INTERPROFESSIONAL EDUCATION

Healthcare workers' understanding of interprofessional education and collaborative practice in regional health settings: A survey study

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Abstract

Introduction: Interprofessional education and collaborative practice can enhance outcomes for patients and families. Facilitating collaborative practice at the point of care requires skilled healthcare workers who understand relevant terminology and concepts. However, gaps persist in the understanding and facilitation of interprofessional education and collaborative practice in some health settings. This survey study investigated healthcare workers' perceived knowledge and understanding of interprofessional education and collaborative practice.

Methods: A bespoke online survey was administered to healthcare workers from two regional health services in Queensland, Australia. Data were subject to descriptive and inferential analyses.

Results: Data were available from 235 healthcare workers. Multiple regression analysis revealed that claiming to understand the difference between different models of service delivery, the ability to explain interprofessional education to a colleague and being an allied health practitioner were statistically significant predictors of a high knowledge of interprofessional practice score. Very few respondents were trained in this area (6%, n = 14), and those trained reported higher confidence in facilitating interprofessional education and collaborative practice at the point of care.

Conclusion: This study has highlighted the gaps in healthcare workers' perceived knowledge and understanding of interprofessional education and collaborative practice. Healthcare workers need targeted professional development opportunities to develop the skills, knowledge and attitudes necessary for practising in interprofessional teams. They also need opportunities to facilitate it with students and others. Improving

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interprofessional and collaborative practice within teams will ultimately improve healthcare outcomes of patients serviced by healthcare workers.

Keywords: interprofessional education; collaborative practice; continuing professional development

Introduction

Interprofessional education and collaborative practice (IPECP) ultimately seeks to improve health and social care for patients/clients. Collaborative practice between healthcare workers is essential for bringing teams together to improve patient care (Barr, 2012). Collaborative practice, which happens when multiple healthcare workers from different professional backgrounds work together with clients, families, carers and communities to deliver the highest quality of care, has been shown to strengthen health systems and improve health outcomes (WHO, 2010). Furthermore, duplication, mistakes and delays are minimised when professions work together (Thylefors et al., 2005). Interprofessional education (IPE) is defined as occasions when health team members or students from two or more professions learn about, with and from each other to improve collaboration and the quality of care and services (CAIPE, 2019). IPE occurs across a continuum from pre-qualifying to post-qualifying learning. While there may be questions about IPE diluting professional identity, IPE in fact recognises and respects profession-specific requirements and safeguards the identity of each profession (Barr et al., 2017).

Reeves (2016) argues that, for over 3 decades, health policy makers globally have identified the key role of IPE in improving outcomes for clients and health organisations. IPE is considered an important mechanism to enhance communication and practice among healthcare providers, optimise participation in clinical decision making and improve the delivery of care (Baker et al., 2011). A report by the World Health Organization in 2010 exposed the health workforce crisis in 57 countries, equivalent to a global deficit of 2.4 million doctors, nurses and midwives. Subsequent reports (Frenk et al., 2010; WHO, 2013) acknowledged that increased production of health workers was not the only answer, rather they recommended stakeholders address issues of quality and relevance and use a systems approach to fulfil population needs. IPE is one strategy that has been postulated to transform healthcare in the 21st century to meet population health needs (Frenk et al., 2010; WHO, 2013).

There has been a push to promote IPECP as important learning and clinical practice initiatives that promote positive client outcomes (CIHC, 2012). Evidence suggests that training healthcare providers using a team-based approach is a pragmatic, effective strategy for enhancing patient safety by reducing medical errors (Clapper & Ching, 2020). There has been a growing international move to enhance the focus of IPE in pre-qualifying health programs. However, it is well-documented that IPE opportunities in the workplace are lacking (CAIPE, 2019). When students enter the workforce, or attend practice placements in health organisations, there is a real risk that IPE opportunities will

be lacking and, therefore, what was learnt in the classroom will be difficult to sustain. Facilitating IPE can be challenging, and educators need preparation and training to do this effectively (Khalili et al., 2019; Lie et al., 2016). However, a recent report identified that courses and training to prepare staff for delivering IPE are uncommon and not yet systematically delivered (WHO, 2010). Therefore, it is not surprising that educators often feel underprepared, undervalued and confronted with that role. Internationally, more educators who have an understanding and confidence in facilitating IPE are needed in the workplace (CAIPE, 2019).

