

Aligning Health Occupation Students for Valuable Interprofessional Learning: Evaluating Program Structure, Resources, and Student Experiences in a Regional Clinical Setting

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Abstract

Developing Interprofessional Education (IPE) programs for undergraduate health occupation students pose multiple complex challenges, in both university and workplace learning settings. These challenges can hinder the widespread adoption of IPE, despite evidence showing its potential to enhance knowledge of other professions' roles, foster collaborative practice and build interprofessional identity. This study aimed to provide an overview of an IPE program implemented in a regional health service during student clinical placements, and to evaluate student perceptions regarding the value of the program to their learning experiences. A retrospective mixed-methods survey was conducted with students from fourteen disciplines (n=136) who participated in eight IPE workshops. The survey sought to assess their perceptions of the program's effectiveness. Most participants were in their senior years and came from Physiotherapy, Occupational Therapy, Pharmacy, or Social Work disciplines. Students particularly valued the clinical simulation training, the structured approach to communication education, and the timely multi-source feedback provided during the program. They highly valued the opportunities for interprofessional learning that allowed them to learn with, from, and about students from other disciplines (World Health Organisation [WHO], 2010, p. 7). These elements are instrumental in enhancing interprofessional learning and collaboration.

Keywords: clinical competence; feedback; health occupations; interprofessional education; professional identity; role perception; simulation training; students; workplace learning

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Introduction

Due to changing population demographics, the rising prevalence of multi-morbidity, and a growing emphasis on client-centred care, health professionals are increasingly confronted with the need to respond to complex client cases (Read et al., 2017). Barr and Coyle identified best practice in responding to these situations is for clinicians "... to work more closely with other professions to spread the load and respond more fully to the range of needs [of the clients]" (2013, p. 185).

Interprofessional education (IPE) is an experience that "occurs when two or more professions learn about, from and with each other" (World Health Organisation [WHO], 2010, p. 7). IPE opportunities for undergraduate health care students enable students from more than one professional background to learn alongside each other. These opportunities facilitate the development of role clarification within the healthcare team, improved teamwork skills, development of interprofessional identity, and encourage interprofessional collaborative practice (Anderson et al., 2016; Brewer & Flavell, 2020; Kent et al., 2018).

Participating in IPE has been shown to enhance interprofessional collaboration and result in improved teamwork for better patient outcomes (Cox et al., 2016). The WHO endorses IPE in the Framework for Action on Interprofessional Education and Collaborative Practice (2010). The framework outlines the need for IPE and collaborative practice to improve patient safety in health systems globally. However, the literature suggests that IPE rarely features as an organised, regular component of workplace learning curriculum (Anderson et al., 2016; Kent et al., 2018).

IPE delivered via workplace learning is increasingly recognised as a key component of the undergraduate health student curriculum (Venville & Andrews, 2020). In comparison to IPE in the university setting, workplace-embedded IPE during clinical education provides the added benefits of increased relevance, contextual learning, and opportunities to practice, reflect and consolidate learning. However, IPE programs delivered in healthcare workplaces for undergraduate students are uncommon (Kent et al., 2018).

Complex challenges impede the success, scale up and sustainability of formal IPE with students in the healthcare work setting. These include insufficient resources, logistical issues, diverse clinical roles, and profession-based subcultures (Grace, 2021; Kumar et al., 2018). Considering these challenges, a team of educators developed a structured IPE workshop specifically targeting undergraduate health occupation students. The initial IPE program was delivered in 2015, and the program continued to evolve in response to iterative formal evaluation by participants and informal feedback from workshop facilitators. The interprofessional education program has been effectively sustained over time and consistently draws high levels of student participation and engagement.

The aim of this study was to evaluate an IPE program targeted at health occupation students on placement within a regional healthcare service. The research questions asked were:

1. What influence (if any) did the program have on students' self-perceived learning?
2. How did students perceive the delivery of the program?
3. What elements of the program were perceived to have most value by students?

Workplace IPE program for health occupation students

While this program has been running for several years, this evaluation reflects the updated 2019 content and delivery of the program. The aim of the IPE student program was to facilitate opportunities to bring undergraduate students together to facilitate learning with, from and about each other's professions. The topic used to facilitate IPE in a face-to-face practical workshop format related to the shared interprofessional core skill of communicating for patient safety (Australian Commission on Safety and Quality in Health Care, 2023).

