FOUNDATIONS OF ADULT NURSING

EDITED BY

Dianne Burns

3RD EDITION

Sage

1 Oliver's Yard
55 City Road
London EC1Y 1SP

2455 Teller Road
Thousand Oaks, California 91320

Unit No 323-333, Third Floor, F-Block
International Trade Tower Nehru Place
New Delhi – 110 019

8 Marina View Suite 43-053
Asia Square Tower 1
Singapore 018960

Editor: Martha Cunneen
Editorial Assistant: Sahar Jamfar
Production Editor: Gourav Kumar
Copyeditor: Clare Weaver
Proofreader: Derek Markham
Indexer: KnowledgeWorks Global Ltd
Marketing Manager: Ruslana Khatagova
Cover Design: Sheila Tong
Typeset by KnowledgeWorks Global Ltd
Printed in the UK

Library of Congress Control Number: 2023935661

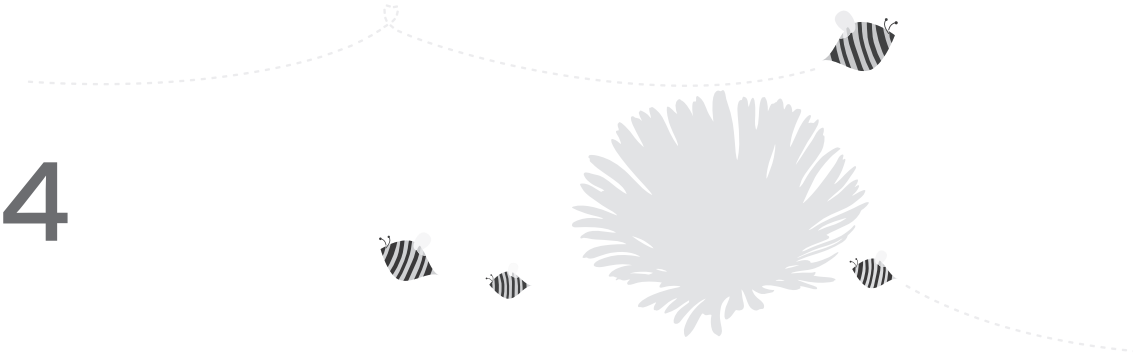
British Library Cataloguing in Publication data

A catalogue record for this book is available from the British Library

ISBN 978-1-5297-7598-3
ISBN 978-1-5297-7597-6 (pbk)

Contents

PART 2 CARING FOR ADULTS IN A VARIETY OF SETTINGS



4

INTERPROFESSIONAL AND MULTIDISCIPLINARY TEAM WORKING

Jean Rogers and Sarah Booth

Chapter objectives

- Define the terms multidisciplinary and interprofessional working;
- Reflect upon and identify the factors that contribute to the development of partnerships and team working, considering how you can develop these skills;
- Identify and reflect upon factors that can prevent collaborative partnerships and team working;
- Explore strategies for overcoming the barriers to interprofessional working and consider how you can develop these skills;
- Explore the benefits of effective team working in the provision of safe and effective healthcare and consider how you can apply these within a contemporary healthcare setting.

So far, the previous chapters have focused on the knowledge and skills required to be an adult nurse as well as the concept of safe and effective person-centred care. However, often good health care cannot be provided or achieved by one individual- it takes a team of health and social care professionals to deliver truly effective, person-centred care. The aims of this chapter are to explore how interprofessional and multidisciplinary working can positively impact the health needs of individuals and identify factors that contribute to the development of collaborative working partnerships.

Related Nursing and Midwifery Council (NMC) Proficiencies for Registered Nurses

The overarching requirement of the NMC is that all nurses must be able to play an active and equal role in the interdisciplinary team, collaborating and communicating effectively with a range of colleagues. They must work effectively across professional and agency boundaries, actively involving and respecting the contribution of others to ensure the provision of integrated person-centred care. They must know when and how to communicate with and refer to other professionals and agencies to respect the choices of service users and others, promoting shared decision making to deliver positive outcomes and coordinating smooth, effective transition within and between services and agencies (NMC, 2018a).

TO ACHIEVE ENTRY TO THE NMC REGISTER YOU MUST BE ABLE TO

- Demonstrate an understanding of the roles, responsibilities, and scope of practice of all members of the nursing and interdisciplinary team, and know how to make best use of the contributions of others involved in providing care;
- Understand and apply the principles of partnership, collaboration, and interagency working across all relevant sectors;
- Demonstrate the knowledge and confidence to contribute effectively and proactively within an interdisciplinary team;
- Demonstrate the ability to write accurate, clear, and timely records and documentation;
- Effectively and responsibly use a range of digital technologies to access, input, analyse and apply information and data within teams and between agencies;
- Confidently and clearly share and present verbal, digital and written reports or information and instructions with individuals and groups when delegating or handing over responsibility for care;
- Demonstrate knowledge of when and how to refer people safely to other professionals or services for clinical intervention or support.

(Adapted from NMC, 2018a)

Throughout this chapter we will use real examples and case studies so that you can gain a wider perspective of interprofessional and multidisciplinary working. However, before exploring interprofessional and multidisciplinary work in more detail, it would be useful to consider what each term means.

- What do the terms 'multidisciplinary' and 'interprofessional' working mean to you?

Multidisciplinary working describes the mechanism by which holistic care is ensured and a seamless service delivered across the boundaries of primary, secondary, and tertiary care (Hastie et al., 2016). However, it is about the task and not necessarily the collective working process, so it does not imply collaboration. There are some distinct advantages and disadvantages to multidisciplinary working (Table 4.1).
Alternatively, Pollard et al. (2014: 13) define ***interprofessional*** working as:

> 'the process whereby members of different professions and/or agencies work with each other and patients/service users, to provide integrated health and/or social care for the latter's benefit'.

This is supported by NHS England (2014: 12) who advise that working together enables professional teams to 'explore problems outside of normal boundaries and reach solutions based on a new understanding of complex situations'. Similarly, there are also some clear advantages and disadvantages to interprofessional working, which will be discussed later in the chapter.

Table 4.1 Advantages and disadvantages of multidisciplinary working

Advantages	Disadvantages
Individuals receive better all-round care.	Different professions work together but keep their defined role (working in their silos).
All plans can be discussed so that all pros and cons can be considered.	Takes more time to come to conclusions.
More likely to provide comprehensive care and less likely that anything is missed.	Information not always shared properly.
Team members aware of progress in case anyone becomes ill.	Communication can be a challenge.
Better use of resources.	Professional rivalry and mistrust.
Reduces the number of people to whom recipients of care need to relate.	

Jovanović et al. (2020) believe the prefix 'multi' indicates the involvement of personnel from different professions and does not imply collaboration, whereas 'inter' implies collaboration. Therefore, it is sensible to define collaboration.

- What does the term 'collaboration' mean to you?

Wei et al. (2020) define collaboration as working together to achieve something that no profession could achieve alone. When working collaboratively, knowledge and expertise are brought

together to facilitate decision making, which is undertaken jointly with shared viewpoints from several professions, for the benefit of those receiving care. The terms 'interprofessional' and 'multidisciplinary' are often used interchangeably and thus, for the purposes of this chapter, we will be using the term 'interprofessional working.'

Interprofessional team working is a key objective in any contemporary health and social care setting and working interprofessionally is seen by all professional bodies as essential for promoting effective care. However, it is not a new concept because team working has been an integral part of healthcare from the 1960s onwards (Baldwin, 1993). Before this, staff from various disciplines worked in distinct professional teams (silos) and had no concrete knowledge of what each other's roles entailed. This required multiple duplication of documentation, which often resulted in those receiving care being repeatedly asked for the same details. Care delivery was also fragmented. Ongoing developments in approaches to service delivery has resulted in elevated levels of specialisation. Babiker et al. (2014) maintain that this meant it was not possible for any one professional to have the knowledge and skills to respond appropriately, particularly where the complex needs of communities or individuals are required.

