Title

Knocking down walls and opening doors: reflections on implementing interprofessional learning in practice

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Abstract

In 2021, the [identifier] led the design, implementation and evaluation of a pilot project called [identifier] which assessed the feasibility of an interprofessional student placement scheme in care home settings. The purpose of this paper is to explore the reflections of the interprofessional academic and practice team who implemented this initiative. Borton's (1970) framework has been utilised as a guide to (1) detail what happened during this experience; (2) make sense of the experience; and (3) utilise the insights and understanding gained to consider the future of interprofessional learning in practice. It is hoped that this paper will inspire others to consider implementing interprofessional education (IPE) in diverse social care settings and recognise the value of engaging reflectively with this practice.

Keywords

reflection; interprofessional education; social care; student placement; care home.

Introduction

In 2021 a team of researchers from the [Identifier] investigated the impact of a six-week interprofessional (IPE) student training experience within three care home settings in Greater Manchester. The research project sought to uncover what impact IPE had on the three groups involved: students, care home staff and residents. A diverse group of students (n=15) from nursing, physiotherapy, social work, podiatry, counselling, and sports rehabilitation were placed within the homes to work in an interprofessional environment. There was a mix of full-time and part-time students and their placement duration spanned anywhere from six to sixteen weeks. Some were placed in the homes as part of usual placement provision, others were self-selecting. During an overlap period of six-weeks the students and care home staff attended weekly multidisciplinary team (MDT) meetings to address the goals of residents as part of a collaborative team. The pedagogical approach of these MDT meetings was action learning, facilitated by academics and practice education facilitators (PEF). To measure the impact of the intervention semi-structured interviews were undertaken with residents (n=10), care home staff (n=12) and students (n=30). AGEIN questionnaires were also collected from students pre and post placement (n=13). The findings highlight that care homes provide students with an ideal environment for interprofessional working and learning whilst changing perceptions of aged care. Care home staff reported improvements in their knowledge and skills, enhancing care delivery. They also noted that the students brought different perspectives which allowed for new ways of working. Residents placed value on the intergenerational learning, which in turn improved their physical, social, and emotional health. Some residents reported how participating in the project enabled them to gain a sense of meaning and purpose from interacting with the students (Stephens et al., 2022).

Whilst a long time in the making, the project began to take shape in January 2021 when an advisory group was formed to help guide the progression of the scheme. The group was comprised of stakeholders, programme and placement leads, academics and health and social care leads who met monthly to engage in the project design, development, and planning process. Over the course of the scheme, through regular contact, a smaller core operational group naturally emerged from the original advisory group and met regularly to respond to the 'on the ground' implementation of the project. The purpose of this paper is to explore the reflections of the interprofessional academic and practice team who implemented this initiative, utilising Borton's (1970) framework both as a reflective model and to provide structure to the layout of the article. Organising our paper in this way rather than using the traditional Introduction, Methods, Results, and Discussion (IMRAD) structure of scientific papers (IMRAD) (Barron, 2006) was felt to be more appropriate. Our rationale, based upon the work of Schõn (1987) as we assign to the belief that health and social care research is like clinical practice and takes place in the *'swampy lowlands where messy confusing problems defy technical solution' (p.42)* and the critical gaze uniting role of researcher and practitioner/academic is turned towards the self and the constituents of the research is deconstructed (Freshwater & Rolfe, 2001). This approach is also congruent with the methodology of the original project. Heron & Reason's (2001) cooperative inquiry, a participatory research approach was used by the team in order to promote a group of people coming together to explore issues of interest and concern to (1) understand our world, make sense of our lives, and develop new and creative ways of looking at things and (2) learn how to act to change things we may want to change and (3) find out how to do things better.

Reflection

Reflection has long been recognised as an invaluable tool in health and social care given its capacity to promote continuous learning, facilitate rich insight, and inform change for future practice (Schön, 1987; Kinsella, 2010; Gustafsson and Fagerberg, 2004). Schön (1987) stresses that reflection is an active, rather than passive, process and that in this way, professionals should be encouraged to continually reflect and make decisions in the course of their work. Yet, as Rolfe (2014) argues, the way in which reflective practice has been adopted in recent years can be far removed from this conception, with reflection often presented as a separate activity from action rather than as being embedded in everyday practice.

The contemplation and scrutiny required to transcend from mere 'doing to being' when critically reflecting clearly highlights that this activity requires depth of reading and personal value examination (Freshwater et al., 2005). Otherwise, the process prematurely closes the event being reflected upon, stifling personal development (Hancock, 1999).

