December 8, 2008 #7

in•BC
Interprofessional Network of BC

NEWSBLAST

IP in BC

AN INTERVIEW WITH DOUG COCHRANE

On December 1st Alix Arndt, Communications Consultant for In-BC, had a chance to speak with Dr. Doug Cochrane, Neurosurgeon at BC Children's Hospital and Chair of the BC Patient Safety & Quality Council.

AA: Can you tell our readers a bit about what the B.C. Patient Safety & Quality Council does and how it came about?

DC: Built on the principles established by the Patient Safety Task Force, the Council's primary objective is to provide advice and make recommendations to the B.C. Minister of Health Services on matters related to patient safety and quality of care. Our key objectives include:

- Bringing together a plan for patient safety and quality in B.C.
- Organizing and bringing together the groups across the province who are doing great work in the areas of quality and safety in healthcare
- Improving the transparency of information for the public

The Council is comprised of a multidisciplinary membership that approaches the issues of patient safety and quality from a variety of perspectives. In our role we also have the ability to raise questions about existing legislation and regulation for the purposes of providing advice in these areas.

> *"Interprofessional teams and collaborative practice are fundamental to patient safety and quality. In healthcare practice you are on a team."*

AA: Given your work and interest in patient safety policy and accountability, how do you see interprofessional education and collaborative practice fitting in with the issue of patient safety policy?

Doug Cochrane

DC: Interprofessional teams and collaborative practice are fundamental to patient safety and quality. In healthcare practice you are on a team. To use a hockey analogy, when you're out on the ice everyone has their roles and they fulfill them as part of a bigger team.

Part of collaborative practice is understanding individual and interdependent roles and responsibilities. Being clear about roles and responsibilities and understanding how the team approach benefits patients is a critical component of patient safety and quality. We approach the patient from a holistic perspective, understanding the whole patient and what is required for long-term care. Initially the Patient Safety Task Force offered Health Authorities the chance to visit the simulation labs at Vancouver General Hospital (VGH). The opportunity was developed to provide teams exposure to the simulation labs and to work on team development. The Council has discussed the option of bringing this practice back because one of the key issues we're working on is developing the capacity within each discipline to understand that the quality of what we do as healthcare professionals is important and that we need to be accountable to the patients.

In addition to the reintroduction of the use of

In-BC wishes you a happy holiday season

simulation, Health Authorities are taking steps to develop an interdisciplinary performance review system. So, as a healthcare provider you get a sense from colleagues how well you are doing.

While communication around patient issues does occur, the health system could do better in allowing transitions of care to occur in a seamless risk free environment. Care becomes fragmented without communication. This is important to rectify because the transition of care is a reflection of how well the team works. To mitigate this we've taken steps to help people understand how to delegate care and learn how areas of practice work together.

AA: Do interprofessional education and collaborative practice have a significant impact on patient safety issues? Are there examples you've seen of this?

DC: Without a doubt. Here a few examples of how interprofessional care and collaborative practice have impacted patient safety and quality issues.

The Spinal Cord Clinic at Children's Hospital is a great example of disciplines working together to benefit patient safety and quality. Patients at the clinic are seen individually but collaboration occurs in a round-table setting whereby each member of the healthcare team assesses the situation. A plan for care is established out of these meetings and of course the patient is informed of this plan by a case manager. This is a great representation of collective thinking about a patient. When a clinic does not operate this way, something can be missed which in turn may negatively impact the patient. From a patient and safety point of view, this model means that problems are acted on quickly and in collaboration with the entire healthcare team. The patient is treated and is not put at risk.

Rapid response teams that exist inside hospitals work this way all the time. Each member of the team knows each other and communicates constantly in order to benefit the patient. While they may not sit down at a table and discuss the care, in order to treat the patient problem solving occurs within teams. A similar structure exists within an operating room.

This method of working is not necessarily one that upcoming healthcare professionals have as they come out of school. It has to be taught. One teaching method is to have an experienced professional show you how to work in this collaborative fashion. The best teaching method is problem solving and case based learning around teams.