One of the challenges in the IPE field is the lack of consistent and uniform terminology. As this field advances, the need for common terminology is growing (Khalili et al., 2019). Clarification of commonly used interprofessional terminology plays a significant role in the progression of IPE knowledge and science (Khalili et al., 2019). However, there is confusion and lack of consensus regarding IPE terminology at the point of care (Barker et al., 2005), which compounds the lack of educator preparedness to facilitate IPE. Various terms used (some interchangeably) include interprofessional education (IPE), interprofessional learning (IPL), interprofessional practice (IPP), interprofessional collaborative practice (IPCP), interprofessional education and collaborative practice (IPECP), interprofessional practice learning (IPPL) and team-based interprofessional practice placement (TIPP). This variation and confusion in terminology is also mirrored when describing how teams operate. Terms that are used include multidisciplinary team (MDT), multi-professional team (MPT), interdisciplinary team (IDT), interprofessional team (IPT) and transdisciplinary team (TDT). For a healthcare worker at the point of care, this can be a source of great confusion. The literature has shown that confusion in terminology can hinder understanding of a given concept, thereby hindering its uptake (Martin et al., 2017).

Accurate and valid baseline measurements are vital to gauge the level of understanding of IPECP in health settings. This will then guide development of appropriate training and resource packages to upskill healthcare workers in this area, with the ultimate aim of enhancing IPECP in the workplace. This study investigated healthcare workers' perceived knowledge and understanding of IPECP, their perceived skills and confidence in IPECP and their preparedness to facilitate IPE in the workplace.

Methods

Study design

This was a cross-sectional, cohort study that used a survey approach to collect data.

Setting and participants

This study was conducted in two regional (non-metropolitan) hospital and health services—HHS A and HHS B—in Queensland, Australia in 2018–2019. Each included health service has a larger hub (regional) and numerous smaller satellite sites (rural and

remote). Both health services are part of Queensland's largest public health system and were chosen as they were representative of the health services included in the system. Allied health practitioners—including audiology, clinical measurements, exercise physiology, medical radiation, music therapy, nutrition and dietetics, occupational therapy, physiotherapy, podiatry, prosthetics and orthotics, psychology, social work and speech pathology—pharmacists, doctors and nurses were invited to participate in the study.

Procedure

The survey was distributed online to participants using Survey Monkey. The study was advertised through the local health service newsletters in both the health services. Additionally, all eligible participants were sent an email with the participant information sheet and the link to the survey. Three email reminders were sent to boost the response rate. Implied consent was assumed for participants who responded to the survey.

Data collection

Data were collected through a de-identified bespoke survey developed by researchers with expertise in IPECP and survey development and informed by the IPECP literature. The survey consisted of 24 questions, with an opportunity to provide additional free-text comments for some questions. Questions related to the participant's professional background, their understanding of IPECP, how their teams operate and their perceived skills, knowledge, and confidence in practising and teaching IPECP. The survey was piloted with five healthcare workers with expertise in survey development and IPECP and enhanced based on their feedback. The final survey is included in the appendix. Data were collected between January and April 2019.

Data analysis

The analysis was carried out using SPSS V24 (SPSS, Inc., Chicago, IL). Demographic data were summarised descriptively and presented in tabular form. Continuous measures were reported as means and standard deviations, and categorical data were reported as counts and percentages. Inferential testing was used to examine correlations and compare between group differences, with non-parametric testing being carried out on non-normally distributed data. A multiple regression analysis was used for predictive analysis. Qualitative data were analysed using a content analysis approach, where the data is read and re-read to find meaning and develop categories for reporting. These findings were used to illuminate the quantitative findings reported here. The full analysis process and qualitative findings will be reported in a subsequent paper.

