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‘Practice Educators’ Perceptions of Interprofessional Education and Issues Surrounding its Implementation in the Clinical Placement Setting’

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AUTHORS DECLARATION

I, the undersigned declare that this project which I am submitting is all my own work and that the data presented is authentic.

_____ (Printed Name)

_____ (Signature)

Date / /

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Abstract

Title: Practice Educators' Perceptions of Interprofessional Education (IPE) and Issues Surrounding its Implementation in the Clinical Placement Setting.

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Background: IPE occurs when two or more professions learn with, from and about each other to improve collaboration and care (CAIPE 2002) It is being increasingly considered as part of undergraduate health professional training (Hammick et al 2007). Much of the existing literature centres on IPE post-registration, in academic settings and on students' perceptions of IPE. To date, there has not been a study on Irish practice educators' perceptions of IPE.

Objectives: To investigate practice educators' views in regards to implementing IPE in a placement setting and discover what they perceive to be barriers and facilitators to its implementation.

Methods: Four focus groups were conducted including sixteen practice educators from physiotherapy, occupational therapy and speech and language therapy working in various settings. Groups were audio recorded and transcribed verbatim. Data was coded and a thematic analysis performed (Krueger and Casey 2000).

Findings: Three main themes emerged: (i) perceptions, (ii) issues surrounding planning and resources available and (iii) outcomes. Participants had good awareness and positive perceptions of IPE. They felt that negative attitudes of some health professionals could be a barrier. Planning issues such as placement timing, student assessment, caseload, local and university support were frequently mentioned as things requiring consideration for successful IPE. Improved teamwork, knowledge and patient care were recognised as the main outcomes of IPE.

Conclusions: IPE has potential benefits but requires planning and coordination. Findings may be useful for organising clinical placements. Further research is required to investigate if these can be replicated on larger scales.

Key words: Interprofessional education, perceptions, practice educators.

1. Introduction

Interprofessional education (IPE) takes place when students from different professions learn from, about and with each other to allow successful partnership and teamwork and improve patient outcomes (WHO 2010). IPE is a broad topic and is often used interchangeably with the term "interprofessional learning". Internationally there are several groups and governments working towards its implementation (Oandasan and Reeves 2005a, Barnsteiner et al 2007). Groups such as the CAIPE (Centre for Advancement of Interprofessional Education), NAIRTL (National Academy for Integration of Research, Teaching and Learning) and EIPEN (European Interprofessional Education Network) all work towards promoting and developing IPE.

The Irish Department of Health and Children Statement of Strategy 2008-2010 states there is a need to deliver high quality services. Integrating care and service delivery provide such quality services (Department of Health and Children 2008). Initiatives such as interprofessional education can help accomplish this integration and improve teamwork, services and the development of practice (Hammick et al 2007, McNair 2001). There is a vast amount of the research in existence related to IPE but much is of mixed quality with a lack of standardised approaches (Zwarenstein et al 2009, Reeves et al 2010).

IPE for qualified health care professionals is frequently mentioned in the literature with some views that it may be more effective than undergraduate IPE (Headrick et al 1998, Barr 2000, Parsell and Bligh 1998). Many sources state that there is in fact more literature relating to post-qualifying IPE and that it is either performed more or documented more than pre-qualifying IPE (Barr et al 2006, Freeth et al 2002). However, several bodies of evidence state that IPE should be and is part of undergraduate training programmes to help with integration, role awareness and role development (Carlisle et al 2004, McNair 2005, Hoffmann and Harnish 2007). A large quantity of research relates to the academic setting but there is less quality

evidence on the clinical setting for students (Reynolds 2003, Parsell and Bligh 1999, Gilbert 2005, Hall and Weaver 2001). There is a lot of literature regarding student involvement in IPE (Tunstall-Pedoe et al 2003, Parsell and Bligh 1999). However, there appears to be less detailed literature surrounding the practice educators involved in placements for students, their opinions, preparations and situations and less on them specifically (Reeves 2002, Oandasan and Reeves 2005a, Hammick et al 2007).

It was decided that carrying out a study on practice educators' perceptions of IPE and its implementation in an Irish setting would be beneficial. There has been no such study previously. A previous focus group study of undergraduate students from various disciplines also evoked the author's interest in this area (McMahon and Taylor 2010). This study with practice educators will compliment that.

This paper will feature the findings of the focus group study of practice educators from physiotherapy, speech and language therapy and occupational therapy in an Irish setting. The data collected was analysed by thematic analysis with the main themes highlighted and subsequently discussed in detail. This study was considered meaningful as IPE has been found to improve outcomes. However, as of yet it is not carried out on a large scale in an Irish clinical setting for undergraduate students.