- What do you think are the key strengths of interprofessional working?

One of the key strengths of interprofessional working is that the combined expertise of a range of health professionals is used to deliver seamless, comprehensive care to individuals. The World Health Organization (2010) suggests that interprofessional collaboration is an essential component of satisfactory service delivery. Mayo and Woolley (2016) argue that the quality of service received is dependent on how effectively different professions work together. This is supported by Jovanović et al. (2020) who believe that the modernisation of healthcare delivery has initiated a move towards the collaborative delivery of care and that effective teamwork links to more positive care outcomes. The UK healthcare provision has changed radically and rapidly in the last decade, and this is reflected in political and policy decisions at all levels; regionally, nationally, and internationally (Department of Health, 2021). Due to the unprecedented pressures faced, the NHS has had to adapt and evolve their systems to meet these new challenges. As a result, we have seen collaboration in health and social care increase at an unimaginable scale and pace (Department of Health, 2021).

Activity 4.1

What recent changes are you aware of that have impacted on the delivery of health and social care services? Make a list of these.

Now access one of the following websites below and identify the relevant government health policy documents that highlight the changing context in which healthcare is delivered in your area:

England: www.gov.uk/government/organisations/department-of-health
Scotland: www.scotland.gov.uk
Northern Ireland: www.dhsspsni.gov.uk
Wales: www.wales.gov.uk

In England, several documents highlight the changing context in which healthcare is delivered. These include the *Health and Social Care Act* (DH, 2012) (see www.legislation.gov.uk/ukpga/2012/7/contents/enacted), *Willis Commission Report* (2012), *The Care Act* (2014) (see www.legislation.gov.uk/ukpga/2014/23/contents/enacted), the *Health and Social Care (safety and quality) Act* (DH, 2015), *The Berwick Report* (DH, 2013), *The NHS Long Term Plan* (DH, 2019), *Build Back Better: Our Plan for Health and Social Care* (DH, 2022a) and *Coronavirus: Lessons Learned to Date* (DH, 2022b). These documents emphasise the increasingly busy environment in which care delivery takes place; the constantly changing staff population; the growing use of technology; the increasing acuity of recipients of care; an ageing population and the move to more community-based services with limited resource availability. It is expected that these changes will continue and there is now, more than ever, a realisation of the importance of holistic person-centred care and a wider recognition that true collaborative working requires all team members to work closely together (Wei et al., 2020). Morley and Cashell (2017) also maintain that the active contribution of recipients of care to the decision-making process will make working together truly collaborative with UK governments promoting the principle of working in partnership. There are some excellent examples where health and social care teams have been able to work effectively and collaboratively together. For example, *'Discharge to Assess',* a new integrated person-centred approach model, was introduced to ensure the safe and timely discharge of individuals from an acute setting to a community setting, whilst acknowledging the need for assessment of health *and* social care needs (GMCA, 2017). Other examples include health and social care professionals working together in intermediate care settings addressing the complex needs of those receiving care by combining expertise, perspectives, and resources; forming a common goal to restore, maintain and improve care outcomes.

Reflect on the teams you have previously worked within.

- Has your experience been a positive or a negative one?
- Why do you think this might be?

Over the last decade considerable progress has been made towards creating environments where interprofessional working can thrive and be a positive experience, but in some practice areas this is not so easy to achieve and has been implemented on less than robust evidence (Lalani et al., 2020). There have been numerous examples where difficult interprofessional working

has been reported. Rawlinson et al. (2021) suggest that this is because some professionals are not convinced of the benefits for those receiving care; some care providers perceive it as a loss of continuous and holistic care, a loss of professional identity or of their own jobs' attributes.

You may recall in Chapter 1 we highlighted that until late in the twentieth century, some groups predominantly male occupations (e.g., medicine), were identified as professions with distinct characteristics of completing a course of education to at least graduate level, having autonomy and self-regulation, and remaining free from managerial control. Alternatively, other predominantly female occupations (e.g., nursing and midwifery) were seen as semi-professions, who in contrast received 'training' and were regulated and overseen by other occupational groups (Traynor, 2013). However, today, nursing is seen as a profession with qualified nurses (and other professionals) having the autonomy and authority to work independently (The King's Fund, 2020).

Healthcare Provision in A Prison Setting

A large prison sends individuals with medical problems for scans to the local hospital. Only one person at a time can attend for security reasons and must be accompanied by a member of prison staff at a cost of £250 a visit. Therefore, waiting times for these individuals are significant. There are also further problems in that those in need of a scan must be handcuffed, resulting in a high failure rate for scans (for security reasons the individual receiving care is not told in advance the day or time of the scan). This often means that they are not prepared properly, for example having eaten when they should not have done so. In response to the issues identified above, the prison service and local Clinical Commissioning Group (CCG) developed a more collaborative approach to meet healthcare needs. The local CCG commissioned a GP-led ultrasound team who visit the prison once a week, working with and alongside the prison healthcare team, scanning seven or eight individuals at any one time. This has the potential to save money, improve efficiency and provide dignity for those receiving care.

The above scenario provides a good example of how money can be saved in the NHS. However, it is not just about saving money, but also utilising precious resources more efficiently and effectively, to achieve a better standard of care for individuals and their families. This may require greater involvement and collaboration between the private sector and charities, as well as healthcare providers. The public have also become much more knowledgeable through the increase in technology and education, making knowledge more accessible. However, sometimes that knowledge is incorrect or limited and does not provide the full picture. It can then be much more challenging to negotiate and compromise with members of the public. This has influenced policy, creating turbulence where policy is formulated to achieve political goals, address systemic failings, and produce rapid-fire responses to public disillusionment (Buzelli et al., 2022). Healthcare professionals working within these environments are often left to make sense of new ways of working and demands, i.e., what they do and how they should go about it.

List the reasons why people may lose faith in the NHS.

- What effect do you think this might have on the healthcare professionals working within this service?

Across the UK poor interprofessional collaboration has been identified as a contributing factor in numerous high-profile cases with poor outcomes, for example, Mid Staffordshire NHS Foundation Trust (2013), Morecambe Bay (Kirkup, 2015), Liverpool Community Trust (Kirkup, 2018) and Shrewsbury and Telford NHS Foundation Trust (Ockenden Report, 2020). Following such criticisms, people lose faith in the NHS because they are concerned with carelessness in services, long waits, and poor communication. For health professionals this can cause disillusionment within the profession and lower morale. There are assumptions that interprofessional working will prevent such tragedies as well as poor practice; however, as yet there is no real research or evidence to support this assumption. This is due to the complex nature of the research, the funding available and the collaboration needed across practice and higher education institutions (HEIs) (Hammond and Morgan, 2022).

- There are some advantages to interprofessional working. What do you think these are?

The advantages to interprofessional working include:

- Enhancing personal and professional confidence;
- Promoting mutual understanding of all professionals and their roles;
- Promoting interprofessional communication and breaking down barriers to communication;
- Recognising and respecting each professional role and their contribution to care provision;
- Contributing to job satisfaction: working together in harmony makes working life much better;
- Sharing information and knowledge to provide improved decision making about person-centred care;
- Problem sharing: as the adage goes 'a problem shared is a problem halved.' Just talking through care delivery issues with another professional colleague can sometimes help to provide the solution to a problem.