Ethics approval for this study was obtained from the Institutional Human Research Ethics Committee (Ref: HREC/18/QTDD/38). Subsequently, site-specific approvals were obtained from both the health services.

Results

Emails were sent to over 5,000 healthcare workers in two regional hospital and health services. Of these, 179 emails were undeliverable. A total of 235 completed questionnaires were returned, with 155 from HHS A and 80 from HHS B. As healthcare workers often work away from a computer and may not use their email regularly, the number of people that gained access to the survey cannot be determined, making it challenging to calculate an accurate response rate. Respondents were mostly nurses (57%), followed by doctors (13%), occupational therapists (8%) and pharmacists (3%). The number of responses from other professions was low, therefore, professions classified as allied health (including occupational therapy) were combined into one category representing 26% of respondents. Other allied health respondents were from medical radiation, nutrition and dietetics, physiotherapy, podiatry, psychology, social work and speech pathology. Most respondents worked in a clinical role, had been in their current role for 10+ years and had 10+ years of experience in their profession. Table 1 summarises respondent characteristics.

Table 1

Respondent Characteristics by Location (HHS)

Characteristic	HHS A Control	HHS B Continuous	Total
Number of respondents	155	80	235
Professional group: Number (% of total respondents)			
Nursing	94 (40)	40 (17)	134 (57)
Medicine	24 (10)	6 (3)	30 (13)
Allied Health	30 (13)	31 (13)	61 (26)
Pharmacy	4 (2)	2 (1)	6 (3)
Other	3 (1)	1 (0.4)	4 (2)
Clinical role: Number (% of total respondents)	137 (88)	77 (96)	214 (91)
Years in current role: Number (% of total respondents)			
0–2	31 (13)	24 (10)	55 (23)
3–5	35 (15)	11 (5)	46 (20)
6–10	22 (9)	12 (5)	34 (15)
10+	67 (29)	33 (14)	100 (43)

Characteristic	HHS A Control	HHS B Continuous	Total
Years experience in profession: Number (% of total respondents)			
0-2	12 (5)	5 (2)	17 (7)
3–5	18 (8)	16 (7)	34 (15)
6–10	17 (8)	9 (4)	26 (11)
10+	108 (46)	50 (21)	158 (67)

The knowledge questions in the survey (see Question 15 in the appendix) asked respondents to categorise different team descriptions as examples of multidisciplinary, interdisciplinary or transdisciplinary working. Allied health practitioners had the best understanding of interprofessional practice terminology, with a mean score of 4 out of 7 for the knowledge questions. Nurses had the lowest mean score, 2.1 out of 7. Almost half (48%) of the allied health respondents indicated that they understood the difference between multidisciplinary, interdisciplinary and transdisciplinary teams, whereas 30% of doctors reported understanding the difference. Few respondents were aware of different terminology used to describe IPE—the majority group indicating awareness of different terminology was allied health at 25%, and the minority group was nursing at 16%. Very few respondents were aware of the existence of IPE frameworks. Medicine had the most respondents with this knowledge, with 10% of medical staff indicating an awareness of IPE frameworks compared with nursing and allied health (3% and 4%, respectively). Even fewer staff had undertaken training in IPE/IPL, with the highest proportion in the allied health group, in which only 12% of staff had undertaken training. Table 2 presents a summary of results by professional group.