AA: As someone who is a neurosurgeon, has served in a variety of high-level policy positions and has been an educator, you've had a chance to "sit" at virtually all levels of the healthcare continuum. How do you see IP fitting in or making a difference at these various levels?

DC: At the practice level it becomes really personal. You have someone about whom you are trying to problem solve. There's a real person here we need to help through the process of interprofessional collaboration.

From my perspective on the education side teaching is still too "siloed." While you might work with another medical discipline my perspective is more time should be spent learning from other disciplines as well. Through the process of changing the way we educate our future healthcare professionals, we can bring them into the practice arena with a more collaborative approach.

At the policy level we've set a variety of ground rules for organizations to work both collaboratively and interprofessionally. The Health Professions Act is a great example of how interprofessional practice is worked into policy.

AA: Are there examples of where a lack of IP collaboration diminished patient care, policy, education and practice?

DC: Fortunately I don't have specific examples of how this has happened. I can tell you that the single worst thing that can happen among the healthcare team is poor communication. Poor communication can negatively affect the patient (as well as the quality of care they receive and their safety).

IP Across Canada

- The Canadian Interprofessional Health Collaborative (CIHC) is currently conducting focus groups in Toronto, Saskatoon, St. John's, Winnipeg and Vancouver. The focus groups provide a perspective from a decision maker point of view with respect to the document entitled "Knowledge Transfer & Exchange in Interprofessional Education: Synthesizing the Evidence to Foster Evidence-based Decision-Making" www.cihc.ca/resources-files/The_Evidence_For_IPE_July2008.pdf
- The BC Academic Health Council (BCAHC) is hosting the Simulation Knowledge Exchange conference in Vancouver, B.C. on December 10, 2008. www.bcahc.ca/index.php?view=details&id=9%3Asimulation-knowledge-exchange&option=com_eventlist&Itemid=61
- Collaborating Across Borders conference will be held in Halifax, Nova Scotia on May 20-22, 2009. www.cabhalifax2009.dal.ca
- The Journal of Research in Interprofessional Education (JRIPE) is now open for submission of journal articles. www.jripe.org/index.php/journal

IP Internationally

The UK Interprofessional Student Network (UKIPSN)

In March 2007, Birmingham City University (BCU) was approached by Marilyn Hammick, the former Chair of Centre for the Advancement of Interprofessional Education (CAIPE), to develop an interprofessional student network. The network was developed in collaboration between the Centre for Stakeholder Learning Partnerships at BCU and CAIPE. CAIPE also had linkages with the National Health Science Students' Association (NaHSSA) in Canada.

The impetus to create a network grew out of a desire to answer the numerous inquiries received by CAIPE from students. The inquiries showed that many students were actively engaged in interprofessional projects all over the UK.

In November 2007, BCU agreed to fund and host an open meeting for students and staff interested in the development of a network. Over 50 students and staff participated.

In its first year, the network has much to be proud of. Accomplishments include:

- Recruiting members and creating a contact list
- Recruiting a full UKIPSN Steering Group
- Developing, maintaining and supporting the student section of the CAIPE website
- Supporting students from institutions across the UK to present at the *All Together Better Health Conference* held in Sweden in June 2008
- Developing links with a variety of regional networks
- Developing a student network for postgraduate students doing research in interprofessional education

Links and Resources

- In-BC website: www.in-bc.ca
- Interprofessional Rural Program of BC (IRPbc): www.irpbc.com
- BC Patient Safety & Quality Council: www.bcpsqc.ca/index.htm
- Patient Safety Task Force Announcement: www2.news.gov.bc.ca/nrm_news_releases/2004HSER0018-000280.pdf
- BCU: www.bcu.ac.uk
- CAIPE: www.caipe.org.uk
- NaHSSA: www.nahssa.ca

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We welcome contributions to our In-BC newsblasts. Please feel free to share your IP success stories. Space is at a premium so please try to keep your entries to 150-200 words. You may email your entries to info@in-bc.ca