Collaborative Learning Environment
Well-Woman and Maternity Care

Update- Progress Report Q2
July 1-September 30, 2010

by

June MacDonald & Jane Wojcik
Project Support Team

October 31, 2010

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The CLE Project

Background

The Collaborative Learning Environment for Health Professionals in Well-Woman, Maternal and Newborn Child Clinics (CLE) is a skills-building initiative with demonstration, research, and evaluation components and is supported by funding from Health Canada through the Health Care Policy Contribution Fund. While the focus of CLE is on community-based women's health and child health services, the learning will be adaptable to any community with a need for high quality, accessible, primary care.

The aim of this project is to develop, implement, and evaluate innovative approaches to enhancing the skills of health professionals so they may work together synergistically along with patients, their families, carers and communities to deliver the highest quality of care. Ultimately, primary health care facilities will have access to regional expertise, interprofessional competencies training tools, and change management strategies.

This project is expected to be of considerable significance to the future sustainable delivery of health care in all participating jurisdictions. Additional funding from a range of sources will be sought to enable the project to continue after the initial phase. The second phase would ideally extend another 24 months, during which time the successful sites would be fully evaluated and the resultant template for change could be extended to more sites, thereby confirming the successful process for sustainable change.

Introduction

The CLE project has begun to develop demonstration sites in Atlantic Canada and to promote partnerships among health professions, other health-care providers, employers, regulators and governments. The project supports the definition of collaboration developed by Health Canada;

> *"Collaborative patient-centred practice is designed to promote the active participation of each discipline in providing quality patient care. It enhances patient and family-centred goals and values, provides mechanisms for continuous communication among care givers, optimizes staff participation in clinical decision making (within and across disciplines), and fosters respect for the contributions of all disciplines."*

The outcome is anticipated to be transferable models that promote high quality care by optimizing the knowledge and skills of all members of the health care team, while enhancing work life satisfaction, recruitment and retention. Over time, the sites will serve as centres of excellence. They will provide learning tools, resources, processes and models to facilitate replication of the successful interprofessional competency development and change management processes which support both post-licensure continuing education activities. It will also provide high quality clinical placements for students in a number of health disciplines. It is hoped that through future clinical placements budding health care practitioners will experience as the norm, the process and behaviours that promote collaborative practice.

Progress Reporting

This report is an update of CLE Progress Report 2, May 1 to July 31, 2010. Updated information is highlighted in blue. The complete report with updates provides a summary of activities on this project and highlights accomplishments and challenges for the second quarter of 2010-2011. The report is a compilation of brief monthly reports from leaders of the components of the CLE team. They are organized around the broad objectives of the workplan and support the progress reported against the work plan at the end of each quarter. Those components are:

1. Interprofessional Education (IPE)
2. Change Management, (CM)
3. Knowledge Transfer (KT) and Communications
4. Process Evaluation, and
5. Project Management and Support

The following narrative reports are organized so as to parallel the overall workplan categories and supplements the information reported on end of quarter CLE workplan progress reports. (Appendix A.1)

Progress to Date

Overview

Since July 1, 2010, the CLE Project Implementation and Evaluation Teams have been diligently working toward project goals and objectives. During the second quarter of 2010-2011, a number of activities have been undertaken to support the CLE initiative across the Region. As of September 30, 2010, there are five identified sites:

- 2 sites at St Martha's Hospital, a facility of the Guysborough Antigonish Straight Health Authority (GASHA) in Antigonish, Nova Scotia. http://www.erhb.ns.ca/Services/St_Martha/.
- Captain William Jackman Memorial Hospital Located in Labrador City West, a facility of the Labrador-Grenfell Regional Health Authority, in Newfoundland and Labrador; http://www.lghealth.ca
- Two Victorian Order of Nurses (VON) New Brunswick, "Health Baby and Me" program http://www.von.ca/branch/nb.html sites in Miramichi City and a second site yet to be identified by VON.

Government Advisory Committees are either established or under development in all four provinces. The Advisory Committees in PEI and New Brunswick are reviewing reports of developments of the CLE Project (Departments of Health in those two provinces are unable to support implementation sites at provincial Health Authorities at this time). Lines of communication for knowledge transfer have been established.

Partnership Agreements (PAs) with participating sites have either been signed or are in process of being signed. The NS site is complete; the NL site PA is drafted; a PA for VON NB is pending ethics review of the project by VON Canada. NS and NL have identified clinical leads and site champions have been identified.

In NS, an initial survey assessed readiness for IP learning of clinicians and administrators in the Low Risk Obstetrical clinic. In addition, the Civility Respect and Engagement in the Workplace (CREW) program completed an assessment of the team skills of the site staff.

For the NL site, CLE staff developed and delivered a presentation on CLE to NL government representatives and administrators at the Labrador City facility. Staff also met clinicians at Captain William Jackman Memorial Hospital and

reviewed team based delivery of health services as well as IP benefits. Staff sent to clinicians a learning readiness survey.

CLE clinical Forms are in place and integrated with other work at NS site. Standard patient information and consents are being used at the site. It is planned that NL will adopt similar forms including the clinical call schedule for shared care.

Ethics approval has been received for the NS site. In NL the ethics review is in process and in NB, it has been deemed by VON Canada ethics that no review is required until the results of the needs analysis and the intervention plan is complete.

Medium and long-term outcomes for the CLE project have been discussed with the Western and Northern HHR Forum (WNF) and the Atlantic Advisory Committee on HHR (AACHHR). WNF and AACHHR are currently working on the evaluation framework. An outcomes evaluation/framework meeting was held in BC in June 2010.

Project presentations have been made for a number of stakeholders including: the Midwifery Regulatory Council in NS, teleconference presentations in NL and the WNF. Letters have been sent to numerous professional and regulatory bodies throughout Atlantic Canada offering information and/or a presentation about the CLE. Follow up letters will be sent.

