

Interprofessional Learning in Adult Critical Care

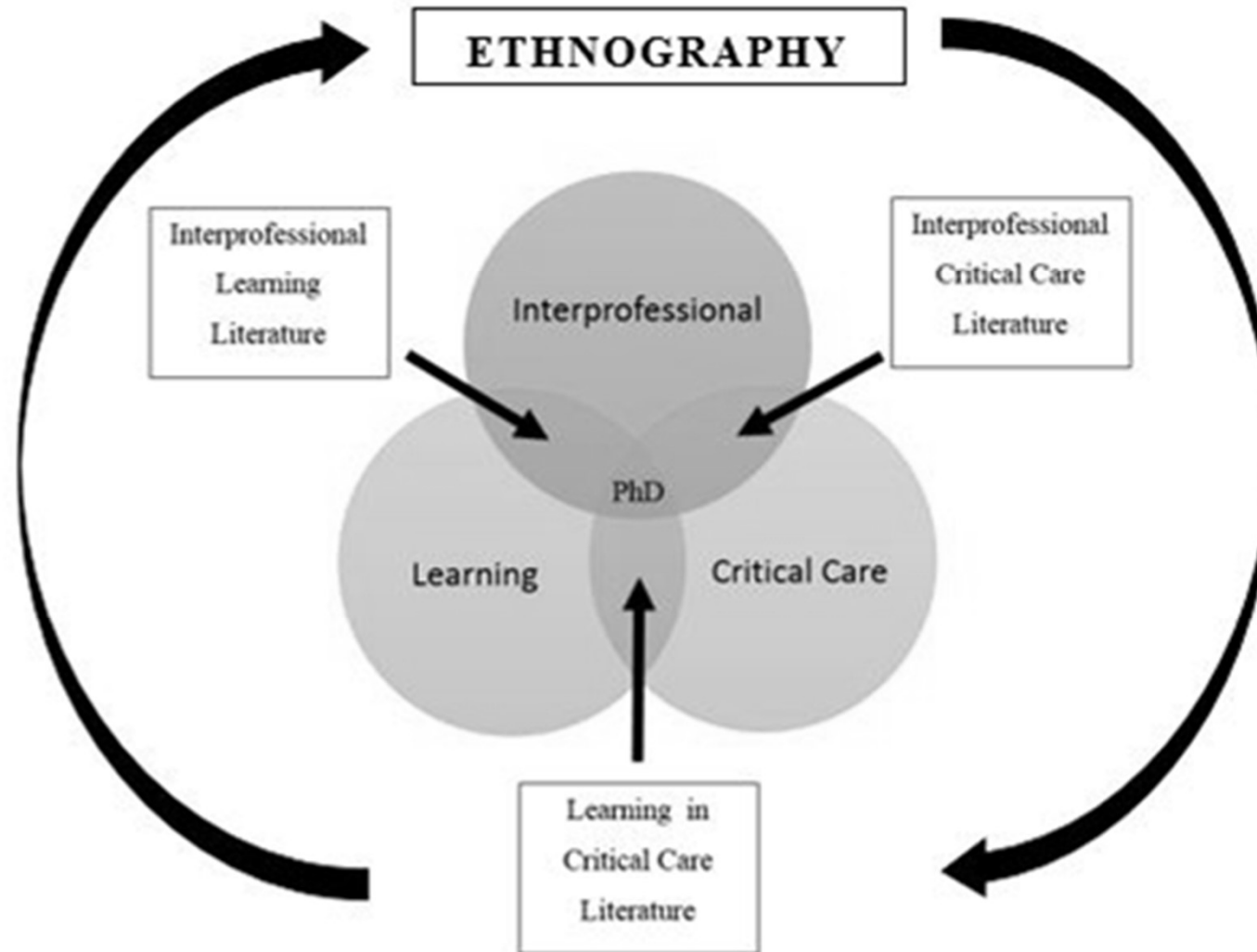
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The PhD focus



The Research

AIMS

- Develop a rich description of the interprofessional learning culture in adult critical care.
- Gain in-depth understanding of critical care staff perceptions and experiences of interprofessional learning within adult critical care.
- Identify the perceived factors promoting or inhibiting interprofessional learning in adult critical care.