Underlying theoretical framework

The IPE student program aligns with interprofessional practice theory and the principles of adult learning ([Anderson et al., 2016](#); [Reime et al., 2017](#)) including universal design for learning principles ([Centre for Applied Special Technology, 2014](#)). The workshop was designed to include undergraduate students from up to fourteen professions working and learning together in small interprofessional groups whilst engaging in practical tasks including simulation. Simulation in healthcare enhances critical thinking, problem-solving, and other essential professional skills ([Alanazi et al., 2017](#); [Henrico & Oostdam, 2022](#)), and a percentage of student practice education hours can be attributed to simulation training in most health disciplines by relevant accrediting bodies. Program activities included concrete, practice experiences which provided opportunities for reflection and the building of shared meaning ([Anderson et al., 2016](#)). An upper limit of 24 participants per session was enforced to maximise interactivity and opportunities to participate in simulation. Educators explicitly facilitated active student participation as a means of maintaining attendee engagement and enhancing transferability of new skills to practice ([Reime et al., 2017](#)).

Description of the development process

The overarching topic of focus for the program, communication, was decided through discussion and collaboration between the educators from each discipline. Similar communication sessions had been delivered by student educators for their respective cohorts. The team sought opportunities to avoid duplication, pool resources from these existing programs, and model interprofessional collaboration. The program was designed to meet the needs of diverse professions and for students of varying year levels and clinical experience. Therefore, discipline specific tailoring was not required and would have been contrary to the interprofessional aims of the program.

The workshop evolved into a sustained, consistently well-subscribed program, delivered independently of university partners. This success can be attributed to the structured and sustainable workshop framework, the willingness of clinician educators from the health service who had experience with facilitating IPE to develop and deliver the program, and access to the optimum blend of students for interprofessional learning.

Program Setting

The workshops were facilitated in the education facilities of a large regional public health service during student clinical placements to enhance student practice-based learning. Practice-based learning includes elements such as clinical supervision, reflection, feedback, and the development of professional competencies through active participation ([Penman et al., 2024](#)). The organisation serves a geographically dispersed population through twenty-one sites. Services include emergency, acute care, mental health, primary care, community services, aged care, and rehabilitation. The primary catchment for the organisation has a population of 350,000 extending to 500,000 for some services.

Target Population

At the start of the year, the team met to plan suitable workshop dates based on student placement bookings, when high numbers of students from multiple disciplines were on clinical placement to maximise the diversity of health professional students in each workshop.

Students were recruited from Audiology, Exercise Physiology, Nuclear Medicine, Nursing, Nutrition and Dietetics, Occupational Therapy, Pharmacy, Physiotherapy, Podiatry, Prosthetics and Orthotics, Radiography, Radiation Therapy, Social Work, and Speech Pathology. Students were from several Australian universities and represented different undergraduate year levels. No more than four students per profession were encouraged to attend each workshop to encourage a rich blend of interprofessional learning.

Program content, resources, and format

Once program dates were confirmed, the venue was booked, and workshop educators and facilitators were arranged. A workshop coordinators package was developed to prompt planning and to ensure consistency in the delivery of each workshop. The package included: (1) the workshop plan and schedule including group configurations, (2) the Acknowledge, Introduce, Duration, Explanation, Thank you (AIDET) communication template for students, (3) simulated patient scenario and instructions including a scenario requiring the use of communication ramping techniques, (4) simulation facilitation tips, (5) observer feedback checklists for facilitators and students, (6) attendance sheets, (7) completion certificates for students, and (8) student post-participation evaluation surveys. AIDET refers to an evidence-based communication model utilised by the health service to improve communications with patients ([Huron, 2023](#); [Scott, 2012](#); [Skaggs et al., 2018](#)).

Communication ramping refers to strategies used to facilitate two-way communication with someone with a communication impairment ([Schwartz, 2009](#)) such as eye contact, speaking clearly, repeating or refreshing questions, one idea at a time/shorter sentences, write down key words, draw or use pictures, use gesture, provide choices, Yes/No questions, allow time, check understanding, and slower rate of speech.

Minimal additional equipment was required for the workshop, although props were needed to support realism for some simulation activities such as patient gowns, blankets and gait aids.

A mixed delivery format (see [Appendix](#)) was chosen for optimal adult learner engagement. Simulation activities were chosen to maximise the tangible development of communication skills, with the program comprising mostly experiential and interactive activities based on real-world clinical scenarios. Simulation training facilitates critical thinking, problem-solving, assessment and collaborative decision-making, in a safe environment ([Reime et al., 2017](#)). Effective simulations for improved clinical practice include clear objectives, interprofessional teamwork and realistic scenarios; however, aligning diverse professional perspectives and creating simulations that accurately reflect real-world situations can be a challenge ([Reeves et al., 2017](#)). Timely feedback from multiple sources was also provided via immediate feedback from the facilitator, simulated patient, and peer observers.