To encourage reflection-in-action (praxis), the [identifier] core-operational group continually examined their diverse perceptions around the development, implementation and evaluation of the project. In drawing from these reflections, the aim was to provide insight into the multi-layered factors that influenced the deliverance and the complexities of working to achieve interprofessional learning outcomes in this setting. This, as Clark (2021) suggests, is necessary

if we are to truly understand and critically example the underlying processes that shaped this educational strategy.

To examine our learning, we utilise Borton's (1970) reflective model which is comprised of three questions - what, so what, and now what? This enables us to firstly identify what happened, make sense of the situation, and then evaluate how to move forward by proposing recommendations for the future (Smith et al., 2016, pg. 2). The advantages of using Borton's model is primarily its simplicity which assists in making the model accessible to aid understanding of the process of reflection. However, the simplicity can be considered a limitation as it lacks depth in comparison to other models and theories, leading to superficial reflection. The simplicity is thought to inhibit the opportunity for deeper thinking, challenging of perspectives and professional values and perspective transformation. Despite these limitations Borton's model of reflection was used to guide the process and framing of the reflective processes only. Rather than impose on the authors as to what critical reflection is (Lucas, 2012).

What

We begin by identifying and describing the process of implementation. As Driscoll (2007) suggests, this question calls for consideration into six key areas: what happened; what we were trying to achieve; what we did; what we were aware of; what worked well and what didn't; and what our reaction looked like.

The context of the project was to create a different model of learning in the care home setting. Care homes offer rich learning opportunities and are places where students can thrive and develop (International Longevity Centre UK, 2016), yet historically only take students from nursing (and occasionally occupational therapy). Anecdotal evidence suggests that as people admitted into nursing home environments tend to need complex nursing interventions, care should be provided by registered and regulated nurses. With the advent of role emerging placements Occupational Therapy (OT) students can also choose to work in an organisation where there is currently no OT employed, and some chose to have a placement in care home settings.

More recently the allocation of students to clinical placements was challenged with the introduction of the National Teaching Care Homes Project (NTCH) (Care England, 2017) which was to empower and embolden the workforce in care home nursing. This occurred concurrently as the Enhanced Health in Care Home (EHCH) Vanguards programme (NHS England, 2016) was rolled out to improve services and outcomes for people living in care homes. Despite the impact of these programmes being evaluated, neither have yet to fully demonstrate the impact on clinical placement expansion for nursing and the wider disciplines (International Longevity Centre UK, 2017) or provide published evidence of local positive impact on support from the wider integrated team (Coleman, Croke & Checkland 2020).

In the delivery of this IPE care home project, we hoped to dismantle the tradition of uni-professional and adhoc placements by opening opportunities to multiple professions. We also sought to create environments of collaborative practice and, by doing so, challenge embedded negative perceptions of care-home work.

Customarily, clinical placements - the arenas in which students apply practical skills from the theories taught in university (Laitinen-Väänänen et al, 2007) - are delivered utilising a traditional model where a student is supervised and supported by a single practice assessor/educator (Millington, Hellawell, Graham & Edwards, 2019). These placements are usually conducted in 'silos', where students from the same profession are placed together, which fosters a lack of collaborative learning in practice. The aim for this project was to facilitate a model where students, with the support of academics, social care staff and supervisors, take responsibility for the delivery of care to promote a form of peer learning similar to that practiced in Scandinavia (Balgård et al., 2021) and Holland (Willis, 2015). Adopting a *"communities of practice"* approach to interprofessional learning meant that we could bring together *"a group of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly" (*Wenger 1998). The hope was to achieve similar findings such as those from other studies where patient satisfaction rates and student outcomes showed positive results (Oosterom et al., 2019).

There was a number of main steps involved in implementation. First, we needed to recruit and liaise with care homes to ensure they understood their involvement, had educational audits in place and were supported to choose the students they felt would most benefit their home. Next, given the students recruited came from three different Higher Education Institutes (HEI's) we had to decipher the 'overlap' periods in which students from multiple professions were out on placement at the same time. Then we needed to consider how to quickly recruit these students; some were allocated as part of their natural placement cycle, others volunteered as part of a 'spoke' learning opportunity. Fourth, we had to consider models of supervision as professional groups had different assessment regulations and some required 1 to 1 supervision of students, whilst others adopted a long arm (off site) supervision approach. Finally, we had to organise the delivery of weekly multi-disciplinary team (MDT) meetings at each care home to create a space for students to learn from, with and about each other, whilst caring for the residents.