Table 2

Results by Professional Group

Variable	Nursing	Medicine	Allied Health	Pharmacy	Other
Number of respondents	134	30	61	6	4
Knowledge of IPP terminology score: Mean score out of 7 (SD)	2.1 (1.5)	2.7 (2)	4 (1.9)	3.5 (2.3)	4 (2.3)
Understand the difference between MD, ID and TD teams: Number (% within profession)	53 (40)	9 (30)	29 (48)	2 (33)	1 (25)
Aware of different terminology to describe IPE: Number (% within profession)	21 (16)	7 (23)	15 (25)	1 (17)	0 (0)

Variable	Nursing	Medicine	Allied Health	Pharmacy	Other
Aware of IPE frameworks: Number (% within profession)	4 (3)	3 (10)	9 (15)	0 (0)	0 (0)
Undertaken training in IPE/IPL: Number (% within profession)	3 (2)	3 (10)	7 (12)	0 (0)	1 (25)

There was a statistically significant negative correlation between knowledge of interprofessional practice terminology score and years post qualification, indicating that the more recently qualified respondents had a greater understanding of the functions of different types of teams (r = -0.190, p = .003). As would be expected, those staff who had received training in IPE/IPL reported statistically significantly higher scores for their knowledge of interprofessional practice terminology (U = 892, p = .011) compared to those who had not received training. There was also a statistically significant association between receiving IPE/IPL training and respondents' ability to explain interprofessional practice terminology (X^2 = 16.869(2), p > .001) and receiving IPE/IPL training and their perception that IPECP improves patient/client outcomes (X^2 = 17.757(4), p = .001). Those who had received training in IPE/IPL were also more confident about the prospect of facilitating IPE with students (X^2 = 19.256(8), p = .017) and other staff (X^2 = 18.960(8), p = .019). There were more staff trained in IPE/IPL in HHS A compared to B (X^2 = 13.013(2), p = .001) but no significant difference in knowledge of interprofessional practice terminology scores (U = 6049.5, p = .758). However, only 6% (n = 14) of the respondents overall had received IPE/IPL training, so these results should be interpreted with caution. Table 3 provides a summary of analysis results.

Table 3

Analysis Results

Variable	Test statistic (DF)	*P*-value (two-tailed)
Correlation between knowledge of IPP terminology score and years in profession	r = -.190	.003*
Difference in knowledge of IPP terminology score between those who had received IPECP training and those who hadn't	U = 892	.011*
Correlation between ability to explain IPE terminology correctly and having received IPE/IPL training	X^2 = 16.869(2)	> .001*
Correlation between view that IPECP improves patient outcomes and having received IPE/IPL training	X^2 = 17.757(4)	.001*
Correlation between having undertaken training in IPE/IPL and confidence in facilitating IPE with:		
Students	X^2 = 19.256(8)	.017*
Other staff	X^2 = 18.960(8)	.019*

Variable	Test statistic (DF)	*P*-value (two-tailed)
Difference between HHS A and B in whether staff are trained in IPE/IPL	X^2 = 13.013(2)	.001*
Difference between HHS A and B in the knowledge of IPP terminology score	U = 6049.5	.758

Note: DF = degrees of freedom, *P < .05

A multiple regression model was used to determine the predictors of a high knowledge of interprofessional practice terminology score, as this was the only objective measure in the questionnaire that enabled determination of respondents' level of understanding of IPECP. The model revealed that claiming to understand the difference between multidisciplinary, interdisciplinary and transdisciplinary teams (β.189, p = .001), perceived ability to explain IPE to a colleague (β.196, p = .001) and being an allied health practitioner (β.312, p > .001) were statistically significant predictors of a high knowledge of interprofessional practice score, whereas being a nurse was not predictive of this knowledge (β-.092, p = .293). This model accounts for 29.5% of the variation in knowledge of terminology scores. Table 4 summarises the multiple regression model output.