OVERARCHING QUESTION

What influences interprofessional learning (IPL) culture in the adult critical care environment?

The Process: *An overview*

Research Design

Ethical Approval

Quality Assurance

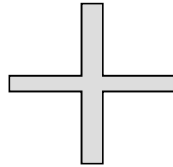
Data Collection

Analysis

Dissemination

The Process: *In stages*

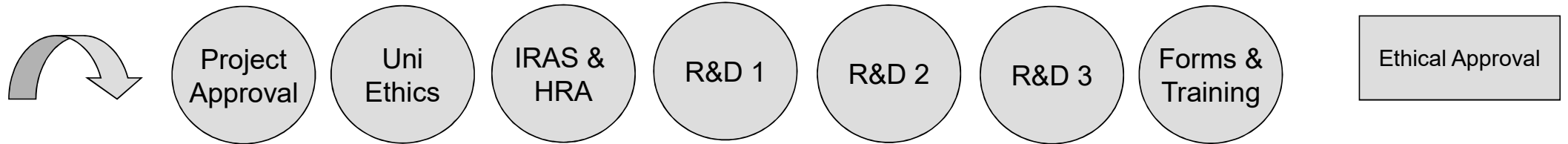
3x aims
Overarching
question



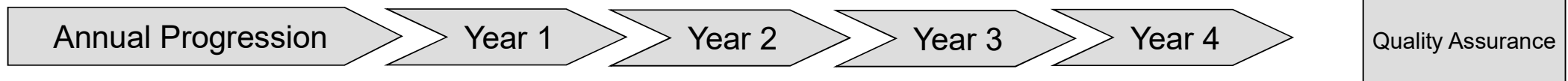
Philosophical Position		
Ontological	Epistemological	Methodological
Social Constructionism Interpretivism	Sociocultural Learning Theory	Focused Ethnography

