., Woermann, U., Schlegel, C. (2015). Interprofessional education in anatomy: Learning together in medical and nursing training. Anat Sci Educ, 8(4), 324-330.

Hoffman, S.J., Harnish, D. (2007). The merit of mandatory interprofessional education for pre-health professional students. Med Teach, 29, 235–242.

Illingworth, P., Chelvanayagam, S. (2017). The benefits of interprofessional education 10 years on. Br J Nurs, 26(14), 813-818.

Joseph, S., Diack, L. (2015). Playing interprofessional games: reflections on using the Interprofessional Education Game (iPEG). J Interprof Care, 29(3), 260-262.

Lapkin, S., Levett-Jones, T., Gilligan, C. (2014). The effectiveness of web-based interprofessional learning modules on health professional students' behavioural intentions in relation to medication safety: A quasi- experimental study. Focus on Health Professional Education. 16(1).

Leggat, S.G. (2007). Effective healthcare teams require effective team members: defining teamwork competencies. BMC Health Serv Res. 7.

Lidskog, M., Löfmark, A., Ahlström, G. (2007). Interprofessional education on a training ward for older people: students' conceptions of nurses, occupational therapists and social workers. J Interprof Care, 21(4), 387-399.

Kilner, E., Sheppard, L.A. (2010). The role of teamwork and communication in the emergency department: a systematic review. Int Emerg Nurs, 18(3), 127-137.

Malt, G. (2015). Cochrane Review Brief: Brief: Interprofessional Education: Effects On Professional Practice and Healthcare Outcomes. OJIN: The Online Journal of Issues in Nursing, 20(2).

Nisbet, G., Lee, A., Kumar, K., Thistlethwaite, J., Dunston, R. (2011). Interprofessional health education - a literature review: overview of international and Australian developments in interprofessional health education (IPE). 33.

Morse, J.M. (1996). The Application of Qualitative Approaches. Nursing Research, 1(2), 1-194.

Olenick, M., Allen, L.R., Smego, R.A. (2010). Jr. Interprofessional education: a concept analysis. Adv Med Educ Pract, 1:75-84.

Thistlethwaite, J., Moran, M. (2010). Learning outcomes for interprofessional education (IPE): Literature review and synthesis. J Interprof Care, 10, 503–513.

Walker, L. O., Avant K. C. (2005). Strategies for theory construction in nursing. New Jersey, Pearson Prentice Hall

Walker L. O. and Avant K. C. (2011) Strategies for theory construction in nursing (5th ed.). New Jersey, Pearson Prentice Hall.

WHO Expert Committee on Continuing Education for Physicians & World Health Organization. (1973). Continuing education for physicians: report of a WHO expert committee [meeting held in Geneva from 28 June to 4 July 1973]. World Health Organization. https://apps.who.int/iris/handle/10665/41063

WHO Study Group on Multiprofessional Education of Health Personnel: The Team Approach & World Health Organization. (1988). Learning together to work together for health: report of a WHO Study Group on Multiprofessional Education of Health Personnel: The Team Approach [meeting held in Geneva from 12 to 16 October 1987]. World Health Organization. https://apps.who.int/iris/handle/10665/37411

Co-funded by the Erasmus+ Programme of the European Union