# Chapter 7 Qualified to practice

*Susanne Lindqvist*

**Introduction** This chapter will prepare you for the step into practice and highlight the importance of lifelong learning and role modelling effective interprofessional practice. It will give you some guidance to help you on your way and some tools that you may find helpful as you pro-actively engage with improving services.

**Case:**
*Siri is 24 years old and has recently graduated as a nurse. Finally, she will be able to make a difference and put into practice all she has learnt during her years at university. Siri is very excited, as she has secured a job at Solø community hospital. She completed a placement experience there during her studies and met Eva who is leading pioneering work related to care within the home setting – making sure homes are safely prepared for patients returning home after stay at hospital, as necessary.*

*During the first week at work, Siri meets Amund who has suffered a stroke. He struggles to talk and move his left arm and leg. One morning when Siri arrives, Amund is very agitated as he cannot do up a button on his garment. Siri greets Amund and immediately offer to help by doing up the button, but in the process of doing so, one of her colleagues, Ragnhild who is an occupational therapist, intervenes and asks Siri not to do that. Ragnhild undoes the button, asks Amund to try again, turns around and leaves them both.*

*Siri initially feels very confused and upset about the experience and cannot stop thinking about it when she comes home.*

**Interprofessional learning (IPL) in practice**
At the point of qualifying, you are given the permission to continue learning on your own – by practicing on real people. Many of you will have much experience of working with patients and some experience of interprofessional learning (IPL) to develop skills necessary for interprofessional practice. However, the skills needed to efficiently work together with others - in a collaborative manner - require ongoing learning and a pro-active approach. Throughout this chapter, try empathise with the different people involved in the case above and consider ways of how best to continue your IPL in practice.

| | | |
|---|---|---|
| Being a student is much about picking up a range of tools and starting to use them under supervision in the practice setting with colleagues and patients until you are considered competent. |  | Being a practitioner is much about developing and exploring the way you use these tools – in different situations and with different people – whilst actively looking out for new tools and sharing them with others. |

**Figure 1.** The figure above describes and illustrates the transition from student to practitioner (image from www.clipartbest.com).

***Preparing 'self'***

*"In order to improve communication with others,*
*the starting point is with 'self'"*

Brent and Dent, 2010 "The Leaders Guide to Influence"

When arriving home, Siri reflected on the incident using the model presented by Gibbs (1988) by using the following questions to guide the process:

- What happened?
- What did I think and feel?
- What was my problem with the experience?
- Why did I have this problem? Did others have the same problem?
- What conclusion can I draw from this?
- What will I do to overcome this problem?

The outcome of this process was that Siri realised that herself and Ragnhild had approached Amund's recovery by adopting two different philosophies of care because they belong to two different professions. Siri concluded that rather than to simply think her approach was the better one, she would speak to Ragnhild the next day to explain how she felt and ask her to explain the rationale for his approach.

Siri is very aware of the importance of being emotionally intelligent. Therefore, she prepared how she would initiate the conversation with Ragnhild, what she wanted to address and how. She tried to empathise with Ragnhild by imaging what she may think and feel as she told her how she had felt. By doing so, Siri prepared a best way of going about it. According to Goleman (1995), someone who is emotionally intelligent will be skilled in regulating their own feelings so that they can achieve positive outcomes when interacting with others. Although Siri considered herself proficient in this aspect, she started to feeling anxious by the thought of actually approaching Ragnhild. In order to boost her self-esteem, she watched the Amy Cuddy's Ted Talk about empowerment and started reading "Feel the Fear and Do it Anyway" by Susan Jeffers (2012) before she went to sleep.

***Approaching 'the other'***

Siri arrived at work and practiced the body language in front of the mirrow, as encouraged by Amy Cuddy. She went to the staff room and approached Ragnhild. Siri politely introduced herself, asked if Ragnhild remembered her from the day before and if it was a convenient time to talk. Ragnhild said that it was and agreed to chat with Siri over coffee.