The program was delivered via a single three-and-a-half-hour workshop, which was repeated eight times over the course of 2019. These workshops were held in the health service's education and training facilities at both the acute and subacute sites. Some students were required to travel between campuses to the facility and were provided with time to do so by their placement supervisors. The facilities provided sufficient space for the learning activities, along with smaller break out rooms for simulated scenarios. The space was initially set up with small tables of up to six students, preferably comprising one student per discipline. The students remained in same student peer group for the entire workshop; however, they moved between different environments according to the activity being undertaken.

Program providers

An interprofessional team drawn from a local network of Allied Health and Nursing student educators and clinical educators facilitated the workshops. The coordinator organised the educator team, which comprised of a minimum of two presenters for the presentation component of the workshop, and a minimum of four facilitators and four simulated patients for the simulation training component of the workshop. 'Simulated patients' were drawn from either the clinical educator staff or from a pool of ten trained volunteer actors accredited at the health service.

Methods

This study utilised a retrospective descriptive analysis of anonymous mixed methods post-participation surveys collected from health occupation students. An embedded mixed methods design was utilised, collecting quantitative data within a generally quantitative cross-sectional survey ([Cresswell & Plano Clark, 2018](#)). Ethics approval was secured from the Health Service Ethics Board (#64730) to collect,

analyse, and publish the evaluation data. The methods, results and discussion sections of this study complied with the CRiteria for DEscribing and evaluating training interventions in healthCare Professions (CRe-DEPTH) (Van Hecke et al., 2020).

Recruitment and data collection

All workshop participants were invited to complete an anonymous pen and paper survey at the completion of the workshop. This outcome measure was an applied assessment of the participants' learning and experience of the program. Survey responses were entered into the REDCap electronic data capture tool hosted at the health service. REDCap (Research Electronic Data Capture) is a secure, web-based software platform designed to support data capture for research studies, providing: (1) an intuitive interface for validated data capture, (2) audit trails for tracking data manipulation and export procedures, (3) automated export procedures for seamless data downloads to common statistical packages, and (4) procedures for data integration and interoperability with external sources (Harris et al., 2009, 2019).

As shown in Table 1, the survey comprised seven statements using a Likert scale (1 = strongly disagree to 5 = strongly agree) and one open-ended question. The first three statements were standard features of the organisation's clinical education and training department's evaluation process. The remaining statements addressed the aims of the workshop. The open question concluded the survey and prompted participants to identify the most valuable aspects of the workshop from their perspective.

Table 1:

Evaluation Survey

- | |
|--|
| <ol style="list-style-type: none">1. This session provided me with new clinical communication knowledge/skills.2. The facilitation style was engaging and interactive.3. The session duration, pace, & resources were appropriate for my needs.4. The simulated patient scenarios were valuable for my practice & learning.5. I found value in learning with, from & about other professions.6. I gained an appreciation of the benefits of interprofessional teamwork.7. I will be able to apply some of these learnings to my clinical practice.8. What worked well/did you find most valuable? |
|--|

Data analysis

Responses to the closed statements were analysed using simple descriptive statistics, including the median and interquartile range. Quantitative analysis was undertaken using the SPSS package, while qualitative analysis was completed in an Excel database.

Open question responses were analysed using descriptive thematic analysis based on a five-stage team-based framework (Ritchie & Spencer, 2002). Six members of the research team began by familiarising themselves with the overall data set by reading through the responses and tentatively identifying major themes. A researcher, independent of the workshop delivery team, identified the coding framework by developing initial themes along with descriptions and example quotes. All other research team members reviewed this framework and collaboratively agreed to the final version. All data was coded according

to the framework before the research team collaboratively identified patterns in the data. The patterns formed the basis of finalised themes, which were interpreted in relation to the existing literature in this field.

Findings

One hundred and forty-four students participated in the eight workshops delivered in 2019, including participants from 14 disciplines. Most participants were Physiotherapy, Occupational Therapy, Pharmacy or Social Work students (see [Figure 1](#)) in predominantly the third or fourth year of their course (see [Figure 2](#)). Of the 144 students who each participated in a workshop, surveys were completed by 136 students indicating a response rate of 94%. Of the 136 students who completed the survey, 135 completed both the quantitative and qualitative sections and one student only completed the quantitative section.