2. Aims and Objectives

The aim of this study was to investigate practice educators' views of interprofessional education.

The objectives of the study were as follows:

- To investigate what practice educators think about implementing IPE in a clinical placement setting.

- To discover what are the perceived barriers and facilitators that exist to implementing IPE

3. Ethical Approval

Ethical approval was sought and granted by the University of Limerick Faculty of Education and Health Sciences Research Ethics Committee prior to the commencement of the project.

4. Methodology

4.1 Study Design

Qualitative data was obtained through a focus group study. This was justified because focus groups are suitable for obtaining information on people's viewpoints, outlooks and getting different perspectives on a subject (Litoselliti 2003). Focus groups are frequently used in healthcare research and this approach allowed interaction between participants. This could then lead to one participant stimulating another participant to say something; providing more meaningful information.

4.2 Sample Selection

Practice educators from occupational therapy, speech and language therapy and physiotherapy were chosen to be part of the focus group.

A recruitment email with an attached information sheet was sent to the practice education co-ordinators of each of the above mentioned departments in the University of Limerick. They forward this on to practice educators on the University of Limerick Database. Interested parties replied via email (n = 34). Emails were sent

to these about potential times and locations of groups. A number of educators were unable to take part due to work constraints or other commitments (n = 18).

It was originally thought that each group would contain members of one discipline as participants may be more comfortable among people of the same profession (Kruegar and Casey 2009). However, there were fewer interested occupational therapists and speech and language therapists. Therefore, separate groups would reduce numbers, thereby reducing the amount of information obtained. It was decided to hold mixed groups, which could highlight similarities and differences in opinions, leading to a more in depth analysis (Morgan 1997).

4.3 Questions

Questions were created to be open-ended and avoid bias (Krueger and Casey 2009) (Table 3, Appendix 8.4). These were piloted on four final year physiotherapy students as the moderator was inexperienced. Feedback from this led to some minor modifications.

4.4 Data Collection

Participants were given information sheets and signed consent forms permitting the usage of the data in the study. Four groups were conducted. It was initially decided that there would be three groups but an opportunity arose for a fourth when a group of interested therapists working closely together contacted the investigator. Two groups were conducted in the Health Science Building in the University of Limerick. The other two were conducted in sites in Cork city where students have clinical placements.

For each focus group the moderator (researcher) asked questions and an assistant moderator (colleague of researcher) observed, taking field notes. After each

group the moderator and assistant moderator discussed the group, the main issues and any other observations (Appendix 8.4). These were recorded for analysis.

4.5 Analysis

The conversations were digitally recorded and transcribed verbatim. It was considered to use the Jefferson system when transcribing. However, for thematic analysis, the amount of detail required in transcripts is less than other types of analysis for example conversation or narrative and it therefore was not used (Braun and Clarke 2006). Participants' names and any identifying features were coded to ensure anonymity. For example, participants in the first focus group were referred to as Group A, #1, Group A, #2 etc.

Transcripts were read several times to familiarise the investigator with them. Data was analysed question by question and themes were sought within and across questions, as recommended for inexperienced moderators (Kruegar 1998). It was coded and organised and sections of data were labelled and categorised based on content (Coffey and Atkinson 1996). It was analysed for themes, subthemes and concepts which were reviewed and refined frequently (Aronson 1994, Braun and Clarke 2006).

The main findings were grouped and merged into themes. Data was checked with participants to ensure accuracy (Creswell et al 2000). To increase validity, the frequency (how often a theme was spoken of), intensity (how passionately participants spoke of a theme) and extensiveness (how many participants spoke of a theme) were all taken into account when forming themes (Kruegar and Casey 2000).

5. Findings

5.1 Participant Demographics

Table 1

Participants	**Physiotherapists**	**Occupational Therapists**	**Speech and Language Therapists**
Total: 16	12	3	1

Table 2

Areas of Practice:		**Previous Experience with a formal IPE pilot project:**	**No. Involved in Management:**
Paediatrics: Primary Care: Learning Disability: Rehab: Mixture (Outpatients/Acute):	8 3 2 1 2	5	2

5.2 Main Findings

Throughout the groups there was good interaction. There were lively discussions with participants genuinely interested in the subject. From the thematic analysis conducted three main common themes emerged.

5.3.1 Table of Main Findings

Table 4

Main Themes	
• Issues surrounding planning and resources:	o Placement timing and participant selection o Local resources vs. university aims o Support from others o Assessment
• Perceptions of IPE:	o In general o In a placement setting o Interested educators
• Positive outcomes:	o Teamwork o Continual professional development (CPD) o Improved patient care

5.3.2 Planning and Resources

Many educators (frequency = 17, extensiveness = 12) considered time an issue when thinking about implementing IPE. They felt correlating placements and having

students on site at the same time was not always feasible and this then made IPE more of a challenge.