Table 4

Regression Model to Determine Predictors of a High Knowledge of IPP Terminology Score

Model	Unstandardised Coefficients	Standardised Coefficients		*P*-value
	B	Std. Error	Beta	
Knowledge of terminology score (constant)	1.203	.612		.051
Years of experience in profession	-.203	.112	-.106	.070
I understand the difference between multi-disciplinary, interdisciplinary and transdisciplinary teams	.713	.221	.189	.001*
I can explain IPE to a colleague	.745	.225	.196	.001*
AH compared to doctors (constant)	1.302	.355	.312	.000*
Nurses compared to doctors (constant)	-.346	.329	-.092	.293

Note: R^2 = .295, *P < .05, AH = allied health

Several free-text comments (see Table 5) were received in the survey. Whilst some responses indicated a clear or reasonable understanding of IPECP, there were many comments that indicated a lack of understanding of what IPE/IPECP is and what it

involves. Several participants openly expressed frustration at their lack of awareness of IPE terminology and acronyms, with some stating that they have never heard the term "IPECP" before.

Table 5

A Selection of Free-Text Comments

You are asking about something that is not really discussed in my workplace. I suspect it is something that we do, but it is not formalised in any way.
The terms used in this survey are not widely used in our department. Since we have students, education and training would be enormously beneficial.
I think some education session about this may be required, otherwise those of us not up to date/not in the loop have no idea what you are talking about.
A new bunch of letters without warning, education, direction
I need training about this topic.
Sounds good. Would be keen to learn more. I am sure I do a lot of this but, not knowing the jargon and definitions, am unable to answer all the questions.
Sorry I have answered so poorly but honestly have not had to consider the differences in these terms before.
Implementing this would be great and arguably more rewarding for individuals as well as tackling the malignant effects of professional hierarchies in healthcare.
It would be helpful if you defined these terms, given that I don't have a clear understanding of them.
I have never heard of this term before but would assume it refers to people in different disciplines across the spectrum but at the same level.
Participant definitions of IPECP: What are you talking about; I've never heard of it before; I have no idea really - but it's probably something about working with students from a variety of areas to see the bigger picture of healthcare as a whole and not as individual unique sets of skills to get the best possible care for all clients; I don't know; I don't fully understand the concept; this is a new terminology to me, I wouldn't be able to answer the question; buzzword; not sure; no idea, don't know; who knows ask our educator; I could not answer that; a five-letter acronym
Participant definitions of interprofessional: Teamwork between others of the same professions; senior staff within the group working together; within a discipline; within one profession, e.g., physiotherapy team; same discipline, different levels; not sure; don't know; within one group of professionals - professional affiliation (Aust College of Nurses)
Participant definitions of transdisciplinary: got no clue; new term; sorry, is this a gender??; a discipline who can't make up their mind

Discussion

This paper has reported findings from a survey that investigated regional healthcare workers' perceived knowledge and understanding of IPE terminology, their perceived skills and confidence in IPECP and their preparedness to facilitate IPE. Language is powerful in progressing any field (Martin et al., 2017) and, also, plays a key role in IPECP (Cahn, 2017). This survey has identified gaps in this aspect of IPECP and highlighted

the need for using consistent and uniform terminology. It has further highlighted the need for targeted professional development opportunities for staff at the point of care. Findings from this study will be of use in planning and delivering targeted IPE training, as well as upskilling staff in IPE to enhance their confidence and skills to embed IPECP in standard clinical practice.

Some disciplines and age groups were more attuned to IPE in the clinical setting. Allied health practitioners reported a greater understanding than their nursing colleagues. Further investigation is needed to unpack these professional differences. Also, recent graduates appeared more knowledgeable and confident with IPE, presumably owing to the transformation academic institutions have undergone in recent times to include IPE in the core curriculum (Khalili et al., 2019). Health services can make use of these cohorts to facilitate learning in practice amongst colleagues in IPECP.

This study has highlighted the need for targeted professional development in IPE, notwithstanding that training needs may vary between different professional groups and cohorts. A training needs analysis may be a good first step to inform the process. Respondents who had undertaken IPE training reported more confidence in facilitating IPE/IPECP with students and other colleagues when compared to those who had no such training. It has been acknowledged that focused professional development opportunities are needed to support teaching and learning in IPE as healthcare workers cannot be expected to automatically have the knowledge, skills and attitudes to facilitate learning between learners from various professions (Khalili et al., 2019).