Figure 1:

Participants by health discipline

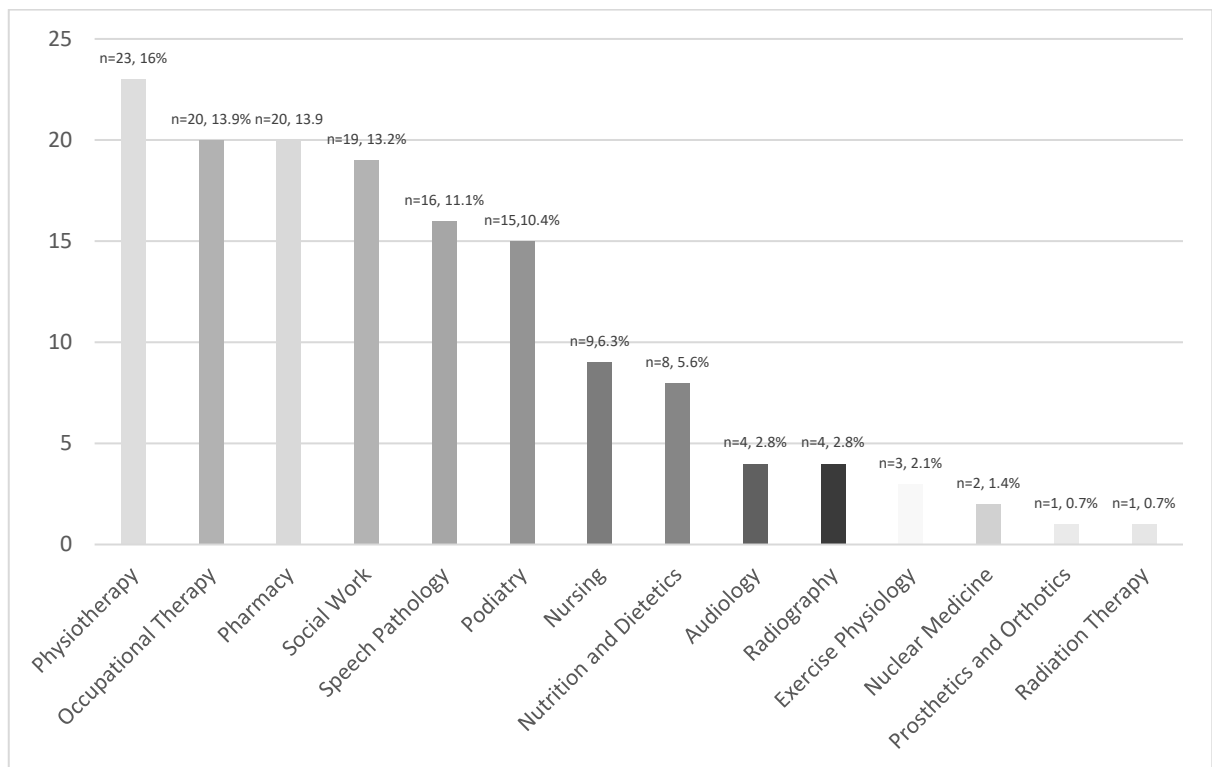
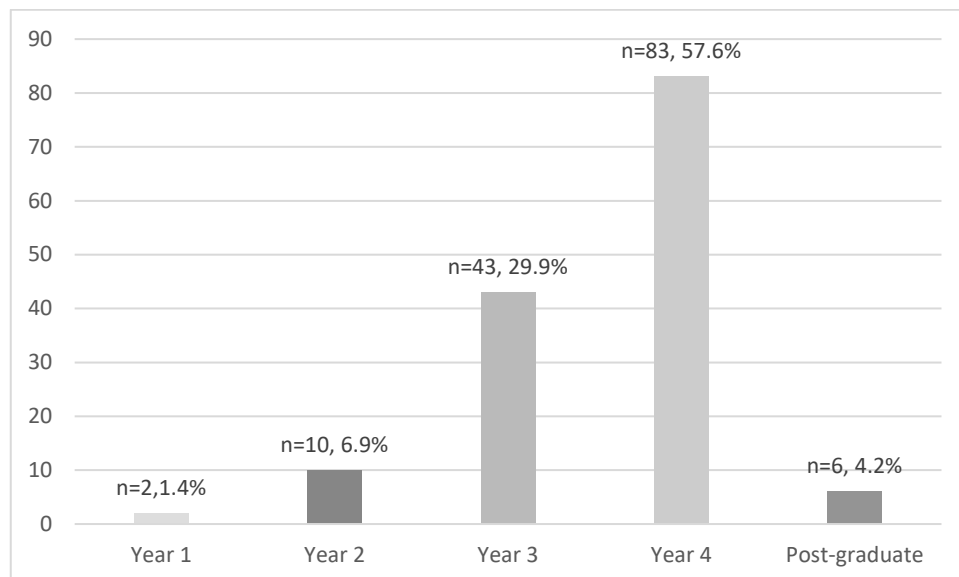


Figure 2:

Participants by year level



Self-perceived learning and program delivery

The median ratings indicated students Agreed with the outcomes of the program from their perspective. The only item with a different median was ‘the simulated patient scenarios were valuable for my practice and learning’ which was most often rated as Neutral. Both items including reference to transferability of learning to practice (Items 1 and 4) demonstrated minimal variance in responses. [Table 2](#) and [Figure 3](#) highlight data relating to participant responses.