> *"…lucky that we happened to have a placement of students of both colleges at the one time and I don't know how you would coordinate that". (Group D, #1)*

Dividing time up between that devoted to IPE and time for normal clinical duties on placement was also stated as something that requires consideration.

> *"From the perspective of time, it just depends on naturally clinical time versus IPE time; it's more the value for money". (Group B, #2)*

The year of the student is something that participants had differing views over. The majority thought that it was better to have student in their third or fourth year because at that stage they're familiar with their own role. However, the occupational therapists felt having students observe other disciplines initially was a positive movement.

> *"I think that is maybe beneficial for them but I suppose it depends on how it's structured really". (Group C, #3)*

The quality of the students and patients that are part of IPE was regularly referred to by several of the participants.

> *"…the patient we had was ideal and very articulate and had a broad spectrum there and the two students were good….So ultimately it would depend on the level of ability of the student". (Group A, #2)*

Most educators (frequency = 17, extensiveness = 12) believed that students themselves have to be good students interested in IPE.

> *"…unless we have students actually enquiring together instead of feeling that they have all the answers and having an openness about the journey of learning that they are doing I think it's going to keep people very much in their silos". (Group B, #4)*

Support from the university was mentioned throughout (n = 18). Some group members (those without an onsite clinical tutor) felt university support in the form of a Regional Placement Facilitator (RPF) was important. Others (those with a tutor on site or that had neither a tutor nor RPF) felt that while the university encourage movements such as IPE, it has to be more driven locally to be fully successful.

> *"…a local system of managing it may be the more appropriate because if it is driven by the request from the university for a group if students coming in to a local area it may not match what is available". (Group B, #2)*

The majority (n = 10) also judged it should have some impact on the student's grade if it is highlighted so much.

> *"…they put such time and work and gathering information into it that I think it should have been (part of assessment)". (Group D, #2)*

All participants agreed IPE was more suited to some areas of practice than others. Many considered rehabilitation and neurology, in particular paediatrics to be areas best suited but some agreed that there could be openings in other areas also.

> *"Outpatient physio though that doesn't need it. It depends on the area really…Neurology is best really". (Group C, #1)*

It was felt by the most of educators that geographical issues which were potential barriers could be overcome. However, obtaining support locally, from managers and colleagues primarily, in addition to from the University was something that was repeatedly referenced.

> *"…with the best will in the world for the therapists on the ground sometimes you're overruled by the workload or who your line manager is" (Group D, #2)*

The majority believed that if people are interested enough and if it is possible time can be made available. However, participants in two of the groups agreed that caseload and time constraints can be huge barriers. They were very definite that caseload and the assignment of time or resources available can be one of the biggest challenges.

"It's down to what resources you have. You can only work with what you have". (Group A, #2)

5.3.3 Perceptions of IPE

All participants had positive perceptions of IPE both in general and as part of a student placement. While some struggled to give an exact definition they all had an understanding of the main aspects of IPE and were aware of the evidence supporting it.

"(It's about) learning from each other between disciplines". (Group C, #3)

It was also agreed that IPE enhances understanding of each others roles greatly among health professionals.

"…just fostering a better understanding of each other's professions as well as the client focus at the end of it". (Group B, #1)

Participants' perceptions were based on previous experiences or the setting that they work in. Most of the participants referred to joint assessments as a means of IPE.

"What we started doing was team assessments…with some of the professionals observing and some in with the child and then we meet back afterwards to actually see". (Group D, #2)

The majority of participants also referred to team or joint treatment sessions with a patient as the manner in which they are most familiar with IPE or some aspect of it.

"The whole team works in the same way..." (Group A #1)

However, IPE team meetings, specific organisations and models of practice were mentioned in three of the groups, while journal clubs were mentioned in two of the groups as a means of IPE.

"*Well what we do here are journal clubs and that's kind of the big thing for us" (Group C, #3)*

As regards specific views of IPE for students, all the participants were positive. What had been said previously as regards IPE in a general sense was largely reiterated with some extra points made. Educators regarded IPE with students involved in a more formal way.

"Teaching of speech and language students with OT students and physio students together or different lecturers from different disciplines". (Group B, #3)

Participants in three out of the four groups had some previous experience with a formal IPE project. These pilot projects were operated by academic institutes in placement sites that involved some of the educators were portrayed in a very positive light. Participants felt that such projects with an educator facilitating between the different disciplines were beneficial.