Sanjit

Sanjit was admitted to hospital after a stroke resulting in left-hand side weakness and speech difficulties. Once medically stable, Sanjit was transferred to a Discharge Assessment Unit for further multidisciplinary assessment, prior to discharge home. The multidisciplinary team which included an occupational therapist, physiotherapist, and members of the nursing team worked closely with the community

specialist teams (e.g., moving and handling team, speech and language therapy and social workers), to ensure a smooth discharge home with a full package of care. However, the physiotherapist was concerned that Sanjit's family would not be able to manage. Therefore, a joint home assessment was also carried out with all staff involved, to ensure the appropriate equipment was in place. Family members living at home were trained to use the equipment as required.

Referring to the above scenario:

- What do you think went well?
- What could have been improved and how?

This scenario displays good interprofessional working, although this could have been improved further by including Sanjit and his family in the discussions. Service users and carers can offer a unique perspective on how a particular illness or disease affects them or their loved ones. It is therefore essential that interprofessional teams ensure that those receiving care and their carers, are fully consulted, involved in decision-making processes about care provision and that their contribution to care planning, implementation and evaluation is meaningful.

Over the last decade healthcare policy in the UK and Scotland has been centred on empowerment, with service users/carers being at the centre of decisions made around their care (DoH, 2019). One example is that of individuals with dementia who come into hospital with their own passport of care. In this case, the multidisciplinary team members who have been working with the person with dementia clearly identify what they have been doing and what works or does not work for that person. The individual receiving care and their important others are also able to input their thoughts, feelings and needs. This then allows staff to work towards getting the individual home in optimal health.

Team Working

Working in health and social care settings usually involves some aspect of team working. Effective teamwork does not just happen when a team of people work together – in fact, teamwork could be poor in a group of people working together or could be effective. The Royal College of Physicians (2017: 3) define teamwork as:

> 'a small number of people with complementary skills who are committed to a common purpose, performance goals and approach for which they hold each other mutually accountable'.

James (2021) agrees, though he advises that teamwork also requires more than just communication and mutual goals. He states that effective teamwork requires a collaborative mindset and a recognition of the value of the team model and a commitment to building effective relationships.

Within health and social care settings, teamwork is vital in delivering high-quality care. The best outcomes are achieved when professionals work and learn together as well as engaging in audits and generating innovative ways of moving the practice and service forward.

Consider your current or recentplacement and the teams you have worked in:

- Did the teams work well together or not?
- Why do you think this was the case?
- Try to identify all the potential barriers to effective team working. How do you think these might be overcome?

There are some key factors required to encourage teamwork (Babiker et al., 2014) including the following:

- *Personal commitment*: this comes from individuals who are committed to the success of the team and requires that the leader of the team allows members to ask questions. In teams where this occurs, all members will have an idea about what best practice is and are not expected to go beyond their level of competence unsupported. An individual's weaknesses are minimised and their strengths maximised, thereby releasing their true potential.
- *A common goal or vision*: all teams need to develop a common goal or vision. When teams are working towards a common goal they are committed and this inspires team members to learn and gain confidence. In fact, within a healthcare team there may need to be two visions – one for the team and one for the organisation.
- *Clarity of roles*: team members need to be clear about their various roles within a team because this will maintain their motivation. It is also important that they are clear about the roles of the other team members. In today's environment, we are increasingly working with members from different organisations and professional groups. It is thought that this understanding encourages a team approach to care needs assessment, where information and knowledge are shared to enable improved decision making about care provision (Hammond and Morgan, 2022). This will also encourage mutual trust and respect within teams.
- *Communication*: effective communication between team members is crucial for safe care provision. It encourages joint problem solving and the provision of excellent interprofessional person-centred care. The team should adopt two-way information giving rather than unidirectional pathways; thus, ensuring that information is shared with the whole team.
- *Support*: the best teams work most effectively where there is a framework to support interprofessional working, although Green and Johnson (2015) believe the degree of support can be variable.

Activity 4.2

Consult the views of current members of the team in which you are working.

- What do they think are the advantages and disadvantages of team working?

There are some clear advantages to team working in a healthcare setting (Royal College of Physicians, 2017; Rosen et al., 2018). In the activity above, your colleagues may have identified some or all of these:

- *Improvements in the quality-of-care provision*: when the team communicates effectively and works together as a unit, the quality of care increases. They have a clear commitment to excellence of care. This increases coordination, especially in complex cases.
- *Improvements in safe care provision*: if teamwork is effective the person in receipt of care can become an active partner. They are listened to, monitored and the procedures implemented are based on their feedback. This has the potential to reduce medication errors and unnecessary procedures, thereby creating a safer care environment.
- *Improvements in staff satisfaction*: teams that work efficiently and effectively brainstorm and problem solve together. The workload tends to be distributed more evenly and stress is reduced.
- *Improvements in communication*: because the team members regularly interact with each other they can contribute to the decision making in the team, thus making their shared goals and visions achievable.
- *Improved knowledge of each person's role*: a team working well together will learn about each person's role and limitations. This strengthens relationships and builds unity in the team.
- *Enhanced reflection*: efficient and effective teams regularly reflect on how they work together and how effective they are being.
- *More innovative approach to work*: a team that works well together can potentially be more innovative in their outlook. There is verbal and practical support for innovative ideas, thus moving the team forward.
- *Improved problem solving*: an effective team bounces ideas off each other. Each person offers their unique perspective on a problem and produces the best solution.
- *Enhanced skills*: no one person is the same as another and so teams need to use each person's unique skills to improve one another and be more productive in the future.

Disadvantages of team working

As you can see, there are many advantages to team working that are often talked about, but there are some disadvantages here too (Sims et al., 2014; Wei et al., 2020) including the following:

- *Unequal participation*: sometimes some members of the team will sit back and let others do most of the work. This can have an adverse effect by causing resentment, which can then cause conflict and affect morale.
- *Members who are not team players*: some people do not function well as part of a team and prefer to work alone. They can be excellent workers in the right situation but have difficulty fitting into a team, thus causing dissatisfaction and disharmony.
- *A lack of constructive conflict*: once a team works well together members may become reluctant to argue or dispute a point. If all conflict is avoided resentment can build up and team members can become lazy and apathetic, thus stifling creativity.
- *Traditions and professional cultures*: for some this can cause split loyalties between the team and their own discipline. Some team members may be reluctant to accept suggestions from other professions and become very defensive, particularly if they are used to assuming sole responsibility.
- *Personality clashes*: not all people can get on all the time and personality clashes can occur. These can then cause unwanted conflict in a team and even split the team.

You will no doubt have come across some of the barriers identified above in some of your practice learning environments. How do you think these could be overcome? Before reading on, note down your ideas.

Barriers to effective team working

While acknowledging that there are some real advantages to interprofessional working, we must also admit that there are some real barriers. Rawlinson et al. (2021) maintain that not acknowledging barriers to interprofessional working is a cause of failure and therefore advise that it is crucial to recognise all the obstacles encountered. Some of the common barriers to interprofessional working might include the following:

- Suspicion of the motives behind collaboration e.g., is it about improving care or is there a different agenda?
- A lack of confidence in one's own professional knowledge base for fear of being wrong, e.g., a newly qualified nurse might not challenge a more senior practitioner because of fears they may be wrong and do not want to appear as if they are not sure what they are talking about.
- Traditional professional cultures, e.g., joint working is difficult where there are perceived status differences between occupational groups. Some practitioners view this as a threat to their professional status, autonomy and control when asked to participate in more democratic decision making.

- Mistrust of other professions due to a lack of knowledge leading to stereotyping.
- Lack of training and preparation to work in teams.
- Lack of shared values, visions, and principles.
- Lack of investment on an individual, professional, and organisational level.

