“Expert Program Bristol 2017”

Report on a professional healthcare group trip to Bristol with a focus on interprofessional education & simulation training in health care

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Background

As a result of demographic changes in Germany, the growing proportion of elderly people with chronic, multiple diseases is making increasingly complex demands on health care professionals. A trend analysis at the University Hospital of Munich (Klinikum der Universität München, KUM) has shown that, in recent years, the proportion of patients 65 years or older has risen, especially in intensive care.

The growing number of cases with a significant reduction in the average length of stay and the increase in complex treatment and care needs (Bartholomeyczik 2007) make it necessary to reallocate tasks as well as rethink the cooperation between health professionals in acute patient care (Kuhlmey 2011; Renz et al. 2014). To meet these new challenges, it takes trusting collaboration within the therapeutic team (Reeves 2012; Renz et al. 2014).

However, professional practice and public health care assessments show that the structural conditions and the professional skills of health professionals in Germany are not conducive to (interprofessional) cooperation (WHO 2010; Sieger et al. 2010). Doctors and nurses, the main health care professionals treating patients in the hospital who aim to prevent errors and improve patient care (common team goal), often have difficulty working in teams: nurses sometimes blame doctors for communication deficiencies while physicians want their workload to be acknowledged by other health care professions (Hibbeler 2011). Communication problems within the health care team in
turn may lead to poor patient outcome (see Sachverständigenrat 2007; Okuyama et al. 2011; Boev & Yinglin 2015).

In 1999–2002, the pilot project “Interprofessional Communication in the Hospital”, initiated and implemented by the German Medical Association (Bundesärztekammer) and the German Council of Nursing (Deutscher Pflegerat), polled doctors, nurses and patients on their communication and collaboration style(s), focusing on different hospital tasks, such as patient admission and discharge and ward rounds. The results of the project showed major communication and collaboration gaps and a clear need for improving team cooperation (see Lecher et al. 2002). In 2007, the Expert Council on Health Care (Sachverständigenrat für Gesundheit) also referred to these problems, noting that the current division of tasks and lack of cooperation between the health professions is not suited to meeting the demographic, structural and innovative demands (see Sachverständigenrat 2007).

The operating room and the intensive care unit especially are considered high-risk, error-prone areas, and teams working in these areas need to communicate clearly and effectively for the patients’ safety (see Dossow & Zwißler 2015). However, due to decision-making under time pressure and the high workload especially in these departments, communication difficulties often occur. Therefore, a common concept, for example the SBAR-communication tool, is needed to achieve a shared team language and reliable flow of information (see De Meester et al. 2013).

**SiHaKo Project – Overview**

In 2015, the project “Strengthening Interprofessional Collaboration through Shared Learning Seminars (Stärkung der interprofessionellen Handlungskompetenz durch gemeinsame Lernseminare, SiHaKo)” was launched by Heike Penner and Rita Hofheinz from the Department of Staff Development/Continuing Education at the University Hospital of Munich with support from the Robert Bosch Foundation. The interprofessional project is directed at medical residents and nurses participating in the post-graduate course in intensive care. Residents and nurses examine, discuss and reflect on the treatment strategy of chronically ill patients with multiple illnesses. The overall objective of the project is to improve collaborative practice and quality of care.

The course includes 68 education units, divided into an orientation and development phase and consisting of, among other things, communication seminars, demand-driven theoretical classes, and simulated interprofessional case discussions. The main focus of the seminars is on team communication and patient safety. By learning how to use various interprofessional communication tools (Interprofessional Team Reasoning Framework, SBAR) and quality tools (such as validated scoring systems, e.g., CAM-ICU) during simulated interprofessional case discussions, the participants develop an awareness of their respective perspectives, similarities and differences. The simulated interprofessional case discussions are held in a so-called “protected classroom” environment. The
students newly experience themselves in the “classroom” context, perceive others and their roles, learn to solve problems together and thus overcome their limitations and fears within the team. The objectives of the simulations are both formative and summative, allowing students to practice and demonstrate team-based skills including communication, mutual support, leadership and “knowledge circulation” which aims to make all participants (nurses/doctors/supervisors) equal partners (DeJong 2012). The intensive project experience aims to facilitate trust and create a team that continuously reflects on and optimises its actions and communication processes and is able to design its workflows effectively and efficiently.

