



## A national study of paramedic and nursing students' readiness for interprofessional learning (IPL): Results from nine universities



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### SUMMARY

**Background:** The development of successful and functional interprofessional practice is best achieved through interprofessional learning (IPL). Given that many paramedic programmes still take an isolative uni-professional educational approach to their undergraduate courses, it is unclear on their preparedness for students' IPL. Therefore, the objective of this study was to assess the attitudes of undergraduate paramedic and nursing/paramedic students from nine Australian universities towards IPL over a two year period.

**Methods:** Using a convenience sample of paramedic and nursing/paramedic students—attitudes towards IPL was measured using the Readiness for Interprofessional Learning Scale (RIPLS) 5-point Likert-scale (1 = strongly disagree and 5 = strongly agree).

**Results:** A total of 1264 students participated (n = 303 in 2011 and n = 961 in 2012) in this study, consistent with a 43% response rate. Surveyed students were predominantly first year n = 506 (40.03%), female n = 748 (59.2%) and undertaking single paramedic degrees n = 948 (75.0%). Nursing/paramedic students demonstrated significantly lower Negative Professional Identity (M = 6.26, p = 0.004) and Roles and Responsibilities means (M = 6.87, p < 0.0001) and higher Positive Professional Identity means (M = 15.68, p = 0.011) compared with paramedic students.

**Conclusions:** The impact of nursing/paramedic education was shown to significantly enhance student attitudes towards interprofessionalism and the individual universities involved in this study generated students at varying stages of IPL preparedness. Students' year level appeared to influence IPL readiness, yet there are compelling paradoxical arguments for both earlier and later inclusion of IPL within curricula.

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### Introduction

As heralded in the influential 2010 Lancet report 'Health professionals for a new century: transforming education to strengthen health systems in an interdependent world' (Frenk et al., 2010), healthcare systems around the world are undergoing landmark reforms in an attempt to rejuvenate burgeoning systems of healthcare delivery and education. Fundamental to this is the need to reject segregated healthcare and embrace collaborative interprofessional models of care. The World Health Organization believes that interprofessional practice could exponentially strengthen healthcare systems globally (World Health Organization [WHO], 2010), effectively transcending uni-professional barriers by placing the patient at the epicentre of clinical decision making and curtailing hierarchical care (Frenk et al., 2010; Orchard et al., 2009; Lapkin et al., 2013; Mitchell et al., 2006). Health

outcomes are improved when professionals can exchange patient management opinions without fear of derision (Cowan and Eagar, 2013; Konrad and Browning, 2012), which is achieved through the interprofessional approach of addressing power imbalances by promoting partnerships of reciprocity. It is argued that interprofessionalism not only improves patient care and enhances cost effectiveness, but it also addresses the needs of population increases and staffing shortages (Mitchell et al., 2006; Bainbridge et al., 2010; Jansen, 2008; Young et al., 2011).

To best prepare future clinicians for collaborative practice a targeted educational model has been suggested, henceforth referred to as Interprofessional Learning (IPL) (Bainbridge et al., 2010; Hammick et al., 2007; Thistlethwaite, 2012; Ateah et al., 2011; Thistlethwaite and Moran, 2010; Curran et al., 2007). Whilst many perhaps see IPL as a contemporary approach in better preparing future clinicians, it is important to note that IPL has evolved from the 1960s globally and 1970s in Australia, and is therefore a well-established approach with varying levels of success (Nisbet et al., 2011). Such success is captured by a systematic literature review of 884 full papers that demonstrated that IPL improves health services by enabling the transfer of the

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knowledge and skills required for collaborative teamwork (Hammick et al., 2007). Considered the authority on interprofessionalism, the Centre for the Advancement of Interprofessional Education (CAIPE), defines IPL as 'occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care' (Centre for Advancement of Interprofessional Education (CAIPE), 2002). Interprofessional learning aims to develop the skills of communication, leadership, functional teamwork, constructive negotiation, knowledge of other clinicians' roles and personal empowerment (McClelland and Kleinke, 2013; Öberg, 2009; Barr et al., 2006; Canadian Interprofessional Health Collaborative [CIHC], 2010; MacDonald et al., 2010; Suter et al., 2009; Paterson et al., 2007; Braithwaite and Travaglia, 2006; Thistlethwaite and Nisbet, 2007). Despite some mistaken assumptions to the contrary IPL is distinct from the more traditional 'Multidisciplinary Learning' (MDL) healthcare educational approach (Choi and Pak, 2006). Multidisciplinary Learning uses shared teaching to physically bring together differing professions in the same space to passively listen to a common subject (Choi and Pak, 2006; Klein, 1990). Interprofessional learning builds upon this by requiring these professions to then engage with one another about the common topic to identify interdependent links through active shared learning (Choi and Pak, 2006; Klein, 1996).