Overcoming the barriers

Barriers can be overcome with time and patience and by undertaking the following:

- *Choosing the right members of the team*: although this is not always possible in a healthcare setting, as far as it is practicable this should be done. Some team players may have to move to another area if they cannot work collaboratively in the team.
- *Team building*: allow time for team members to get to know each other and each person's role and unique contribution to the team. This allows team members to develop respect for each other.
- *Developing an atmosphere of trust and respect in the team members*: this takes time and effort, and actions speak louder than words.
- *Ensuring clarity of team goals*: members of the team need to understand the team's common goal and vision. These should include specific and measurable outcomes.
- *Encouraging a supportive environment*: make sure that all members are aware how their action or inaction might impact on those in their care and other team members.
- *Encouraging debate and constructive challenges*: this can help the team to keep improving and producing their own ideas. Mechanisms need to be developed to review goals and roles over time.

Practice Learning Models

Over recent years, a range of models have developed to help meet the need for increased learning opportunities within practice settings, whilst maintaining the required quality of educational support (NHS Employers, 2022a). These new models can also provide excellent opportunities to promote interprofessional learning as an important part of the overall practice learning experience. The Nursing and Midwifery Council's (NMC) *Standards for Student Supervision and Assessment* (NMC, 2019a), move away from a traditional mentoring model, to one that separates out the supervisor and assessor roles. The standards advise that students can be supervised by either an NMC registered nurse, midwife, nursing associate or any other registered health and social care professional. The NMC (2019b) therefore advise that learning experiences should also have an interdisciplinary and interprofessional learning focus, which includes learning with and from other healthcare professions where relevant. These models use a coaching approach whereby

students are directly involved in hands-on care delivery and are empowered to take a greater level of responsibility for their own self-directed learning. Students from different year groups work together as a team, supported by a practice-based educator who uses a coaching approach to encourage them to explain their practice and identify their own learning needs. They are also encouraged to work alongside other healthcare students and staff to promote collaborative learning and enhance person-centred care. Collaborative learning in practice (CLiP) is the most commonly used coaching model (NHS Employers, 2022b). This model encourages a 'whole team approach' to learning, giving students more exposure to a range of different clinical areas and professionals, providing them with a much more realistic view of care delivery and pathways (NHS Employers, 2022b).

Activity 4.3

- What different practice learning models have you experienced?
- How might these models help you to develop your team-working skills?

Skills that could be achieved by applying a coaching model include:

- *Gaining a greater understanding of other professional roles;*
- *Developing effective collaborative working skills to enhance care;*
- *Development of practice assessment skills;*
- *Development of negotiation and delegation skills;*
- *Development of reflection skills;*
- *Development of leadership and management skills.*

Reflect on the above list of skills with your practice supervisors and assessors. Do you feel your practice learning experiences have helped you to develop any of these skills? What else would help you to develop these skills further?

Team integration

Wherever you are working, it is essential that you try to integrate into the team as soon as possible. There are many challenges and opportunities in healthcare today. You will need to plan and identify your learning needs before you enter the practice learning environment and, once there, it is a good idea to let your assessor/practice supervisor know what these are.

As a student (or even as a newly qualified nurse moving into another area of practice), consider how you might integrate into a new team.

- Who will be the members of the team?
- What could you do to enhance your integration into the team?

Here are some suggestions:

1 Do a little detective work and find out about the team you are joining before you get there. This might involve visiting the organisation's website or calling the practice learning area to ask them a little about themselves. If possible you are near try to arrange to pop in for a short visit. This can often make a good first impression, although consideration should always be given to the demands on staff, particularly in a busy environment.
2 Once you are in a practice learning setting, find out who the key members of the multi-professional team are and arrange to spend time with them, in collaboration with your assessor or practice supervisor. Identifying key members of the team can help you identify relevant learning opportunities.
3 Be proactive rather than reactive and try to take responsibility for your own learning needs where appropriate, rather than always waiting to be directed by your supervisor. This will help make a good impression and may also help you to meet your own personal learning needs.
4 Know what you want to learn about the specialism and the team before you meet with your practice supervisor/assessor. So long as this plan meets your specified learning outcomes, the team should help you achieve these.
5 Demonstrate a willingness to work as part of the team in all aspects of care planning and delivery.
6 Ask questions. Learn as much as you can about all the professionals working to provide holistic person-centred care. Do not be afraid to ask any member of the team what they contribute to the overall package of care (no question is a silly question!).

The Importance of Record Keeping and Teamwork

There is no denying that record keeping is crucial in healthcare and each member of a team has personal responsibility and accountability for good record keeping, including students (NMC, 2018b).

Record keeping is one of the most basic clinical tools that we can use to ensure that individuals receive the best possible care. This helps us communicate with each other and is essential for ensuring that an individual's assessed needs are met in a timely and efficient manner.

The principles of good record keeping apply to all types of records (e.g., electronic, hand-held, or written), with the electronic record becoming more popular. The essential ability for healthcare professionals to be able to communicate effectively also demands that systems are developed that will allow this collaboration. Mayo and Woolley (2016) suggest that the related technology is the easy bit. What is much harder is navigating the legal framework

around data sharing. This is where clinicians need to have a satisfactory level of knowledge and understanding of local and national policies to allow them to safely share medical information without fear of legal repercussions.

- What can you do to ensure that you are involved in effective record-keeping processes?

It is important that you are involved in all aspects of record keeping. You will need to discuss with your assessor/supervisor the best ways you can do this within your placement. However, your record keeping should clearly differentiate between facts, opinion, and judgements.

The way in which record keeping is undertaken is set out by the employer and in the past each discipline within a multi-professional team would have maintained their own separate records. However, with an ever-increasing focus on improving the quality of care, one of the main components of clinical governance is the use of high-quality systems to effectively monitor care for clinical record keeping and the collection of relevant information (NHS England, 2021). This has led to many employers looking towards integrating record keeping for all disciplines. The NMC (2023) supports the use of the same documentation within agreed protocols by all members of the team providing care, because this can enhance collaborative working. The advantages of having one document for a care recipient's notes are:

- Improved communication;
- Reduction in the duplication of information;
- Reduction in the recording of irrelevant data;
- Maintaining the continuity of a person's care journey;
- Encouraging deeper discussion about an individual and their care.

Electronic record keeping has now become more prevalent, as national programmes for the use of information, communication technology and electronic record keeping are introduced throughout the UK. Electronic records that are complete, integrated, and legible offer added value because they can be accessed from multiple sites and used to generate risk alerts and prompts, indicating that added information is available (Pullen and Loudon, 2006). This approach can sometimes cause issues for learners in the practice area because they need to be able to obtain a password to access the systems. However, paper records are not yet obsolete and the principles of good record keeping must be adhered to regardless of how records are held.

Confidentiality

Confidentiality is as crucial in record keeping as it is in all aspects of healthcare and is identified in Article 8 of the European Convention on Human Rights (European Court of Human

Rights, 1990). It is not acceptable for any member of staff to discuss an individual or their care outside the clinical setting (e.g., in public where they could be overheard or on social media), or to leave records unattended where they could be seen. People need to be assured and have confidence in all staff that their data is protected. All of this is covered by the Data Protection Act 2018 (see www.gov.uk/data-protection) which governs the processing of information that can identify individuals. This is covered by legislation from common law and statute law. Common law refers to decisions made by a court of law; statute law is passed in parliament. Under these laws every individual can expect that any information given to a healthcare practitioner (including students) will be used only for the purpose given. It also encompasses a person's right to control access to their health information. Therefore, if a relative were to ask for information on an individual, that person would have to be consulted. In fact, confidentiality requirements also continue after the death of a person.

Consider how a person's confidentiality can be breached.

- How might this occur?
- What would you do if you suspected that there had been a breach in confidentiality?