Identification of Competency and Interprofessional Learning (IPE)

Report 2: Sept 30, 2010 **Summary Progress Report**

To: CLE Implementation Team

From: Janet Davies and Kelly McKnight

Subject: Interprofessional Education

Objective: Design and assess methodologies for enhancing clinicians' competencies to support the inter-professional delivery of health-care providers.

Deliverable: Observational reports and research results

Activities:

- Delivery of education activities for CLE clarified at meeting with CREW staff; CREW system includes tools to support the development of inter-personal communications skills within a team. The tools focus on building 'respect' and 'civility' among team members, whose backgrounds (read professions) and priorities may be different.
- A CLE Project Implementation Framework (Appendix B.1) and
- The CLE Implementation Team has identified a protocol for data collection. (Appendix B.2)
- Collaborative Practice Assessment Tool (CPAT) chosen as the measurement tool
  (Appendix B.3)
- Permission gained from the Office of Interprofessional Education and Practice at Queens University to utilize the tool for the CLE Project.
- Data collection tool with guiding criteria for the research associate approved. (Appendix B.4)

- An initial meeting and needs analysis was completed with the Advisory Committee for the "Healthy Baby and Me" program at Miramichi, NB. Preliminary feedback indicates a perceived need for change management and conflict management programs. Analysis is underway to identify content and best delivery modes for IPE activities.
- During the same period, work on IPE involved identification and assessment of self-directed training materials in terms of their application to the needs of clinicians and administrative staff in both Labrador and Miramichi.

Upcoming Tasks:

- Training of Research Associate on data collection tool;
- Observational recording of team meetings at GASHA;
- Transfer of model to new sites;
- Preliminary analysis of observational recordings.
- Choosing or designing learning modules ad modes of delivery for Labrador and Miramichi.

Issues:

- Decisions around implementation of second VON site in New Brunswick.

Change Management, (CM)

Report 2: July 31, 2010 **Summary Progress Report**

To: CLE Implementation Team

From: Janet Everest and Janet Davies

Subject: Change Management

Objective: Describe change management processes needed to support, and resource implications of, inter-professional collaboration at each site.

Deliverable: Change Management Process

Activities:

- Analysis of findings of IP readiness Survey of clinicians and administrative staff at St Martha's, NS;
- Draft Change management framework designed (Appendix C.1)
- CREW program identified as vehicle to support IP skills development at NS site;

  A sample team profile for CREW is found in Appendix C.2
- Presentation of CREW to Administrative TEAM, St. Martha's hospital;
- MoreOB program identified as vehicle to deliver change management skills enhancement to staff at GASHA site. Appendix A
- Initial meeting with St. Martha's Hospital Leadership and Erika d'eon CREW lead COR&D to discuss target participant group, facilitator and process. (Aug 10). Facilitator identified as Debbie Cotton, Dr. Hillyard co-facilitator.
- Target group identified as Senior Leaders, Midwifery Implementation Committee
- Facilitator Training and Activity Plan discussed. Facilitator Training commenced. Meeting between D. Cotton and Erika d'eon, crew lead for

- COR&D in September at Acadia. D. Cotton participated in the CREW midpoint meeting September 16th. Backup facilitator identified and orientation with D. Cotton commenced. (September)
- Electronic distribution of survey including clinical team August 5, 2010
- Deadline extended from August 13th to unknown pending ethics approval
- As of September 30 responses received, 4 were administrative staff.

Upcoming Tasks

- Full Implementation of CREW at GASHA;
- Monitoring and reporting on progress;
- Introduction of CREW program in NL site.

Issues:

- Clarifying the perimeters of the Senior Leadership Group not Clinical Staff as participants.
- Frequency of meeting schedule (every two months) and attendance could be an issue.
- Development of 6-month activity plan still in progress.
- Weekly teleconferences with COR&D Lead for support/updates.
- Jan Hanifen, Nurse Manager has championed the CREW project as lead in survey distribution and monitoring.

Knowledge Transfer (KT) and Communications

Report 2: September 30, 2010 Summary Progress Report

To: CLE Implementation Team

From: Janet Davies

Subject: Summary Progress Report, KT and Communications

Objective: To inform government, and health care providers/ communities of the IP project

Deliverable: Standardized presentation and letters to discuss IP competencies and learning tools

Activities:

- Letters sent to the CEOs of various professional colleges and associations of health professions in NS, NB, PE and NL;
- Standard slide show utilized in follow-up meetings and presentations carried out with the Midwifery Regulatory Council in NS, teleconference presentations in NL and with the WNF working group for Evaluation Framework;
- Met with PEI government. PEI government is unable to support the identification of a site before March 2011.
- Met with VON NB. VON proposed CLE consider working with its program for vulnerable moms and moms-to-be; it identified two teams serving a bilingual population.
- A presentation was made to the Healthy Baby and Me Advisory Committee in Miramichi
- Awaiting identification of a second site in New Brunswick by VON NB.

Development of Evaluation

Report 2: July 31, 2010 **Summary**

Progress Report

To: CLE Implementation Team

From: Pat Saunders & Andrea Patchett

Subject: Summary Progress Report, Physician Pilot Evaluation

Deliverable: Process evaluation of CLE Pilot site: St. Martha's, GASHA. Model to be shared with Western Forum and transferred to other CLE project sites as they are identified.