"It was really good. I think the students really enjoyed it… the different disciplines looking at the child saw different things". (Group D, #1)

Other people's perception of IPE was frequently mentioned across all four groups. This was seen as one of the main facilitating or inhibiting factors in regards to implementing a successful IPE programme.

"…it's the people that put up the barrier. If something wants to happen and we want it to progress everyone has to want it". (Group C, #1)

Cultural and hierarchal issues were something that many of the educators (frequency = 13, extensiveness = 9) mentioned as a potential limiting factor but it was also suggested that IPE could help break these down some. There was a belief that different professionals have certain preconceived views about other professionals.

"I would imagine that perspective can be a negative or a positive in that different perspectives are going to potentially open up understanding but…within reason I would imagine that they're going to stick within those perspectives". (Group B, #1)

5.3.4 Outcomes

The final key theme that arose from the focus groups was the predicted positive outcomes of IPE. All members agreed that IPE enhances teamwork and were of the opinion that the focus nationally is going towards interdisciplinary working, and working in teams and that IPE can play a role in improving this. It was felt it can help improve working relationships, communication, break down barriers and bring about improved collaboration.

"Any perceived offensiveness is acknowledged but not allowed to be a barrier so that everybody is comfortable and can grow in their own space". (Group B, #2)

Many of the educators considered that it is sometimes difficult for students to go from an academic setting to clinical setting and that it can be a challenge to interact with other health professionals. However, IPE was seen as a means of improving this.

"It does away with the hierarchy which I think coming as a student from different placement sites in other hospitals there was a very distinct hierarchy within and between some of the therapies". (Group A, #2)

The majority of participants thought that IPE improves the level of patient care.

"…just fostering a better understanding of each other's professions as well as the client focus at the end of it." (Group B, #1)

They felt that with IPE clinicians become more mindful of other issues that could be going on in the background by linking in with other team members.

"You know a global look at the whole child rather than just looking at the physical side". (Group D, #1)

There was also a belief among many of the therapists (frequency = 13, extensiveness = 12) thought that IPE can lead to better prioritising of patients across the disciplines and more appropriate referrals.

"You'd know what they do and who you refer to rather than just randomly referring them". (Group C, #5)

The majority of participants in three out of the four groups felt that as regards organisation and efficiency, there were gains and that IPE can give a "valuable CPD opportunity"(Group B, #2), which is something all practitioners need to keep a focus on.

"Interdisciplinary working does provide interdisciplinary education…it's ongoing and it keeps you fresh, it keeps you fresh in your job". (Group D, #2)

The majority of the focus group participants believed IPE enhances productivity and outcomes.

"There didn't look like there was any gap in the care". (Group A, #4)

Many educators deemed IPE for students beneficial to themselves as qualified, therapists, as it expands their own knowledge and awareness which improves patient care.

"You get a global look at the whole child rather than just looking at the physical side, what did this whole person need in terms of management". (Group D, #1)

All educators were of the opinion that IPE aids students in setting goals as part of a team, using evidence, being active learners and using the experience of team members more effectively.

"*But if you have both the facts, or the evidence base or the experiential backing to the value that you would bring to a particular case". (Group B, #2)*

The majority of therapists (n = 12) regarded IPE as helpful to encourage professionalism and show students what is ahead when qualified, because teamwork is a significant part of professional practice.

"Well it's setting them up for going out in the real world". (Group C, #4)

6. Discussion

6.1 Main Body

Issues surrounding planning can be potential barriers to successful IPE implementation. Educators felt IPE required a lot of planning and support from various sources other than the individual educator. Lindqvist and Reeves (2007) reported that being a facilitator of IPE can be a challenging experience as it requires a lot of time and planning. This may put practice educators under strain as it was discovered that many of them already have busy caseloads.

There is some ambiguity over the role educators have in IPE. Some educators felt that they would have to take on a teaching role of other disciplines as well as students of their own discipline. However, the majority, and all those with any previous experience felt their role was more to facilitate students, for example allow students time and resources to problem solve a case study. Similarly, it is stated that practice educators need to become familiar with facilitation techniques and be adequately prepared to give support to students in order achieve a good level of interprofessional practice (Freeman et al 2010 and Anderson *et al* 2009).

