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Implementation of an interprofessional error disclosure experience: A multi-institutional collaboration

Carla Dyer [a, *], Erin Abu-Rish Blakeney [b], Eric Johnson [c], Sarah Shrader [d], Gretchen Gregory [e], Andrew Knight [f, 1], Sarah Shannon [b, 3], Karen McDonough [g], Les Hall [h, 2], Brenda Zierler [b]

[a] University of Missouri, Department of Medicine, DC043.00, One Hospital Drive, Columbia, MO 65212, USA
[b] University of Washington, School of Nursing, Department of Biobehavioral Nursing and Health Informatics, Health Sciences Building, 1959 NE Pacific Street, Seattle, WA 98195, USA
[c] University of North Dakota, Department of Family and Community Medicine, 501 North Columbia Rd Stop 9037, Grand Forks, ND 58202-9037, USA
[d] University of Kansas, School of Pharmacy, University of Kansas Medical Center, 3901 Rainbow Blvd, Kansas City, KS, 66160, USA
[e] University of Missouri, Sinclair School of Nursing, DC007.10, Columbia, MO 65212, USA
[f] University of North Dakota, Grand Forks, ND, 58202-9037, USA
[g] University of Washington, School of Medicine, Division of General Internal Medicine, Health Sciences Building, 1959 NE Pacific Street, Seattle, WA, 98195, USA
[h] University of Missouri, Department of Medicine, One Hospital Drive, Columbia, MO 65212, USA

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ABSTRACT

Creation of educational experiences to promote interprofessional education (IPE) and collaborative practice team skills can be resource-intensive and beyond the capacity of many institutions. Implementation of developed IPE curricular elements to other institutions is a promising means of expanding access to IPE. This paper describes the process of implementing an IPE error disclosure experience used at one academic health center to three additional centers during 2012–2013. Participating institutions found that implementing an existing IPE curricular experience to their institutional sites required minimal resource investment in case development, allowing them to focus their efforts on implementation and evaluation. Student and faculty feedback were positive and participating institutions continue to use the activity as part of their IPE offerings.

1. Introduction

Accreditation requirements increasingly mandate interprofessional education (IPE) experiences for health professions students. It is widely recognized that development of successful IPE curricular elements requires expertise in both clinical content and IP competencies.[1,2,3] Development of IPE experiences is also resource intensive and this presents a barrier for many institutions desiring to integrate IPE into their health professions programs.[3,4] Thus, there is a growing opportunity and need for high quality IPE experiences that can be readily integrated into health professions curricula. In this manuscript, we describe the implementation of a developed IP Error Disclosure (ED) experience from one institution (the University of Washington (UW)) to three external institutions (University of Missouri (MU), University of North Dakota (UND), Medical University of South Carolina (MUSC)).

Uniprofessional health education provides relevant examples of replication of educational modules to meet changing needs. For example, Quality and Safety Education for Nursing (QSEN), a national initiative in the USA to improve quality and safety education

* Corresponding author.
E-mail addresses: dyerca@health.missouri.edu (C. Dyer), Erin2@uw.edu (E. Abu-Rish Blakeney), Eric.l.johnson@med.und.edu (E. Johnson), Sshrader2@kumc.edu (S. Shrader), gregoryg@health.missouri.edu (G. Gregory), Andrew.knight@colostate.edu (A. Knight), shannons@ohsu.edu (S. Shannon), kmcdonou@uw.edu (K. McDonough), Les.hall@uscmed.sc.edu (L. Hall), brendaz@uw.edu (B. Zierler).
[1] Present: Colorado State University, School of Music, Theatre and Dance, UCA305, 1778 Campus Delivery, Fort Collins, CO 80523, USA.
[2] Present: University of South Carolina, School of Medicine, Office of the Dean, 6311 Garners Ferry Road, Columbia, SC 29209, USA.
[3] Present: Montana State University, College of Nursing, P.O. Box 173560, Bozeman, MT, 59717-3560, USA.

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among pre-licensure nursing students formed a national learning collaborative involving 15 schools of nursing during its second phase.[5] During this phase, participating schools learned from national educational leaders and from their peer institutions regarding the implementation of quality and safety curriculum. Participating schools reported that this learning collaborative led to development of new teaching strategies and improvement of curricula during the year of participation, noting that teaching strategies and simulation scenarios shared by other collaborative members were beneficial.[5] The QSEN competencies were further disseminated during Phase 3, as greater than 1100 faculty from 662 programs attended regional faculty development workshops to learn effective strategies for incorporation of quality and safety content, approaches to faculty development to meet these competencies, and methods to teach students to provide safe and high quality care.[6]

