Robert Bosch Stiftung

Improving Patient Care through Teamwork

Handbook for Tutors on Interprofessional Training Wards

Beat Sottas – On behalf of the Robert Bosch Stiftung

Contents

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Foreword

Experience has shown that effective interprofessional collaboration is not something that occurs organically, but rather requires preparation and guidance. From initial to advanced vocational training and academic education, all health care professionals must acquire the competencies needed to prepare them to work effectively in teams of different specialists, allowing a collaborative approach in care to develop. When working within an interprofessional team, they need to learn to affirm their own specific competencies, as well as to recognize the importance of, and take advantage of, collaborations that involve other professional competencies. Interprofessional Education (IPE) is therefore a key prerequisite for Interprofessional Practice (IPP) or Interprofessional Collaborative Practice (IPCP).

Fortunately, the idea of improving interprofessional training has recently been widely discussed and accepted across German-speaking countries. Much has been done to advance the development of interprofessional teaching formats in medical schools, as well as in training programs and study courses for nursing and therapeutic professions. Numerous projects have been launched and a variety of approaches have been tested and evaluated for how to best design the teaching units in terms of content, methods and didactics, and structure. In addition, a new format for interprofessional training wards, based on the Swedish model (a model developed in the 1970s in Linköping, usually abbreviated here as ITW) has been successfully introduced in Germany and has met with a great deal of approval, among both teachers as well as students and trainees.

This development marks an important transformational stage in overcoming mono-professional training and socialization patterns, something that has been clearly demonstrated. What is more, it is vital that tutors, students, and trainees are offered the best possible environment, tools, and guidance.

The Robert Bosch Stiftung is committed to ensuring that all the valuable insights gained from the projects it supports are made available to all interested parties. The same is true for the many workshops and networking events, as well as international study visits. This handbook is based on the “Practical Guide Interprofessional Training Wards”, published in 2018 with the aim of creating a methodological tool for tutors on interprofessional training wards.

This handbook was developed by the above-mentioned authors over the course of many in-depth workshops and discussion groups with Swedish experts as part of a study visit to Stockholm in November 2019. It summarizes the authors’ practical experience of working on ITWs in Germany as well as ideas inspired by the Stockholm study visit.

Our thanks must go to all the participating authors who graciously shared their knowledge and expertise. The chapters are not designated by author because key additions and connections were made in collaborative, peer-review groups.

Experience has shown that certain questions tend to come up in training and continuing professional education. So as to improve readability, the contributions have been arranged in such a way that the questions are separated into clear chapters. We have also added a toolbox to each chapter summarizing the key points. We sincerely hope this handbook proves to be a great help for tutors.

Beat Sottas, PhD
formative works

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Improving through Teamwork

Tutors Facilitate Interprofessional Competency Acquisition

Since the 1970s[1], it has been postulated that there is a need to not solely rely on one's own professional expertise but also harness the potential held by other professions by means of interprofessional collaboration.

For over 40 years now, it has been known that 80 % of mistakes in treatment are caused by poor communication, pigeonholing, a disregard for those from other professions, or hierarchical claims.

Comparing systems internationally expounds the difficulty in establishing interprofessional education and collaboration universally. Cultural and sociological patterns can have an equally beneficial or detrimental effect. Challenges and success factors can be presented as follows:

German model Master/capacity principle	Anglo-Saxon model Innovation/competition	Scandinavian model Social welfare
Apprentice, novice ⟶ master (superior) Lead in knowledge and skills Professional status Skills and capabilities Reserved activities	Identify opportunities Knowledge and status less formal Trial and error Courage to make a leap of faith Ability to convince	Coverage/health for all Egalitarian – not much of a status mindset Profile, not profession Talking to one another Team performance
Authority ⟶ hierarchy (The superior is always right)	Authority ⟶ entrepreneurship (Justified by success)	Authority ⟶ capacity for integration (Successful case management)
Corporatism (guild mindset): protecting economic interests	Forge alliances Defeat competitors	Ability to cooperate Welfare state model
"Therapeutic relationship" My patient and I Individual therapeutic approach	"Patient assets" Health as a commodity Gain market share	"Action-based community" Health as a societal asset Interface management

Table 1. Patterns and stereotypes in a simplified system comparison
Source: Sottas, own research

Fragmentation and mutual delineation are at odds with the real-life practice of care, which is increasingly being provided in teams owing to the growing complexity of therapies, as well as the cross-professional and cross-sectoral processes required.

In preparation for trainees' future work life, education also has a duty to provide solutions that cater to these changes. As such, interprofessional education and advanced training are effective strategic options for preparing health care professionals for the different types of collaboration needed from day to day (Reeves et al. 2017), for giving them an awareness of crucial points, and for establishing a collaborative mindset among health care professionals.

Compelling evidence from many countries substantiates the need for training to be, at least in part, interprofessional. Interprofessional teaching and learning is increasingly recognized as a success factor for effective, efficient, safe, and sustainable health care (e. g. WHO 2010, Schot et al. 2019).

Additionally, the new draft of the medical licensing regulations for Germany places a special focus on interprofessional education as a vehicle for improving future interprofessional collaboration.

What stands in the way of rapid and effective implementation is the fact that teaching and learning is primarily designed and organized mono-professionally. This is particularly true in Germany, as a result of narrowly conceived professional responsibilities. The predetermined end point is solely based on profession-specific competencies. Shared, and above all, interprofessional competencies rarely, if ever, form part of the learning process. Successful interprofessionalism, however, is essentially based on what is known as "collaborative competencies":

[1] OECD and WHO 1975, Paris Conference on Health Universities, see Sottas et al. 2013

Profession-specific competencies	Knowledge, skills, and capabilities which are individually imparted across each occupational group and which constitute the core and/or expertise of the profession and define professional action in the narrower sense. Creating methodological skills and identity so that clarity about roles can develop in the first place. **Complementary competencies** identify and acknowledge the diversity of roles, tasks, and skills (what's learnt during training)
Shared competencies	Law, health care policy, economics, ethics, communications, documentation, research and evidence, quality management, self-determination rights, and patient participation or user focus **Decision-guiding knowledge** health care system competencies
Interprofessional skills	Principles of teamwork, organizing division of labor, interface management, appreciation, group dynamics and power, interprofessional conflict management, transfer of knowledge into practice, process facilitation, cooperative leadership principles **Cooperation skills** (what's usually still not learnt in training)

Table 2. Typology of competencies
Source: Sottas, Kissmann, Brügger 2016; building on Barr 1998

However, interprofessional learning (with one another – from one another – about one another) is not a uniform concept, but one that manifests itself in a variety of different forms.

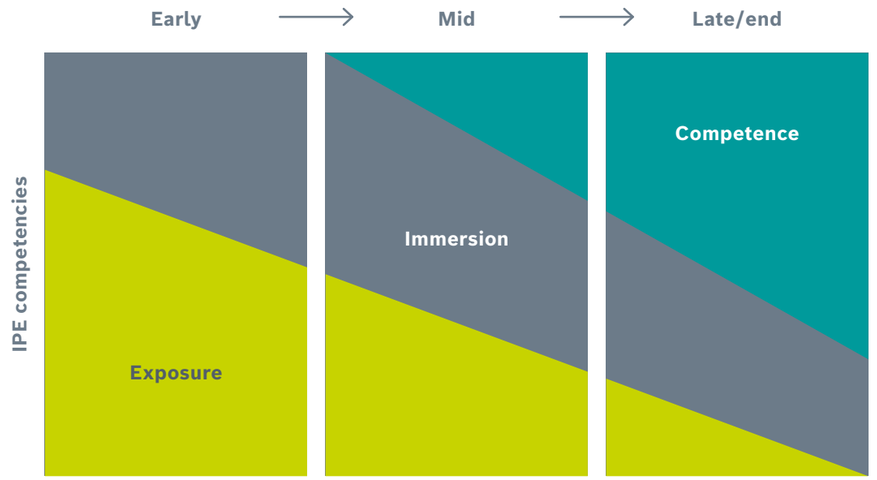
There are many different interdisciplinary and interprofessional teaching and learning formats which all have different goals and qualities:

Classification		Learning methods
6	**Practice-based learning**	Practical interprofessional exercises in a realistic future working environment
5	**Action-based learning**	Joint projects, problem-based learning, case-based learning, joint research
4	**Simulation-based learning**	(Long-lasting, complex) role plays, skills training, simulations using puppets or actors
3	**Observation-based learning**	Observe professional practice, shadow a professional's daily routine
2	**Exchange-based learning**	Debates, games, case discussions, problem-solving, seminars, workshops, improv role plays (classroom/seminar room)
1	**Theory-based learning**	Introductions, lectures on IPE concept and evidence; normative dimension, building awareness (rehearsal)

Table 3. Classification of interprofessional learning arrangements
Source: Sottas und Kissmann 2016

This classification scheme makes it clear that the demands on pedagogical and didactic preparation, and the resources required, increase from stage to stage. Education experts would state that learning arrangements become increasingly taxonomically complex with each vertical stage. Interprofessional training wards belong to type 6, i. e. they are among the most demanding learning formats.

To summarize, the success factors involved in interprofessional learning can be represented using the Canadian three-stage model by Charles/Bainbridge/Gilbert:



Three-stage model by Charles/Bainbridge/Gilbert 2010

1. **Time** is crucial: Interprofessional competencies are acquired gradually. Time is required for shared learning and reflection processes.

2. **Focus on the process:** Once is not enough: Interprofessional action requires more than singular exercises. The aim is an overall concept with different IPE activities and means of processing the learning experience.

3. **Scheduling:** Interprofessional learning should begin early on. In the early stages, contact and opportunities for interaction (getting to know one another, trust) that facilitate sharing and learning from and about one another are important. Joint decision-making in complex situations comes at a later stage (added value is experienced in real life).

4. **Emotional control:** Organize feelings and break down prejudices. Recognize attitudes toward 'us' and 'them'. Altering how other professions are perceived and valued. IPE-related outlook, values, and attitudes are regulated by emotions (reflection!).