It is therefore IPL rather than MDL that should be considered fundamental to the design of all undergraduate healthcare degrees (Choi and Pak, 2006). Contemporary healthcare education has been likened to isolative discipline-oriented 'silos' (Orchard, 2010), with minimal interaction between students studying the various health specialities. Segregated education potentially leaves students vulnerable to viewing all other professions as alien, a notion best surmised by Henri Tajfel's Social Identity Theory (Tajfel, 1981). This theory explains the sense of belonging and connection students feel towards members of their own speciality, with the reciprocal connotation that all other disciplines must thus be considered 'outsiders' (Tajfel, 1981; Wilhelmsson et al., 2011). This 'us-versus-them' mentality may carry into the clinical environment, where lack of collegial understanding can lead to turf wars that compromise patient care for clinician ego (Orchard, 2010; Lewitt et al., 2010; Barnsteiner et al., 2007). The implication for paramedics is further compounded by the reality they embody 'pre-hospital' clinicians, yet most other disciplines are predominantly 'in-hospital' based (Power, n.d.; Kirves et al., 2010; Fullerton et al., 2012). Thus students are already being primed to practice in a physically divided workplace. This is dangerous to paramedic conduct as critical injuries and illnesses are best managed through interprofessional co-operation to minimise delay to emergency interventions (Hallikainen et al., 2007).

As with most developed countries, Australia is also facing change in its healthcare sector, service delivery, policy and capacity for inter-professionalism (Renewal Consortium A, 2013). This change is both rapid and complex. In their recent national audit, Dunstan et al. provided an overview of the enablers of better integration of interprofessional collaboration and teamwork in Australian health care system. Some of their key recommendations included nationally aligned curricula, consistent IPL competencies and nationally accredited IPL programmes (Renewal Consortium A, 2013). For emergency ambulance services, the notion of IPL is still relatively new and has yet to face the same barriers as many other parts of the healthcare system (Williams et al., 2013). As each Australian state operates its own independent paramedic service variations between both paramedic practice and education exist. However all Australian paramedic services aim to deliver optimal patient care and thus can be considered comparable entities. All universities included in this study deliver nationally accredited pre-employment undergraduate paramedic or nursing/paramedic tertiary degrees and aim to instil similar values and clinical aptitudes in their graduating alumni.

The objective of this study was to assess the attitudes of undergraduate paramedic and nursing/paramedic students from nine Australian universities towards IPL over a two year period.

## Method

### Design

This cross-sectional study used convenience sampling of first, second and third year undergraduate paramedic students.

### Participants

Participatory students were enrolled in undergraduate paramedic degrees or nursing/paramedic double degrees at Charles Sturt University (CSU), Edith Cowan University (ECU), Monash University (MU), Queensland University of Technology (QUT), Victoria University (VU), Australian Catholic University (ACU), University of Tasmania (UT), La Trobe University (LU) or Central Queensland University (CQU). These degrees were either single degree paramedic or double degree nursing paramedic streams, resulting in 1264 students being eligible for inclusion. Criteria for inclusion constituted full time enrolment status in a participatory university in 2011 and/or 2012, and voluntarily consenting to participate in the study.

### Instrumentation

This study utilised the 'Readiness for Interprofessional Learning Scale' (RIPLS) which is the most commonly used self-report questionnaire used to examine students' attitudes towards IPL. The RIPLS is a standardised self-reporting 19 item scale that consists of four subscales, with Subscale Two being reversed scored. The subscales include Subscale One: Teamwork and Collaboration (Q1–9), Subscale Two: Negative Professional Identity (Q10–12), Subscale Three: Positive Professional Identity (Q13–16) and Subscale Four: Roles and Responsibilities (Q17–19). Each item uses a 5-point Likert-scale (1 = strongly disagree and 5 = strongly agree). The RIPLS was determined valid and reliable during original inception (Parsell and Bligh, 1999), and subsequent studies have substantiated this (McFadyen et al., 2006; Hind et al., 2003; Horsburgh et al., 2001). However more recently King et al. demonstrated weak internal consistency of Subscale Four: Roles and Responsibilities (King et al., 2012). Demographic questions relating to age, gender, year level, degree type and university were also sought.

### Procedures

Eligible students were invited to participate at the conclusion of lectures at each of their respective universities during the first three weeks of semester 2 (July–August, 2011–2012). Participation was voluntary and anonymous, and an explanatory statement was provided. Questionnaire completion took 15 min and consent was implied through submission. No follow-ups were undertaken. Students were neither rewarded nor penalised for participation decision.

### Data Analysis

Data storage, tabulation and generation of inferential and descriptive statistics were provided through SPSS (Statistical Package for the Social Sciences Version 18.0, SPSS Inc., Chicago, Illinois, USA) programme. Demographic data was summarised through means [m] and standard deviations [SD]. Comparative differences between age groups, gender, year level, degree type and university were generated through inferential statistics, t-tests and one-way analysis of variance [ANOVA], including post hoc tests. Unless otherwise stated all tests were two tailed, with a  $p$  value < 0.05 demonstrating results of statistical significance; effect sizes ( $d$ ) were also calculated for quantifying the differences between mean scores. Data were combined and analysed over two years.

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