Some IP educators have documented the spread of successful curriculum to other schools or institutions. Demarco, Hayward, and Lynch[7] described the successful expansion of case-based instruction from senior-level nursing curriculum to a senior physical therapy student group, leading to the creation of an IP case-based course.[7] The MedED portal database is also a well-known repository of educational modules and increasingly includes cases with IP components.[8] However, for institutions that aspire to initiate or advance their IPE opportunities and effectiveness, there is a relative paucity of literature describing the process of implementing established IP curricular elements in new settings. The goal of this paper is to describe similarities, differences, student perceptions, and lessons learned from implementing this IP ED experience at multiple institutions. Implementing institutions identified formal ED training as a curriculum element needing improvement at their institutions. This team based ED experience allowed for both content delivery and an opportunity to advance IP collaborative practice skills. While IPEC Core Competency domains were not yet published when the ED experience was developed and piloted in 2010, it maps clearly to the four core IPEC domains of Values/Ethics, Interprofessional Communication, Roles and Responsibilities and Teams/Teamwork. Using an established online ED Toolkit as a resource, implementation of the learning experience at the three external institutions (UND, MU, MUSC) met IP and content curricular needs and required minimal additional investment in curricular development. Participant experiences demonstrated the adaptability and applicability of this IPE exercise in differing IPE settings with a variety of health professions students.

2. Background

2.1. Original error disclosure experience at University of Washington (UW)

The UW has a long history of IPE initiatives dating back to 1997.[9,10] While ED training was rapidly becoming interprofessional in the clinical arena, ED training was still uniprofessional in the academic setting until 2008 when the UW received a Macy Foundation grant to develop and integrate interprofessional team training into existing curricula in the health sciences schools of medicine, nursing, pharmacy and the physician assistant program.[11,12]

Although each school already covered medical errors and disclosure with its own students, there was growing agreement that errors should be discussed and disclosed in teams. In the summer of 2010, a pilot ED experience was offered for volunteer students from medicine, nursing and pharmacy.

The original ED experience included an interactive large group introductory lecture covering basic ED principles. Learners separated into small groups in pre-assigned rooms (approximately 12 students per room) with two trained interprofessional faculty per group. Each group studied the same clinical scenario of an elderly patient who was admitted to the emergency department from a skilled nursing facility. The patient presented with emergent pneumonia then developed an adverse reaction following treatment with a medication contraindicated due to a known allergy. Each profession's version was written from the perspective of that profession (nursing, medicine, pharmacy, physician assistant) and hence, contained slightly different information. Students discussed the error and subsequently divided into three interprofessional teams (a representative student from each of the professions) to devise a plan to disclose the error to the patient's family member. One faculty member, the “content” faculty, played the patient's family member and was trained to express different emotional responses to each team allowing the same clinical scenario to be used in three cycles of disclosure by the students. The faculty facilitator debriefed each team after their error disclosure practice. At the end of the learning experience, both the content faculty and facilitator faculty provided feedback to the students while debriefing on both ED and IP “take-home” learning points.

The pilot experience confirmed that ED was an effective topic for IP learning, but it was faculty, time and resource intensive, and needed both a more sustainable model and a curricular home. As a result, the ED experience development team revised a number of aspects of the pilot ED experience, including, shortening the didactic lecture and more intentionally matching student learners from different professions. The pilot was adapted for 2nd year medical students (as part of their doctoring skills course), senior nursing students (connected to a nursing theory course), and 3rd year pharmacy students, using an innovative model for communication skills training.[13,14,15,16] The IP ED experience is now a formalized as part of a foundational IPE learning series for health professions students at the University of Washington and has been taught using this model since 2011. All iterations of the ED experience, starting with the original pilot in 2010, have been evaluated for student learning and satisfaction as well as to identify opportunities for improvement.

2.2. Context for multi-institutional implementation

Multi-institutional implementation of the ED exercise originated as part of a year-long pilot train-the-trainer faculty development program that involved over 40 faculty members from eight academic health centers: (UND), MUSC, MU, Columbia University, Indiana University, University of Kentucky (UK), University of Virginia, and UW. The faculty development pilot program is further described in[3,17]. To demonstrate an example of experiential IPE learning in action, faculty development program participants were immersed in the ED experience. They served as content and/or facilitator faculty, with more than 400 health professions students and 76 faculty while on-site at the UW in March 2012. This immersive experience allowed visiting faculty to observe and/or practice facilitation and debriefing of IP student teams during the established ED experience. Immediately following, a discussion ensued about the potential to implement the ED experience at other institutions. MUSC, UND, and MU subsequently implemented the ED experience at their institutions.

2.3. Development of error disclosure toolkit

To promote the portability of the exercise, UW grant staff created an online “ED Toolkit” to serve as a content and process resource for institutions desiring to replicate the ED experience. The toolkit is comprised of the voice-over PowerPoint lecture