Finding Good Tutors

IPANEO Munich [ITW in Neonatology], © Munich Hospital

Moving on from general, more strategic, and conceptual considerations, the following focuses on learning situations where tutors play a pivotal role. Many tutors have already gained a good deal of valuable experience in mono-professional settings. Learning is more demanding in the context of interprofessional education because it adds an additional layer of complexity, namely linking the objectives of one's own profession to those of other professions and pooling them to achieve better and more effective care. With a view to future challenges, the role of the tutor is a key success factor in learning and thus the quality of care.

Requirements and necessary competencies

In terms of suitability for the role of tutor on an interprofessional ward, tutors must meet the technical, socio-communicative and methodological requirements[2] listed below, and must identify with the core competencies of interprofessional collaboration (see Table 2).

Technical competencies.
Tutors should
- preferably have a professional background in health care (nursing, medicine, therapy, psychology, etc.);
- have relevant and robust experience in in-patient care;
- have completed advanced training/classes in practical instruction and medical education; and/or
- be willing to educate themselves further for the role of tutor.

Socio-communicative competencies.
Tutors are
- team-focused;
- empathetic;
- communicative;
- respectful and non-judgmental;
- open to new things;
- flexible;
- tolerant of differences, misunderstandings, and other points of view;
- able to deal with conflict and to work toward conflict resolution;
- structured;
- able to mediate between the experiences and perceptions of others;
- constructive in dealing with uncertainties;
- motivating.[3]

Methodological competencies.
Tutors are able to
- let processes unfold without intervening impulsively or correctively;
- design team- and patient-focused learning processes;
- guide and support learning groups in developing shared objectives and expectations;
- leave space for decision-making and independent problem-solving;
- observe learners in a structured manner;
- adequately utilize tools for evaluating how learning is progressing;
- plan, carry out, and evaluate learning objective tests;
- intervene decisively if patient safety is compromised; and
- reflect critically on their own 'teaching actions' and/or their tutoring.

[2] These requirements are derived from the European Qualifications Framework (EQF). This framework names three aspects: Knowledge, Skills, Responsibility & Autonomy, see https://ec.europa.eu/ploteus/fr/node/1440, The German Qualifications Framework (DQR) also names three aspects: technical competency, personal competency, and social competency. The Standing Conference of the Ministers of Education and Cultural Affairs of the Länder in the Federal Republic of Germany (KMK) adds methodological competency, communicative competency, and learning competency, which are designated as an integral component of technical competency, personal competency, and social competency. https://www.kmk.org/fileadmin/Dateien/veroeffentlichungen_beschluesse/2011/2011_09_23-GEP-Handreichung.pdf

[3] Sargeant et al. (2010) point to the importance of addressing hidden power structures, hierarchies, and stereotypes that may exist between professions.

Profile and attitudes

Identification.
Tutors identify with the internationally recommended core competencies of interprofessional collaboration. These differ from those used across mono-professional practice-based teaching.

An easy way to remember these is using the Canadian British Columbia Framework's criteria, which summarize the impact objectives as follows[4]:

- Shared fundamental values and attitudes
- An understanding of roles and responsibilities
- Interprofessional communication
- Team functioning
- Collaborative decision-making
- Conflict resolution
- Continuous quality improvement

[4] Globally, there are several accepted frameworks for interprofessional core competencies, including:
- the "BC Competency Framework for Interprofessional Collaboration" from British Columbia, Canada;
- the CIHC's "National Interprofessional Competency Framework" from Canada;
- the CAIPE Statement from the United Kingdom;
- the "Interprofessional Capability Framework" (CUILU) from Sheffield, United Kingdom;
- the "Core Competencies for Interprofessional Collaborative Practice" (IPEC) from the USA;
- the "Curtin University Interprofessional Capability Framework" from Australia;
- the CanMeds 2015 Framework from Canada;
- the materials from Nexus, the National Center for Interprofessional Practice and Education, USA;

(not exhaustive; for references please see the Bibliography).
For the first time, the National Competency-Focused Learning Objective Catalogue will have a chapter on interprofessional competencies. Its development has been based on the "Core Competencies for Interprofessional Collaborative Practice"(IPEC).

MIA Mannheim, © Medical School Mannheim, Mannheim University

The Tutors' Roles and Their Understanding of Those Roles

Tutors take on a variety of roles on a training ward.

Roles are social constructs, i. e. people present themselves in a particular way. But they are also perceived by other people in a particular way. The two views often fail to coincide.

On a training ward, tutors have a particular role to play as a result of their function and their pedagogical qualification, but also because of their professional qualifications and age. They are often even required to play several roles simultaneously.

Participants ascribe certain values to their tutors ("model professionals"); they have particular expectations of them (they can distinguish between right and wrong, they are nice, they're always ready to lend an ear and are responsive, they guarantee safety); and they expect certain patterns and ways of behavior (they demonstrate procedures precisely and in detail, they are always supportive and helpful).

On interprofessional training wards, tutors' differing roles are divided into two categories:

- they have roles to fulfil in contact with the learners and
- they have roles to fulfil within the organization.

Roles in contact with learners

Educational developer
This role involves tutors being able to explain topics both in detail as well as more generically. In the case of shortcomings, they are also always skills trainers.

They are also able to explain the importance of self-directed learning and promote its use. To this end, they ensure that the learning process is structured appropriately in terms of both time and space.

A major focus is on being able to recognize situations that offer special opportunities for learning for the learners ("teachable moments").

As the one designing the learning process, the tutors encourage their learners to reflect on their actions over and over again, as well as to share their experience with all those participating.

Motivator
Tutors encourage learners to pursue both the training ward's interprofessional learning objectives as well as their own individual profession-specific learning objectives.

With this in mind, they support learners using both individual and group activities and reinforce attaining learning objectives using a positive mindset. They convey that the experience participants are gaining on the training ward not only promotes medical skills but also, and in particular, the collaborative competencies that are important in work life (see Introduction: Improving through Teamwork).

They exude positive energy to inspire learners to take responsibility for self-directed learning and competency development.

Enabler of communication
Tutors follow patterns of communication that are conducive to individual learning processes (and group processes) as well as to ensuring patient safety.

They facilitate their communication processes in line with need and situation, as well as with learners and in dealing with patients, their relatives/caregivers, and other professionals on the ward.

They create transparent communication structures and address problematic patterns during the reflection period at the very latest.

Observer
Tutors observe learners as they prepare and carry out care processes, as they engage in interprofessional communication, and during the follow-up. In doing so, they keep a critical eye on individual competencies and how said competencies are developing.

Tutors observe and analyze the patterns of interaction between learners, as well as between learners and patients. They pay attention to group dynamics, hierarchical patterns, power plays, paternalism, (un)professionalism, and any emotions that arise.

Role model
Tutors authentically embody the rules agreed upon for the interprofessional training ward.

They are committed to standing up for interprofessional collaboration and do so with conviction. They can demonstrate added value using specific examples.

On interprofessional training wards, tutors have a unique opportunity to convey that interprofessionalism only improves good professionalism.

Assessor
Tutors give learners continuous feedback on their progress and point out areas requiring further improvement.

Formative methods are primarily used for assessment (see chapter on formative assessment).

This differs significantly from examination situations: Tutors provide feedback and guide learners to reflect.

Patient advocate
Tutors protect patients' interests.

In this role, they contribute to protection and safety, and also to maintaining a level playing field between medical professionals and patients and to ensuring that the care team respect the patient's dignity in their behavior. It is not a matter of "cases" or body parts like "the shoulder in room 12", but rather of human beings.

This role also includes dealing honestly with mistakes and accepting responsibility when something goes wrong.

Integration manager
Tutors avoid "us versus them" thinking!

When different professions come together, it is easy for an atmosphere to arise where people feel a need to make a name for themselves or show their superiority. In doing so, it is often overlooked that where such group dynamics are at play, values, concepts, or solutions are imposed on others without discussion, consideration, or consent. Coercion is not a good strategy for using existing diversity – it is about improving through teamwork!

Leader
Tutors are committed and passionate IPE advocates. They are able to demonstrate the added value of interprofessional collaboration with conviction, especially in pioneering phases or where there is a pronounced lack of collaboration between different health workers or professional profiling. They offer a window into IPE for the outside world and, as team builders, they bear responsibility for jointly achieving learning objectives.

Leadership also includes recognizing limits and intervening in situations that endanger patients, interfere with organizational processes, or put financial and technical resources at risk. Creating a culture of constructive criticism is an integral part of this.

Overarching pedagogical-organizational roles

Part of a team of interprofessional tutors
Tutors are part of a team, both professionally as well as interprofessionally.

Sharing within the team ensures the continuity of tutoring when it comes to handovers/team discussions by passing on all relevant information to other tutors (and, where necessary, the ward manager or medical director).

Organizational interface
Tutors serve as an interface between the interprofessional training ward and a regular ward.

They proactively design all the necessary coordination processes by contributing to their planning and organization.

Ambassador for interprofessional education and collaboration
Tutors inform others about the importance and effects of interprofessional education and collaboration.

They are able to justify their importance in a hospital context and to advocate the spread of IPE and interprofessional collaboration.

Reflective tutor
Tutors constantly engage in self-reflection regarding their own (teaching) actions.There is no single correct method, but rather many ways in which learners can improve their learning with, from, and about one another, as well as their work, according to their knowledge, inclinations, and talents.

Toolbox

- Tutors are neither superiors nor colleagues – they are facilitators who expedite interprofessional learning experiences during training sequences.
- They design the learning process and, as such, identify teachable moments.
- They motivate collaborative learning.
- As observers, they keep an eye on communication and group dynamics.
- They address hierarchical patterns, power plays, paternalism, (un)professionalism, and emotions.
- They prefer formative methods of evaluation.
- They promote integration – trainees from other professions are not forced to adopt the tutor's own values and concepts.
- Tutors stay in the background – but they intervene decisively where patients are endangered, processes impaired, or financial and medical resources wasted.
- They reflect on their own teaching actions.