Activities:

- Finalized process evaluation model;
- Meeting with evaluation team to review evaluation data collection plans;
- Finalized data collection tools for collection of Presage/contextual data at NS site;
- Developed ethics submission for NS site;
- Began work on ethics submissions for NB/VON and NL sites;
- Reviewed Western Forum evaluation plan for consistency with our plan- will make some minor revisions to our evaluation plan to mesh with theirs;
- Began scheduling interviews for collection of Presage/contextual site data at NS site.
- July, 2010. Modified service delivery documents for NFL ethics submission. Also, modified service delivery documents for GASHA ethics resubmission

- Ethics submission for NFL completed and delivered to NFL ethics contact. Completed ethics resubmission for GASHA including providing information stemming from questions from ethics committee, and resubmitted to GASHA ethics contact.
- Ongoing -Collection of Presage/contextual information. Met with key informant Rebecca Attenborough at RCP.
- Work on developing logic model for Process evaluation that meshes with WNF
- Outlined rationale for continuing CLE Process Evaluation beyond the pilot period

Upcoming Tasks:

- Results of the Ethics submission from the Ethics Review Board at St. Martha's has been received and revisions are being made to provide clarifications as requested;
- NL and VON Ethics applications will be submitted by August 27, 2010;
- Collection of baseline and context data for each site will begin when respective ethics approvals are granted.
- Phase 2 of NL project will need to submitted
- Once initial needs assessment and IP plan has been determined
- Review NB/VON project plans and submit PHASE 2 activities to VON Ethics CMT if necessary
- Complete collection of Presage/
- contextual information for GASHA site
- Collect Presage/contextual information for NL site as soon as Ethics Approval has been granted
- Review data collection needs for NB/VON sites.

- Review WNF evaluation models and CLE Models with CLE Evaluation team.

Issues:

- Time constraints

Project Management/ Clinical Applications[1]

Report 2: July 31, 2010 **Summary**

Progress Report

To: CLE Implementation Team

From: Jennifer Murdoch & June MacDonald

Objective: Project Management and Clinical Applications for CLE

Deliverables: Overall project coordination, site development, time and cost management; quality management; team communication; human resources management; procurement management; risk management.

Activities:

- The project team activities have been supported;
- Experts have implemented approaches that address the four major project areas: IP Education; Change Management; Service Delivery and Evaluation;
- Administrative processes have supported the project team;
- Regular Implementation and Evaluation team meetings have been booked, facilitated and minutes and records of decisions disseminated and archived;
- Work is almost completed on a CLE web communication area that will include: a calendar, document publishing and archiving and forum posting areas, www.price-macdonald.com Login, CLE;
- A draft service agreement is prepared for review by Labrador West and a contract is under preparation for VON NB;
- Coordination and Communication activities with sites have been on-going

[1] Project management and clinical applications more accurately reflects the work of PMA and J. Murdoch as project leader.

- Review and adjust tools/resources as needed.
- Updates and changes for the MoreOB program received. Appendix A.1.
- Project leader assisted to revised GASHA Ethics to meet with committees comments.
- Revised clinical forms to align with existing forms at GASHA.
- Visited the William Jackman Memorial Hospital site in Labrador.
- Met with clinicians, submitted ethics., obtained letterd of support.

Upcoming Tasks:

- Continue to support the project team in carrying out the activities of the project in all sites, including such administrative activities as: meeting management, team communication management, document tracking and archiving, progress reporting and presentations for AACHHR and Health Canada, cashflow tracking and preparation, translation, travel, payroll, purchasing, etc.

Issues:

- Short time lines around the facilitation of support and communications for inclusion of new sites in NL and NB.
- Time requirements for site development in NL and NB.

Summary

Although initially off to a slow start, initiative by program staff has supported the progress of the CLE project along the projected timelines to completion. All sites are anticipated to be operational and in various stages of development and evaluation by the end of September 2010. Objectives slated for completion by September 30, 2010 either are completed or in stages of progress toward the goals, a workplan report is included in Appendix B .1.

Appendix

A.1: More OB

The 1st of September 2010.

Dear Jennifer:

Report, MORE^{OB} Activity.

We are pleased to provide you with this report about the MORE^{OB} / AMPRO^{OB} Program (these comments apply equally to the Advancing with MORE^{OB} / Avancer avec AMPRO^{OB} Programs as well).

The MORE^{OB} / AMPRO^{OB} Program is a comprehensive patient safety improvement, and professional development program for caregivers and administrators in obstetrical units offered in two languages. Initially created by the SOGC in 2001 - 2002. The goals of the Program are:

•Apply a shared, current, evidence-based body of knowledge in practice.
•Perform fundamental skills confidently and automatically.
•Manage emergencies in an automatic and well-coordinated fashion.
•Use interprofessional collaborative teamwork and communication practices in partnership with patients and families to enhance safe care.
•Evaluate processes and outcomes of clinical practice and organizational systems through interprofessional reflective learning methods.
•Maintain vigilance in order to anticipate and mitigate potential safety risks.
•Modify care practices and organizational systems to reduce safety risks and prevent harm.

In the last 18 months, the program has seen significant growth and recognition. The program has expanded to include over 200 hospitals. We crossed the 10,000th participant mark in the first half of 2010. It is estimated that over 80% of births in Canada occur in a facility that has been exposed to the Program.