Participants felt that in order to be successful there has to be a drive locally because though helpful, support from academic institutions cannot match every site specifically. Individual (micro), organisational (meso) and political and institutional (macro) issues may pose problems to the implementation of IPE (Oandasan and

Reeves 2005b, D'amour and Oandasan 2005). Practice educators thought that caseload was a limiting factor that could not always be overcome. Many felt that while academic institutions encourage IPE there is often not a formal drive towards it. They even said that there may be issues with health authorities and government as regards setting it up because of staffing issues and workload demands. On several occasions throughout the groups it was stated that a conducting a full IPE project was restricted because the service that an educator worked in lacked other team members. For IPE to be a success staff must be prepared to devote time to it and there must be collaborative planning (D'amour and Oandasan 2005, Oandasan and Reeves 2005b). Good leadership is needed and support must be obtained from senior management for IPE to become a reality (Oandasan and Reeves 2005b). Educators believed that implementing IPE that is based on a mix of 'bottom up' and 'top down' approaches may match the specific placement site best. These approaches are detailed in a systematic review by Hammick et al (2007).

The participants agreed IPE is better suited to some areas of practice than others such as a rehab or paediatric setting as opposed to an outpatient one. This is view is reinforced by Professor Maggie Nicol, Professor of Clinical Skills at the City of London University who gave a presentation on IPE in the University of Limerick in December 2010. Professor Nicol feels placements provide opportunities for students to learn from, and with others and that it should be incorporated as a part of the assessment strategy of students. This would make it more worthwhile for students, a point that was made by many of the practice educators and is also supported by the literature (Carlisle et al 2004, Hammick et al 2007).

She believes that IPE cannot be used in every situation and that for learning individual skills single profession education is more efficient. Parsell and Bligh (1998) also believe it necessary to develop in one's own profession initially before being an effective team worker. This was stated by the majority of focus group participants who felt that having a sense of what one's own profession did first before learning about others was required. While some members of the group felt that it was

good for students to initially get a sense of what other professions did in their training. Similarly, the evidence supporting this is mixed. Horsbugh et al (2001) used the Readiness for IPE scale on students of nursing, medicine and pharmacy to help decide on the best time to introduce IPE. They agreed with the conclusion drawn by Hall and Weaver (2001) who stated that there are still questions regarding the best time to learn about other team members and partake in IPE. In contrast, it has also been stated that IPE should be commenced as early as possible to avoid professional socialisation (Carlisle et al 2004, Oandansan and Reeves 2005a). It therefore appears to be a decision that has to be made based on best available evidence, individual educator preference and availability, academic institution preference and also what the individual students themselves feel appropriate.

Practice educators need to prepare, have good relations with other health professionals and be ready for resistance when setting up IPE (Anderson et al 2009). This was agreed by practice educators who commented that people themselves and their negative perceptions can often be one of the biggest barriers to change and improving a system. Several that felt despite IPE some professionals may approach a case very much with their own discipline in mind and that unless people are open they may not understand what other disciplines have to offer. Correspondingly professional cultures and stereotypes are regularly reported as potential limiting factors for instigating IPE (Hall 2005, Oandasan and Reeves 2005a). However, as was also detailed by the focus groups IPE can also help reduce the hierarchy among health professionals (Carlisle et al 2004, Cooper et al 2001)

The presence of champions or experts involved is frequently mentioned and recommended in literature (Barker et al 2005, D'Amour and Oandasan 2005, Hammick et al 2007). This was clearly seen from the groups conducted. The participants felt having interest in IPE was important for implementing it and were genuinely interested in doing so. They had been to education days on IPE, were familiar with literature and anyone with previous experience was more than eager to be involved again. Some educators even made suggestions using mannequins that

nursing and medical students use for allied health professionals training, e-learning and summer school initiatives (Barr et al 1999, Carbonaro et al 2008, Cooper et al 2004).

Only participants with previous experiences of IPE mentioned a framework of IPE (MAGPIE Model) and a number of them were to some extent unsure of what exactly it entailed and were vague in reference to it. This suggests that many practice educators are unaware of the benefits associated with using a model or framework. Much of the evidence in existence suggests that using learning models and frameworks for IPE can allow for more effective implementation, increased learning and more successful outcomes (Cooper et al 2004, Hammick et al 2007, D'Amour and Oandasan 2005). A further point for consideration is that reflective practice was not cited by the participants as something to consider or to complement IPE. Reflection is widely acknowledged as a part of being an effective clinician and is supported in the literature as a valuable part of IPE on both a personal and team level (Hammick et al 2007, Cooper et al 2004, Oandasan and Reeves 2005, Schön, 1987). It therefore appears that while educators are interested in implementing IPE they may need some guidance and information on areas such as learning models, reflection as part of IPE and frameworks to augment success.