MIA Mannheim, © Medical School Mannheim, Mannheim University

Methodological Competencies for Tutors

The methods described below are intended to offer support for providing educational training on interprofessional training wards. They are intended to help people make best use of teachable moments on these wards.

Reading this handbook is in no way a substitute for formal educational training.

Setting learning objectives

Setting out learning objectives is essential for both the teacher and the learner. It delineates an end point and clarifies the learning process. In setting out objectives, it is important that mono-professional or medical learning objectives are differentiated from interprofessional learning objectives.

Setting learning objectives applies both at an individual level (e. g. it can explain their own professional view) as well as at a team level (e. g. social competencies during interprofessional visits).

Example of learning objectives at an individual level:

- At the end of their time on the interprofessional training ward, ITW graduates can explain why and how an informative briefing for a cardiac catheter examination is conducted with a patient in a specific way.
- At the end of their time on the interprofessional training ward, ITW graduates can explain to colleagues how and why the process of balancing a patient's fluids is carried out and documented in a particular way.

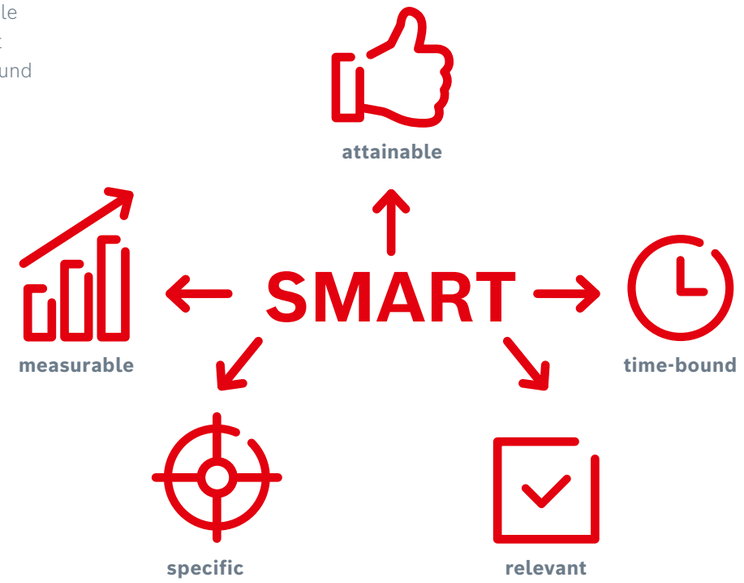
Example of learning objectives at team level:

- ITW graduates can reflect on and explain their own tasks and responsibilities regarding collaboration with other health care professionals.
- ITW graduates can give timely and constructive feedback within their team.

Toolbox

Set SMART learning objectives

Specific
Measurable
Attainable
Relevant
Time-bound



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Strategies for Implementing Learning Objectives

IPANEO Munich [ITW in Neonatology], © Munich Hospital

Scaffolds

Generally speaking, learners should work independently on interprofessional training wards from the very beginning of their placement.

As the learners are going through a learning process, structuring aids (scaffolds) provide important support and security.

These scaffolds can be provided by the tutors or developed by the learners themselves.

Where scaffolds are used, it is important that they can be introduced into the learning process as support. Advanced learners should be given the space to move away from such supports (fading).

A well-known example of scaffolds being used on interprofessional wards is the use of the ISBAR tool during handovers:

Identify
Yourself, your role, and the patient.

> Hello, I'm Michael Müller, medical student. We're dealing with the patient Peter Wolf, D.O.B. 01.01.1962.

Situation
What's the patient's current problem?

> The patient is demonstrating acute shortness of breath.

Background
What's their medical history/ the context?

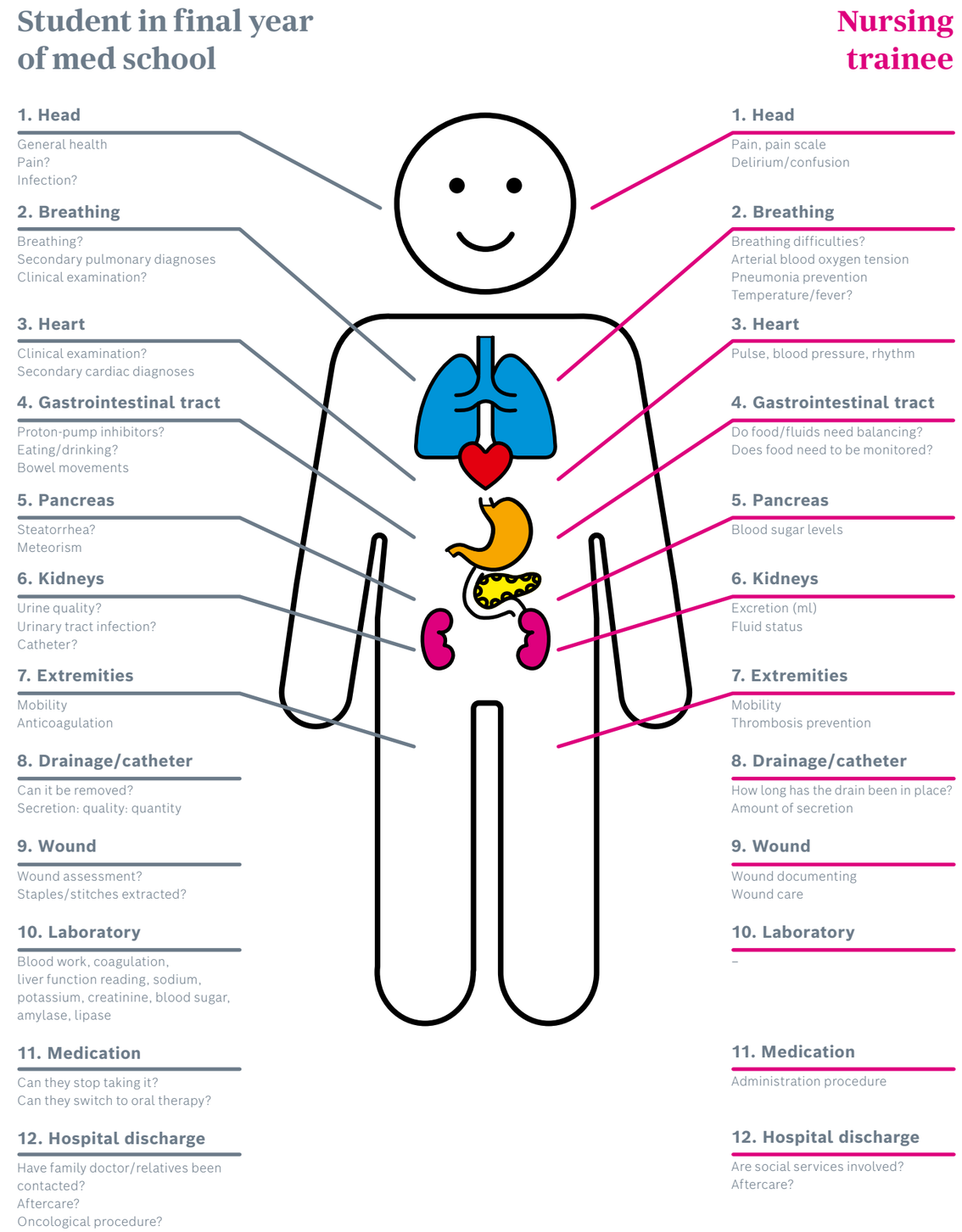
> The patient is three days post-op following a Whipple's procedure for carcinoma of the pancreatic head. His vital signs are: 142/87, pulse 94, oxygen saturation 87%, temperature 37.5. The abdomen is soft with normal bowel sounds.

Assessment
In your opinion, what's the issue?

> I suspect the patient has a pulmonary embolism.

Recommendation
What do you recommend? Wait for feedback.

> I would give the patient oxygen and put him in observation. Also, I'd like it if you, as the senior physician, could take a look at the patient. What else can I do?



Source: From the doctors' rounds tool, Heidelberg Interprofessional Training Ward

Toolbox

ISBAR tool (Identify, Situation, Background, Assessment, Recommendation)
Diagrams, flow charts
SOP checklists (Standard Operation Procedures)
Guidelines used on wards

Peer teaching

Peer teaching refers to learning/teaching situations where learners teach one another.

The advantage of peer teaching for learners is that they can ask questions and make mistakes unreservedly without worrying about their supervisors judging them. Equally, existing knowledge and skills are refreshed and deepened through preparing the lessons. With peer teaching, the learners take on the role of the teachers.

The learners themselves can set the objectives, which should be based on a set patient scenario.

Toolbox

Trainees in health care professions instruct medical students on how to place a bladder catheter.

Medical students explain the importance of cross-sensitivity in antibiotic therapy to nursing trainees or those training in other health care professions.

Physiotherapy trainees demonstrate how to use walking aids for patients following a hip replacement to medical or nursing trainees.

Hospital and Polyclinic for Internal Medicine I, © University Hospital Regensburg, photographed by Marion Schweiger

Methods for Sharing Practical Skills

An instructive teaching/learning relationship may also be necessary even on interprofessional training wards. What makes this decisively different from usual is that the learners have to identify their own shortcomings and then actively ask for guidance from their tutors.

The teaching methods need to be chosen in line with the learners' competencies and the complexity of the activities or skills required.

Toolbox

See one, treat one, teach one (Flexner 1910) – face-to-face

1 A skill is demonstrated.
2 It is carried out by a learner without help but under supervision.
3 Observation, feedback, and repetition ensure technical and professional accuracy.
4 The learners pass on what they have learnt to other learners (see peer teaching).

Four-step approach (Peyton 1998) – also works for small groups

1 The teacher demonstrates the skill once, working at their usual pace. No commentary is given.
2 The teacher repeats the action slowly, explaining each individual step in detail. Questions are encouraged.
3 The teacher asks the student(s) to precisely explain the steps and carries them out one by one according to their instructions; missing steps and mistakes are discussed.
4 The learners try the skill themselves under supervision.