Siri explained to Ragnhild her rationale for helping Amund. Siri also shared how she felt when Ragnhild had taken over, leaving both her and Amund feeling less than satisfied. Ragnhild listened attentively and then apologised for her behaviour. Ragnhild explained that she had completed a number of long shifts as, there were not enough staff on the ward due to illness. Siri accepted the apology, and suddenly felt a bit sorry for Ragnhild as she had not considered what may be going on for her. Despite feeling a bit nervous, she picked up the courage and queried whether there was a reason for Ragnhild asking Amund to do up the buttons himself.

Ragnhild described a number of ways in which she aimed to enhance the recovering pathway by empowering the patient towards becoming more independent by asking them to complete some tasks independently – as appropriate. According to Ragnhild, this will in many cases strengthen the patient, not only physically, but also mentally and emotionally - by increasing their confidence. Siri took it all in, and found it fascinating to hear Ragnhild's point of view and agreed that it made a lot of sense. Siri suggested to Ragnhild that perhaps they ought to share this approach to care with the ward team, so that everyone could work together and thereby make greater impact for the patients. Of course, this would include sharing this way of working with patients too, where possible. Ragnhild agreed, and suggested that they propose to the senior management that the ward team and their close colleagues in the community engage in an IPL intervention aimed at changing practice.

***Changing practice***

Ragnhild presented the Kurt Lewin three-steps model for change to Siri (Figure 2) (Lewin, 1946; Burnes, 2004). The three steps involve: 1) Unfreezing; 2) Moving; 3) Refreezing and Siri found this model very easy to follow. Siri and Ragnhild both agreed to seek support from the management by outlining their project idea, their rationale for why they felt it was needed and their proposed model to use for this IPL project.

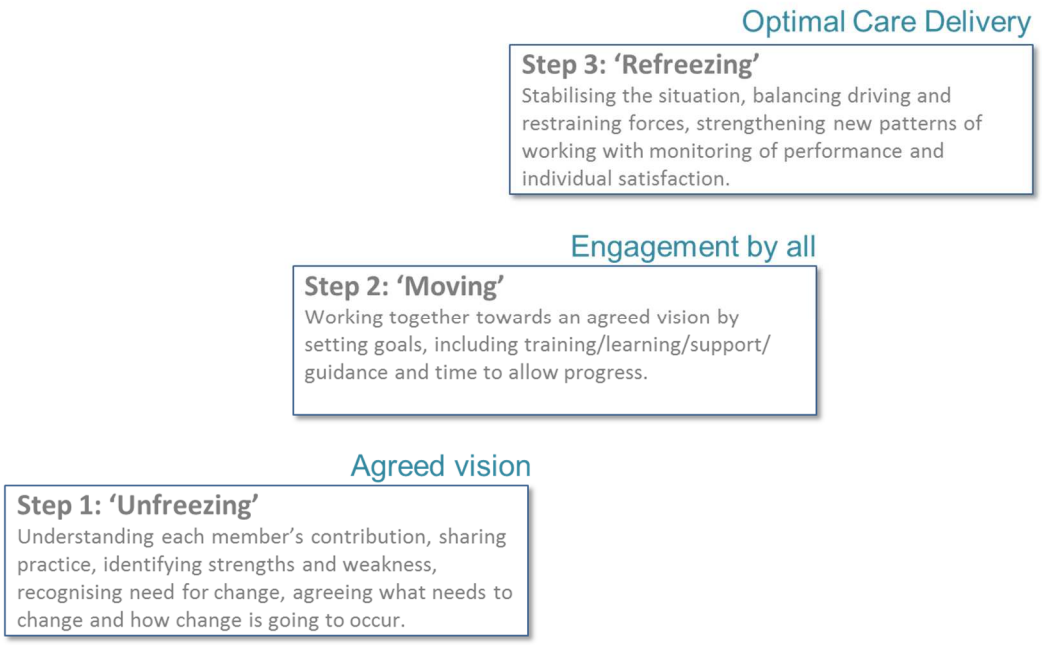


**Figure 2.** The three-steps model presented by Kurt Lewin in 1946 and later adapted by Burnes (2004) to guide changes in practice.