IPE was seen by all focus group participants as a positive movement containing potential benefits for students, educators and patients. This is supported by Hammick et al (2007) who found that IPE increases knowledge and collaboration among health professionals. The majority of participants felt that IPE improves understanding of the roles of other professions and teamwork skills. This is similar to Carlisle et al (2004) who stated in a qualitative study that IPE improves integration and Cooper et al (2001) who found that IPE improves learning and partnerships. Similarly, team assessments, joint treatment sessions and liaising with and referring to other team members were all mentioned as things that IPE can encourage and further develop from their current level. Practice educators considered IPE extremely useful for providing patients with a high level of care. They believed it reduces overstepping

of boundaries and gaps in care, allowing health professionals work more cooperatively (D'Amour and Oandasan 2004, Oandasan and Reeves 2005b).

A Cochrane review found that IPE can improve collaboration, reduce errors and increase patient satisfaction in specific patient groups (Reeves et al 2009). The focus group participants felt IPE ameliorates patient care through several methods. It can help therapists and students increase their knowledge of clinical conditions and other team members' roles, improve communication and safety, and assist with prioritising of cases which all help patient care. Lumague et al (2004) in a paper on the perspectives of students who had been involved in a five week IPE initiative agree with these views. The authors report that students from various disciplines all found IPE helped them improve their communication and level of patient care. However, it should also be noted that not all the evidence gives such a positive overview of the benefits of IPE. Many papers state that even though research is advancing there is still a lack of evidence in certain areas regarding direct links between IPE and patient outcomes due to small sample studies and methodological limitations (Illingworth and Cheivanaygam 2007, Reeves et al 2009).

A systematic review found that facilitators as well as students benefit from increased knowledge and awareness (Cooper et al 2001). Focus group participants shared this outlook. The practice educators saw the presence of students on site as a means of helping interdisciplinary working. They remarked that IPE provides valuable CPD opportunities once qualified, encouraging the usage of evidence based practice and prepares students for the working world once qualified. The opinion that IPE enhances CPD is well expressed in the literature. Barr (2000) discussed collaboration in the UK's National Health Service and how this link with academic institutions. He detailed the implications IPE can have on CPD. It was concluded that professional and interprofessional development should and can be incorporated together and included in the training of health professionals to benefit future practice through cooperation. Similarly, Headrick et al (1998) report that the universal desire

for increased collaboration between health professionals and for a more extensive outlook regarding continuing medical education can be achieved by IPE.

6.2 Methodological Considerations

The investigator who was also the moderator of the focus groups was inexperienced meaning some data could have been missed during the focus groups. This study was conducted on only sixteen practice educators from clinical therapies and the majority of these were physiotherapists. If there had been more occupational therapists or speech and language therapists other issues that were not mentioned in the groups may have been brought up which would enhance the quality and content of this study. In addition if the study had been expanded to include practice educators from other areas the study would have been more comprehensive and more information could be obtained. There were only three or four participants in each focus group. If this had been higher more interaction would have occurred and possibly more data would have emerged. Some group members were also quieter than others and while efforts were made to overcome this through eye contact these members may not have contributed as much as they could have or desired to.

7. Conclusion

Interprofessional education is seen by practice educators as a positive movement. However issues such as matching local resources with university aims, practice educator perceptions, timing, correlating student placements and workload demands can all act as potential barriers to its successful implementation. The general consensus from the four focus groups was that even though there are obstacles they are not overwhelming if people are interested enough. The present economic climate does however present educators with a barrier that is not always surmountable. There are several areas where educators have huge caseloads. In these situations it is difficult to facilitate students to learn interprofessionally as well as adopt the role of practice educator. Findings from this study can provide valuable information to those planning and organising clinical placements.

There is a need for further research into this topic using a lager sample size and study design that allows this to investigate whether findings can be reproduced and generalised. Further research after the implementation of an IPE project could also be carried to investigate if perceptions had changed and how successful IPE was in practice on clinical placements.

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8. Appendices

8.1 Participant Consent Form

UNIVERSITY of LIMERICK

OLLSCOIL LUIMNIGH

Informed Consent Form

- I have read and understand the participant information sheet.

- I understand what the study is about and what the results may be used for.

- I am aware of the procedures and what will be expected of me.

- I know that my participation is voluntary and that I can withdraw at any time and don't need to give a reason.

- I understand that personal information and results relating to my participation in the focus group are strictly confidential and will be used for statistical purposes only.

Subject:

Signature _____ Date: _____

Investigator:

Signature _____ Date: _____

Witness:

Signature _____ Date: _____

8.2 Participant Recruitment Email

UNIVERSITY *of* LIMERICK

OLLSCOIL LUIMNIGH

Dear practice educator,

I am a fourth year physiotherapy student in the University Limerick and I am writing to you regarding my final year project (FYP).