Our reactions to implementation of the IPE scheme were like those experienced when implementing any large-scale change. This included impacts on the affective and cognitive domains of the group. These reactions, we came to learn, would play a crucial role in the success or failure of the project.

So what? Lessons learned

We now consider what this experience has taught us about implementing interprofessional learning in practice. To do so, we identify and reflect on a number of challenges and opportunities that we experienced in the course of delivery.

During the project it was necessary to 'knock down walls' and search for solutions to overcome various challenges. New circumstances often quickly arose that required a rapid response and unexpected complexities posed by the pandemic were sometimes difficult to address. It quickly became apparent that implementation was not a step-by-step process; certain phases needed revisiting and new steps emerged unexpectedly.

According to Kuhn (1979) the implementation of IPE is often complex, since it entails *"recognising both that it is something new and understanding what it is"* (p. 55). Often there is

a difference between what a person thinks they will do (espoused theory) and what they actually do (theories in use), which can create tensions, complications in communication and delays in the deliverance of such schemes (Argyris and Schön, 1974). Therefore, it was necessary to understand this and work continually to ensure congruence across the stages of the project (Moon, 1999).

One of the most significant and complex hurdles faced was sourcing the appropriate supervision requirements. Organising long arm (off-site) supervision[1] for non-traditional roles in the homes (e.g., Physiotherapy) was more complicated than anticipated and relied heavily on the goodwill of supervisors to go above and beyond. This issue presented itself multiple times throughout the project and is regarded in the literature as a *'structural gulf'* between the responsibility for providing placements and the authority to allocate students to supervisors. The gulf occurred as supervisor allocation remains an optional activity and not part of everyday role and responsibilities (Henery, 2001, p32).

Sometimes, solutions were found. For instance, one of the core-operational team utilised their professional networks to create a split-site placement with a community-based practitioner, who agreed to provide long-arm supervision for two Physiotherapy students. This allowed us to work around the issue but was understood to be a 'one-off', which taught us an important lesson in how unsustainable such context-specific solutions are. Further, it was not always possible to find a solution, and some professional groups could not participate due to a lack of supervisors. We now recognise that developing guidelines which clearly outline the supervisory process (see Canterbury Christ Church University, 2018) allows for a strategic approach to the planning and organisation of practice placements and allocation of supervisors.

Recruiting students was also a complex task. We felt that it was crucial to place care home staff at the centre of any decision-making processes, and they were involved in choosing the numbers and types of students they felt would most benefit their home. We also needed to work to ensure that students from at least two distinct disciplines were placed within each home, and given the opportunity to learn from, with and about each other, to meet the definitional requirements of IPE (CAIPE, 2002).

However, navigating fixed placement timetables across multiple universities was challenging and we were sometimes unable to deliver in line with all the care home's requirements (for instance, Occupational Therapists could not be sourced). Members of the core-strategy group often felt a sense of pressure surrounding this as they were keen to provide the home with the professions they requested, which, in turn taught us the significance of managing expectations and communicating effectively in co-produced projects.

These expectations and pressures were not just grounded in wanting to deliver best practice for the care homes, but that some group members - particularly those who were less experienced - felt a sense of pressure to 'perform' for rest of the team. This experience resonates with the idea that less experienced facilitators benefit from development sessions to aid the organisation and delivery of IPE programs (El-Awaisi et al., 2016). Further, the team

[1] Long-arm supervision refers to supervision by an experienced clinician who is not based at the same location as the student.

took time to adopt a collaborative mindset and feel part of a process rather than responsible for individual tasks, which highlighted that a collaborative and synergistic approach to care and education is based upon relationships, and thus not developed instantly (d'Amour and Oandasan, 2005 p.10).

Recruiting care homes was a complex task and worries surrounding whether those that signed up were the most 'suitable' or not, were a source of stress – particularly in cases where aspects of the IPE initiative did not go as planned. Educational audits are initially performed on placement sites to assess capacity, facilities and resources in order to deliver safe and effective learning opportunities for students (NMC, 2019, HCPC, 2017). However, similar to Husebø et al (2018), we found that in order to facilitate a positive learning experience, a well-prepared academic-clinical partnership, good levels of supervision and high-quality nursing care of older people are also required.