Children's ITW Bonn, University Hospital Bonn, photographed by Katharina Wislsperger

Reflection

Work and experiences on the training ward should be reflected upon together with the learners at regular intervals. In doing so, both profession-specific as well as interprofessional aspects (e. g. values and ethics, roles, collaboration, communication, attitudes, emotions, emotional responses, etc.) can be discussed.

Good reflection requires a facilitator, who could even be a student.

Reflection is important for improving through teamwork.

A helpful method for a structured reflection of a specific scenario is Gibbs's (1988) model:

Source: Reflection model of Gibbs et al.

Toolbox

- Set out your reflection objectives in advance.
- Choose a moderator.
- Think back to the situation and summarize it briefly.
- Understanding: How did I respond? How did I feel in the situation?
- Insights: What became clear? What have I learned?
- Evaluate strengths and weaknesses.
- Incorporate existing knowledge: Is there any evidence to consider?
- Take-away: What can we adopt for interprofessional responses?

NIPSTA [ITW] at Nuremberg Hospital, photographed by Giulia Iannicelli

Evaluating and Reviewing Learning Objectives

As places of teaching and learning, interprofessional training wards also deal with the issue of assessing learning progress.

Because learners come to an interprofessional training ward with different knowledge, expectations, and attitudes, it is important to have established a position from the outset.

In many cases, learners from different disciplines are meeting one another for the first time. Tutors must ensure they are aware of the interprofessional competencies the learners have going into their placement on the training ward, and which they still need to develop.

One format that can be used to document this initial assessment is a portfolio.

In their portfolio, learners can set out personal and team (as well as both mono- and interprofessional) learning objectives for their time on the training ward, preferably in the form of SMART goals.

These objectives can be reviewed during training and in the final feedback.

Generally, there are two ways of reviewing learning objectives:

1. Results-based evaluation = **summative assessment:** With this method, performance is classified in terms of a final assessment or grade.
2. Process-based evaluation = **formative assessment:** Information is provided on how the learning process has progressed and any necessary further steps in terms of feedback.

Summative assessment

Summative assessments are a way of checking the extent to which learning objectives have been achieved. Traditionally, summative assessments take place in the form of an examination where a grade is awarded, or it is graded pass-fail.

Because training wards are a protected teaching/learning space, summative assessments should play a secondary role and should only be used where necessary, given the relationship of trust between the tutors and learners.

As qualification-critical learning objectives are also checked during training and on training wards, there should be a clear organizational separation between learning and examination.

Formative assessment

This refers to formation, or design. The aim of a formative assessment is to promote the learning process through results-focused guidance. The learning process is spiral-shaped because giving the learners continuous feedback optimizes their learning results.

Formative feedback can be either structured or unstructured.

An example of a structured formative assessment is observing a learner or group of learners using a structured observation sheet[5].

During the debriefing session, the items on the observation sheet serve to record relevant aspects of the teaching/learning situation and to identify where the learner could develop further based on this.

The advantage of standardized recording is that, over time, changes can be compared and highlighted.

An example of an unstructured formative assessment is directly observing a patient interaction. It occurs spontaneously when a teachable moment is identified. As unstructured assessments are situational, they are selective and not systematic or complete.

[5] IP-VITA from Heidelberg. Mitzkat et al. Publication in progress.

Toolbox

- Always establish the position at the very start of a placement.
- Make a note of knowledge, expectations, and concerns in the portfolio.
- Record individual and shared SMART learning objectives.
- Formative assessments are the method of choice.
- Record structured observations using an observation sheet.
- Make use of teachable moments with unstructured assessments.
- Avoid summative assessments.

Giving Feedback

BIPSTA [ITW] Bremen, photographed by Kerstin Hase

A positive feedback culture promotes a trusting teaching/learning relationship.

In order to establish a feedback culture, it is helpful, particularly in an interprofessional context, for learners to give themselves rules for feedback and to record these rules in writing, for example on a poster put up in a place visible to everyone. On top of that, the rules can be printed on memo cards to go in a coat pocket for reinforcement.

The rules act as a frame of reference, particularly in situations where emotions are running high.

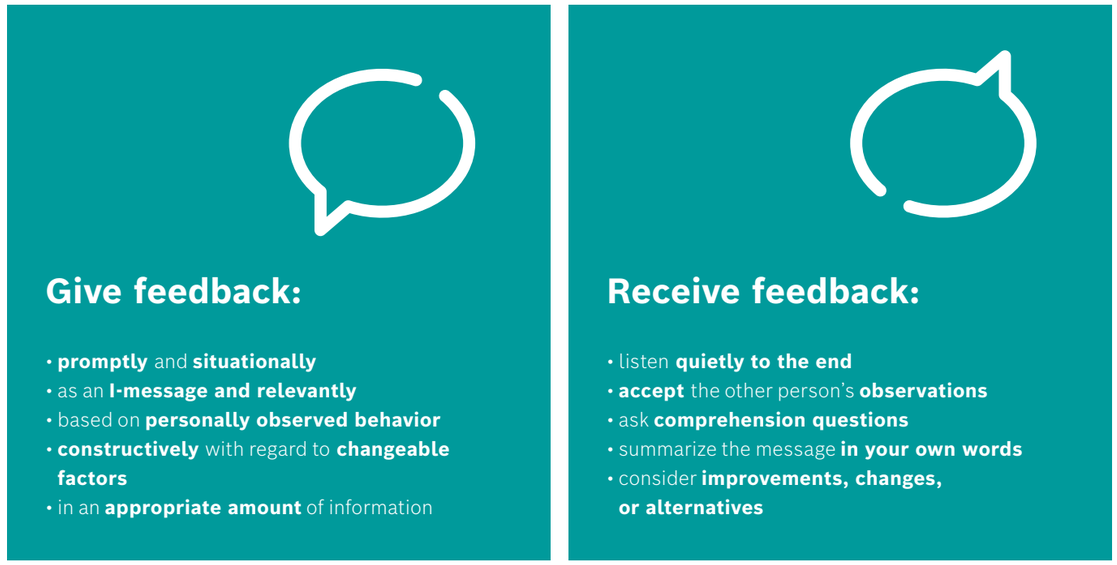
The aim of any feedback is to reduce discrepancies between the behavior demonstrated and the desired goal. Effective feedback therefore answers three questions:

- What am I aiming for? (feed up)
- How close am I to getting there? (feed back)
- What next? (feed forward)

(Hattie & Timperly 2007)

The following presents some methods for giving feedback that are suitable in the context of an interprofessional training ward. Where an institution already has established feedback methods, these may be used.

At Freiburg University Medical Center, a pocket card summarizes the general points:



Give feedback:

- **promptly** and **situationally**
- as an **I-message and relevantly**
- based on **personally observed behavior**
- **constructively** with regard to **changeable factors**
- in an **appropriate amount** of information

Receive feedback:

- listen **quietly to the end**
- **accept** the other person's **observations**
- ask **comprehension questions**
- summarize the message **in your own words**
- consider **improvements, changes, or alternatives**

Publisher: University Medical Center Freiburg, 2019
Concept design: Media center, Sottas, Kissmann, Brügger, 2016; building on Barr 1998

Perception-Effect-Wish feedback

The focus on an observation ensures that the Perception-Effect-Wish feedback is centered on a specific, observed situation. The second step is to ascertain the effect this situation has had on the person providing feedback. The third is to devise a tangible wish.

Below is an example of this kind of feedback following a parent consultation on a pediatric training ward:

Perception	I noticed that you were standing when speaking to the parents, while the mother was sitting.
Effect	It seemed to me as if that intimidated the mother so that she wouldn't feel confident to ask you questions because she had to look up at you the whole time.
Wish	I would like you to sit down next time you speak with parents.

Source: IPAPÄD/IPANEO 2020, Medical School, Office of Student Affairs, Freiburg, Academy for Health Professions, Freiburg

360-degree feedback

360-degree feedback involves everyone present in the teaching/learning situation in providing feedback.

Firstly, the learner themselves reflects on the situation, followed by the other learners. The third step gives the patient the opportunity to give feedback before the tutor adds their feedback at the end.

Below is an example of feedback using the 360° method following a consultation with the mother of an infant on a pediatric training ward:

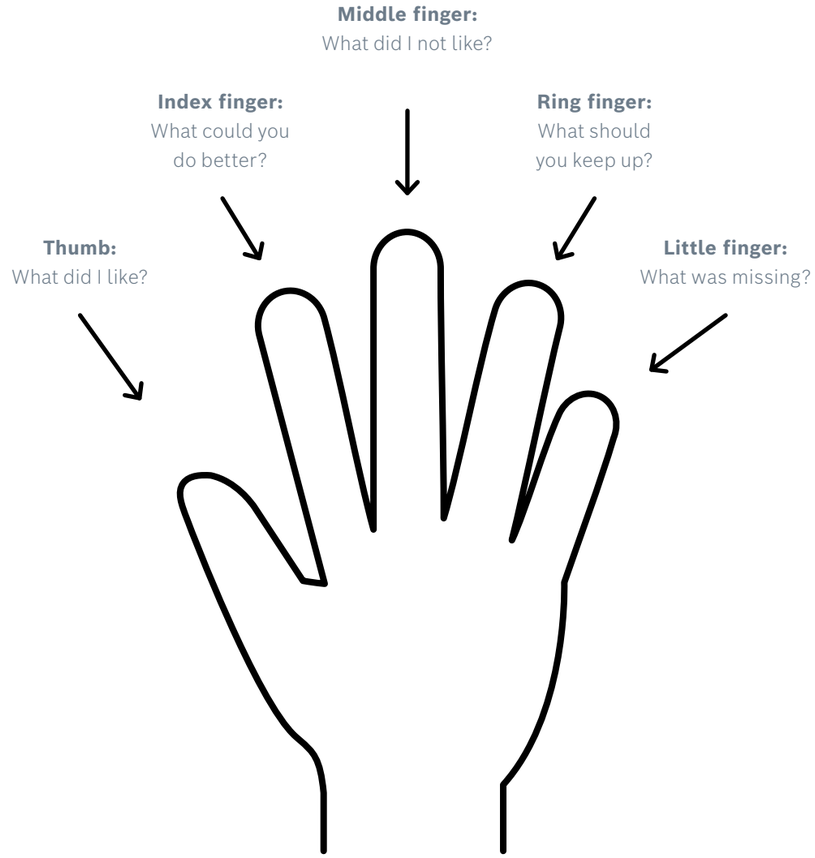
The learner themselves	I felt insecure in the situation and realized that I still lack knowledge when it comes to feeding an infant.
Other learners	I thought you handled it with confidence. I didn't feel as if the mother felt insecure. But I did notice that you didn't ask about allergies.
The patient's mother	I felt well looked after. My questions were answered. But there were some things I didn't understand because of the many medical terms.
Tutor	It would have been helpful for the mother to be informed about expected weight progression in infants.