If you believe there has been a breach of confidentiality you must raise your concerns with someone in authority. A risk or breach of confidentiality may be a result of individual behaviour or organisational systems or procedures. *The Code* (NMC, 2018b: 14) is clear on this and states: '*Act without delay if you believe that there is a risk to patient safety or public protection'*. We all have a professional duty to take action to ensure that the people in our care are protected and failing to take such action could amount to professional misconduct. There are, however, certain circumstances where records can be disclosed.

Disclosure

In all circumstances, if possible, individuals should be consulted and access to their records given with consent. They need to know why and with whom the information is being shared and give their consent freely. The only time that information about a person can be shared without consent is if it is in the 'public interest.' This includes the detection and prevention of serious crime and to prevent abuse or serious harm to others. As healthcare professionals we need to be aware that disclosures of this nature must be justified to the courts and the NMC, so clear and accurate decision trails and documentation, need to be kept. Contrary to widely held belief, the police do not have an automatic right to access an individual's health records and must obtain a warrant to do so. However, if a person is at risk of serious harm, then it is acceptable but must be discussed with your management team and/or your union or NMC and the individual's consent should also be sought.

Record keeping in healthcare is a potential minefield. Therefore, you need to ensure that you abide by *The Code* (NMC, 2018b) and the local policies of the organisation within which you are working.

Interprofessional Education

The high-profile cases already mentioned previously highlight the need not only to move towards collaborative team working, but also to review professional education and training in the UK, with a view to making this interprofessional, as well as driving the interprofessional agenda within health and social care organisations (Van Diggele et al., 2020).

At this point it is judicious to define and explore the concept of interprofessional education further. The World Health Organization (WHO) Framework for Action on Interprofessional Education and Collaborative Practice (2010: 13) defines interprofessional education (IPE) as 'when two or more individuals from different professions within health and social care engage in learning from and about each other to enable effective collaboration and improve health outcomes'. In the past, nurses, doctors, and allied health professionals (AHPs) were educated separately with no real opportunities for learning together. Therefore, cohesive team working in everyday practice did not always occur. However, as a profession we are now much more forward-thinking and across healthcare settings there is an increasing reliance on teams from a variety of specialties (e.g., nursing, physician specialties, physical therapy, social work) to provide care (Mayo and Woolley, 2016). Therefore, the necessity for a more cohesive cross-professions approach to education is becoming more prevalent (Hammond and Morgan, 2022).

The context of healthcare policy and the nature of healthcare itself, have both had a major influence on educational developments in relation to interprofessional teaching and learning. The WHO began to promote IPE and, following their lead, some countries developed organisations that were dedicated to IPE. At the forefront in the UK is the Centre for the Advancement of Interprofessional Education (CAIPE, 2007). Numerous other drivers include relevant professional bodies: the Nursing and Midwifery Council (NMC, 2018a; 2018b; 2018c; 2018d), the Health Professionals Council (HPC, 2017) and the General Medical Council (GMC, 2015). This has resulted in IPE beginning to be provided globally by universities as part of a student's prequalification for graduate practice (Mishoe et al., 2018).

IPE should take place as early as possible within professional development programmes, to help break down the artificial walls that separate professional groups, reinforcing silo working (Lairamore et al., 2018; Berger-Estililita et al., 2020). It is recommended that interprofessional curricula be implemented where students from all disciplines can meet and collaborate before they enter practice settings, so that they can build the basic values of working in interprofessional teams. The WHO (1988) argues that if healthcare professionals are taught together and learn to collaborate throughout their student years, there is much more chance that they will work together in their professional lives. Khullar (2015) advocates that this will ensure

practitioners are equipped with effective team-working skills to enhance care delivery. This is supported by Herrman et al. (2015), who believe that the face-to-face interaction of different professionals should help to prevent stereotyping and inform and challenge outdated beliefs. Although this is the ideal, it is not always possible in practice and can prove difficult to achieve logistically.

Role-emerging placements

'Role-emerging placements' are currently being used by some allied health profession programmes to support practice learning provision. For example, the College of Occupational Therapists (RCOT, 2006) describes 'role-emerging placements' occurring at a site where there is no current occupational role established. Learners are supported by 'on-site' supervisors. They are also supported and assessed by a 'long-arm' educator who is a qualified Occupational Therapist (OT), who may be working in a different local organisation. The OT long-arm educator meets regularly with the learner (either face-to-face or online) to support and guide their practice. They also liaise closely with the on-site supervisors to assess the learner's progress during the learning process.

A Role-emerging Placement

A small charity drop-in centre acts as a role-emerging learning environment for occupational therapy (OT) students. Two members of staff at the charity are registered nurses who have extensive experience of supporting learning in a practice setting and are allocated to the role of 'on-site' supervisors. The drop-in centre provides crucial support for vulnerable adults within a deprived area and includes the following services: a foodbank, signposting service, mental health support, access to computers, other weekly activities to support people's mental health and wellbeing (e.g., 'knit and natter,' craft sessions and a wellbeing group). The charity works in close partnership with the local council, housing services and other local mental health support organisations. This learning environment provides an excellent opportunity for interprofessional and interagency working. At the end of the experience, learners realise that one individual discipline does not necessarily have the means and resources to meet the complex needs of individuals and their families. Working at the charity provides an excellent experience and example of the importance of reaching out and linking in with other services and professions, which is vital to ensure an all-encompassing supportive plan of care can be made to meet service user needs.

Activity 4.4

1 How do you think the example practice learning experience highlighted above could benefit other healthcare students?
2 Why is it important to work closely with other disciplines or agencies to meet the needs of individuals and their families?
3 What local charities and services are you aware of which it might be useful to work collaboratively with to help meet the needs of those in your care?

Reflecting upon your current and any previous practice learning environments, identify all the potential/actual opportunities available to you for interprofessional learning:

1 Have these been arranged by your employment organisation or your educational provider?
2 Is there potential for you to be able to arrange individualised/bespoke/informal IPE for yourself (i.e., bespoke experience days with other professionals)?

Write down/make a list of all the potential opportunities available to you. Discuss the practicalities and possibilities of these with your practice assessor/supervisor.

You can often find creative ways for IPE to occur throughout your career so that you can continuously develop the skills you will need to work with other professions. Although IPE does take place in practice on a day-to-day basis, Rees et al. (2018) explore how learners and staff may have a different understanding of this and therefore IPE may not always be easily recognised or acknowledged by staff; if it does occur, it is usually very sporadic and ad hoc, with a lack of planning for specific experiences and a reliance on opportunistic experiences. Rudawska (2017) agrees and believes that even if staff do value the importance of IPE, they choose to prioritise profession-specific skills.

It is important here that we differentiate IPE from 'shared learning' (e.g., where professionals sit in the same lecture theatre). Recognising that some key skills all health professionals use could be taught together (e.g., communications skills such as listening, gathering information, and building a rapport with those in receipt of care) would help learners challenge discriminatory statements about other professions (Reeves et al., 2016). IPE should, however, also include the opportunity to collaborate, discuss and learn about each other with the aim being to improve care provision. The aims of IPE are to enhance the sharing of skills and knowledge across healthcare professions, which in turn allows for a better understanding of each other, sharing values and respecting each other's role. If this can be established, then the quality and safety of care provision can be optimised. We have already seen in the high-profile cases identified earlier how poor healthcare team working and communication can have a negative impact on care outcomes.

IPE can work well if all professions can work together to make this happen in both practice and academic settings (Mayo and Woolley, 2016; Hammond and Morgan, 2022).