**Health Care Group Visit to Bristol (Great Britain)**

Our “expert group” visit to Bristol took place on 27–30 June 2017. Our host during the trip was Sabine Torgeler and her “English for Nurses (EfN)” team who organised and arranged our visit. Health care professionals from Hamburg, Munich and Bremen participated in this year’s program. These expert visits allow healthcare professionals, managers and academics to spend time in Bristol and gain first-hand experience of hospital facilities and nursing education/training. The group was joined by the patron of “English for Nurses”, Professor Jacqui Filkins, from the University of Cumbria. Prof. Filkins is an internationally designated expert in nursing and nurse education. She is a founding member of the European Nurse Directors Association (ENDA) and remains its Honorary Chairman. Until recently, Prof. Filkins was also a Board member of the Cumbria Partnership NHS FT (see more at: [http://www.hca-network.eu/index.php/projectteam/132-prof-jacqueline-filkins-uk](http://www.hca-network.eu/index.php/projectteam/132-prof-jacqueline-filkins-uk)).

**Trip Schedule:**

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<th>Day 1</th>
<th>28 June 2017</th>
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<td>guided tour &amp; visit to the Stroke Unit;</td>
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<td>Professional Training Academy</td>
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<tr>
<td>Weston-super-Mare Hospice</td>
<td>interprofessional team &amp; care</td>
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<td>Hosts: Sue Milton (WGH); Bella Mare (UWE)</td>
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<td>University of the West of England (UWE)</td>
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<td>Hosts: Fergus &amp; Rob</td>
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<td>Bristol University Hospital</td>
<td>Education Research Centre</td>
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<tr>
<td>IPE – Simulation ICU, CPR etc.</td>
<td>discussion</td>
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Day 1, Morning Visit: Weston General Hospital

On our first day, we visited the Weston General Hospital (30 min. train ride from Bristol) and were able to experience and observe a range of acute hospital services, e.g., Intensive Therapy Unit (ITU), Stroke Unit, and also briefly visited the Weston NHS Trust Education Centre open to all health care professions and students. The Trust serves a resident population of around 212,000 people in North Somerset with over 70 percent of people living in the four main towns of Weston, Clevedon, Portishead and Nailsea (see more at: http://www.waht.nhs.uk/en-GB/About-The-Trust/). Our guided hospital tour was led by senior nurse Sue Milton and Bella Mare, Senior Lecturer at the University of the West of England (UWE).

As members of the staff development department (continuing education in intensive care) and former intensive care nurses, my colleague and I were mainly interested in the health care services for the critical ill. At Weston General Hospital there is a 20-bedded Stroke Unit and 5-bedded ITU. In both units, hospital staff work and also train together in an interdisciplinary and interprofessional team. Both in ITU and the Stroke Unit there is a general rule to have 1:1 support (one nurse per patient) in intensive therapy areas, and 1:2 support one nurse for two patients in high-dependency care. Here, the standards of care are compared with that of around 200 other units in the United Kingdom, to ensure that the appropriate standards are achieved. Those units seem to perform well in the prevention of MRSA and Clostridium difficile infections. According to the visitors board, at the time of our visit there was no patient admitted with any of these infections. It was also nice to see that the hospital provides uniform identification posters for patients and visitors:
**Day 1, Afternoon Visit: Weston-super-Mare Hospice**

Weston Hospicecare provides palliative care for people living with a life-limiting illness in Weston-super-Mare and the surrounding areas. The services provided are free of charge for the patients and families. To be able to provide the free of charge services they rely on annual donations from the community (approx. £3 millions).

Our group first met with Alison Sopp, Director of Fundraising and Communications, who gave us an introduction into charity work in general and Weston’s charity work in particular.

![Fundraising Graph](http://westonhospicecare.org.uk/how-were-funded/)

We also heard something about the chaplaincy and spiritual care of the hospices and how the chaplaincy team (a chaplain and a small team of volunteers) tries to support the patients and their families with spiritual and emotional care throughout their hospice or home stay.

The hospice has more than 700 volunteers supporting the hospice across 40 different roles. Their dedication and support saves the hospice money, allowing them to focus their spending on providing care and support to local people affected by life-limiting illnesses. (To learn more about their different roles, see: [http://westonhospicecare.org.uk/volunteer/](http://westonhospicecare.org.uk/volunteer/)).