On reflection, whilst many issues were addressed to mitigate risk (and all sites had completed their educational audits), a review of the competencies that could be achieved during placement for each professional student group would have been beneficial to include. Historically, students have viewed placements in care homes as 'counterintuitive' to what they are learning at university. Experiences of 'quick' task focused work (often due to understaffing) are felt to lead to the depersonalisation of residents and misalign with their goal to provide holistic care (Grealish, Bail & Ranse, 2010, p. 2292). Further work is required therefore, to consider how one assesses the culture and values of the homes involved, so as to ensure placements are those that demonstrate person-centredness and a welcoming learning community.

It was also taxing to recruit students who were attending as part of a voluntary opportunity. Most of this group had never worked in a care home before, and few had ever been out on placement due to the Covid-19 Pandemic. It was necessary then to handle the emotional as well as practical side of their integration into the care home setting, which highlighted the importance of supporting their journey *into* the care home, not just within the care home (Grealish, Bail & Ranse, 2010). For instance, through this process we learnt that Counselling and Psychotherapy students can have placements in care homes but should not take part in group IPE activities (due to an incompatibility between the visibility of group work and their professional and ethical guidelines).

Often, students regarded their time in the care home as a kind of 'one off' opportunity and struggled to understand how this environment connected with different care settings, which complicated the recruitment process. As negative preconceptions about the nature of work in care homes are embedded societally, we stress that further work is necessary to reconcile the intentions of education and the learning that transpires (Gallagher 2007).

The development of weekly MDT meetings was informed by communities of practice theory (Wenger, 1998) in order to promote shared learning and foster critical reflection on the care provided. This approach did allow for a shift in perceptions of aged care work (Author Citation, 2022), however more work is required around the placement framework if students are to understand care homes as an integral part of the system, rather than an aspect that sits outside of it.

During the weekly MDT meetings, students would work with designated residents on their individual health and wellbeing goals. Whilst collaboration was highly valued and enabled students to take part in decision making, and person-centred care planning, we quickly recognised that a 'one size fits all' IPE approach in care homes was naïve in regard to the diversity of different care homes and lives of those within them. At one home, for instance, it became apparent that an in-person format was not suited to the needs of the residents. A virtual delivery model was created where care home staff acted as advocates. This introduced participants to potential new ways of working and fostered a community of critical inquiry within a meaningful and relevant IPE experience (Hayward et al, 2021).

Successful implementation rested on a willingness of all to embrace flexibility and let go of established ways of working, across all levels of engagement. While at the start of the scheme we recognised that students would likely encounter the necessity to break down a silo mentality, it has become apparent that it was critical for us to do the same and learn from, with and about each other.

Over the development and delivery of the project, trust was built between members of the core-operational group. This enabled us to work as critical friends (Foulger, 2010), identify omissions in our individual knowledge and skill sets, and speak with candour about our actions, reflections and ideas; or as we liked to refer to it, we could 'knock down walls and opening doors' together. A quote by Heron and Reason (2001, p.180) resonates here:

> 'We believe the outcome of good research is not just books and academic papers but is also the creative action of people to address matters that are important to them. Of course, it is concerned too with revisioning our understanding of the world, as well as transforming practice within it'.

However, having a smaller core operational group deal with various unexpected challenges could result in people's roles blurring and become complex to balance. Nonetheless, in avoiding looking at the process through one lens we could adapt more effectively to changes that occurred during the scheme through consideration of different perceptions and interpretations. This ensured that learning occurred at all levels, which created a more fluid atmosphere for growth, inclusion and development (d'Amour and Oandasan, 2005).

Now what? Moving forward

Finally, we now consider what these lessons mean and discuss how such initiatives can be taken forward. Overall, the IPE care home scheme was reported to have a positive impact on those involved and seeing meaningful changes in the participants approaches and outlooks was a rewarding experience. The vignette below captures this

Vignette on meaningful change

The IPE student training care home project was initially developed by an academic/ researcher who was also a registered nurse. Whilst this person had combined their subject knowledge with work leading the development and delivery of other IPE interventions. The IPE care home concept emerged from a nursing influenced perspective and initial formal interactions with members of the advisory group.

In order to deliver on the project's objectives, key members of the advisory group needed to achieve consensus on the timing of scheme across the four HEIs and three care homes, ensure sustainability of IPE scheme for the future, fully resource the MDT meetings to develop care home staff skills in facilitation of learning and reduce resistance from professional groups who did not view IPE as important within the pre-registration curriculums.