IPE

A community occupational therapist (OT) attends an 'Interprofessional Learning (IPL) Champions' Forum' (a forum that has been developed to enable IPL champions from all disciplines to meet and learn together). Another member of the group (a podiatrist) shares information about some new drop-in sessions that they are holding in their area and is surprised that the OT was unaware of these as the information had already been distributed on flyers to all the clinics. However, the OT is based in another building that had not been included in the distribution. In addition, due to the hectic pace of NHS work, flyers and distribution information is often missed. The IPL Forum allows time for the podiatrist and OT to liaise and learn more about each other's services and remit, and the specific changes that are being implemented locally to improve care. The OT immediately starts to refer individuals to the drop-in, which leads to much more timely treatment being provided for those in their care. The podiatrist also becomes much more aware of the necessity for effective communication and the need to ensure that all appropriate colleagues are aware of any new services.

Over recent years, the need for IPE and collaborative learning has been recognised as being more important than ever (Singh and Matthews, 2021). Park (2022) agrees, advising that IPE presents a conduit, aligning professional requirements with professional strategies and workplace demands, thereby bridging the liminal space between practice and theory, though delivery can be complex. For example, online conversion of IPE can be challenging, presenting barriers to some, and widening participation to others. Look at further examples of IPE approaches below:

Case examples

1 A virtual ward is developed at one hospital to facilitate students from various disciplines to learn together. It is designed collaboratively as an innovative way of enabling different professions to work together in teams and develop their communication skills, learning about each person's role and responsibilities while caring for people.
2 A Higher Education Institution (HEI) uses simulation scenarios (SIM) to encourage learners from different professions to work together in problem solving complex care issues. This is undertaken in the SIM suite where everyone can work together in a safe environment and make mistakes without causing any harm to care recipients. It involves recreating real-life events so that learners can experience that event through use of a high-fidelity environment, thereby gaining new skills, knowledge, and attitudes. This can be extended further by scenarios being enacted in the clinical areas at random and with no prior notice.
3 An IPL forum founded in partnership with a mental health trust and the local council brings together key staff interested in education and learning where they can work towards integrated learning in practice. This involves having IPE champions at all levels in the

organisation to help promote IPE in practice. A person-centred approach is promoted, and the IPL forum advocates the importance of partnership working with all practitioners involved in care delivery.

4 An organisation has an online preceptorship programme which brings different professions together via an online platform, allowing staff to learn together and share examples of good practice during the first year of their new roles.

In some areas HEIs have yet to pursue IPE fully, due to the organisational complexities involved. In the past some have argued that there has been a lack of research as to the effectiveness of IPE, suggesting that the cost, amount of labour required, lack of support and timetabling difficulties have helped to fuel this reluctance (Van Dieggele et al., 2020). For example, even simple differences such as terms, length and different assignment requirements can often cause a problem and make it logistically difficult to achieve. However, in the UK evidence has grown for its implementation (Choudhury et al., 2020).

Health Education England (HEE) have recognised the need for extra support for learning in practice and developed the role of the practice education facilitator (PEF). This has now been extended, with a realisation that developing a sustainable growth in allied health professions' workforce is vital to delivering ambitions of the NHS long term plan (DoH, 2019). Scotland also focused on practice education in their paper The Healthcare Quality Strategy for NHS Scotland (Morrison, 2010), and have extended this by developing the Quality Standards for Practice (NHS Quality Improvement in Scotland, 2020). Wales has also developed a similar role (RCN (Royal College of Nursing) Wales, 2016). Although initially slow to develop (Wright and Lindqvist, 2008), the role has been instrumental in the practice setting for supporting and managing practice-based multi-professional learning. As the PEF role has developed and the need for IPE has become more widely recognised, the role of the PEF has now expanded to assist and support assessors/supervisors and students across all disciplines. Indeed, most healthcare organisations have embraced the notion of IPE and developed structures to support it.

It has also been recognised that, as well as the need to work interprofessionally with other healthcare professionals within one area or organisation, there is also a broad consensus about the importance of working across both acute and community settings. This includes working collaboratively with a wider range of NHS, private and voluntary organisations to meet future complex care needs. *The NHS Long Term Plan* (DoH, 2019) and *Build Back Better: Our Plan for Health and Social Care* (DoH, 2022a) continues to describe a future that will see the NHS dissolving the classic divide between GPs (General Practitioner), hospital care and health and social care. Instead, the NHS will form primary care networks which will empower those receiving care to take more control over their own treatment plans. The review also calls for a radical upgrade in prevention and public health, recognising the crucial role that healthcare students can play within this important agenda. The increasing need for all healthcare students to gain valuable public health experience, together with the new models of integrated working across both health and social care services, has led to new opportunities for increased interprofessional working experiences for pre-registration students which could also play a crucial role in their public health exposure.

IPE Case Study: Promoting Public Health

Public health experiences within practice learning environments are often ad hoc and dependent on the mindset of the practice assessors/supervisors. One organisation was keen to develop a new initiative that would strengthen, promote, and formalise the public health experience for learners, providing them with a deeper understanding of the wider issues involved when caring holistically for individuals and their families. They developed an annual 'Public Health Conference' for healthcare learners in collaboration with two local HEIs and a private healthcare organisation. The conference provided a more formalised opportunity for attendees from a range of professions to learn together about local public health services and explore their role in promoting health and signposting services to those in their care. This enabled the learners to see public health in action and helped them link theory to real-life practice.

- What opportunities do you think public health might bring in relation to IPL for healthcare learners?
- How do you think your own public health experience could be strengthened and formalised?
- When providing holistic care what do you think the wider issues might be in relation to public health?
- Do you think it is important for learners from different professions to learn together?
- What do you think the key learning might be for those attending this conference?
- How do you think this conference might improve the care provided to individuals?

IPE advantages and challenges

There are some key advantages to IPE including:

- Understanding the theoretical principles of team working and collaboration early in a student's career;
- Understanding all the roles involved in the service-user experience;
- An ability to communicate appropriately and understand the language of different healthcare professionals;
- An understanding of the professional responsibilities, values, and accountability of healthcare professionals in meeting the needs of individuals;
- Being able to work effectively in an interprofessional team;
- Understanding how different professions make decisions about care provision;
- Understanding how IPE produces better teamwork, which in turn improves care delivery;
- Removal of the fear of other professions;
- The ability to challenge professionals to ensure quality care provision.

There are also some challenges, including:

- Difficulty in mapping the curricula for different professions;
- Recognising that there needs to be a commitment from all stakeholders to effective planning of IPE;
- Recognising that time and opportunity need to be given for professions to address differences;
- Allowing for coordination and resourcing difficulties because learning in small groups is often labour-intensive and costly;
- A lack of evaluation of the IPE that has already been implemented; rigorous and robust evaluation is essential;
- A lack of preparation and support for the IPE teachers;
- A lack of student involvement in planning the IPE; Freeth et al. (2005) maintain students should be actively involved in steering their IPE.

Looking into the future of the healthcare service, Schot et al. (2020) believe that we must change the way we educate professionals and change the milieu in which they work. Silo working and training cannot continue, and the development of an integrated, interprofessional, multi-dimensional workforce is critical. For all of this to happen, teamwork is also crucial.

Chapter Summary

Interprofessional working and learning are not new concepts; however, it is obvious that they are essential to the future of healthcare and adult nursing. Indeed, the NMC (2018d) are clear that nursing students should be given opportunities and chances to learn with other professionals and as far as is possible with learners from other professions. However, for this to occur, all professions need to show a commitment to learning and working together to provide the best high-quality person-centred care. This often involves breaking down traditional boundaries and barriers and working flexibly. It also requires clear leadership and a commitment to ongoing collaborative education, all of which should help to build sustainable relationships with mutual understanding, respect and communication which occur through influencing and negotiating. This involves breaking down hierarchical structures and taking a leap of faith and commitment to work proactively for true collaboration.