Only a handful of survey respondents reported awareness of all IPE terminology, frameworks and resources. Targeted training to enhance healthcare workers' awareness of these concepts is essential as are resources that will subsequently facilitate IPE at the point of care. A tailored framework such as the one described by Silver and Leslie (2017) could be used to plan IPECP continuing professional development activities. This framework consists of a needs assessment, clear and measurable learning outcomes, interactive teaching methods and an evaluation typology. Awareness about pre-existing, evidence-based, practical tools that are useful in facilitating IPE may be a first step in gaining confidence to facilitate IPECP. For example, tools such as the Process for Interprofessional Education System (PIPES tool) serve as a checklist that guides clinicians/faculties to consider the factors to progress a uni-professional learning activity to a more interprofessional learning activity (Centre for Interprofessional Education, 2019). Being aware of such tools and resources will equip healthcare workers in their quest to facilitate IPE in a wide variety of patient populations and clinical settings.

This study is not without limitations. Firstly, the survey conducted has only scratched the surface of the situation of IPECP in clinical settings. Further in-depth studies are needed to evaluate knowledge and practices beyond participant perspectives. Secondly, the survey was only completed by a small proportion of healthcare workers from the study

population despite promoting it via organisational newsletters and emails. Declining response rates to online surveys have been acknowledged internationally (Dey, 1997; Rindfuss et al., 2015). Therefore, it is important to note that a low response rate does not automatically indicate a non-response bias (Schouten et al., 2009; Wahlberg & Poom, 2015). As our study has achieved good representativeness, with participants from a wide range of professions and work experiences, the low response rate is not a threat to the study validity (Fincham, 2008; Schouten et al., 2009). In line with the free-text comments received (see Table 5), it is possible that some respondents did not complete the survey because of a lack of awareness of IPE concepts and terminology. As the study aimed to explore whether healthcare workers understood IPE concepts and terminology, it was important to test respondents' knowledge in these areas. It is possible that the level of understanding of IPECP in the population studied may be lower than survey results indicate, as those who did not have awareness of IPE terminology or concepts may have avoided the survey. This has been investigated and confirmed in a follow-up, multi-methods study, which has been reported elsewhere (Martin et al., 2021). As not all healthcare workers in this study population have access to a dedicated computer for use at work or access their emails on a regular basis, future studies in this population will need to use additional methods of recruiting participants, such as displaying printed posters in clinical areas and/or making hard copy surveys available.

Conclusion

This survey study investigated healthcare workers' awareness and understanding of IPE terminology; their perceived skills, knowledge and confidence in IPECP; and their preparedness to facilitate IPE in a regional context. It has provided a baseline measure that can inform targeted training to upskill healthcare workers and teams in IPECP. It has added to the evidence base that identifies gaps in regional health settings related to IPECP. Many healthcare workers are unaware of the concept of IPE and, thus, may not possess skills and knowledge to learn about, from and with other practitioners and students within an IPE framework. IPE training plays an important role in influencing healthcare workers' understanding of IPE and, subsequently, their perceived confidence, skills and knowledge in facilitating IPECP. More targeted IPE professional development opportunities (including training) need to be made available to these healthcare workers. Improving interprofessional and collaborative practice within teams will ultimately improve the health outcomes for patients/clients and their families.