Table 2:

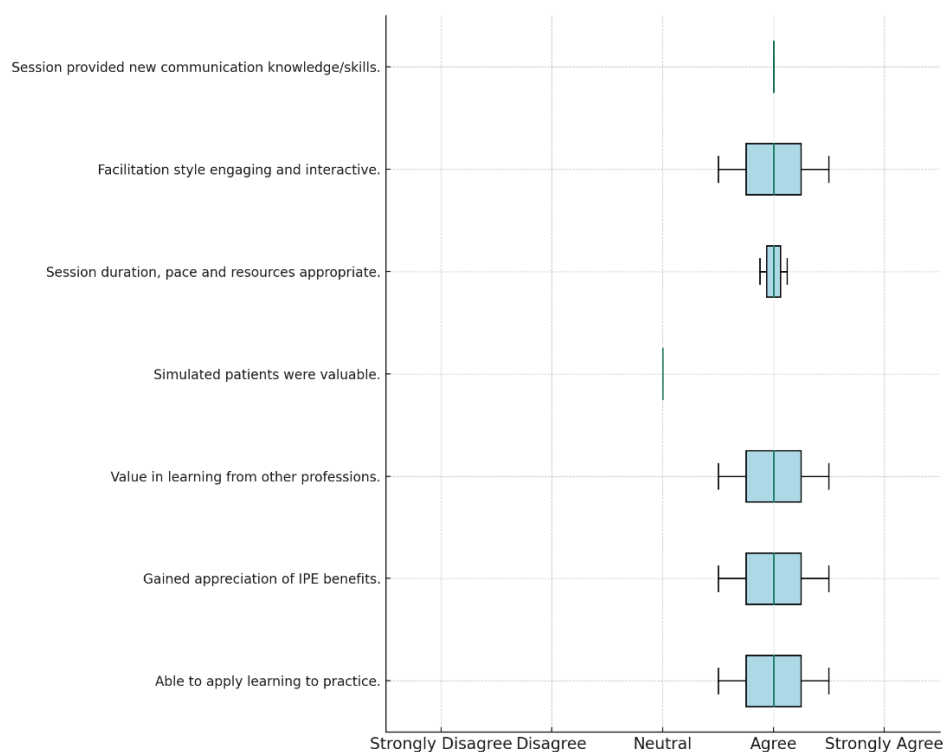
Student Responses to Likert Items on evaluation survey

Rating 1 – 5 (maximum agreeance)	N =	Med (IQR)
The session provided me with new clinical communication knowledge/ skills	136	4 (1)
The facilitation style was engaging and interactive	136	4 (1)
The session duration, pace and resources were appropriate for my needs	136	4 (1)
The simulated patient scenarios were valuable for my practice and learning	136	3 (0)
I found value in learning with, from and about other professions	136	4 (0.25)
I gained an appreciation of the benefits of interprofessional teamwork	136	4 (1)
I will be able to apply some of these learnings to my clinical practice	136	4 (0)

Med (IQR): Median Interquartile Range (measure of statistical dispersion).

Figure 3:

Student responses to evaluation survey



(Evaluation surveys questions have been abbreviated on chart; see [Table 1](#) for complete statements).

Valued elements of IPE program

Two themes were identified in relation to the IPE program elements students most valued: (1) interprofessional learning, and (2) content and structure that facilitate IPE.

Interprofessional learning

The theme of interprofessional learning related to the value of learning with, from, and about other disciplines in a health care context via the program. The largest number of codes supported this theme. The workshops provided opportunities for students to observe how colleagues from different professional backgrounds approach clinical cases and employ communication methods. For some students, this was a novel learning experience, “[This is the] first time in a 4-year degree [I have experienced] joint collaboration between professions” (Participant 72).

Participants frequently perceived their learning experience as enriched by learning alongside and observing students from other professions. Their experience included the opportunity to learn about the roles of other healthcare professionals, as shared by Participant 87, “Having students from another field - watching them interact and learning more about their role”. Students were also able to develop an understanding of the interface between their own discipline and others by reflecting on their diverse contributions to patient care: “The interprofessional experience helped put my profession in context and gave a broader view of patient experience” (Participant 29).