Research Design

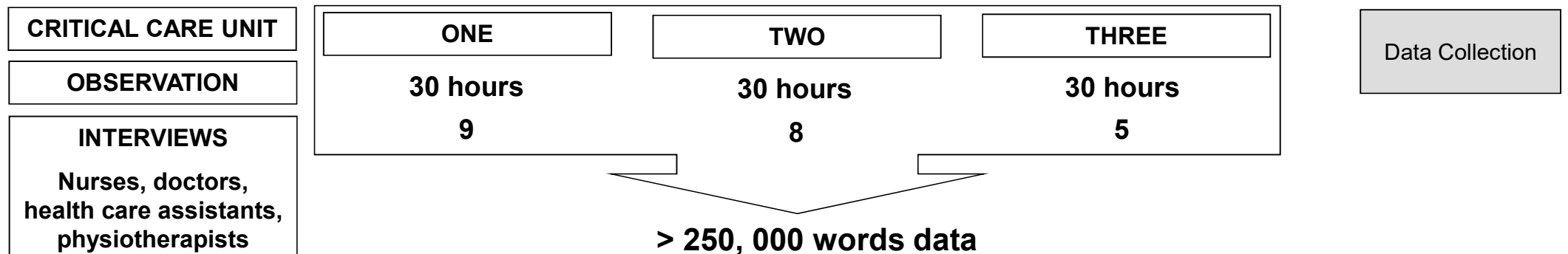
The Process: *In stages*



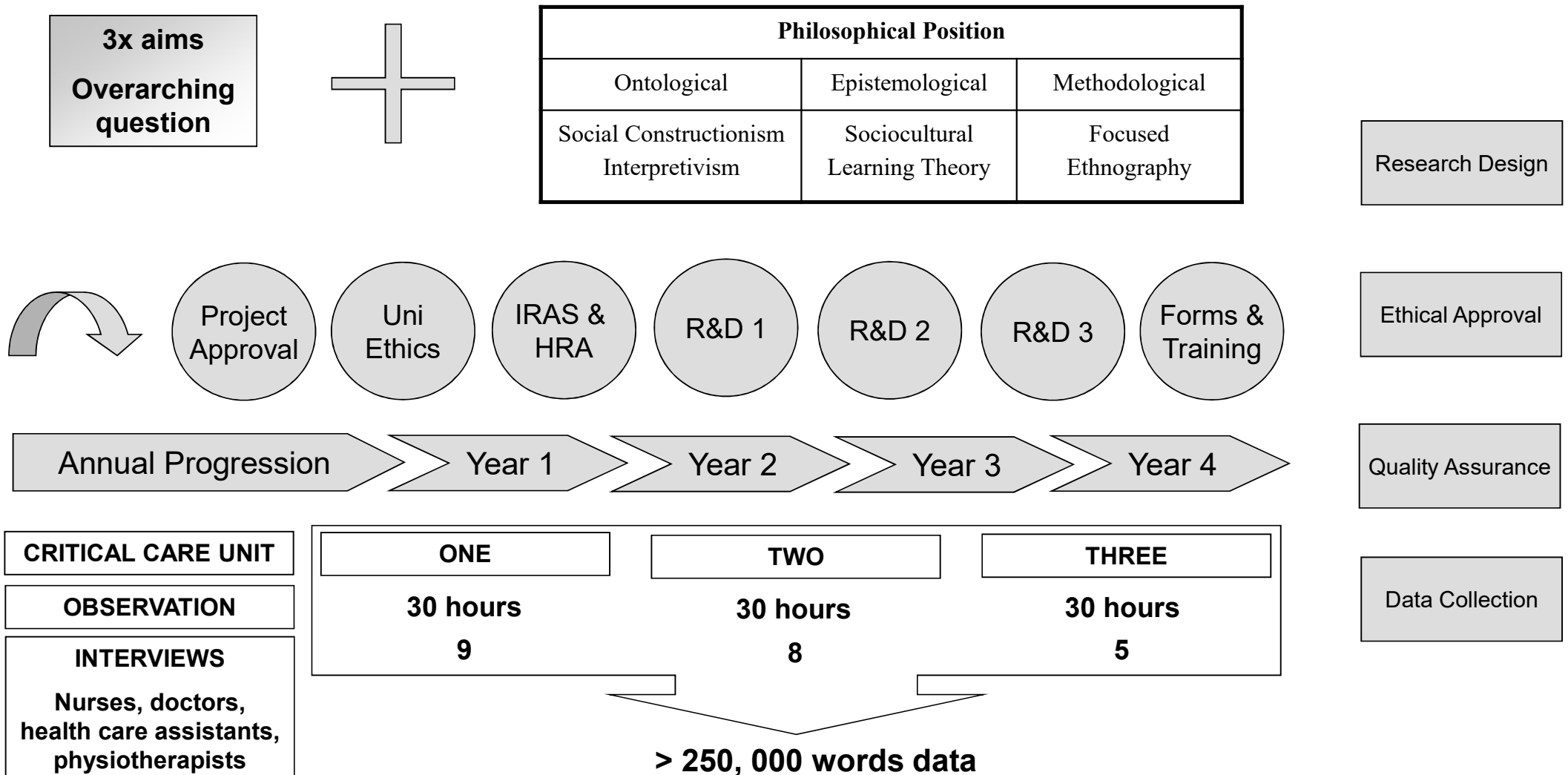
The Process: *In stages*



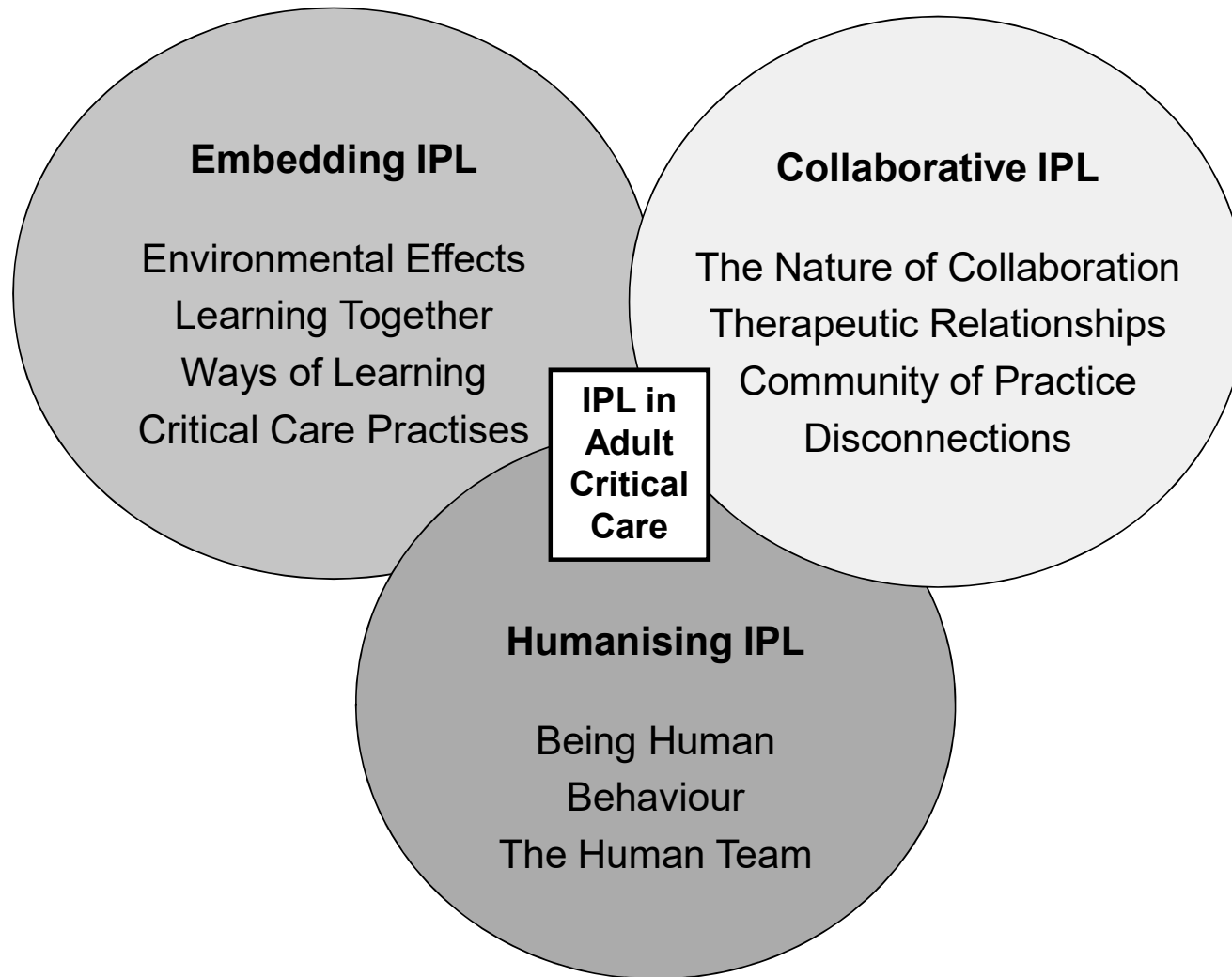
The Process: *In stages*



The Process: *In stages*



The Findings



Analysis

Thematic Analysis

3 Overarching Themes

11 Themes

38 Subthemes

Key Findings: *The IPL Climate*

Interprofessional learning in critical care is affected by the IPL climate.