We also met John Bailey, Director of Patient Services, who talked about the day and inpatient unit hospice care. The hospice has a ten-bedded inpatient unit with garden access from each room. The rooms are very spacious, which allows family members to stay overnight, if necessary. Every room is equipped with an adjustable bed, an adjustable armchair, a TV screen, a little table as well as a hoister for patient transfer. Since 2014, the hospice has offered complementary therapies for patients and their family carers in the so-called “Wellbeing Centre”. Available therapies include adapted massage, aromatherapy, reflexology, a variety of relaxation techniques, a range of beauty treatments and Indian head message (see: [http://westonhospicecare.org.uk/complementary-therapies/](http://westonhospicecare.org.uk/complementary-therapies/)).

For us, it was wonderful to see how volunteers and professionals work together as teams for the welfare of the residents and patients providing them with a warm and welcoming environment.
Day 2: University of the West of England (UWE Bristol)

With over 28,000 students (around 4,000 international students) and 3,000 staff, UWE Bristol is one of the largest providers of higher education in the south-west of England.

Our visit at UWE mainly focused on the “Interprofessional Simulation Suites” at Glenside Campus. These facilities provide excellent opportunities for demonstrating and practicing professional competencies in an interprofessional context.

The VERT

The VERT (Virtual Environment Radiotherapy Training) at UWE Bristol is a life-size 3D virtual radiotherapy treatment room complete with patient and linear accelerator.

In the simulation lectures students wearing 3D glasses use a control identical to the one used in a real-life situation to position the virtual table and deliver doses of radiotherapy to a virtual patient. In one of the simulation lecture theatres, our group could test the 3D glasses by watching a small show movie with giant insects flying directly towards us (see more at: http://www1.uwe.ac.uk/whyuwe/fantasticfacilities/virtuallinearaccelerator.aspx).

Skills Simulation Centre

The new Skills and Simulation Centre at Glenside Campus mimics a real hospital ward enabling the students to practice what they learn before going into a real hospital on work placement.

For us, it was very impressive to see the new replica maternity and children’s unit. Here, health care students can practice in a safe environment that reflects as near as possible the actual conditions in health care practice. The Centre uses a comprehensive range of manikins including newborns, infants, adults and birthing manikins. The simulation wards provide interprofessional learning opportunities where undergraduate and postgraduate student nurses, midwives, radiographers, paramedics, and physiotherapists can learn together.

The Suite has video recording and playback equipment to review group interactions and assess individual attitudes and communication skills (see more at: http://www1.uwe.ac.uk/whyuwe/fantasticfacilities/skillssimulationsuite.aspx).

From an interprofessional point of view, we learned that at UWE Bristol the medical department is not situated on the same campus as all the other health care professions. This raises an important question in terms of health care student interactions and simulation training: How can health care students learn together and from, with and about each other in order to improve care (see Barr 2002; Barr & Low 2011) if not all health care professions study at the same campus/location?

Interprofessional communication and collaboration in health care does not happen on its own, it should be offered early and practiced as a lifelong process. If health care students are (made) aware
of their own professional roles and the roles and perspectives of other health care groups from the beginning, they may find it much easier to support interprofessional practice in their later career. To achieve this goal, all health care professionals need to learn together that decision making in patient care requires the shared effort of the entire health care team.

Several papers on interprofessional learning and practice report that doctors and nurses especially – the main health care professionals treating patients together – often have difficulty working in teams despite a common team goal: improving patient safety (Lecher et al. 2002; Hibbeler 2011; Dossow & Zwißler 2015).

Other studies of health care team interactions show that it requires interventions such as joint daily interprofessional ward rounds or early interprofessional education via both educational programs and patient simulations to improve nurse-physician collaboration (Reeves 2012; Renz et al. 2014; Boev & Yinglin 2015).

The need for an early start and lifelong learning in the area of interprofessional cooperation in health care is also called for by the WHO in its “Framework for Action on Interprofessional Education and Collaborative Practice” 2010.

In our “SiHaKo” pilot project (2015–2017), we conducted observation studies during simulated interprofessional (IP) case discussions. The subject of investigation was the interactions between the two professional groups (nurses/physicians) and the professional perspectives of the students. From the perspective of the observer group, it was striking how often nurses neglected their own perspectives or roles in the IP case discussions (nurses immediately – and automatically – adopted the doctors’ assessment/perspective). By ignoring their own role and competencies, nurses failed to present and/or defend their professional perspective and diagnoses; as a result, important information is not discussed. Another interesting aspect was that interprofessional team discussions were rather rare. The students, doctors and nurses working in intensive care teams had their case
discussions in a rather traditional style and seemed to feel more comfortable discussing within their own professional groups.