This required group understanding of the IPE intervention, the care homes selected for the study, the programme requirements for each student group, the supervision requirements, and the technology used (to name but a few) so that the IPE scheme could become established and feasibility of it tested. Space was created fortnightly and then monthly to allow for updates on actions which also included critical reflection. This is when a core operational group recognised that where necessary, transcending beyond boundaries occurred. For example, whilst the Allied Health Professional group members had highlighted the issue of recruiting long arm practice supervisors (LAPS) to support students in the care homes, the reality of this did not emerge for some of the group members until the students had been recruited. LAPS quickly became a cross profession issue and a willingness to address this occurred. At the same time the group recognised that this approach would be useful for other professional groups and further work in this area is now in development with a scoping review to develop guidelines for the region.

The IPE student care home project moved from a multidisciplinary study (team members working independently and interacting formally to offer breadth to the study) to a transdisciplinary approach. The team returned unexpected results such as LAPS as each member became familiar with the concepts and approaches of his and her colleagues. This began to blur disciplinary boundaries to focus on the problem as part of a broader phenomena i.e LAPS being suitable for all professions and learning from this leading to broader and deeper analysis and changes in education delivery (Russell, 1988).

Writing this article, connecting with each other and critically reflecting more deeply on these reflections (Clark, 2009) and individual experiences has been invaluable in relation to the process of implementing IPE in a care home context. We recognise that this ‘journey’ of unearthing our own growth and development allowed us to make sense of what happened. Through looking at our experiences and understanding it within the context in which it occurred (O'Carroll and Park, 2007), we have been able to develop our own practice and incorporate aspects that are imperative to IPE being conducted successfully in this setting.

Moving forward, it is important to reshape placement supervision models if we are to enable such initiatives in the long term to ensure IPE becomes established practice. As has been noted in other contexts (RSPH, n.d.), some professions could be recruited with ease given they were already familiar with ‘remote’ long arm supervision arrangements (Social Work, for example). Other groups, however, are more accustomed to having full-time practice staff within the setting to provide supervision, and the ‘unfamiliar’ of a long-arm approach could create instant barriers to inclusion. We are now working on the development of a supervision and placement model and examining other types of delivery from the literature (Millington, Hellawell, Graham & Edwards, 2019)

It is also important to dismantle long established placement traditions. For students, being placed in a care home should not be a 'one off' or uncommon aspect of their learning journey. We realise how important it is for students to learn from, with and about each other not just in one setting, but across many (hospitals, intermediate care and home care, for example) so that they can experience and witness the full picture of a person's journey in health and social care practice. We suggest then that learning in practice should involve students being allocated to a community, rather than one specific location, as this would help them to better understand how all placement opportunities are entwined and key components of a journey to becoming a registered practitioner. Currently IPE is not the norm, despite the importance it plays in delivery of person-centred care. Barriers to its implementation includes lack of consensus on timing of IPE activities, lack of key stakeholders who would ensure sustainability of IPE interventions, lack of external support from government, HEI's, professional bodies to fully resource IPE interventions and resistance from professional groups who do not view IPE as important within the pre-registration curriculum (Wong, Chen & Saw, 2021).

Not only should those involved in creating in an interprofessional environment be passionate about their vision to foster collaboration, but the vision itself should be flexible to account for the unique challenges and opportunities that arise in the course of delivery. In our experience, stepping outside of our personal and professional preconceptions allowed us to understand how other team members and professions worked, whilst developing self-insight and mutual understanding (Clark, 2009). This allowed for the creation of a core-operational group, and our super-ordinate (or shared in-group) identity helped us to facilitate cooperation, supporting efficient decision-making processes and keep people focused on common objectives. We therefore place importance on the willingness of group members to move from 'me' to 'we' (Hanson, 2013) and work side by side with others, who they may not know, to learn from them and improve processes of care. It is only then that interprofessional learning environments will truly flourish.

Conclusion

This reflective paper is centred on our experiences as academics and practice staff who worked to create and implement an interprofessional training initiative in care home settings. It focuses on the challenging aspects of implementation that are often overlooked, which can highlight measures that could support students, while at the same time empower colleagues. The process of writing this reflective paper enabled us to unpack diverse perspectives about the complex nature of engaging in the project, and, by doing so, we have been able to recognise and gain more understanding around *why* we found particular aspects difficult, and what that means for future practice. Undoubtedly, this was a learning curve for us all and we hope that these lessons will help those who conduct similar initiatives in their decision-making if they encounter similar situations in the future.

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