FEATURES

- The IPL climate:
 - fluctuates and IPL levels are changeable
 - can be immediately affected by influential factors
 - is affected by holistic factors

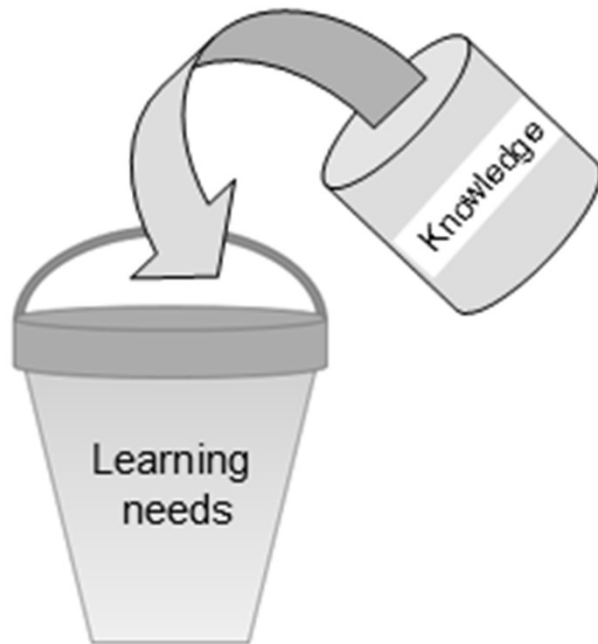
INFLUENTIAL FACTORS

- People affect levels of IPL through:
 - behaviour
 - 'being human'
- Environmental factors affect IPL climate, such as:
 - temperature extremes, staff shortages
- Hierarchy & leadership influence IPL climate:
 - senior staff affect the climate more than junior

IPL culture is more entrenched, takes longer to change and is heavily influenced by organisational culture.

Key Findings: *Knowledge Exchange*

Filling the knowledge gap:
*The emptier the bucket,
the less it is filled!*



An unexpected finding:

The greater the knowledge gap, the less is shared.

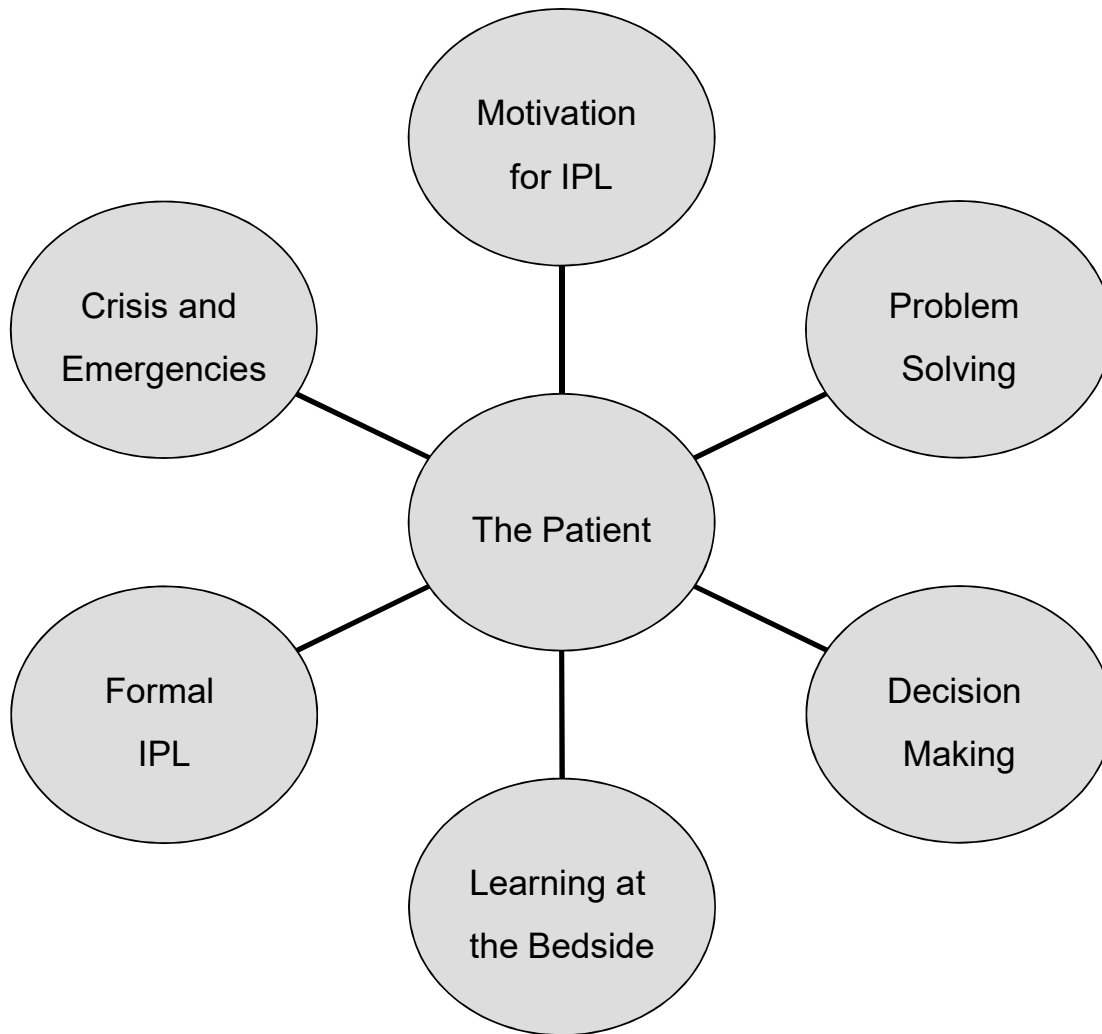
In terms of levels of expertise, the greater the knowledge differential between staff, the less knowledge was shared.