Other participants identified new understandings about information gathering, processing and use by other disciplines, including Participant 63, “I found it interesting to learn about how the other professions interpret the same information about a client and what they think the key information is ...”

Content and structure that facilitate IPE

There were three elements to the content and structure of the program that participants perceived as facilitating IPE. These included clinical simulation training, structured approaches to communication and timely multi-source feedback.

Clinical Simulation Training

Participants valued the use of simulated patients in the workshop, with many describing them as “authentic”, “engaging”, and “enjoyable learning experiences” in response to the open-ended question. Students indicated that clinical simulation training during the program enhanced their understanding of interdisciplinary care and team roles by observing other students mimicking the ‘real life’ world of clinical practice, “Simulation with very good actors, being able to have a realistic experience but without real life consequences” (Participant 87). The simulations also enabled many students to engage with complex and yet commonly encountered clinical scenarios, such as communicating with a patient with aphasia or a hearing impairment within a safe, low stakes learning environment. Some participants however, felt that the simulated clinical scenarios were not relevant to their profession and therefore limited their engagement with and learning from the practical component of the workshops. In relation to their new knowledge, students also discussed how the simulation training activities supported translation of this new knowledge into practice, as highlighted by Participant 80, “Being able to put new skills and information into practice straight away in the simulations”. Students developed enhanced practical understandings of the roles of the members of the interdisciplinary care team, free from expectations of what they ‘should’ know by this stage in their education:

While we were all nervous about the clinical simulations, they were very helpful to identify the questions [to ask and the] roles of each profession. It was great to practice with different cases and seeing how all roles can work with a patient ... (Participant 69).

Structured Approaches to Communication

Communication, while a fundamental clinical skill, can be difficult for undergraduate health occupation students to improve without a supporting framework to provide structure and without the opportunity to practice and receive feedback. The focus on communication as an interprofessional clinical skill in this program was perceived as assisting students to develop the skill of balancing structure and rapport for effective clinical communication. The benefits of learning these structured approaches to communication was a strong theme in the data and was perceived to have direct relevance and applicability to practice, indicated by Participant 51, “Talking through AIDET and the ramping was helpful in structuring my interactions”.

In addition, the AIDET tool was highlighted by participants as a strategy which could be easily implemented and directly translated to daily practice during placement, “The AIDET concept will be very useful on placement daily” (Participant 51).

Timely Feedback

Opportunities for participants to receive timely and constructive feedback from the range of people (both participating in and delivering the workshops) was also a strong theme in the data. Feedback as a concept was described with respect to peer feedback (generally), peer feedback (from another profession), facilitator or simulated patient feedback. Participants commented on the unique opportunity to receive feedback from each of these perspectives and perceived it to be beneficial to their practice,

with one participant sharing the following: “I found it valuable to receive feedback from the other students, educators and the actual patients as it gave me a different perspective for my learning” (Participant 13).

The timing of feedback was also identified as an important aspect of the program. Feedback directly after the practical component of the workshop enabled immediate review and consolidation of communication skills: “The realistic scenarios and the group feedback straight after. I found this very useful for problem solving and identifying areas to improve in” (Participant 73). In addition, iterative feedback supported reflection and ongoing development of their learning from multiple perspectives, including, “Most valuable being the feedback received from other students and instructor and actors themselves on my performance” (Participant 5). Repeated opportunities to receive feedback within the single day workshop also accelerated their skill acquisition, as Participant 66 pointed out, “Being able to practice two times was great, did allow to improve our skills/the interaction in general after the simulations”.

Discussion

This evaluation of a program targeted at health occupation students within a regional healthcare service indicates it is a sustainable adjunct to workplace learning. The program had a positive influence (Likert scale = Agree) on the students’ self-perceived learning, and they also expressed positive perceptions of its delivery. Having the opportunity to engage in interprofessional learning was identified as a major benefit of the program, which enabled students to reflect on how their learning could translate into interdisciplinary practice. Three specific features of the program were also highlighted as facilitators for their learning: clinical simulation training as an effective approach to learning, skill development for structured communication approaches, and the availability of timely feedback from instructors, peers, and simulated patients. Overall, students indicated that they experienced the program as engaging and interactive, and its format and duration were appropriate to their learning needs.

