The enquiry based learning essay

ASSIGN BUSTER

Part 1. The Enquiry Based Learning (EBL) is a method of learning which involves a student-centred approach.

In EBL each student is responsible for their own learning and for the learning of other group members. This method of learning will help and assist us to develop the transferable teamwork skills which Miller (1999) and Russell (1999) consider essential to developing a collaborative approach to care. EBL is an interactive process in which students first identify a problem or trigger, which becomes the starting point of the process. After that, the students discuss this with one another sharing different ideas and opinions, and tasks are allocated. The next step is individual research and learning.

Finally each student will share their findings with other members of the group which will generate a different range of perspectives and opinions. The trigger is then revisited and if necessary new issues identified. This cycle is repeated until all questions are addressed. EBL involves students taking part in their learning and working cooperatively as a team.

The students work in small groups and are responsible for themselves and the members of their group. Within the groups there are different roles; a chair person, a scribe and the team members. The chair person leads the group. The scribe keeps an account of all the topics that are raised and discussed.

The team members have freedom to organise their own pattern of work, research topics and feedback to the group, which help to develop a deeper understanding of the subject. Part 2. At the beginning of the session, in small groups, we worked through the set triggers. We were six people in my group

and, after introducing ourselves, we proceeded to designate a scribe person among us. We failure, however, to designated a chair person, a person that could lead the group, manage feedback and who could encourage all members of the group to participate.

This was due, I believe, to the fact that no one in the group felt confident in taking on this role, and also due to a lack of motivation among all of us. This had a large impact on the dynamic of my group resulting in a lack of active participation from most of the members and also resulting in some confusion, quite often, as to what the discussion was about. Some of the group members brought forward their experiences of primary, secondary and tertiary health care. After that, we spent some time working in different elements of the triggers and we decided that there were three important elements for us within the two triggers.

The first element was the need of effective collaboration between Social and Heath care professionals in order to meet the complex heath and social needs of patients/clients (Kennedy 2001 & Laming 2004). The main point that we raised from this element was the need to look at the patient care in a holistic form. It implied for us that patients should be able to trust in healthcare and social professionals. Every patient is entitled to dignity and confidentiality.

Also the patient needs to be continuously informed and has the right to choose where, how and when the care is provided. The second element that we felt was important to discuss was the roles of the heath care professionals (Kennedy 2001, Laming 2003). For us a healthcare

professional should always co-operate with other members of the staff and have continuous training and up dates of skills and knowledge. Also she or he has the duty to report problems and information, as well as the responsibility of knowing other professional's roles.

The third element that we thought was important was related to Interprofessional working and how it can be enhanced through interprofessional education (Barr, 1995), which for us involved students from different professions having an understanding of social hierarchy and learning how to break down myths and stereotypical views. In the next session we developed a shared understanding of these three main elements but we failed to explore it further due to a lack of research, so the discussion returned again to the key points. However, I feel I have learned a lot from this experience. I have learned how a good discussion relies on the active participation and a sense of shared responsibility among its members, qualities that we lacked in my group.

I also feel that working in small groups with different heath care students has improved my communication skills. Interprofessional education is very important, it creates positive attitudes and students acquire skills for future professional roles (Soothill , 1995). Interprofessional working is the desired result, where professionals from all Heath and Social Services agencies work together seamlessly. The way to achieve this is through effective education of all the staff working in these agencies. EBL is the tool that takes the student from Interprofessional education to Interprofessional working. Part 3The aim of this essay is mainly to explain my understanding and experience of interprofessional working.

I will explore the different aspects related to this concept, the reason for interprofessional working and the policies behind it, the notion of user centred practice and its relationship to interprofessional working. I will consider what knowledge, skills and attitudes are required, and discuss barriers for interprofessional working. Finally, I will discuss organisational factors that influence it. Interdisciplinary refers to professionals working together.

According to Goorman (1998) inter-disciplinary indicates that all members and disciplines of the team recognise theabilities, skills and critical contributions of each of the others. There is a number of ideological, practical and political explanations that can be identified to explain the emergence of interprofessional care. The idealogical explanation is related with the re-discovery of the ” whole patient” during the 1970s. It was recognised that patients/clients often present with multi-factorial problems, that can be defined as both “ medical” and ” social”, that a few agencies alone are/were unable to address. The political explanations came from the reform of the government’s role in delivery of health care that has placed a demand on service providers to use resources efficiently and get value for money.