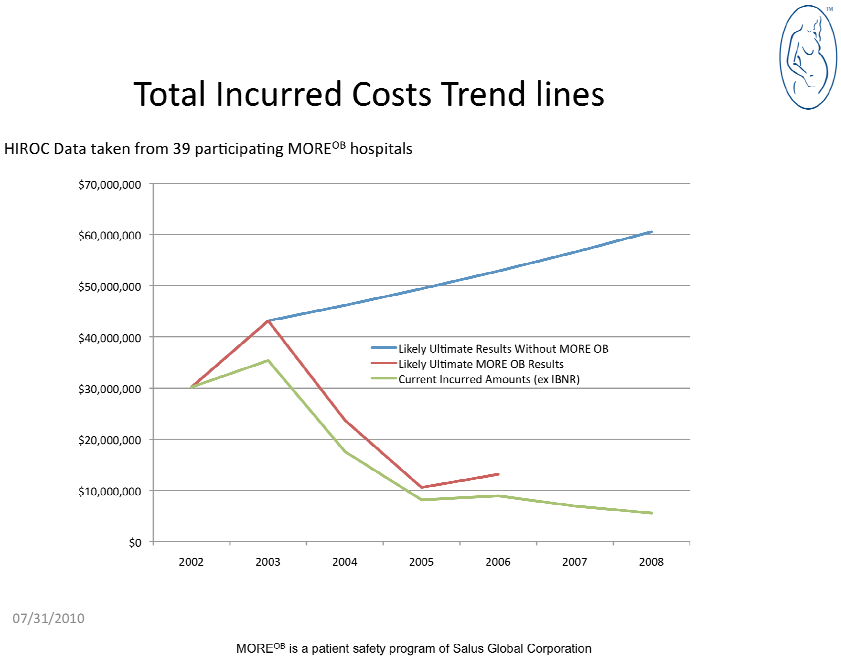
We have expanded The MORE^{OB} Program's American version into the United States. The Program has recently been implemented at 4 new US sites. As a result, we are currently seeking accreditation for our colleagues through the AAFP. We are endorsed by the Canadian Association of Midwives and accredited and supported by ACOG, in addition to the RCPSC and CFPC.

The Program has caught international interest and is being examined for possible adoption in several other countries.

The Program has enjoyed positive critical appraisal as has been demonstrated by an independent review in the JOGC, August 2010, and a favourable editorial in the same edition. In addition, our Culture Assessment Survey methodology has also been published recently (June 2010 edition of

the JOGC). Our Program and its impact was published in Risques et Qualité, 2009, volume VI, N°3; as well as taking up the whole supplement of the Journal des acteurs de la gestion des risques médicaux en établissement de santé, avril-mai 2009, N°7.

We continue to be privy to very useful legal information about the impact of the Program from one of our parent companies: HIROC. The following is a graph, created by their actuaries, speaks for itself.



Salus Global Corporation has partnered with research groups studying the impact of different tools within the Program on the future training and delivery in obstetrical care, as well as other projects on the go.

<u>Updates to the Program</u>

A valued tool of the Program is the robust and relevant up-to-date Clinical Content. The process to keep the Content current begins with the interdisciplinary Obstetric Content Review Committee of the SOGC. This yearly update, to our knowledge unique to any Professional Organisation anywhere, reviews the world literature and triggers an update to the Chapters and all of the tools and materials (Emergency Drills, Decision Trees, Workshops and OSCEs, multiple choice examinations, etc..). The committee is guided in part by the feedback of the participants through the Chapter Feedback Mechanism. Listening to the recommendations of participants, a new clinical chapter has also been added (Imminent Birth).

The platform has also been updated to include tools to assist the Core Team in managing the Program at their site based on their identified needs. Again, the aim of the Program is not to do more work, but to work differently and more efficiently. For example, the ability to develop quality reflective learning by an effective audit process has been facilitated. Personal Audit Tools

have always been present, but Unit Audit form generation, to answer issues specific to the unit, has been automated.

In a further attempt to further capitalize on valuable reflective learning, recommendations from Unit Audits are instantly stored and accessible to all Participants to view, closing that "feedback loop". Further, Personal Learning Projects methodology has been facilitated based, in part, on the excellent feedback from participants.

To work toward a culture where everything is debriefed, we have facilitated routine debriefing by adding debriefing tools to Emergency Drill Scenarios.

A further improvement in Emergency Drills is the addition of two new Emergency Drills: Imminent Birth, Amniotic Fluid Embolus. In 2010-2011 we will be adding Ruptured Uterus and Crash Section. Further, we are developing a series of "add on" Emergency Drills based on the current NRP protocols. These in short will take teams interested through the possibility of adding to that "difficult delivery" drill a "difficult resuscitation" drill. The goal is to have the whole team at a much higher level of functional preparedness. Just this last year an article illustrated what we all already knew, 6 months out of a traditional training program the knowledge has, to all intense and purposes, disappeared. We have shown through the use of interdisciplinary exercises the ability to maintain and in some cases increase knowledge over time. Others, as well as ourselves, have shown improved readiness and preparedness by the use of Emergency Drills. We anticipate that the team will become much more effective and prepared for infant resuscitation with the use of regular Neonatal Resuscitation Emergency Drills. This is a logical assumption, since their performance in OB emergencies have improved dramatically. Imagine their comfort level the next time they will need to recert for NRP!

We hope that these improvements meet with your approval. We believe that the program is neither static nor resting on its laurels, but continuing to challenge itself and the traditional definition of Continuing Education. Scholarly articles are now alluding to a clear relationship between a Culture of Patient Safety approach and improved outcomes, be they maternal or infant or even in healthcare utilization (yes, cost savings!). Along with this, we see clear improvements in quality of life and reduction of stress at work. We could assume that this would bring less stress home and ultimately improve the longevity of our careers. We continue to believe that our comprehensive approach, involving the whole team, is the future of quality patient care.

We sincerely thank you in your continuing support of our programs.

Respectfully submitted,

P. James A. Ruiter, MD.
Manager Obstetrical Patient Safety Programs,
Salus Global Corporation.
Safety Performance Solutions.
jruiter@salusgc.com
226 268 4551.