Siri and Ragnhild successfully gained buy-in from senior staff and it was decided that 12 staff members would be invited to participate in four two-hour meetings spanning across a period of six months. Together, Ragnhild and Siri invited staff members linked to the ward and key professionals working in the community to join the project, including Eva. Siri told Ragnhild about Eva's work in the home setting and how this could be joined up with the work in secondary care more effectively. Following a number of email conversations, 12 professionals signed up. Eventually, they all managed to agree a mutually convenient date and time for their first meeting, something that turned out to be quite a task! They planned their project and first meeting carefully and agreed that Ragnhild was going to act lead facilitator whilst Siri would act co-facilitator.

*Step 1*

At the first meeting, Ragnhild asked participants to describe each other's professional roles and responsibilities when delivering care and to exchange views on what works well and not so well within the ward, the discharge process; and once the patients are back in their own home. This exercise helps to: identify the need for change; highlight similarities and differences; and elicit possible goals that are common to all and made possible through improved interprofessional practice within and across care settings.

Since not everyone belonged to the 'core' team, Ragnhild handed out the Belbin Inventory (Belbin, 1981) to encourage individuals to explore their preferences towards different team roles so that they could all contribute in the most efficient way and work collaboratively as a team. According to Belbin, a team needs to adopt a number of roles in order to efficiently accomplish any task. Initially, Belbin presented eight roles: 'leader', 'plant', 'completer finisher', 'monitor evaluator', 'teamworker', 'resource investigator', 'shaper', and 'implementer' that were later extended to nine – including also the 'specialist'. Siri scored high on 'teamwork' and came out as a competent 'completer finisher'. Ragnhild, on the other hand, scored high as 'shaper' and 'co-ordinator', roles that are more linked to those who tend to lead a team. Siri started to ponder how she could develop her own leadership skills. Once everyone had completed this exercise, the team was looking at the things that had been identified as 'not working very well'. Four areas emerged that evolved around:

1. The actual philosophy of care on this elderly ward.
2. Staff illness.
3. Bed blocking, i.e. patients ready for discharge, but cannot leave hospital for other reasons.
4. Homes were not appropriately equipped to provide a safe environment to patients as they returned home from the hospital following a stroke.

The team created the following vision statement:

"*We strive to change our philosophy of care from being caring only to becoming enabling,*
*so that people will be able to safely return to their own home.*
*We will optimise our available resources*
*within teams in the hospital and in the community.*
*We will enhance our discharge process and integration of teams*
*by improving our interprofessional communication and completing a number of set goals.*
*This will lead to less bed blocking*
*and homes readily equipped for patients as they return home.*
*This new way of working will increase the wellbeing of the people we care for*
*as well as our selves"*

Ragnhild asked participants to split into four small groups linked to each of the areas above and join the one most relevant to them. When seated in their small groups they were asked to share with each other the outcome of the Belbin Inventory. Siri placed herself in the first group, which was going to address the actual philosophy of care on the ward, together with three others who were working on the ward. During their sharing of preferred team roles, Siri asked if she could act leader of her group, despite scoring low on roles linked to this. She wanted to develop her leadership skills and felt this may be a good opportunity. Ragnhild asked each group to nominate a leader and supported Siri's proposal by saying that the team

role exercise was simply used as guide to identify strengths and weaknesses, and that each group could deal with this, as they felt most appropriate.

Ragnhild reminded members about the different stages groups commonly go through, as described by Tuckman (1965), which are referred to as the forming, storming, norming and performing phases. She reassured the groups that entering the "storming phase" is normal and that even if they feel confused and unsure about next steps – with support – they would all be able to set a number of goals in their strive to work towards their vision. To facilitate the process, Ragnhild showcased a range of tools that can help identify the "root of the problem", one being Root Cause Analysis using the fishbone diagram (Figure 3).