The key challenges have been identified here and the commitment to work through these challenges and develop effective policies is apparent (Park, 2022). For adult nurses, teamwork is key and therefore every opportunity should be taken during your programme to join in all teamwork activities.

Further Reading

Day, J. (2013) *Interprofessional Working. An Essential Guide for Health and Social Care Professionals*. Hampshire: Cengage Learning.

Department of Health (2021) *Integration and Innovation: working together to improve health and social care for all*. Available at: www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version (last accessed 17 February 2023).

James, T. (2021) *Teamwork as a Core Value in Health Care*. Harvard Medical School. Available at: https://postgraduateeducation.hms.harvard.edu/trends-medicine/teamwork-core-value-health-care (last accessed 25 January 2023).

McLaney, E., Morassaei, S., Hughes, L., Davies, R., Campbell, M. and Di Prospero, L. (2022) 'A framework for interprofessional team collaboration in a hospital setting: advancing team competencies and behaviours', *Healthcare Management Forum,* 35(2): 112–17.

Thistlethwaite, J.E. (2012) *Values-Based Interprofessional Collaborative Practice. Working Together in Health Care*. Cambridge: Cambridge University Press.

References

Babiker, A., El Husseini, M., Nemri, A.A., Frayh, A,A., Juryyan A.N., O Faki, M., Assiri, A., Al Saadi, M., Shaikh, F. and Al Zamil, F. (2014) 'Health care professional development: working as a team to improve patient care', *Sudanese Journal of Paediatrics*, 14(2): 9–16.

Baldwin, D. (1993) *Development of Health Professionals to Maximise Health Provider Resources in Rural Areas. National Rural Health Association HRSA Contract*. Washington, DC: Bureau of Health Professions.

Berger-Estilita, J., Chiang, H., Stricker, D., Fuchs, A., Greif, R. and McAleer, S. (2020) *Attitudes of Medical Students Towards Interprofessional Education: A mixed methods study*. Available at: https://doi.org/10.1371/journal.pone.0240835 (last accessed 4 February 2023).

Buzelli, L., Cameron, G. and Gardner, T. (2022) *Public Perceptions of the NHS: and social care performance, policy, and expectations*. Available at: www.health.org.uk/publications/long-reads/public-perceptions-performance-policy-and-expectations (last accessed 30 January 2023).

Centre for the Advancement of Interprofessional Education (2007) *Creating an Interprofessional Workforce: An Education and Training Framework for Health and Social Care*. London: CAIPE (supported by the Department of Health).

Choudhury, R.I., us Salam, M.A., Mathur, J. and Choudhury, S.R. (2020) 'How interprofessional education could benefit the future of healthcare – medical students' perspective', *BMC Med Educ* 20, 242. Available at: https://doi.org/10.1186/s12909-020-02170-w (last accessed 17 February 2023).

College of Occupational Therapists (2006) *Developing the Occupational Therapy Profession: Providing new work-based learning opportunities for students*. London: COT.

Data Protection Act (2018) Data Protection Act 2018. [online] Legislation.gov.uk. Available at: www.legislation.gov.uk/ukpga/2018/12/pdfs/ukpga_20180012_en.pdf (last accessed 12 July 2022).

Department of Health (2012) *Health and Social Care Act*. London. DH. Available at: www.legislation.gov.uk/ukpga/2012/7/contents/enacted (last accessed 1 January 2023).

Department of Health (2013) *Berwick Report into Patient Safety*. London: DH.

Department of Health (2015) *Health and Social Care (Safety and Quality) Act 2015*. London: DH.

Department of Health (2019) *The NHS Long Term Plan*. London: DH. Available at: www.england.nhs.uk/long-term-plan/ (last accessed 17 February 2023).

Department of Health (2021) *Integration and Innovation: Working together to improve health and social care for all*. Available at: www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version (last accessed 17 February 2023).

Department of Health (2022a) *Build Back Better: Our Plan for Health and Social Care*. London: DH.

Department of Health (2022b) *Coronavirus: Lessons learned to date. (Sixth Report of the Health and Social Care Committee and Third Report of the Science and Technology Committee of Session 2021–22)*. London: DH.

European Court of Human Rights (1990) *Article 8 of the European Convention on Human Rights*. Available at: www.echr.coe.int/documents/convention_eng.pdf (last accessed 1 January 2023).

Freeth, D., Hammick, M., Reeves, S., Koppel, I. and Barr, H. (2005) *Effective Interprofessional Education: Development, Delivery and Evaluation*. Oxford: Blackwell.

General Medical Council (2015) *Promoting Excellence: Standards for Medical Education and Training*. Manchester: GMC.

GMCA (2017) *Discharge to Assess – Standards for Greater Manchester.* Manchester: GMCA.

Green, B.N. and Johnson, C.D. (2015) 'Interprofessional collaboration in research, education, and clinical practice: working together for a better future', *Journal of Chiropractic Education*. 29(1): 1–10. doi: 10.7899/JCE-14-36 (last accessed 27 July 2022).

Hammond, K.M. and Morgan, C.J. (2022) 'Development of interprofessional healthcare teamworking skills: mapping students' process of learning', *Journal of Interprofessional Care,* 36(4): 589–98.

Hastie, C.R., Fahy, K.M., Parratt, J.A. and Grace, S. (2016) 'Midwifery students' experience of teamwork projects involving mark-related peer feedback', *Women and Birth,* 29(3): 252–9.

Health Professionals Council (2017) *Standards in Education and Training*. London: HPC.

Herrman, G., Woermann, U. and Schelgel, C. (2015) 'Interprofessional education in anatomy: learning together in medical and nursing training', *Anatomical Sciences Education,* Jul-. Aug; 8(4): 324–30.

James, T. (2021) *Teamwork as a Core Value in Health Care*. Harvard Medical School. Available at: https://postgraduateeducation.hms.harvard.edu/trends-medicine/teamwork-core-value-health-care (last accessed 25 January 2023).

Jovanović, S., Maja Stanković, M., Kilibarda, T., Trgovčević, S. and Ivanović, S. (2020) *The terminology used to describe teamwork in the health care system: A literature review*. UDC. Available at: https://scindeks-clanci.ceon.rs/data/pdf/0365-4478/2020/0365-44782004013J.pdf (last accessed 16 February 2023).

Khullar, D. (2015) 'Doctors and nurses not learning together'. https://archive.nytimes.com/well.blogs.nytimes.com/2015/04/30/doctors-and-nurses-not-learning-together/ (last ast accessed 4 February 2023).

Kirkup, B. (2015) *The Report of the Morecambe Bay Investigation*. London: The Stationery Office, William Lea Group.

Kirkup, B. (2018) *Report of the Liverpool Community Health Independent Review*. Available at: www.england.nhs.uk/2018/02/independent-review-liverpool-community-health-nhs-trust-published/ (last accessed 1 January 2023).

Lairamore, C., Morris, D., Schichtl, R., George-Paschal, L., Martens, A., Maragakis, A., Garnica, M., Jones, B., Grantham, M. and Bruenger, A. (2018) 'Impact of team composition on student perceptions of interprofessional teamwork: a 6-year cohort study', *Journal of Interprofessional Care*, 32(2): 143–50.

Lalani, M., Bussu, S. and Marshall, M. (2020) 'Understanding integrated care at the frontline using organisational learning theory: a participatory evaluation of multi-professional teams in East London', *Social Science and Medicine*, 2020 Oct; 262:113254. doi: 10.1016/j.socscimed.2020.113254. Epub 2020 Jul 31. PMID: 32768774.

Mayo, A.T. and Woolley, A.W. (2016) 'Teamwork in health care: maximizing collective intelligence via inclusive collaboration and open communication', *AMA Journal of Ethics,* September 18(9): 933–40.