Appendix A

A.2 Workplan Report Q2, 2010-2011

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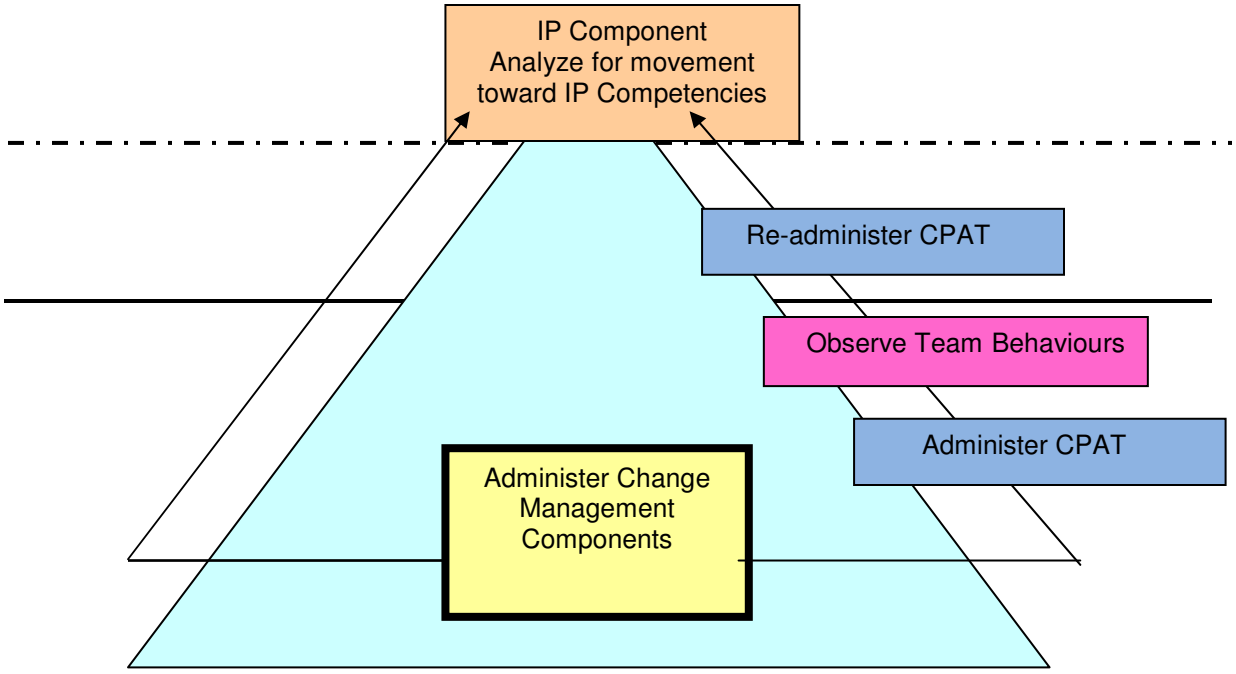
Appendix B

B.1 Sample Site Implementation Map for CLE



Change Management Components:

1. Therapeutic – i.e. CREW
2. Practical – i.e. MOReOB and Service Delivery
3. Physical – i.e. Administrative Support

Process:

- CPAT tool will be administered;
- The 3 Change Management pieces are interventions to develop an enhanced IP team;
- CREW, MOReOB and Service Delivery will all collect information throughout the project;
- 2 times a month approximately, an observer will use the IP Collection Tools to document and tract observable IP behaviours;
- At the end of the project, these documentations will be analyzed in concert with the documentation collected from the Change Management pieces;
- CPAT Tool will be re-administered;
- Results will be compared to initial test and analyzed for change;
- Recommendations will be generated for the final report.

B.2 Interprofessional Education Protocol

PROJECT: AACHHR COLLABORATIVE LEARNING ENVIRONMENT PROJECT

COMPONENT: INTERPROFESSIONAL EDUCATION

Part 1: Needs Assessment:

The clinical team will complete the Readiness for Inter-professional Learning (RIPL) survey and results will be combined to assess current levels of Inter-professional competencies.

The RIPL was developed to assess readiness for learning and has been used primarily in educational settings.

The aim is to help teams and researchers identify interprofessional development needs and corresponding educational interventions.

Results will be aggregated to create an understanding of overall team functioning as well as to protect anonymity.