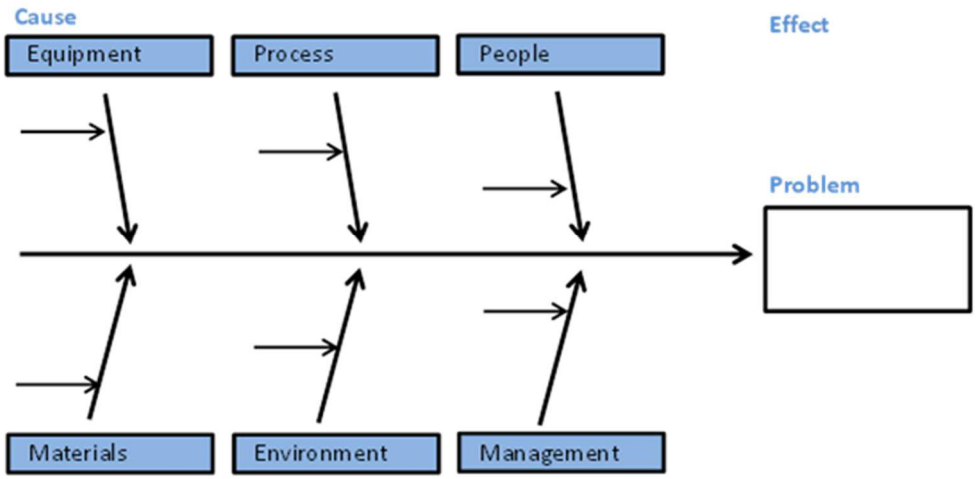


**Figure 3.** A Fishbone diagram can be used to explore cause and effect of different elements of a problem.

Root Cause Analysis is a useful tool when trying to understand the actual cause(s) to a problem. The actual 'bones' on the fish will help break down the problem in smaller parts to tease out how best go about to go about solving it. As illustrated in figure 3, a group of 'bones' linked together can be given a heading to further break down the underlying reasons for why the problem exist. The 'Five Whys' are also commonly used in combination with Root Cause Analysis. In simple terms, this means that every time you answer a question, you repeat the question 'why?' and each answer forms the basis of the next question (Van Vliet, 2012). Looking at this scenario, one 'problem' appears to be that too many patients are based in the hospital, and for too long. When considering one of the headings 'people' (see Figure 3) and adopting the 'Five Whys', the analysis may look something like this:

**Question 1:** Why are too many patients based in the hospital, and for too long?
**Answer 1:** There is inadequate number of trained staff on the ward.
**Question 2**: Why is there inadequate trained staff on the ward?
**Answer 2:** Many staff are off ill and temporary staff are not adequately trained?

**Question 3:** Why are many staff off ill?
**Answer 3**: Some are off due to stress in response to the increased workload.

**Question 4:** Why can we not decrease stress by decreasing the workload?
**Answer 4:** Patients are stuck in ward as they cannot go home.

**Question 5:** Why can the patients not go home in a timely fashion?
**Answer 5:** Staff at the hospital are not 'enabling' the patients and there is lack of communication between staff in the hospital and the community. This results in homes not being safely prepared and patients staying in hospital for too long.

Ragnhild clarified that the headings suggested in Figure 3 can be changed, and that the 'Five Whys' can be applied to each - in order to better understand what goals need to be set in order to address the cause(s) to the problem(s). Ragnhild went on explaining that once the root of the problem(s) has been identified, each group needs to set a number of SMART goals. SMART goals were originally presented by Doran (1981) and have since then been interpreted in many ways. Ragnhild proposed the below for the purpose of this project:

**S**pecific
**M**easurable
**A**ttainable
**R**esourced
**T**ime-bound

Ragnhild encouraged each leader to get their group together before the next team meeting, to start thinking about their possible goals.