Multidisciplinary practice was viewed as a panacea for: the inefficiency in health service delivery; for communication failures within and between disciplines and for professional separatism (Irvine, 1985). The last element that explains the emergence of interprofessional care refers to the specialisation that has occurred during the twentieth century where generalist workers have been replaced by a diversified range of occupations

and specialists focused on particular fields of work (Abbott, 1988). The result of this professional and functional specialisation, fragmented knowledge, is that it is no longer possible for any one profession to have all the knowledge and skills necessary to address a particular need, issue, or problem. Every profession, then, overlaps by necessity other professions. Also, the reform of health care systems and the emergence of evaluative systems contributed to the multiplication in the number of social agents involved in the delivery of services to the public.

Against this situation, the belief emerged that progress in heath care delivery could only be made by professionals who were able to ignore disciplinary boundaries, and who could work in a new interdisciplinary way. This approach was viewed as a possible solution to the problems which emerged from traditional hierarchical relationships in the division of labour. In health and social care, there was an early recognition that the boundary between these two public services was a key issue for service users and for the notion of user centred practice that the government wanted to achieve (Glasby, 2003). It was with the publication of it’s White Paper on the NHS (department of Health, 1997), that the government announced its intention to bring down what it described as the “ Berlin Wall” that had grown up between heath and social services (House of Commons Debates, 1997). Following this, the government introduced a number of policy initiatives to promote effective partnerships between health and social care.

The first one, The Parnership in Action (1998) proposed new legislation to remove existing barriers to joint working and facilitated inter-agency collaboration but this proposals however did not tackle the root cause of the

problem. The second one, The Royal Commission on Long Term Care (1999) focused on the shortcomings of the current system for organizing and funding long-term care, the inequitable distinction between health care (free) and means-tested social care, but the Commission's failed to resolve the inconsistency inherent in the current system. Finally the third one was The NHS Plan (Department of Health, 2000a), which was intended to be a long-term strategy to re-built the NHS , where the government, among other things, promised financial incentives for joint working but it also threatened decisive action against the ones who failed to work collaboratively. According to Gasby (2003) creating halfway houses somewhere in between was not an answer to the longstanding issues that the social care divide raises, and would only postpone the inevitable.

During the past years the importance of IPW, as well as Interprofessional education, has been growing and they are now seen as process that are essentials for the effective running of Heath & Social Services agencies to deliver a patient-centred approach. As we have seen, Interprofessional team working has become one of the main issues in the field of social care. The article called " Interprofessional Teamworking: what makes teams work well" showed the results of a research project in the North- east of England which aimed to identify and evaluate the positive characteristic that make good interprofessional working. The research showed that there are three main themes that help to develop good team working. One of these characteristics was the motivation and commitment of staff.

Another characteristic was good communication within the team, small numbers of staff and the members of the group working from the same base

seemed to ease the communication. The last characteristic was the lack of guidelines and methods of working, which seemed to have facilitated the flexibility and adaptability of each member of the team which helped to develop creative working methods. It helped to work across boundaries and created good working relationships and good working practices, a multi-professional model of working in a patient centred way. Communication and reflection are two key issues for IPW, they facilitate positive working relationships.

In order to have good relationships within the team all the staff need to feel confident in their own role to be able to share their knowledge with others. If the level of confidence is not achieved jealousy and conflicts may appear in the team. The team members then are unable to work in a positive environment and, as a result, the patient care delivery could be damaged (Molyneux, 2001). Professional attitudes are important also for IPW. IPW, and IPE, required mutual understanding and respect between professionals, minimised stereotypical thinking, more open-minded attitudes and views, more inter-professional empathy and more adaptability to change (Barr, 2000).

As a result of this, there are behavioural changes within professional practice, students and staff. They can see different approaches in the delivery of care and, as I did in my IPW sessions run at the UWE, understand, value and learn from other people’s point of view. Changes in the organisation, like joint training, will bring improvement in health for the patient as a result of a more efficient staff. Poor communication has been the root of many catastrophic failures in care in the last twenty years, one

example is the Victoria Climbie case where the lack of communication between the services resulted in a fatal consequences for a patient (Barret, 2005).