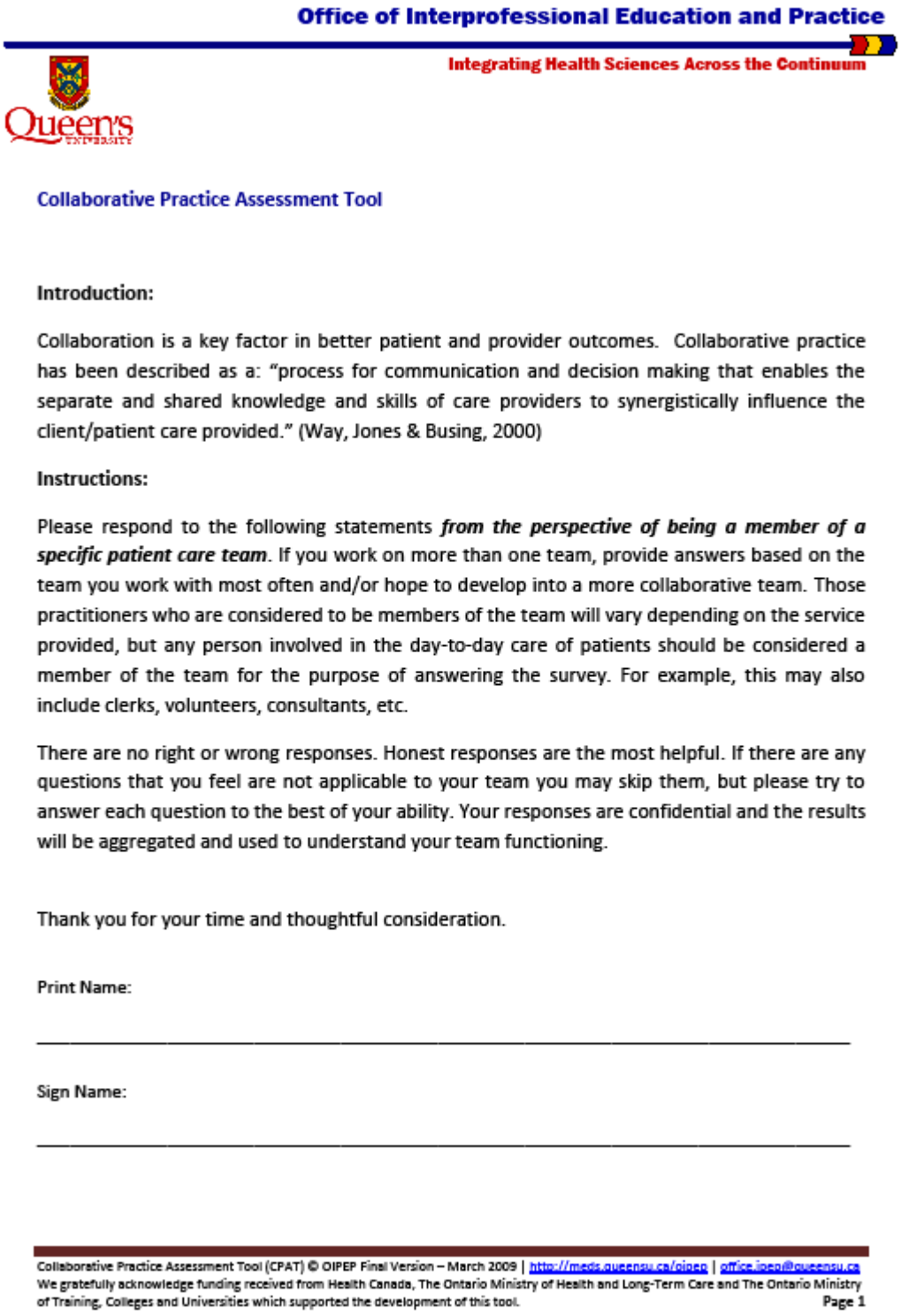
Part II: Team Observation:

CLE Researchers will observe clinical meetings and notate the findings on a chart that is comprised of 11 overarching statements. They include:

1. The particular skills and expertise of individual members are acknowledged by others on team;
2. With regard to each patient care plan, team members are clear about who is responsible for delivering which aspects ;
3. Team member s share responsibility for logistics and discussions of team meetings (chairing, creating agenda, recording decisions, facilitating participation);
4. Team members include the patient/client and family in decisions about care plan;
5. Team members advocate for the patient/client;
6. Each team member shares accountability for team decisions and outcomes;
7. Team members communicate the results of their analysis of patient and provide their expertise;
8. Conflicts are addressed directly during the meetings;
9. All members of the team attend team meetings regularly;
10. All members of the team participate in discussions at team meetings;
11. Team interaction exhibits inter-personal respect.

These overarching statements are in turn linked to the Interprofessional Facilitator Competencies that have been developed by CIHC.

B.3 CPAT Tool



Office of Interprofessional Education and Practice

Integrating Health Sciences Across the Continuum

Queen's University

Collaborative Practice Assessment Tool

Introduction:

Collaboration is a key factor in better patient and provider outcomes. Collaborative practice has been described as a: "process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided." (Way, Jones & Busing, 2000)

Instructions:

Please respond to the following statements ***from the perspective of being a member of a specific patient care team***. If you work on more than one team, provide answers based on the team you work with most often and/or hope to develop into a more collaborative team. Those practitioners who are considered to be members of the team will vary depending on the service provided, but any person involved in the day-to-day care of patients should be considered a member of the team for the purpose of answering the survey. For example, this may also include clerks, volunteers, consultants, etc.

There are no right or wrong responses. Honest responses are the most helpful. If there are any questions that you feel are not applicable to your team you may skip them, but please try to answer each question to the best of your ability. Your responses are confidential and the results will be aggregated and used to understand your team functioning.

Thank you for your time and thoughtful consideration.

Print Name:

_____

Sign Name:

_____

Collaborative Practice Assessment Tool (CPAT) © OIPEP Final Version – March 2009 | http://meds.queensu.ca/oipep | office.oipep@queensu.ca

We gratefully acknowledge funding received from Health Canada, The Ontario Ministry of Health and Long-Term Care and The Ontario Ministry of Training, Colleges and Universities which supported the development of this tool. Page 1

B.4 IPE Data Collection Tools

IP Team Behaviours	Yes	No	Comments
1. The particular skills and expertise of individual members are acknowledged by others on team			
2. With regard to each patient care plan, team members are clear about who is responsible for delivering which aspects			
3. Team members share responsibility for logistics and discussions of team meetings (chairing, creating agenda, recording decisions, facilitating participation).			