The key elements of the program that the participants valued are consistent with previous evaluations of IPE programs delivered in university settings ([Iverson et al., 2018](#); [Reime et al., 2017](#)). A recent systematic review by [Mattiazzi et al. \(2024\)](#) confirmed IPE opportunities occurring within clinical settings provide authentic opportunities to build collaborative competence. This review and other studies have highlighted professional socialisation with other disciplines as a key learning strategy ([Kent et al., 2016, 2017](#)), and this feature of the program was clearly valued by the participants in this study. This program included an exceptionally wide range of disciplines, and consideration should be given to maximising diversity to optimise student access to socialisation experiences.

Maintaining authenticity and relevance are key to optimising learner engagement and experience ([Anderson et al., 2016](#)), hence the inclusion of clinical simulation training within the evaluated program.

While these simulations were perceived positively, they can be challenging to design and enact in interdisciplinary contexts. Designing clinical scenarios that are universally relevant to diverse disciplines requires complex skills and may require significant human and other resources ([Ju et al., 2022](#)) to support their authenticity. A study of interprofessional allied health education ([Robson et al., 2023](#)) also highlighted they may need clear triggers for each discipline incorporated into simulation material, to support their emerging understanding of their professional roles. Investment in design and resourcing must be negotiated during program design, to maximise the benefits of authentic learning. Program designers can draw on a significant body of evidence that supports the benefits of allowing students to take a break from real life clinical practice and making pedagogical use of simulated situations ([O'Brien et al., 2017](#)).

Specific skill development around structured approaches to communication were also identified as a valued aspect of the program. Responses from the students indicated that this content met their professional development goals, which is pivotal to learning engagement ([Kumar et al., 2018](#)). Adopting a structured, tangible approach to teaching and learning communication skills can ensure

undergraduate health occupation students develop positive communication values (Braverman et al., 2015), and developing skills in specific communication techniques has been reported as a learner priority in an international study (Schwarzbeck et al., 2019). While communication styles vary between individuals, programs such as those evaluated here can successfully develop clinical communication skills (Vermeylen & Wood, 2020) by providing novice health professionals with clear guidelines, opportunities for reflective observation of peers and timely constructive feedback.

While health professions students on placement receive feedback from their supervisors daily, the evaluation highlighted a role for the program in supporting feedback from multiple perspectives including peers, colleagues from other professions, and simulated patients. Stegmann and colleagues (2012) found that students engaged in collaborative learning which included structured peer feedback had better learning outcomes than those completing traditional 'learning by doing' learning. In their systematic review of peer-assisted learning, Sevenhuysen et al. (2016) found this approach confers numerous benefits to learners but acknowledged more research is needed to determine the most effective approaches. In this project, the students were actively engaged in feedback, as they both gave and received feedback while iteratively building their knowledge and skills together (Ajjawi & Regehr, 2019). Quality feedback for interprofessional education should also be open, respectful, relevant, responsive and actionable (Tielemans et al., 2023), which can be facilitated by program leaders within each session.

Pleasingly, most participants in this program reported they felt they could apply their learning to their future practice. Given that the workshop is delivered in the healthcare placement setting, the students were able to practice their new skills in the clinical environment and build their understanding of their interprofessional identity immediately after its conclusion (Grace, 2021). Healthcare settings hosting students from more than once discipline should routinely grasp the opportunity to bring learners together, to learn with, from and about each other in similar practice-aligned IPE workshops.

The findings of this evaluation indicated that interprofessional learning in non-clinical environments may be supportive of practice improvement, provided the learning content and resources are designed to be as authentic as possible. However, a study of knowledge translation following interprofessional education between nurses, pharmacists, and physicians (Mann et al., 2009) identified several potential barriers to implementing program learning, including the impact of workloads and resistance from multidisciplinary colleagues. Future longitudinal research of evaluation translation and implementation by health professions students in the months following the program could confirm whether their intentions come to fruition.

Strengths and Limitations

This evaluation provided an insight into the impact of a sustained, consistently well-subscribed IPE program. Unlike other programs evaluated in the literature, this program has been delivered independent of university partners in the workplace and therefore offers a unique perspective on work integrated IPE.

However, there are also several limitations that must be considered when interpreting the results. Collecting data immediately following the program contributed to a high response rate but does not address post-program implementation of new knowledge and skills. The evaluation was also limited to student perspectives, and could therefore be improved through feedback from other key stakeholders such as higher education institutions and student clinical supervisors. While the survey format reduced time burden for participants, this format cannot collect in-depth qualitative reflections which may include valuable insights. Demographic specific data was not collected, and so analysis into discipline specific need or themes could not be undertaken.