Knowledgeable staff made assumptions about other professions levels of knowledge and their motivation to learn.

This affected the depth of IPL and knowledge was often retained and summarised, resulting in brief interprofessional learning exchanges.

However, rich knowledge was exchanged between experts.

Key Findings: *Patient Centred Care*



A consistent finding:

The critically ill patient is at the centre of IPL.

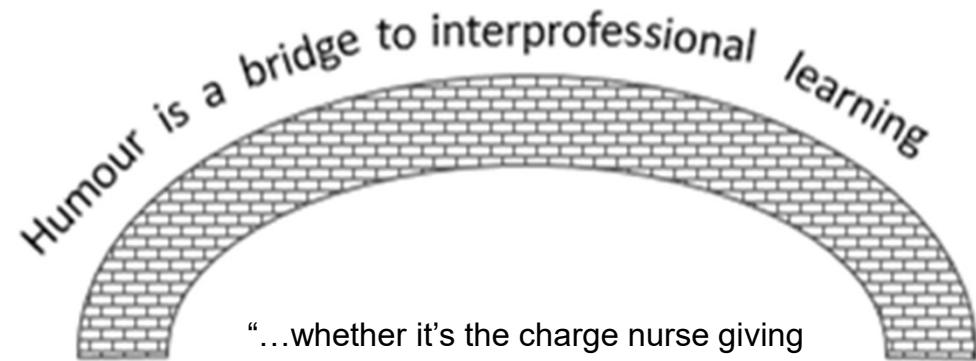
Staff learned from each other to:

- care for patients,
- save lives,
- plan care,
- make effective decisions,
- minimise disruption for patients,
- promote patient wellbeing

Key Findings: *Humour*

Humour:

- Could be learned through IPL
- Created connections
- Developed rapport
- Improved staff morale
- Promoted job satisfaction
- Helped staff to cope
- Forged secure relationships and trust
- Was an icebreaker
- Broke down hierarchical barriers
- Created opportunities to interact
- Improved engagement with IPL
- Needed to be used professionally



“...whether it’s the charge nurse giving one of my colleagues a fake patient name on April Fools Day, that if read out loud was slightly dodgy... or it’s just day-to-day light heartedness about certain things... it’s probably a sign of fairly healthy morale I think”

Interview 1



Key Findings: *Emotions*

- Emotional behaviour was shaped by IPL.
- Emotions were associated with humour and coping in critical care.
- Critical care staff had limited structures to process emotions and to learn from them.
- Staff would box emotions away, or deflect them with humour, rather than process them.
- Debriefs were a largely unexplored vehicle for IPL and emotional development.