Source: IPAPÄD/IPANEO 2020, Medical School, Office of Student Affairs, Freiburg, Academy for Health Professions, Freiburg

Five-finger feedback

Five-finger feedback allows you to structure feedback in a way that balances positive and negative aspects.

Each finger on the hand represents a leading question:



Below is an example of giving five-finger feedback following a blood sample:

Thumb	I liked that you took the patient's concerns seriously and reassured her.
Index finger	Next time, make sure you disinfect your hands after taking the blood sample.
Middle finger	I noticed that you just put the used needle down on the patient's bed. Next time, please make sure you have the needle drop ready for disposal.
Ring finger	I liked that you closed the door to the examination room. Keep up being conscious of privacy.
Little finger	You forgot to inform your colleagues that a blood sample had been taken. In future, please make sure you communicate with your team.

Source: IPAPÄD/IPANEO 2020, Medical School, Office of Student Affairs, Freiburg, Academy for Health Professions, Freiburg

This simple example of a skill works well as a template, for example, to prepare a discharge consultation following hip replacement surgery in an interprofessional team consisting of medical, physiotherapy, nursing, and social work professionals.

Peer feedback

A special form of feedback is feedback learners give one another.

Peer feedback is particularly suited to the context of an interprofessional training ward because it is not only those receiving the feedback who benefit from it, but also those giving the feedback, as they must observe attentively, and discuss what they have observed with the person they are giving feedback to.

As this promotes interprofessional learning, students and trainees should be encouraged to provide peer feedback. This also fosters communication competencies.

As a rule, all the methods presented above are suitable for peer feedback. The feedback can be given both mono- and interprofessionally.

It can be helpful to start with profession-specific peer feedback, as the learners usually find this easier, particularly at the beginning of their placements.

As the placement progresses and interprofessional socialization increases, the learners find it easier to give feedback to other professional groups. Situations can arise during medical history consultations (medicine and nursing), ward rounds (medicine, nursing, physiotherapy, occupational therapy), getting patients back on their feet after surgery (physiotherapy, nursing), educating patients (medicine, nursing, nutrition counseling), etc.

Where learners observe one another as part of peer feedback over a longer, previously defined period of time, this is known as shadowing.

Toolbox

- The learners must establish feedback rules by day three at the very latest. Ideally, these should be set out on day 1 of the placement.
- Make these rules visible to everyone on a poster or on pocket cards.
- Provide feedback on three questions:
  - What are we aiming for?
  - How close are we to getting there?
  - What do we do next?
- Encourage those participating to test out feedback forms and to adopt one of the methods of feedback.

Tutors Empower Themselves

Getting Feedback on Tutoring (Evaluation)

IPAPÄD Freiburg, © University Medical Center Freiburg im Breisgau

Tutors too require constructive feedback on their work in order to improve themselves, as well as the learners.

One option is to gather feedback during the placement on the interprofessional training ward, or at least at the end of the placement.

Both structured and/or unstructured methods can be used.

An example of a structured evaluation is through using pre-prepared evaluation sheets. These have the advantage of being able to collate a great deal of information on predefined topics.

One-minute paper

The one-minute paper is an example of unstructured feedback that can be collected on an ad-hoc basis. It offers a way to provide free text comments on brief, open questions.

I especially liked ...

I'll keep in mind that ...

I'm still not clear about ...

Feedback among colleagues and tutoring supervision

Tutors themselves have a great potential to support one another with feedback.

Feedback among colleagues can take the form of ad-hoc feedback in specific tutoring situations they have experienced (e. g. sitting in on a ward rounds debriefing session) or can be planned and structured.

International experience has demonstrated the importance of tutors meeting regularly to share their experiences.

Below is an example agenda of a regular tutor meeting:

Tutor meeting agenda

ITEM 1: The latest from the training ward
Currently, are there any challenges or points to note in the group of learners?
Currently, are there any challenges regarding patients?
Have there been any organizational developments or changes?

ITEM 2: The latest in terms of tutoring
What tutoring experience has been gained since the last meeting?
Were there any situations that went particularly well? Why?
Were there any situations that went less well? Why?

ITEM 3: Learning objectives
What learning objectives have the participants set themselves?
How have these been checked?
Which have, and which have not, been achieved, and why?

ITEM 4: Methods toolbox
Which methods have been used since the last meeting?
What worked well, what less well?
Were there situations where particular methods would have been desirable?
Anything interesting to report from other training wards or publications?

ITEM 5: Summary and, if necessary, distribute tasks for the period until the next meeting

HIPSTA [ITW] Heidelberg, photographed by Peggy Rudolph

Briefing and Debriefing

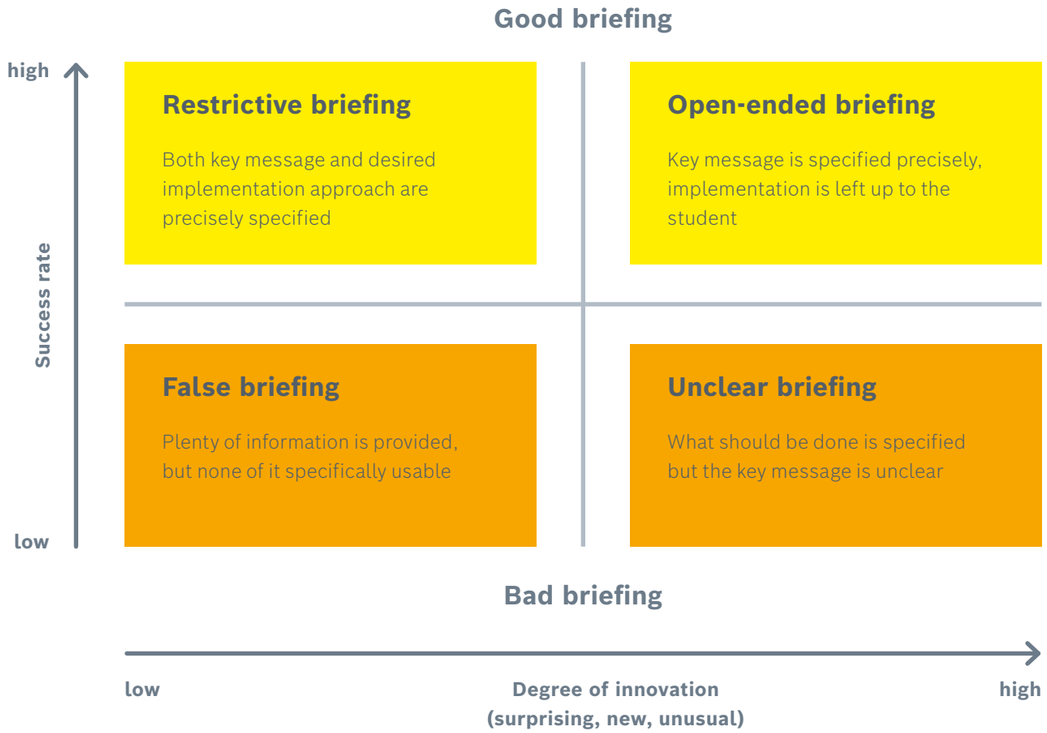
The briefing is a short instruction before a task.

Briefing elements include a description of the activity at hand, as well as a discussion of the task's general conditions, particularities, and possible pitfalls.

Depending on the learners' level of training, it may be necessary to lay out the steps in great detail and to place several sequences one after the other. This is particularly important if the activity is highly complex, or if there are risks to patient safety.

Queries and teach-back sequences (see the next section) are key.

In the case of more advanced learners, the briefing can be closer to the practical application to follow later. An open briefing offers more freedom in deciding how the action will be designed.



Source: Chirurgische Arbeitsgemeinschaft Lehre [Surgical Syndicate for Teaching], amended according to Monzel, 2011, www.adoach.de

Once the task has been carried out, it is important that the tutor holds a debriefing session.

A debriefing is a structured discussion after the event.

Debriefing elements include reflecting on what happened, identifying the problems that occurred during the task, and how these were dealt with, as well as possible suggestions for improvement.

When it comes to debriefing, there is large overlap between feedback (see section on feedback) and reflection (see section on reflection). Since debriefings are particularly concerned with the learners' emotions and the problems that have arisen, they are particularly suited to a structured discussion following an emotionally challenging situation, such as medical emergencies (see section on challenging situations).

The following formula is an example of a structured debriefing following a complex situation:

- Explore emotions ("How do you feel?")
- Describe the situation ("What happened?")
- Analysis
- Personal learning message ("What can we take from this?")

In both their nature and scope, briefing and debriefing are dependent on situation and context.

For advanced learners or routine situations, they can be short.

Toolbox

- Separate the briefing into small steps for complex situations, or cases involving patient safety.
- Use teach-back to ensure clarity and safety.
- When debriefing, explore feelings and allow learners to phrase their take-aways.