4. Team members include the patient/client and family in decisions about care plan	**Yes**	**No**	**Comments**
5. Team members advocate for the patient/client			
6. Each team member shares accountability for team decisions and outcomes			
7. Team members communicate the results of their analysis of patient and provide their expertise			
8. Conflicts are addressed directly during the	**Yes**	**No**	**Comments**

meetings			
9. All members of the team attend team meetings regularly			
10. All members of the team participate in discussions at team meetings			
11. Team interaction exhibits inter-personal respect			

Partners for Interprofessional Cancer Education

Interprofessional Facilitator Competencies

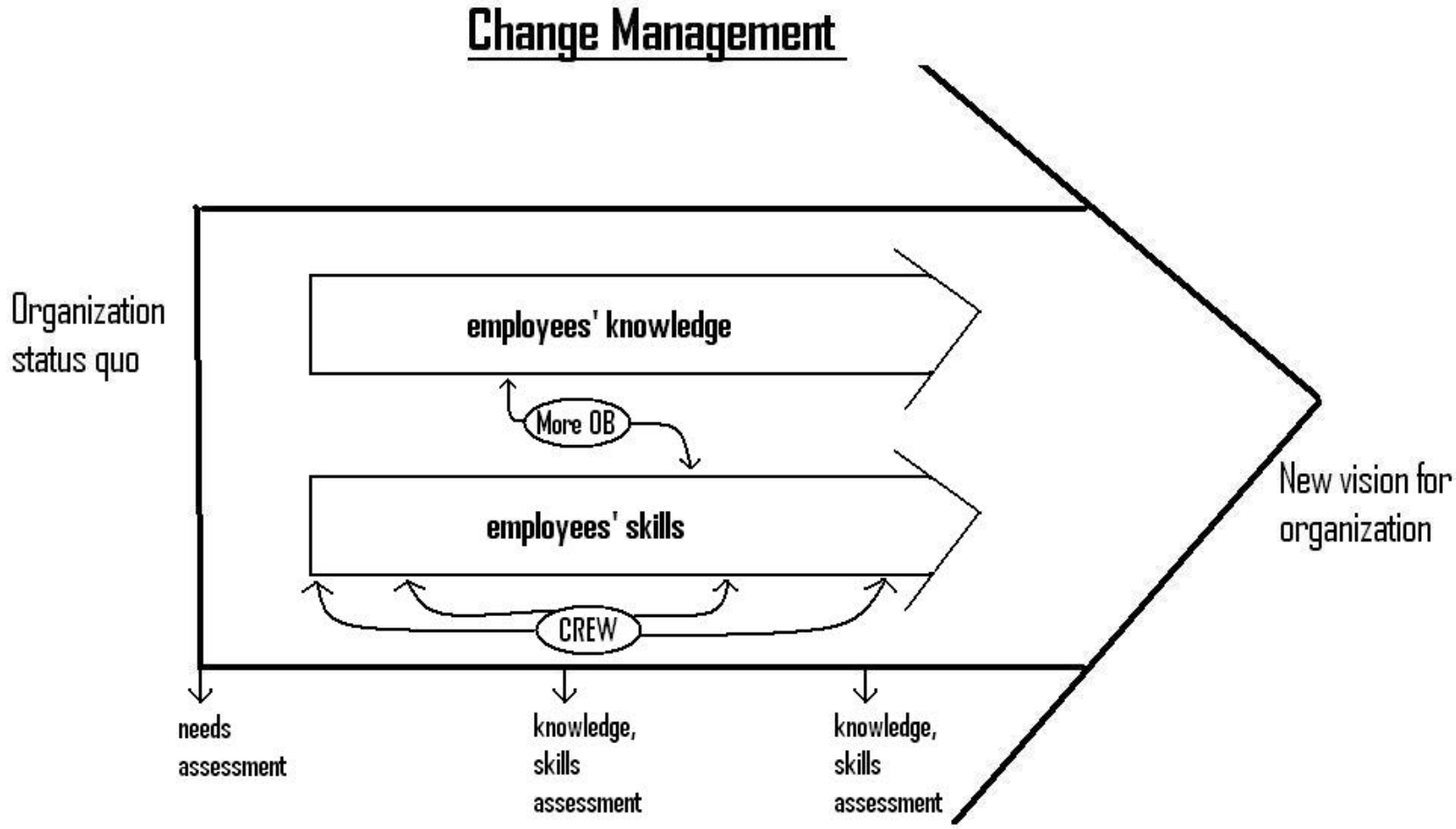
COMPETENCY DOCUMENT

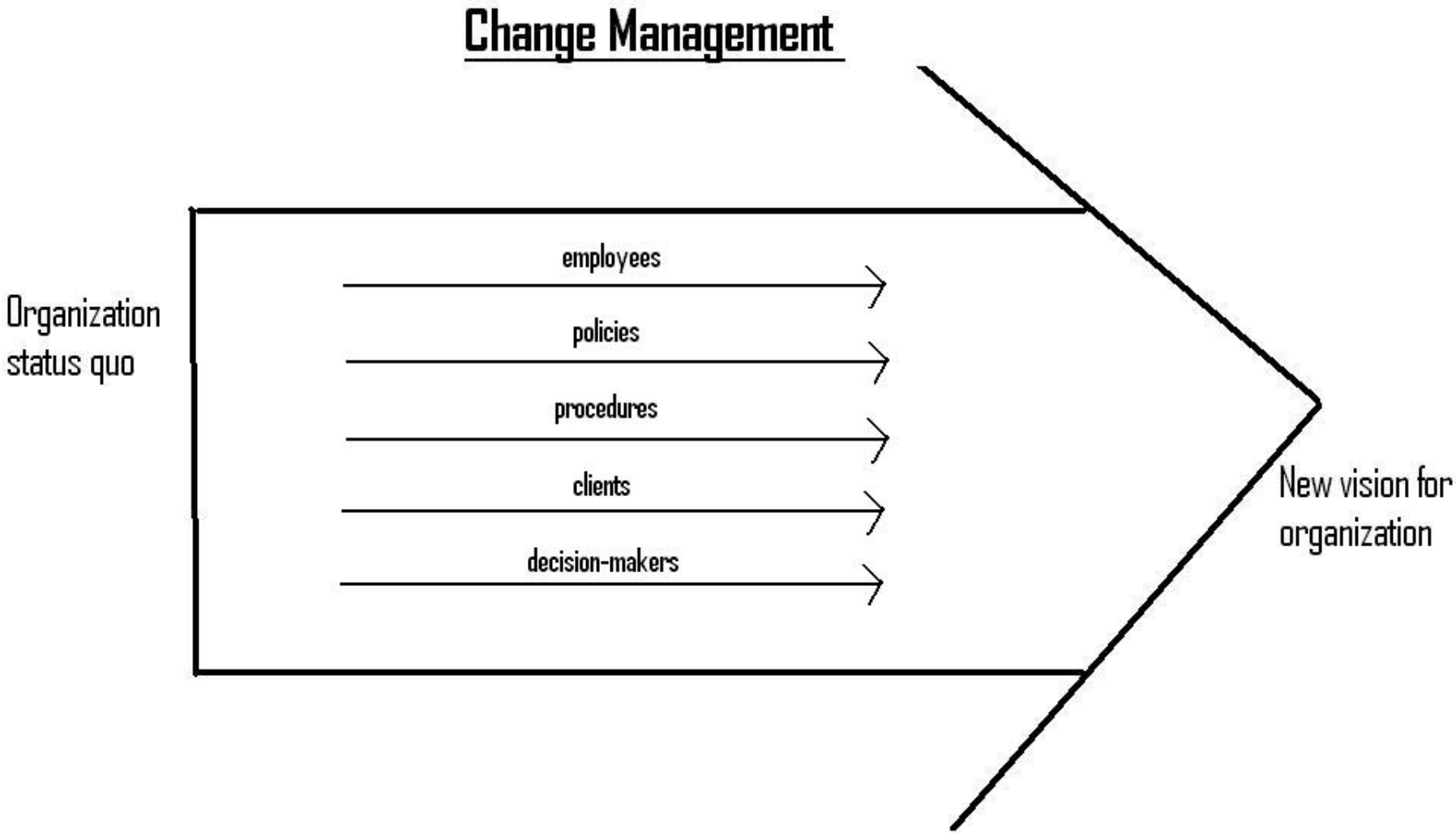
These competencies have been developed for health professionals who, as a portion of their practice, care for patients/families experiencing cancer and who want to take an active role in fostering interprofessional collaboration. The Interprofessional Facilitator Development workshop, facilitation of the Interprofessional Core Curriculum (ICC) modules and clinical practice will provide the opportunities for participants to achieve the proficiency level of Advanced Beginner. An Advanced Beginner has the required knowledge, skills and prior exposure/experience required for the performance of the three competency areas: Interprofessional Facilitation, Collaborative Patient-Centred Practice, and Cultural Sensitivity and Safety.

When confronted with changing design and/or delivery of the ICC modules and/or difficulty with a competency, the Advanced Beginner will manage these challenges through reflection, discussion with colleagues and/or consultation with program developers/project manager.

