

Online Learning: Integrating Interprofessional and Patient Safety Competencies Into Doctor of Nursing Practice and Doctor of Pharmacy Curricula

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ABSTRACT

Although integrated interprofessional education is widely endorsed, few reproducible models for accomplishing this have been published. An online interprofessional team-based learning module focusing on patient safety was integrated into existing final clinical management courses for doctor of nursing practice family nurse practitioner students and doctor of pharmacy students. Medication error case studies, root cause analysis of the errors, and interprofessional communication formed the backbone of the module. Upon completion of the learning module, the majority of students agreed or strongly agreed that they had achieved competencies based on Interprofessional Education Collaborative Expert Panel core competencies.

Keywords: doctor of nursing practice, doctor of pharmacy, interprofessional, Interprofessional Education Collaborative Expert Panel, online, Quality and Safety Education for Nurses

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The Institute of Medicine¹ and World Health Organization² strongly endorse teaching health care professionals in a cooperative, interactive environment, and credentialing bodies^{3,4} increasingly expect integrated interprofessional education as an indicator of high-quality programs. A curricular emphasis has also been placed on teaching health professionals to participate in a safe system of care delivery that prevents and learns from errors.⁵ The IOM⁶ called for the creation of a health care environment in which organizations identify errors, evaluate causes, and take appropriate actions to improve future performance. However, graduate curricula are very content heavy, and integrating quality and safety content into new interprofessional courses requires the adjustment of content and coordinated curricular changes that may seem insurmountable. These challenges of coordination across disciplines can prevent the development of meaningful interprofessional learning experiences. In addition, the increasing focus on online education

programs has fundamentally changed the nature of some degree programs making face-to face interaction across disciplines even more challenging.

To address both safety and interprofessional requirements, an online interprofessional team-based learning module related to medication errors was integrated into existing final clinical management courses for doctor of nursing practice (DNP) family nurse practitioner (FNP) students and doctor of pharmacy (PharmD) students at a university health science center in Florida. As patient safety initiatives underscore the importance of improved communication among different providers to prevent medical errors, communication issues have been identified as a leading root cause of sentinel events reviewed by The Joint Commission.⁷ Thus, developing and demonstrating interprofessional communication strategies to address complex medication errors was selected as the focus of the module.

Learning objectives and evaluation were based on interprofessional core competencies developed by the

Interprofessional Education Collaborative Expert Panel.⁸ The Quality and Safety Education for Nurses graduate-level safety and teamwork competencies were used to develop the content of the learning experience.⁹ Because medication knowledge and safe prescribing practices are integral to both professions, medication error case studies, root cause analysis of the errors (Joint Commission on Accreditation of Healthcare Organization),¹⁰ and interprofessional communication formed the backbone of the module. The final product of this case-based learning experience was an online synchronous team presentation involving all student team members.

MODULE PLANNING

Developing the interprofessional module required faculty to explore best practices for collaborative learning. Faculty developed module objectives and reviewed their respective courses to ensure consistency with nursing and pharmacy course objectives. Faculty responsibilities related to the new joint activity were negotiated. As planning began, the faculty dialogued about the personal attributes needed by student team members in order to be a good team citizen. The ability to resolve conflicts was considered essential, requiring open and direct communication, a willingness to find solutions, and respect for team members.¹¹ It was also essential that students work independently in their teams. Students needed to engage in active learning, developing relationships, and communicating well to facilitate attainment of the learning outcomes.

Although FNP and pharmacy students were both taking the final course in their respective programs, the 2 curricula were structured very differently. The FNP student cohort was comprised of working nurses with 2 prior semesters of advanced practice student clinical experiences, whereas pharmacy students had not yet experienced their first patient clinical encounters. Because of this, the pharmacy students needed resources related to communication skills that were not considered necessary for the FNP students. Because students lived across the state, face-to-face student meetings would be unlikely for most students, and resources to support collaboration had to be available online.

DEVELOPING STUDENT RESOURCES

Faculty next turned to the task of identifying resources to enable students to develop the presentations. Although therapeutic communication between patients and health professionals was taught in both programs, there was nothing in either curriculum specific to interprofessional communication strategies. Because modeling effective teamwork and communication has been shown to promote student satisfaction with team experiences,¹² a script was developed, and a video was recorded that showed how listening, willingness to be assertive, and respectful communication between a pharmacist and an NP prescriber averted a major medication error. The same scenario was repeated with the same faculty actors, showing that impatience, rudeness, and inattention in the same situation led to an error resulting in patient harm. A brief publication developed by the American Association of Critical-Care Nurses¹³ titled “Silence Kills” was required reading for the module because it highlighted the importance of speaking up when health care colleagues cut corners, demonstrate incompetence, or make mistakes. Because the pharmacy students were clinical novices, their faculty member provided them with team member dynamics training adapted from *Crucial Conversations: Tools for Talking When Stakes Are High*.¹⁴ This training encouraged respect for others, emotional intelligence, and the use of shared dialogue to develop mutual understanding and positive resolutions.

Another video was developed outlining the steps involved in performing a root cause analysis. It was posted online along with a typeable cause and effect (fishbone) diagram to help students visualize the medication error in their case studies graphically. The root cause analysis template developed by The Joint Commission was included to provide a reporting structure for student presentations.¹⁰ Finally, faculty developed medication error case studies for each interprofessional student team through an iterative process to ensure that each contained elements of responsibility by both an NP provider and a pharmacist. The case studies incorporated common issues such as posthospitalization medication reconciliation, look-alike/soundalike drugs, warfarin adjustment by multiple providers, and multicultural communication (Table 1).

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