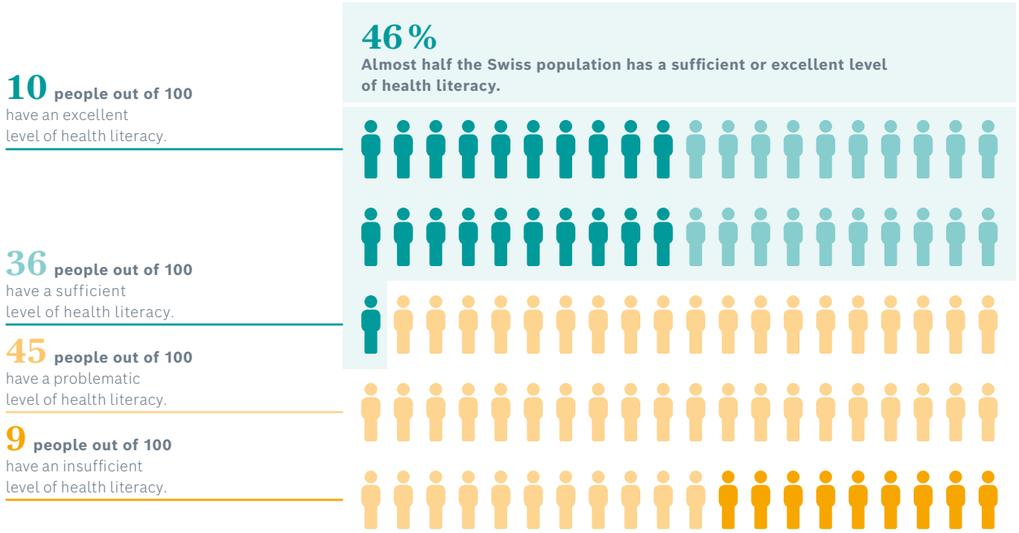
Why Teach-back is Important

ZIPAS [ITW] Zurich, photographed by Christoph Stulz

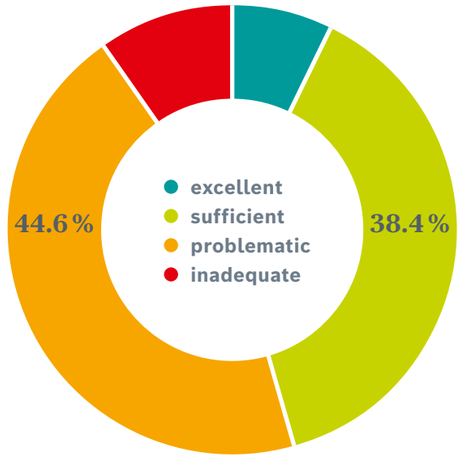
A great deal of information is forgotten right after, and even during, a conversation.

Teach-back requires patients to repeat what they have just heard in their own words. Incorrect or missing information can then be corrected and/or supplemented according to individual needs.

Studies on health literacy from Germany, Switzerland, and other European countries demonstrate that half the population does not understand health-related information. Therefore, it is important to let patients describe what they have just heard or been told in their own words.



Source: Population survey on health literacy 2015,
http://www.bag.admin.ch/themen/gesundheitspolitik/00388/02837/index.html?lang=de



More than half the German population (54.3 %) faces considerable difficulties when dealing with health-related information.

Figure: Level of health literacy in Germany (as a percentage of the population) Schaeffer et al. 2016
Source: Nationaler Aktionsplan Gesundheitskompetenz [National Health Literacy Action Plan].
https://www.nap-gesundheitskompetenz.de/gesundheitskompetenz/forschungsergebnisse-f%C3%BCr-deutschland

Health literacy is dependent on age and education. People with chronic diseases are disproportionately lacking.

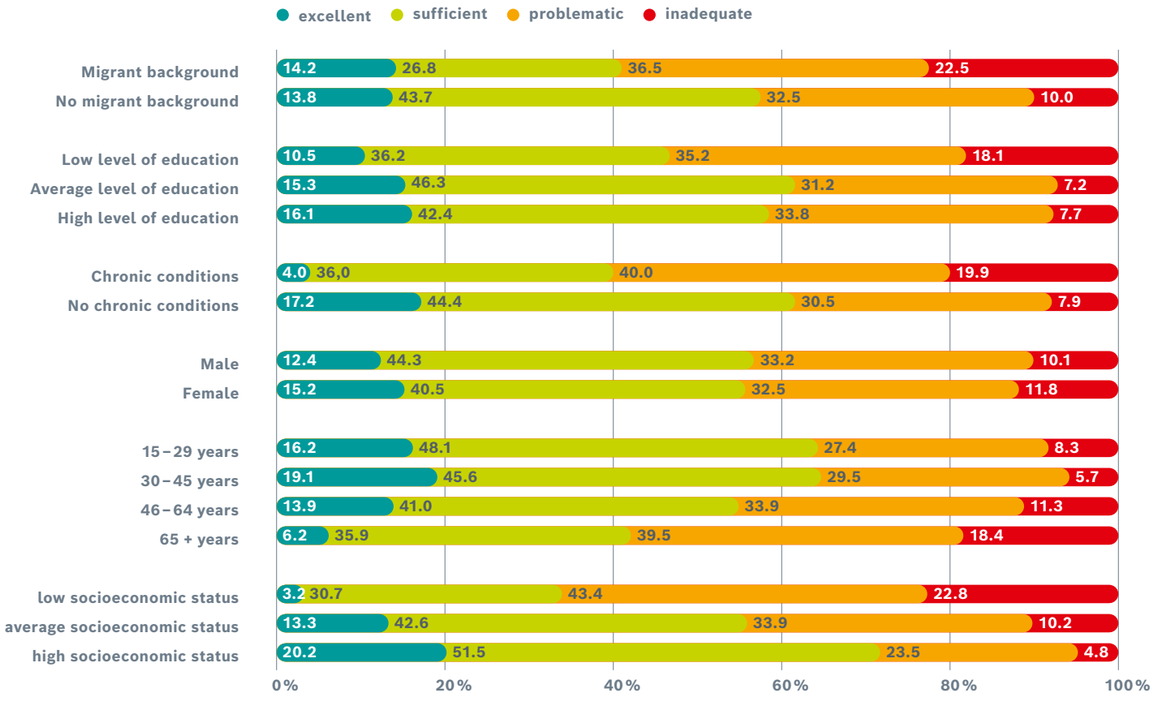


Figure: Health literacy levels based on understanding information, by subgroups in percent
Source: Schaeffer et al. 2016

ZIPAS [ITW] Zurich, photographed by Christoph Stulz

Standard Situations

Behavioral recommendations for tutors that deal with frequently occurring standard situations help prevent unnecessary irritations and discussions, as well as better achieve the learning objectives that have been set out.

The following list of standard situations includes several examples that can be expected to arise on any interprofessional training ward, as well as others that are more likely to occur on profession-specific wards.

When it comes to the profession-specific examples, possible behaviors are presented as examples that can be transferred analogously to other situations.

Occasionally, aspects are mentioned that should be taken for granted as social and personal competencies for good professional conduct across the health care sector.

Requirements/preparation

1. Tutors ensure that the conditions are right, and that the environment is ideal for interprofessional learning.
2. Alongside interprofessional learning objectives, professional/mono-professional learning objectives should be known and, if possible, visible to all.
3. Tutors ensure that patients are informed about the special features of an inter-professional ward:
   - Training not only focuses on professional knowledge, but also on communication, collaboration, professional conduct, emotions, etc.;
   - Trainees do not pose any danger because the tutors monitor professional accuracy and patient safety;
   - Training means that several people are often in the room at once.
4. In cases where there is a great deal of work, or a particularly complex situation, the tutors are the ones to set the priorities – who does what, and when?
5. This prioritization is discussed with the medical and nursing (ward) management.

Patient rounds

1. All learners introduce themselves and those taking part greet the patients.
2 Stand where the patient can see you.
3. Minimize the patient's need to look up to you: lift the adjustable top part of the bed and raise the entire bed.
4. All those taking part should have their say in order to bring in relevant professional aspects.
5. Actively involve the patient:
   - Allow and encourage questions;
   - Explain how things stand and what is next in lay terms;
   - Get the patient to repeat what has just been said in their own words (teach-back).
6. Follow the rounds procedure set out by the department and use structuring aids.
7. Check that information, findings, changes, and instructions are documented correctly by the learners responsible for these.
8. Address problems, challenges, or risks that are relevant to the patient.
9. Address incidences where there is a lack of social competency or misconduct.
10. Caution: It is not the tutor's round – tutors stay in the background. Tutors only offer support where needed, before fading straight back into the background.

Handovers

1. Introduce patients according to a formula (e. g. (I)SBAR/SOAP, etc.), using scores where necessary (e. g. pressure ulcers, DM, falls, pneumonia, MMS, GCS, etc.).
2. Keep to the set time frame.
3. Require the full concentration and attention of those taking part in the handover.
4. Encourage questions that foster understanding.
5. Ask for clarity if there are any communicative misunderstandings.
6. Use teach-back – not only where there are uncertainties.

Treatment plan/care plan and discharge management

1. All partners involved plan together.
   (Caution: There are many different organizational forms for this across hospitals.)
2. Proactive planning: Establish therapy/treatment goals interprofessionally for right now, today, and the medium and long term.
3. Everyone's voice should be heard.
4. Involve patients, relatives, and caregivers at an early stage: as co-creators, not just to follow orders.
5. Prepare documentation to the necessary standard.
6. Prepare any necessary documents in good time (prescriptions, sick notes, transfer sheets, doctor's notes, etc.).
7. Check whether, and how, measures are implemented.