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Conflicts of interests and funding

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Appendix A

Survey questions

1. My professional group is:
   - Doctor
   - Nurse
   - Allied health assistants
   - Audiology
   - Clinical measurements
   - Exercise physiology
   - Medical radiation professionals
   - Music therapy
   - Nutrition and dietetics
   - Occupational therapy
   - Pharmacy
   - Physiotherapy
   - Podiatry
   - Prosthetics and orthotics
   - Psychology
   - Social work
   - Speech pathology
2. I have been in this role:
   - 0–2 years
   - 3–5 years
   - 6–10 years
   - More than 10 years
3. Years of experience in my profession:
   - 0–2 years
   - 3–5 years
   - 6–10 years
   - More than 10 years
4. My current work role is:
   - Clinical
   - Non-clinical
   - Both (please specify)
5. I am aware of different terminologies used to describe interprofessional education (IPE)
   - No
   - Yes, the terms I am aware of are _____
6. I can explain to a colleague what interprofessional education (IPE) is
   - No
   - Yes, this is what I would say IPE is _____
7. If I am asked to explain interprofessional education & collaborative practice (IPECP) to someone, this is what I would say:
   - IPECP is _____

8. I can differentiate between interprofessional education (IPE), interprofessional learning (IPL) and interprofessional practice (IPP)
   - Yes
   - No

9. Interprofessional education & collaborative practice (IPECP) leads to improved patient outcomes
   - Strongly agree
   - Agree
   - Neither agree or disagree
   - Disagree
   - Strongly disagree

10. I understand the difference between multi-disciplinary, interdisciplinary and transdisciplinary teams
    - Yes
    - No

11. I would describe the following terms as
    - multidisciplinary _____
    - interdisciplinary _____
    - interprofessional _____
    - transdisciplinary _____

12. I would describe teamwork in my current work team as _____

    _____

13. Team members in my work team practise collaboratively to provide a high standard of patient care
    - Strongly agree
    - Agree
    - Neither agree nor disagree
    - Disagree
    - Strongly disagree

14. My team uses the following approach to patient care:
    - Multidisciplinary
    - Interdisciplinary
    - Transdisciplinary
    - Other (please specify) _____

15. I would describe the following teams as: multidisciplinary, interdisciplinary or transdisciplinary
    - Team members' roles are clearly defined and communication between members is relatively limited
    - Different team members work with the same client yet function independently
    - Each team member completes their own discipline-specific assessment and formulates discipline-specific goals. The results are then shared at team meetings

- Collective identification of client goals that is achieved through cooperation and joint intervention between the various clinicians, the clients and their family
- Team members engage in problem solving and care delivery from their discipline. Recommendations are a result of group decision making that may include problem solving beyond an individual's particular knowledge base
- Each team member becomes familiar with the roles and responsibilities of other team members so the tasks and functions become interchangeable to some extent
- Team members work across disciplinary boundaries

16. I am confident in facilitating interprofessional education (IPE) for students from my own profession
    - Strongly agree
    - Agree
    - Neither agree nor disagree
    - Disagree
    - Strongly disagree
17. I am confident in facilitating interprofessional education (IPE) for students from other professions
    - Strongly agree
    - Agree
    - Neither agree nor disagree
    - Disagree
    - Strongly disagree
18. I have the skills required to facilitate effective interprofessional education (IPE) for students
    - Strongly agree
    - Agree
    - Neither agree nor disagree
    - Disagree
    - Strongly disagree
19. I am confident in facilitating interprofessional education (IPE) for other staff
    - Strongly agree
    - Agree
    - Neither agree nor disagree
    - Disagree
    - Strongly disagree
20. I have the skills required to facilitate effective interprofessional education (IPE) for staff
    - Strongly agree
    - Agree
    - Neither agree nor disagree
    - Disagree
    - Strongly disagree
21. I am aware of interprofessional education (IPE) frameworks
    - No
    - Yes, please list them _____
22. I know where to find interprofessional education & collaborative practice (IPECP) resources
    - Yes
    - No

23. I have undertaken training in interprofessional education/interprofessional learning IPE/IPL
    - No
    - Yes, I attended the ehpic™ (Educating Health Professionals in Interprofessional Care) workshop
    - Yes, I attended other training (provide details) _____
24. Additional comments

_____

_____