Mid Staffordshire NHS Foundation Trust (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary*. London: HMSO.

Mishoe, S.C., Tufts, K.A., Blando, J.D. and Hoch, J.M. (2018) 'Health professions students' attitudes toward teamwork before and after an interprofessional education co-curricular experience', *Journal of Research in Interprofessional Practice and Education*, 8(1): 1–16.

Morley, L. and Cashell, A. (2017) 'Collaboration in healthcare', *Journal of Medical Imaging and Radiation Sciences*, 48(2): 207–16.

Morrison, C. (2010) *The Healthcare Quality Strategy for NHS Scotland*. The Scottish Government. Available at: www.gov.scot/publications/healthcare-quality-strategy-nhsscotland/ (last accessed 206th June 2023).

NHS Employers (2022a) *Expanding Placement Capacity*. NHS Employers. Available at: www.nhsemployers.org/articles/expanding-placement-capacity. (last accessed 16 February 2023).

NHS Employers (2022b) *Clinical Placement Supervision Models*. Available at: www.nhsemployers.org/articles/clinical-placement-supervision-models (last accessed 17 February 2023).

NHS England (2014) *MDT Development – Working toward an effective multidisciplinary/multiagency team*. Available at: www.england.nhs.uk/wp-content/uploads/2015/01/mdt-dev-guid-flat-fin.pdf (last accessed 17 February 2023).

NHS England (2021) *Records Management Code of Practice 2021*. Available at: https://transform.england.nhs.uk/media/documents/NHSX_Records_Management_CoP_V7.pdf (last accessed 1 February 2023).

NHS Quality Improvement in Scotland (2020) *Quality Standards for Practice Learning (QSPL)*. NHS Education for Scotland.

Nursing and Midwifery Council (2018a) *Future Nurse: Standards of Proficiency for Registered Nurses*. London: NMC.

Nursing and Midwifery Council (2018b) *The Code: Professional Practice and Behaviour Standards of Nurses and Midwives*. London: NMC.

Nursing and Midwifery Council (2018c) *Fitness to practise outcomes*: April to September 2018. London: NMC.

Nursing and Midwifery Council (2018d) *Future nurse: Standards of proficiency for registered nurses*. London: NMC

Nursing and Midwifery Council (2019a) *Part 2: Standards for Student Supervision and Assessment.* London: NMC.

NMC (2019b) *Different Learning Opportunities*. Available at: www.nmc.org.uk/supporting-information-on-standards-for-student-supervision-and-assessment/learning-environments-and-experiences/types-of-learning-experiences/different-learning-opportunities/ (last accessed 16 February 2023).

Nursing and Midwifery Council (2023) Part 1: *Standards Framework for Nursing and Midwifery Education*. London: NMC.

Ockenden, D. (2020) *Ockenden Report: The emerging findings and recommendations from the independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust*. London: Department of Health.

Park, V. (2022) Moving interprofessional education to a virtual platform (comment), *British Journal of Nursing*, 10 March 2022. Available at: www.britishjournalofnursing.com/content/comment/moving-interprofessional-education-to-a-virtual-platform/ (last accessed 12 July 2022).

Pollard, K.C., Sellman, D. and Thomas, J. (2014) 'The need for interprofessional working'. In J. Thomas, K.C. Pollard, and D. Sellman (eds), *Interprofessional Working in Health and Social Care, Professional Perspectives*, 2nd edn. Basingstoke: Palgrave Macmillan, Chapter 1.

Pullen, I. and Loudon, J. (2006) 'Improving standards in clinical record keeping', *Advances in Psychiatric Treatment*, 12: 280–6.

Rawlinson, C., Carron, T., Cohidon, C., Arditi, C., Hong, Q.N., Pluye, P., Peytremann-Bridevaux I. and Gilles, I. (2021) 'An overview of reviews on interprofessional collaboration in primary care: barriers and facilitators', *International Journal of Integrated Care,* Jun, 21(2): 32. (last accessed 1 February 2023).

RCN Wales (2016) *Future of Nurse Education in Wales: Education Strategy*, RCN Wales leadership summit, Cardiff.

Rees, C.E., Crampton, P., Kent, F., Brown, T., Hood, K., Leech, M., Newton, J., Storr, M. and Williams, B. (2018) 'Understanding students' and clinicians' experiences of informal interprofessional workplace learning: an Australian qualitative study', *BMJ Open* 2018; 8. https://bmjopen.bmj.com/content/bmjopen/8/4/e021238.full.pdf (last accessed 5 February 2023).

Reeves, S., Fletcher, S., Barr, H., Birch, I., Boet, S., Davies, N., McFadyen, A., Rivera, J. and Kitto, S. (2016) 'A BEME systematic review of the effects of interprofessional education: *BEME Guide No. 39', Medical Teacher*. Jul; 38(7): 656–68. doi: 10.3109/0142159X.2016.1173663. Epub 2016 May 5. PMID: 27146438.

Rosen, M.A., DiazGranados, D., Dietz, A.S., Benishek, L.E., Thompson, D., Pronovost, P.J. and Weaver, S.J. (2018) 'Teamwork in healthcare: key discoveries enabling safer, high-quality care', *American Psychologist,* 73(4): 433–50.

Royal College of Physicians (2017) *Improving teams in healthcare Resource 1: Building effective teams*. Available at: www.rcplondon.ac.uk/projects/outputs/improving-teams-healthcare-resource-1-building-effective-teams (last accessed 25 January 2023).

Rudawska, A. (2017) 'Students' team project experiences and their attitudes to teamwork', *Journal of Management and Business Administration*, 25(1): 78–97.

Schot, E., Tummers, L. and Noordegraaf, M. (2020) 'Working on working together. A systematic review on how healthcare professionals contribute to interprofessional collaboration', *Journal of Interprofessional Care,* 34(3): 332–42.

Sims, S., Hewitt, G. and Harris, R. (2014) 'Evidence of collaboration, pooling of resources, learning and role blurring in interprofessional healthcare teams: a realistic synthesis', *Journal of Interprofessional Care*, 25(1): 20–5.

Singh, J. and Matthews, B. (2021) 'Facilitating interprofessional education in an online environment during the COVID-19 pandemic: A mixed method study', *Healthcare (Basel)*. May 11; 9(5): 567. doi: 10.3390/healthcare9050567. PMID: 34065009; PMCID: PMC8151389.

The King's Fund (2020) *The King's Fund History of Nursing* (online). Available at: https://my.visme.co/view/q6jz4wre-the-king-s-fund-nursing-exhibition-2020. (last accessed 7 July 2022).

Traynor, M. (2013) *Nursing in Context. Policy, Politics, Profession*. London: Palgrave Macmillan.

Van Diggele, C., Roberts, C., Burgess, A. and Mellis, C. (2020) 'Interprofessional education: tips for design and implementation', *BMC Medical Education* 20: 455. Available at: https://doi.org/10.1186/s12909-020-02286-z (last accessed 12 July 2022).

Wei, H., Corbett, R.W., Ray, J. and Wei, T.L. (2020) 'A culture of caring: the essence of healthcare interprofessional collaboration', *Journal of Interprofessional Care*, 34(3): 324–31.

Willis Commission (2012) *Quality with Compassion: The Future of Nurse Education*. London: Royal College of Nursing.

World Health Organization (1988) *Learning Together to Work Together for Health*. Geneva: WHO.

World Health Organization (2010) *Framework for Action on Interprofessional Education and Collaborative Practice*. Geneva: WHO.

Wright, A. and Lindqvist, S. (2008) 'The development, outline, and evaluation of the second level of an interprofessional learning programme: listening to the students', *Journal of Interprofessional Care*, 22(5): 475–87.