Patient consultations (informative, advisory/educational) and family consultations

1. Create a calm atmosphere with minimum potential to be disturbed.
   Aim for eye-level – avoid seating arrangements that force people to look up to you.
2. Strive to use appropriate lay terms and check understanding with further questions.
3. Thoroughly prepare for the consultation and note down as guidelines:
   content/topic, strategy/structure, goal/message, conducting the consultation/important questions, forms (e. g. anesthesia protocol, consent forms, or information sheets (informed consent)).
4. Use tools and resources:
   (e. g. SPIKES for delivering bad news, see Table 4)
   (or NURSE for dealing with emotions)
5. Mind your attitude (reflect on potential paternalism!)
6. Record soft factors in the documentation alongside medical questions:
   worries, fears, emotions, etc.

Including other professional groups (consults)

1. When initiating contact, introduce yourself with your name and role.
2. Use medical language adequately – avoid making status and competency judgments.
3. Present the problem and issue at hand concisely.
4. Clearly word your question and why you need support.
5. Show appreciation for the contribution in a friendly and grateful manner.

Medication

Follow the Rule of Six:
Right patient?
Right dose?
Right time?
Right medication?
Right form of application?
Right documentation?
and: follow correct hygienic procedure!

Admission/diagnosis and measures

E. g. in determining risk profiles (diabetes mellitus, falls, bed ulcers, pneumonia), in clinical tests, or in patient care: bandages, catheters, mobilization, respiratory therapy, swallowing exercises, etc.

1. In your team, name the measures that will be used and plan their implementation.
2. Introduce yourself and your role.
3. Ensure everyone understands the measures to be used, and where necessary explain any sub-steps and difficulties.
4. Obtain the patient's consent.
5. Carry out the measures correctly, where necessary according to guidelines/standards.
6. Update the documentation as required.

Toolbox

- Tutors are not key players and should stay in the background.
  They only offer support where it is needed and then they should fade straight back into the background.
- Alongside the technical-methodological aspect, tutors should use the situation to foster interprofessional sharing and to ask for different professional viewpoints.
- Interprofessional learning moments (teachable moments) often arise spontaneously in standard situations – be sure to use these opportunities and consciously set learning objectives along with participants.
- Conclude every consciously observed learning situation with feedback/reflection.
- Check whether and how measures (instructions, letters, consultations, etc.) are carried out.
- As the learners gain more and more competencies (learning curve, entrustable professional activities), the tutor gradually withdraws.
- Tutors take immediate action if critical measures are needed, and in emergency situations, to ensure patient safety.
- They provide input on proper conduct, and participants should express this in their own words (teach-back).

Challenging Situations

HIPSTA [ITW] Heidelberg, photographed by Peggy Rudolph

Various complications can arise for tutors that pose a challenge to teaching and learning. In this section, eleven situations are presented which, based on experience, are regular occurrences. They are illustrated here in an exaggerated way using everyday hospital situations.

Even if they initially seem disruptive or problematic, tutors can recognize the potential of disruptive situations or irritations for teachable moments and can make use of them in interprofessional teaching situations to improve through teamwork.

The ring-leader/conversation monopolizer

Situation: On the third day on the training ward, you as the tutor notice that a highly motivated nursing student, Marie, always immediately takes the floor during ward rounds and reports on “her” patient. Following her detailed description of the situation and the patient’s condition, she asks Martin, the med student: “Is there anything else from a doctor’s point of view?”.

What can you as a tutor do to find a balance between contributions by nursing and medical students?

Suggested solution 1: Immediately after the ward round, ask the participants how they see the length and nature of oral contributions in terms of professional, social/group dynamics, and communication – record this on a flipchart/board.

Suggested solution 2: On the next day, consciously change the order in which the patients are introduced, i. e. start with medicine, then physiotherapy, occupational therapy, and nursing, so that they can learn effectively from, with, and about one another.

Suggested solution 3: Where there is no time for reflection immediately after the ward round, this point will be actively addressed and worked through in the next joint reflection.

Using peer feedback based on the training ward’s feedback rules, the participants present the positive and negative aspects of interprofessional ward rounds so far and consider together which rounds structure or which approach leads to balanced contributions from the different professional groups.

Jargon at the bedside

Situation: A medical student, Paul, to the patient: “You have an increase of CRP and your urine is nitrite positive. We are considering giving you a bactericidal chemotherapy agent.”

How do you get learners to communicate the situation in terms the patients can understand, so that they can understand what is happening to them and how they themselves can actively participate?

Suggested solution 1: Ask the patient to repeat what they have just heard in their own words (teach-back method).

Make sure you clarify profession-specific terms while still with the patient, so as to avoid any uncertainty.

Suggested solution 2: During the next scheduled reflection, ask the group participants to describe and summarize the situation from their perspective. For example, ask Paul, the med student, to give the patient’s view. In doing so, the group should be able to pinpoint the problem (use of professional language and abbreviations) and develop suggested solutions (target group-focused communication).

Offer Paul the chance to go back to the patient with the group and discuss the situation.

As part of this, you should also convey that, in addition to ensuring the patient understands and is able to comprehend the situation, as a specialist it is also important to show empathy and gain the patient’s cooperation – patients are primary “co-creators of their own health.”

Lateness and extended silences

Situation: During the first week on the training ward, med student Charlotte is noticeably late several times. This impairs work processes and nursing-medical activity coordination. The other members of the team seem dissatisfied with the situation, but they do not express this specifically. There is no mutual feedback between the two teams at all. What can you as a tutor do to help solve this situation?

Suggested solution 1: Act quickly:
- Address the situation: Her being late has not gone unnoticed and it is a source of conflict, even if nobody has mentioned it openly.
- Schedule a date: Find a suitable time and place to discuss the conflict.
- Avoid one-on-one discussions with team members, so as not to create an impression of partiality or choosing sides, as this damages interprofessional team building.

Suggested solution 2: Make a point of it in the review of the week:
When looking back on the first week, first give participants an opportunity to reflect on positive or negative aspects. If the problem is not directly addressed, point out that being late is not acceptable within the department.

The boss is late again

Situation: Associate professor Ernest Eagerling, MD is noticeably late for the round once again and the whole team is waiting.

Suggested solution 1: The training ward's management discusses the situation during management meetings – as it is an issue of hierarchy, it cannot be solved by students/ trainees, or tutors.

Suggested solution 2: The participants continue to work routinely until Dr. Eagerling arrives. Once he has arrived, they show that they are pleased to see him, but also mention the delay and the resulting loss of time and disruption to the schedule for the day.

Reflection within the group allows for the dysfunctionality through hierarchies to be addressed. On the one hand, being consistently late and making people wait is a way of underscoring the power gap, although apologies and genuine reasons for said lateness help to create a positive atmosphere.

On the other hand, being late indicates a drop in quality and wasted resources. Therefore, it should also be conveyed that things must carry on as normal as a matter of principle and that this requires commitment, personal responsibility, and self-control from the inter-professional team.

Is that really necessary?
Where necessity/expediency is questioned

Situation: Ms. Miller (85 years old) has been admitted to the training ward with severe abdominal pain as a result of chronic constipation. She is now waiting for a colonoscopy. The laxative measures have made the patient feel visibly unwell. Following the round, Martin, a nursing student, asks: "Is this really necessary?" Medical student Paula answers: "Yes, of course, otherwise you won't be able to see anything in the endoscopy and she could have a tumor or something." How do you deal with differing values (e. g. in indication/ treatment decisions)?

Suggested solution 1: Address this conflict of aims in the next reflection session. Ask about the participants' experience of the situation and what the intention, for example, behind Martin's question was. Allow the team to discuss this, and make sure you facilitate this interprofessional case analysis.

Suggested solution 2: If the group fails to reach a consensus that all the participants feel comfortable with, involve other players (e. g. a senior physician). Ensure that the differing assessments and viewpoints are presented and discussed – there is rarely just one "objective" evaluation and the patient's right to self-determination is also of paramount importance.

I'm the doctor, you're a nurse!

Situation: It is 9 a.m. on a Monday morning and time for the rounds. Excited, Marie, a nursing student, and med student Paul grab their documents and hurry to the ward. The tutors greet them outside the room. The participants get more and more nervous. Paul starts presenting the case to the tutors by the patient's bed, without any prior arrangements having been made. Marie tries several times to get a word in from the sidelines, but she is barely noticed.

Suggested solution 1: Set out the order in advance and ensure that it changes over time.

Suggested solution 2: During the reflection process, observations made by the various participants should first be discussed using peer feedback. In doing so, the clearly defined feedback rules should be applied.

Defining roles and rounds standards is key to avoiding situations where profession-specific role stereotypes are at play. Interprofessional training wards are places where hierarchies, stereotypes, and prejudices should be consciously reflected upon.

Bad news, dying patients, and personal responses

Situation: After having received the results of her examinations, a doctor diagnoses Ms. Stock with an advanced tumor in the presence of medical student Paula and Martin, the nursing student. Afterwards, Martin is very quiet.

Suggested solution 1: The tutor reflects on the consultation that has just taken place with Paula and Martin on a factual level first and then talks about their feelings. Over the next few days, the matter can be addressed again by tutors to identify whether this needs to be talked through further.

Suggested solution 2: Their personal response is taken as an opportunity to develop possible strategies for overcoming the problem from an interprofessional perspective (supportive/palliative/supplementary interventions). All the professions should offer up suggestions and justify them in terms of feasibility, expected benefits, and acceptance.

The interprofessional framework opens up the possibility of addressing their different individual experiences, as well as the limits of therapeutic options.

Difficult or demanding relatives

Situation: Ms. Anguish, a relative of the patient in Room 21, requests information or intervention from students and trainees several times a day. The many interruptions to the process irritate the participants.

Suggested solution 1: The tutor steps back so that participants can recognize and analyze the challenges on their own and come up with solution strategies – this promotes interprofessional learning and exposes them to the (authorized) presence of relatives.

Suggested solution 2: This situation is taken as an opportunity to discuss the guidelines for dealing with relatives, or to develop and practice such guidelines.

The easiest solution – namely limiting times for visits and consultations with relatives (e. g. in the morning after the rounds and late afternoon) – may not be enforceable.