I am conducting my FYP on interprofessional education (IPE). I am conducting a focus group study on practice educators' perceptions of IPE and issues surrounding its implementation and am asking if you would be interested in participating.

It is the first study of this kind based on an Irish health care setting and the results would be beneficial to students and educators alike. The date and venue of these groups has yet to be decided and will be based primarily on availability of participants.

I am attaching an information sheet with further details. If you are interested please reply to this email.

Many thanks,

Regards,

Marie M Murphy,

Physiotherapy Student,

University of Limerick

8.3 Participant Information Sheet

UNIVERSITY of LIMERICK

OLLSCOIL LUIMNIGH

What is IPE?

Interprofessional education takes place when students from different disciplines learn with, from and about each other to allow more collaboration and teamwork among professions and to improve patient health outcomes (WHO 2010).

It is an area where there has been a lot of research in recent years. However there are still some areas that require further investigation; one of these being practice educators' views and perceptions of IPE.

What do I have to do?

- I am conducting a focus group study as part of my final year project on practice educators' perceptions of IPE and potential barriers and issues surrounding its implementation in the hope to add to the current research.
  You will be asked to participate in one of these focus groups.

- The focus groups will consist of 5-8 people and the sessions will last no longer than an hour in duration.

- The location of the groups is not decided yet. It is anticipated that they will take place in the University of Limerick but if a number of participants are based a distance form the university a group will be conducted at a location closer to them; namely a site that is used for clinical placements.

Are there any risks?

There are no physical risks involved in this study. Participant confidentiality will be ensured throughout the project. Names will be coded and all data stored in a locked filing cabinet.

Are there any benefits?

There are no direct benefits to you from participating in this study. However you will be helping provide information that could be used to help implement IPE in clinical setting and in future research on the topic of IPE.

What if I do not want to participate?

Participation is completely voluntary and educators are under no obligation to take part in the study.

Should you want further information on anything relating to this study you can contact either:

Anne O'Connor, Project Supervisor at anne.oconnor@ul.ie or +353 61 233279

Marie Murphy, Physiotherapy Student at 0730262@studentmail.ul.ie

If you have concerns about this study and wish to contact someone independent, you may contact:

Chairperson of the EHS Faculty Ethics Committee,

University of Limerick

8.4 Focus Group Questions

Table 3

Opening Question	Introduce yourself and state what setting you work in as a practice educator? • What other professions are involved (if any?)
Introductory Question:	What comes to mind when you hear the phrase IPE?
Transition Question:	• What experience, if any have you had with IPE? • If participants do not have experience the moderator will give a brief overview of the area and then proceed with the key questions.
Key Questions:	• What issues (positive or negative) come to mind when thinking about implementing IPE in a clinical placement setting? • What do you think would be the benefits or disadvantages of IPE: o For you? o For the student?
Ending Questions:	• Summary Question: Moderator gives a brief overview of the main questions and responses that were generated during the focus group discussion. Participants are then asked a question to confirm that the key points discussed have been noted: • Is that a good summary of what was discussed during the session? • Was anything missed over the course of the focus group?

8.5 Audit Trail

Following each focus group a discussion of the group took place with the assistant moderator (Krueger 1998). This was to ensure all available data was recorded and that nothing was omitted from analysis.

The main observations from the assistant moderator were as follows:

Group A: One participant more dominant than others and one that did not contribute as much to the group as the other group members.
Main issues that arose:

- Everyone has some knowledge or experience of IPE.
- Those with experience feel positive regarding its benefits for students and therapists.
- Issues such as time, location and resources can be limitations.
- IPE can improve relations and appreciation of the role of others.
- Good supports are necessary for success.

Group B: One participant arrived late. Good interaction seen throughout. Statements made by one participant frequently caused someone else to think of something and contribute more to the group. One group member was not as interactive as the others but responded better when eye contact was made with them during the discussion.
Main issues that arose:

- IPE is a good initiative that improves teamwork and understanding.
- It promotes better awareness of the roles of others.
- Logistics, timing and personalities can be potential barriers.
- Local support and organisation extremely important.

Group C: Participants very comfortable in each others company, very good group dynamic seen with every group member very relaxed in their responses and body language. No hesitation seen at any stage in responses.
Main issues that arose:

- Good awareness and knowledge of IPE.
- Carried out primarily on informal basis; journal clubs, mixed therapy assessments and treatments.
- Seen as a positive for students and health professionals alike.
- Main barriers are people's attitudes and logistics but these can be overcome.
- Important to consider the ICF framework and what happens outside of treatment rooms and remember that therapists don't work in isolation, there's a bigger picture.