**Discussion**

**Qualification Level Concepts and Lifelong Learning in Nursing in Germany and the UK**

The education systems of both countries differ structurally, organisationally, socio-culturally, and historically (see Münk 2006, pp. 547 ff).

According to Lehmann et al. (2015), the field of health care professions is highly differentiated within Europe, with partly different, partly similar or overlapping qualification profiles and areas of responsibility.

In Germany, all professional health care training courses in the secondary education sector conclude with a state-approved exam. In addition, there are dual degree courses for nurses (pilot phase) which conclude with a state-approved exam after 3 years and a bachelor's degree after 4 to 4.5 years.

In the UK, these higher education courses with professional registration (3 years) have been the standard for some time. Unlike in Germany, the professional registration and associated further training courses play a significant role for maintaining the professional qualification. Furthermore, lifelong learning with its related qualification concepts is much more advanced in the UK than in Germany – across all levels, from assistant to doctorate degree (Frenk et al. 2010). In the UK, continuing education or specialisation options often lead to a substantial increase in competence and autonomy. According to Zalpour (2007), this increase in autonomy is sometimes associated with the takeover of tasks that were previously assigned to physicians (e.g., Advanced Nurse Practitioners). Although there are many further specialisation options for nurses in Germany, it seldom leads to an increase in autonomy or salary.

A change in the UK’s qualification scheme has now brought a new nursing qualification into the picture, “Nursing Associates”, which is still in the pilot stage. This is an additional role between Health Care Assistants (HCA, without in-depth training) and registered nurses and is intended to make it possible for nurses to focus on more advanced practitioner tasks. According to Prof. Filkins, the training is to last 2 years; trained nurses will be called “Qualified Nursing Associates” but are not expected to be registered. Therefore, the Royal College of Nursing (RCN) remains sceptical about this new development and concerned that rather than regulating the current HCA situation, it will result in registered nurses being replaced by cheaper staff.

**Learning from the British Health Care Education System?**

Our visiting expert group was able to experience and observe different models of the British health care system (NHS & private sector) as well as the British health education culture (University of the West of England – UWE) in the Bristol area. In all centres, we met highly committed and enthusiastic
British colleagues who welcomed us warmly and work hard to promote a professional spirit in health care.

It remains a crucial question for every health care education department if the present qualification path will sufficiently prepare students for their professional practice. As discussed earlier in this article, demographic changes are transforming socio-economic and legal frameworks while advances in science and medical technology are impacting the requirements for health care professionals.

For the changes to be effective and to meet current and future challenges in health care, it is essential to overcome the theory-practice gap and to adequately translate research results into practice.

Content and methodology training should be further developed, and intra- and interprofessional collaboration should be based on sustainable practice concepts. This is currently not the case in the German health care context.

A recent study by Lehmann et al. (2015), commissioned by the Federal Ministry of Education and Research (BMBF), confirms that theoretical competencies/skills cannot be translated into practice because of a lack of mentorship (shortage of staff) and that students are overwhelmed by complex practice situations.

What does that mean for the German health care system?

The German health care system is undergoing constant reforms, and many projects have never gone beyond pilot project level. It might be good to reflect on international health care qualification concepts before translating them into the German context. With the academisation of the health care professions in the UK, new relationship systems have been formed between the service providers. These are characterised by newly assigned tasks and areas of responsibility as well as changes in interprofessional collaboration towards a collaboration “among equals”.

In the education sector we need to look closely at those new and shorter qualification paths to find out which competencies health care practitioners need to meet future societal needs. The aim is to provide training models at different level of skills and competency that guarantee high quality of patient care while also making the education system more flexible and permeable, in keeping with the model of lifelong learning.

At present, there are further pilot projects on its way, such as for example the “Mentoring for Professional Bridging” project, a model project of the “ANKOM – Transitions from Vocational to Higher Education” initiative of the Federal Ministry for Education and Research (BMBF), which might be interesting in the context of nursing education (see Schreiber, Jungmann & Fischer 2015, p. 49).

Whether newly designed tasks, shorter qualification paths or better permeability of education programs are some answers to these questions will have to be the subject of further studies.
Acknowledgments

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Bibliography