Conclusion

This study evaluated an IPE program targeted at health occupation students within a regional healthcare service. The program had a generally positive impact on the students' self-perceived learning and was positively received by participants. Opportunities to engage in interprofessional learning were valued by the students, particularly via peer observation and the clarification of the roles of various disciplines. Three features of the content and structure of the IPE program were also perceived by students as facilitating their learning: clinical simulation training, structured approaches to communication, and timely multi-source feedback.

The findings have implications for future research and education. As mentioned previously, longitudinal studies to investigate how the skills and knowledge developed in the program are implemented into practice, would measure its impact on both the health service and patient experience. Further exploration of the optimal time within the students' clinical placement structure to complete the IPE workshop could also ensure its content was more appropriately targeted. The components of the program perceived to be facilitative will continue to develop into the future, as the team updates their approach in the light of new evidence and innovations.

It is anticipated that this example of a structured IPE program targeting undergraduate health occupation students delivered in the healthcare setting, will assist other clinical educators and managers to consider ways of overcoming the complex barriers to delivering IPE workshops in the healthcare setting. By harnessing the benefits of increased relevance, contextual learning, and opportunities to practice, reflect and consolidate learning related to IPE, clinical educators have an opportunity to positively impact interprofessional collaboration skills which ultimately improves the delivery of safe quality patient care.

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Appendix

Program content, resources and format

1. Icebreaker – Referral Circle (10 minutes)
<i>Intent:</i> Team role clarification and referral pathways identification.
<i>Format:</i> Small table groups interactive discussion followed by large group discussion.
<i>Instructions:</i> Each table identifies a clinical situation when a student would refer the patient to each of the disciplines present, in turn. The aim is to complete the circle, with the last discipline referring to the first discipline. A representative from each table will briefly tell “the patient story” including the role of all disciplines.
2. AIDET (20 minutes)
<i>Intent:</i> Provide an evidenced based structure for clinical communication applicable to all disciplines.
<i>Format:</i> Large group didactic PowerPoint presentation, followed by small table individual and paired interactive work.
<i>Instructions:</i> Presentation to introduce AIDET. Observation of AIDET in action video. Participants write own AIDET script for current placement using worksheet (available on request from author). Participants practice AIDET script with each other.
3. Communication skills for rapport building (10 minutes)
<i>Intent:</i> To provide communication skills education that balances the development of both rapport and structure.
<i>Format:</i> Small table groups, followed by large group interactive discussion.
<i>Instructions:</i> Brainstorming strategies to build rapport. A representative from each table provides feedback to the larger group.
4. Communication ramping (20 minutes)
<i>Intent:</i> To provide practical education on graded communication skills to enhance effective two-way communication for use with patients with different abilities.

Format: Large group didactic PowerPoint presentation with two videos of a clinician communicating with a patient with Aphasia. Video 1: Clinician communicating with patient with limited effect. Video 2: Clinician communicating with patient using communication ramping strategies effectively.

Followed by large group discussion and individual work.

Instructions: Facilitators describe and discuss examples of communication challenges, communication ramping and its importance. Students are required to identify communication ramping strategies used in the videos and complete associated worksheet (worksheet available on request from author).

Break (10 minutes)

5. Simulation training preparation (10 minutes)

Intent: Create a safe simulation learning environment.

Format: Large group interactive discussion

Instructions: Discuss strengths and challenges of experiential learning via simulation. Outline process and participant guidelines to ensure safe learning environment, including confidentiality and respect.

6. Simulation Training (80 minutes with 40 minutes per scenario)

Intent: Simulated interactive clinical scenarios with simulated patients with communication challenges (Aphasia or Hearing Loss). Initial meeting with client to practice AIDET, rapport building and communication ramping skills via collaboration, practice, observation, and feedback.

Format: Small groups with facilitator. Individual work in small groups. Small group, facilitator, and volunteer actor (as the simulated patient) in customised simulation environment. Students arranged in a fishbowl layout to observe the simulation. The observers are encouraged by the facilitator to provide constructive feedback on whether the student met the simulation aims.

Instructions: Students review client scenario and clarify any concerns with facilitator. Students independently draft their script for the patient interaction. Facilitator introduces the patient and scenario. Each student interacts with the patient to practice their skills for approximately 4 minutes while student observers take notes using worksheet to identify aspects of ADIET and communication ramping used by student (worksheet available upon request to author). Facilitator prompts student observers to provide positive feedback to

participating student. Facilitator asks the participating student “What would you do differently next time?” and provides constructive feedback if necessary.

Repeat with second scenario.

7. Reflection (10 minutes)

Intent: Facilitate reflective practice to assist consolidation of learning.

Format: Large group interactive discussion

Instructions: Guided reflection by facilitators