Authors: Valerie Banfield & Kelly Lackie, Faculty RN-PDC

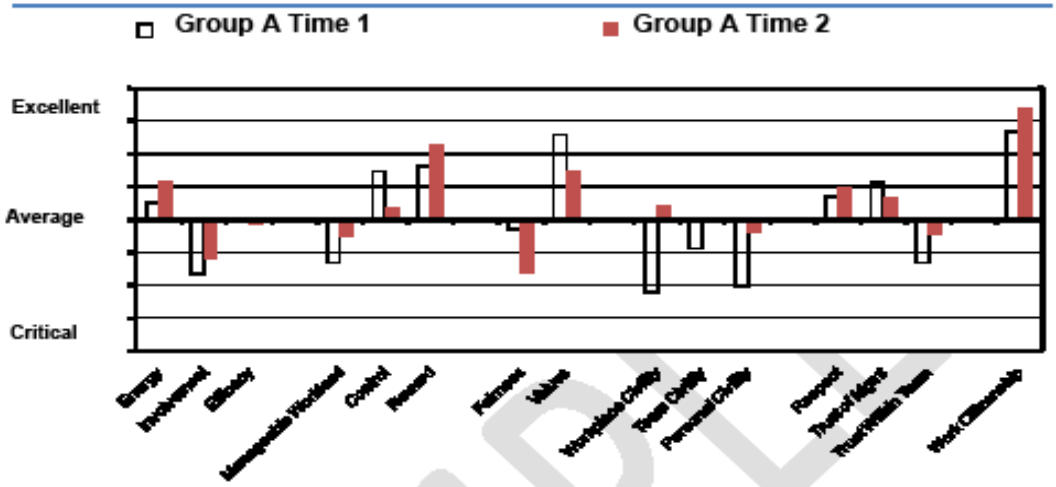
Appendix C C.1: Draft Change Management




Change Management
Organization status quo
employees
policies
procedures
clients
decision-makers
New vision for organization

C. 2 CREW Profile Unit

Unit Profile



Number of Responses: XX;
Percent Return: XX%

Key

- The bars on this graph represent the *unit's* profile.
- The first eight values (***energy, involvement, efficacy, manageable workload, control, reward, fairness,*** and ***values***) are compared to a midline, called "Average" on the graph, which represents an international average.
- The last seven values on the graph (***workplace civility, team civility, personal civility, respect, trust of management, trust within team,*** and ***work citizenship***) are also compared to a midline, referred to as "Average" on the graph, which represents the average of all of the participants in this study.

This profile shows a unit whose workplace community has improved considerably during the past six months. Hard work of the participants has paid off with improvements in their overall scores. Congratulations to all to have contributed to this hard earned success.

Special attention should be paid to ***Workplace Civility***, ***Team Civility***, and ***Personal Civility***; all of the improvements made in these areas indicate growing awareness of civility in the work community. The members of this unit have certainly benefitted from a civility intervention to enhance the quality of their workplace relationships and improve work engagement. Continued efforts in this area should yield even more positive results.

Some areas remain in negative range: ***Fairness*** may require attention in the future.

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