Key Findings: *Space*

VISIBILITY > PROXIMITY

↓ SPACE = ↑ CREATIVITY

CUBICLES

PROXIMITY

Key Findings: *Space*

VISIBILITY > PROXIMITY

Visibility of staff was more conducive to IPL than proximity.

Staff working in the line of sight, were more likely to seek out others
and engage in interprofessional learning.

Key Findings: *Space*

CUBICLES

Cubicles as isolating or protective.

Isolated working meant that staff could be forgotten, so no IPL occurred.

Alternatively, being in a cubicle could protect interprofessional learning, with minimal disruptions and focused learning.

Key Findings: *Space*

↓ SPACE = ↑ CREATIVITY

When there was limited space to learn,
critical care staff became creative and
adapted their environments to create areas for IPL.

e.g. treatment rooms, corridors, empty rooms

Key Findings: *Space*

PROXIMITY

↑ distance from the hub = ↓ IPL

Staff that worked furthest away from hotspots,

such as nursing stations and hubs,

had less interactions that could lead to IPL.

Key Findings: *Environment*

Physical environment	Working conditions
<p><i>Favourable environmental conditions:</i></p> <p>Temperature regulation – air conditioning, drinking water, fresh air</p> <p>Sufficient space</p> <p>Controllable light – dimmers and shutters</p> <p>Minimal sound levels</p> <p>Good lines of sight of colleagues</p> <p>Working in close proximity to staff</p>	<p><i>Favourable working conditions:</i></p> <p>Trust and rapport</p> <p>Safe to ask questions</p> <p>Range of skilled staff and extended roles</p> <p>Organisational support for IPL</p> <p>Learning about each other</p> <p>Professional networking opportunities</p> <p>Interprofessional activities</p>

Key Findings: *the good IPL environment*

A critical care with a rich IPL culture would be likely to include the following:

An open atmosphere which is safe to ask questions.

Good visibility of staff.

Close proximity to interprofessional colleagues.

A range of staff with extended roles.

Staff who know each other well e.g. through professional networking or socialising.

Acceptance of the human characteristics of the people working in critical care

e.g. humour and emotions within the boundaries of professional conduct.

Strong role models and advocates of IPL.

Organisational support - IPL culture permeates down from organisational leaders.

Recognising opportunities for IPL, designing the unit and planning daily activities to promote IPL.

Favourable environmental conditions e.g. temperature, space, light and sound levels.

Designate spaces to learn.

Recommendations: *in a nutshell*

- Raise awareness of the IPL potential of the environment
- Discussing IPL openly may remove assumptions that limit learning between professions
- Create opportunities for interprofessional learning
- Increase collaboration between professions to strengthen the community of practice
- Establish influential factors in the critical care environment
- Optimise the environment: physical attributes and working conditions
- Consider the position of staff in the unit to promote IPL (proximity and visibility)
- Review locations used for learning, and designate and safeguard spaces to learn inside the critical care unit
- Strong role models could be positioned as IPL champions
- Organisational leaders need to support interprofessional learning in critical care

Summary

- Critical care is a knowledge dense environment
- There are many missed opportunities for IPL in daily practice
- An open dialogue and increased recognition of IPL opportunities could promote IPL
- Awareness of the influential factors in critical care could enhance the IPL climate
- Making time and space for IPL may increase the expertise of the critical care unit
- Critical care environments can be adapted to optimise IPL
- For IPL to be collaborative, staff need to connect, to support their community of practice
- Critical care may benefit from humanising IPL, embracing the facets of being human

Thank you for listening

- Further information can be found via:

University staff profile: <https://www.northumbria.ac.uk/about-us/our-staff/p/vikki-park/>

Academia: <https://northumbria.academia.edu/VikkiPark>

Research Gate: https://www.researchgate.net/profile/Vikki_Park