Group D: Two of the participants knew each other well and interacted well. They tried to involve other quieter participant through gestures and leading questions towards them in the conversation.

Main issues that arose:

- Good knowledge of IPE.
- All have either formal (pilot project) or informal (working and learning from other team members) experiences.
- Seen as beneficial and worthwhile for educators and students and will ultimately help clients.
- Getting support from the university, making time for IPE and even having people on placement at the same time can pose problems regarding planning.
- Most of the barriers can be overcome if people want to and plan around things.

After the focus groups were completed the investigator listened back to the conversations repeatedly and once they were transcribed transcripts were read and re re-read. Data was coded to ensure anonymity and preliminary analysis was commenced through repeated reading of transcripts, coding of text and incorporation of the assistant moderators field notes. A reflective diary was also maintained by the investigator.

The frequency, extensiveness and intensity of themes was also noted to ensure that a view of a single participant even if they were very emotive didn't become a theme as this would bias findings and lead to inaccuracies (Krueger and Casey 2000). The intensity takes into account the emotion and specificity of a participant as they make a statement. However, sometimes monitoring this can be very subjective and therefore was not taken into account on its own but in combination with looking at the frequency and extensiveness. The six phases of thematic analysis (data familiarisation, initial code generation, searching for themes, reviewing themes, defining and naming themes, and producing the report) as described by Braun and Clarke (2006) were also taken into account during analysis. Similarly, this paper was used to attempt to avoid potential pitfalls such as mismatching data, claims or theory or stringing sections of quotes together.

At this point the main themes and concepts that emerged were as follows:

- Educator perceptions
- Issues surrounding logistics
- Location and timing
- Cultural issues
- Teamwork
- Patient outcomes
- Relevant topic with good students
- Knowledge and understanding
- Support systems in place

In the weeks and months that followed the transcripts were frequently read and re-read and initial themes and concepts were modified and refined. There were further discussions with the assistant moderator to evaluate how data analysis was proceeding. The reflective journal was continued and the content of this was used to reflect on the process and analysis. Recordings of the groups were listened to more to try to ensure that nothing significant was omitted. At the end stage of this process three main themes emerged (Table 4, section 5.3.1). Participants were sent member checking emails also to ensure there was an accurate and valid interpretation of data.

Some participants did not respond (due to being on leave or unknown reasons) to this email but the majority did so and at least one participant from every group agreed with the findings. It was therefore concluded that there had been an accurate interpretation of findings.

8.6 Member Checking Email

Dear Clinical Educator,

Many thanks for the attending the focus group in December 2010 on IPE.

My study is almost complete and I am just tidying up a few things before submitting it.

To ensure the study is as valid as possible I would greatly appreciate if you would take a few moments and read this email containing a summary of the key findings of the focus groups (with a sample of some of the included quotes) to ensure that the information is interpreted accurately.

Please respond to the email as soon as possible to ensure everything will be up to date.

Many thanks,

Kindest regards,

Marie

1. **<u>Issues surrounding planning and resources:</u>**

    a. **Placement timing and participant selection**

"were just lucky that we happened to have a placement of students of both colleges at the one time and I don't know how you would coordinate that". (Group D, #1)

"were fortunate in that the patient we had was ideal and very articulate and had plenty and a broad spectrum there and the two students were good….So ultimately it would depend on the level of ability of the student". (Group A, #2)

b. Local resources vs. university aims

" local system of managing it may be the more appropriate because if it is driven by the request from the university for a group if students coming in to a local area it may not match what is available to them". (Group B, #2)

c. Support from others

"…sometimes you're overruled by the workload or who your line manager is" (Group D, #2)

d. Assessment

"put such work into it, they put such time and work and gathering information into it that I think it should have been (part of assessment)". (Group C, #2)

2. <u>Perceptions of IPE:</u>

a. In general

"fostering a better understanding of each other's professions (Group B, #1)

b. In a placement setting

"There is certainly a role for it in the rehab setting… all three (therapies) could work on it and that could be really good to see, you know that it would be excellent". (Group A, #2)

c. Interested educators

"If there is ever a barrier it's the people that put up the barrier…" (Group C, #1)

3. Positive outcomes:

a. Teamwork

"You'd know what they do and who you refer to rather than just randomly referring them off into space". (Group C, #5)

b. Continual professional development (CPD)

"Interdisciplinary working does provide interdisciplinary education…it's on-going and it keeps you fresh, it keeps you fresh in your job". (Group D, #2)

c. Improved patient care

"So more people are on top of the case in hand and kind of offer…nobody is falling between stools". (Group A, #2)