Therefore, it is better to develop a viable mode of interaction and to offer relatives consultation times. Tandem consultations (nursing and medicine) empower the participants and help them to develop the competencies needed for this important relationship work.

Just don’t make any mistakes!

Situation: During the rounds, Mr. Shank complains of pain following his knee surgery. He has a documented metamizole intolerance. Nevertheless, med student Paula prescribes 1g of metamizole as a short intravenous infusion. As Paula and Martin are jointly setting up the infusion, you, the tutor, go over to them and hear Martin asking: “Didn’t he have an intolerance to metamizole?”. Paula answers: “Oh, right, I’ll quickly delete the prescription and we’ll give him paracetamol.” Paula and Martin are both clearly uncomfortable when they notice your presence.

As a tutor, how do you address error culture and prevention?

Suggested solution 1: Do not embarrass or tell off the participants – equally, do not respond with threats of sanctions (do not make a summative evaluation!).

This undermines efforts to use the CIRS (Critical Incidents Reporting System).

A major issue is that Paula and Martin seem to be afraid that colleagues, tutors, or supervisors might notice the mistake.

Suggested solution 2: Realize the situation’s potential as a learning situation then and there. By talking to the whole group, you can discuss what caused the error, its possible consequences, and strategies for avoiding such errors in the future. The momentum should come from the group. Frame it as a positive that the error was noticed and communicated in time. The reflection should be both on a factual level (How did the error come about?) and on the relationship level (Do I lose face in front of my colleagues or supervisors when I make a mistake?).

To err is human. The participants should learn to accept mistakes as a normal part of their work and develop strategies for dealing with them in a collaborative and constructive manner (use the CIRS constructively!). An important objective in lifelong learning is to learn, both independently and by sharing with others, to avoid making the same mistakes more than once.

Listless learners

Situation: There are two participants in the group who barely participate, show no interest or initiative, and are clearly waiting for others to do the work. They are always on their phones and it seems like they are totally absorbed by the communication taking place in that virtual world and not in the here and now.

Suggested solution 1: Use binding standards to ensure that personal devices are left in the workroom – the permanent distraction offered by cellphones damages their professional reputation; they appear frivolous and trust dwindles when patients feel that they are a secondary consideration.

Suggested solution 2: Aim to talk to the relevant participants as soon as possible – their behavior does not demonstrate a sense of solidarity and impairs the whole group's learning. If things do not improve, you must impose sanctions.

The training ward is a burden!

Situation: On a Monday morning, you start as a tutor with a new team on a training ward. By the morning handover you have already noticed that when it comes to discussing the patients who are cared for inter-professionally, the ward manager has stopped paying full attention and has become impatient. Later, during the breakfast break, you hear the nursing team complaining loudly that they "now have this training ward to deal with too." It is clear that something is up and that there is a negative attitude lurking under the surface.

Suggested solution 1: First of all, fact-check your impression. If it is clearly correct, seek out the ward manager for a one-on-one meeting to assess the need for clarification. If there are organizational issues (understaffing, high workload, etc.), the situation must be addressed at a managerial level.

Suggested solution 2: If there are general reservations regarding the training ward, the issue must be escalated to the project organization, or project group, and the reporting line (nursing service management, head physicians). They can come to the ward to identify problems and report back to others responsible where necessary.

Experience from other countries has shown that training wards relieve the pressure because the trainees are particularly committed. Through engaging in dialogue, approaches for dividing up tasks and collaboration can be found. Roundtable discussions also make it possible to discuss consolidating and further developing training wards in a way that is acceptable to all parties involved.

Toolbox

- Clearly define roles (in writing).
- Ensure clear discussion and feedback rules, incl. peer feedback rules (in writing – on the first half-day, set these out together, record them on a flipchart sheet and hang them up where everyone can see them).
- Seek out direct conversations (Two people? Three people? Now or later?).
- Empowerment – encourage participants: Observe issues but let the group itself name them. Delegate problem-solving to the team ("Listen but don't get involved!").
- During the reflection session, address matters both at the factual and relationship levels.
- Address social competencies during the reflection.
- De-escalation strategy: First develop internal solution strategies with those directly involved, get others (ward manager, senior physician, project group, project steering group) involved where problems exist.
- Change management: The core team should have regular meetings, strategy meetings at least twice a year, general meetings together with other training wards, and short inputs in internal training courses for specialists who are not involved.

BIPSTA [ITW] Bremen, photographed by Kerstin Hase

Interprofessional Training Wards in Germany and Switzerland

Status quo and aspects of tutoring

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In Germany and German-speaking Switzerland, interprofessional training wards (ITWs) can currently (as at April 2020) be found across nine locations. These are actively supported by the respective local medical school. In an online survey (Unipark/Questback 2020) spanning the period from February 19 through March 20, 2020, relevant individuals from active interprofessional training wards included in a Robert Bosch Stiftung mailing list were written to as part of the Operation Team support program. These individuals were given a link to access an online questionnaire, with the request that only one online questionnaire should be filled out per location. The online questionnaire was completed by nursing staff at two locations, by medical staff at four locations, while another two were completed by other personnel. One was jointly completed by a medical professional and another member of staff. The following table illustrates selected aspects and results from the survey relevant to tutoring on an ITW.

Location (in alphabetical order)	Specialty	Participation mandatory or voluntary	Number of participants per block	Number of patients treated on the ITW per day	Number of tutors on the ITW per day	Number of teaching units to prepare tutors (1 teaching unit = 45 minutes)
			Medical students/ nursing trainees/ other		Medical/ nursing/ other tutors	
University Hospital Bonn	Pediatrics	voluntary	2/2	3	1/1	10
Links der Weser Hospital, Bremen	General/ Abdominal Surgery	voluntary	1/1	6	1/1	3
University Medical Center Freiburg	Pediatrics	voluntary	2/4	4	1/1	2
University Hospital Heidelberg	General/ Abdominal Surgery	voluntary	4/4 / 1 – 2	6	1/2/1	6
University Hospital Mannheim	Internal Medicine	mandatory	12/6/2	12	1/1/1	N/A
Munich Hospital and TUM	Neonatology	voluntary	2/2	2	1/1	2
Nuremburg Hospital	General/ Abdominal Surgery, Gastroenterology	voluntary	4/4	4 – 8	2/2	2
University Hospital Regensburg	Internal Medicine	voluntary	8/4	8	1/2	N/A
University Hospital Zurich	Various (Internal Medicine, Trauma Surgery, Geriatrics, Orthopedics)	voluntary	2/4	6	2/1/1	8

Table 4: Selected aspects from the online survey relevant to tutoring on interprofessional training wards. N/A = not applicable. Data collection and analysis: Bode, S., Krüger, M., Straub, Ch. in cooperation with the above-mentioned interprofessional training wards.

Further results from the online survey that are of relevance to tutoring on ITWs relate to the following aspects:

1. **The professional groups that the participating trainees and students belong to:**
   Across all locations, the nursing trainees (including pediatric nursing trainees) on the ITWs are in their second or third year of training. At seven locations, the medical students participating in the ITW are in their final (practical) year of medical school, while two locations offer placements for medical students as early as in their fifth year of study. At four locations, physiotherapy trainees in their first to third year of training are included in ITW training alongside nursing trainees and medical students. Further participants are occupational therapy and nutrition counseling trainees (at one location), and pharmacy students (at one location).

2. **Placement system:**
   At six locations, the ITW placement is carried out in blocks of two to four weeks. At three locations, placements are continuous.

3. **Opportunities for reflection for ITW participants:**
   All the locations hold final reflection sessions as well as opportunities for reflection with participants at set times. Five locations engage in reflection directly during work processes on the ITW. At three locations, participants reflect independently, while at eight locations reflection is a guided process.

The results of the online survey demonstrate that across currently existing ITWs in Germany and German-speaking Switzerland, the core aspects of execution and tutoring are consistent, but that they are, and must be, adapted to the needs and conditions of the respective locations and specialties. A key requirement for this adaptation is cross-professional collaboration and alignment in viewing tutoring as the driver and catalyst for both interprofessional and profession-specific learning and working on an ITW. Structured reflection is indispensable for consolidating lessons learned and permanently establishing this way of learning.

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Glossary/Terminology

CIRS	Critical Incidents Reporting System
DM	Diabetes mellitus
EPA	Entrustable Professional Activities
EQF/DQR	European Qualification Framework/Deutscher Qualifikationsrahmen [German Qualification Framework]
GCS	Glasgow Coma Scale, scale for estimating the state of a person’s consciousness
IPCP	Interprofessional Collaborative Practice
IPE	Interprofessional Education
ISBAR	Like SBAR, but begins with Identification: where professional and patient are introduced
ITW	Abbreviation for interprofessional training ward
MMS	Mini Mental Status, tools for detecting cognitive disorders
NURSE	Tool for dealing with emotions
SBAR	Structuring communication: Situation, Background, Assessment, Recommendation
Scaffold	Structuring aids, guidance according to constructivist learning theories
SMART	Method for setting objectives
SOAP	Subjective Objective Assessment Plan – scaffolds for medical history, diagnosis, results, and treatment: subjective complaints, objective results, analysis, and planning
SOP	Standard Operation Procedures
SPIKE	Method for delivering bad news in six steps

Phase	Abbreviation	Content/topic	Characteristic
1	S	**Setting**	Involve caregivers, avoid interruptions, set time frame, have information ready
2	P	**Perception** of condition	Query prior knowledge, establish patient awareness, blind spots?
3	I	**Invitation** from the patient to give information	Query readiness to take in the message, accept patient decision and offer further discussion where necessary
4	K	**Knowledge:** giving medical facts	Convey the message clearly and unambiguously, short sentences, no technical terms, code-switching, ensure patient understanding
5	E	**Explore** emotions and sytmpathize	Actively listen and mirror, allow for emotions, give time and space, empathic feedback
6	S	**Strategy** and summary	State outlook clearly and plan discussions/ next steps

Table 5: SPIKES – Protocol for delivering bad news
Source: Baile WF et al. 2000

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