Siri's group met to share their philosophy of care on the elderly ward and Ragnhild joined them too. Ragnhild explained what she meant with 'enabling' the patients and suggested ways in which each profession could support this philosophy in different ways. One group member, Nanna, looked less than impressed at this new proposed way of working. When asked how she felt about it, Nanna responded that she had been a nurse at this hospital for many years, long before Ragnhild arrived! Nanna felt strongly that her patients were too weak to carry out the suggested tasks and that her duty of care was to keep her patients safe. Siri remembered Gordon (2012) highlighting the importance of a team being self-aware and for each member to be able to challenge suggestions. As discussed by Marben (2012), if situations like this are not dealt with appropriately, emotional stress can build up, which in turn can affect care delivery and safety. With this in mind, Siri said that she understood

Nanna's reasoning, but then asked if she could see any positive outcomes form using the suggested approach. After a period of silence Nanna responded that perhaps Amund may actually be able to do up his own buttons. However, it would be quicker if she did it and as she had so many patients to look after, she could not possibly wait for him to finish! Siri asked what would happen if she did not wait for him, but instead explained to Amund why he had been asked to do his buttons up and that she would return after a while to see how he got on. Nanna considered this option and agreed that she could not see a risk to Amund by taking this approach and she was aware that he really wanted to get better so that he could return home to his wife and dog. Nanna subsequently suggested to try out the new approach for one week and then let the group know how it went. By acting bravely, Siri had empowered Nanna who now felt that her concerns had been taken seriously, her experience respected and also – quite possibly – felt excited about trying something new.

Further to asking their patients to do up buttons, the group explored other interventions that could enable the patients. Siri came up with ways that she could support this way of working by making small adaptations to her practice e.g. asking the patient to sit up and going to the toilet without help – in cases where the patient was deemed able and safe to do so. Siri realised that small changes can make a big difference, and how important it is for staff to work together in order to provide the best possible care that remained safe at all times. Siri felt energised and looked forward to the next meeting. Especially as she realised that other wards at the hospital had started to hear about their innovative project. Siri made a mental note to see how Nanna got on later in the week and also to ask her if she could show Siri how to cannulate, as she still felt this needed further practice from someone with many years of experience.

*Stage Two*

During the second meeting, Ragnhild asked everyone to agree a set of SMART goals. At the end of the session they would present these goals to each other so that everyone could explore what different challenges they may encounter and together come up with possible solutions to overcome such barriers to goals being achieved.

Siri's group agreed that in order to disseminate their new philosophy of care to others they were going to work on two goals:

1. Training of relevant staff to make sure everyone was aware of *when* a more "enabling" approach could be used and *how* they could change their current practice.
2. Education for patients and also their loved ones who needed to know about these changes in practice, how everyone could help and why this could be beneficial to patients in their recovery.

In order to ensure these were SMART goals, they created a table (Table 1).

**Table 1.** Table outlining the group's two goals and how they were going to make sure they were SMART.

| **Goals:** | **1. Training for staff** | **2. Education for patients and loved ones** |
|---|---|---|
| **S**pecific | Training, developed by group, delivered by group during the lunch break. | Group to create leaflet and nominate staff to go through this information with patients and their loved ones |
| **M**easurable | Assess length of stay, satisfaction questionnaires. | Assess length of stay, and satisfaction questionnaires. |
| **A**ttainable | Yes | Yes |
| **R**esourced | Two group members to train staff every week for one month | Two group members to design a leaflet and make sure it was produced. |
| **T**ime-bound | Train staff in one month; assess length of stay and satisfaction after three and six months. | Leaflet to be produced within two months; disseminate leaflets and explain their content to patients and their loved ones the following two months and assess stay and satisfaction after six months. |

Siri, felt that her role as leader was going really well. She felt in control and the energy was high. During the second half of the meeting, it was time for each group to present their SMART goals to each other. Siri's group went first. In response to their first goal, some of the audience had asked: how they were going to deal with the fact that not all staff have lunch at the same time; what if the management did not agree with the proposed change; where would they find a good satisfaction questionnaire; how would they measure length of stay and who would analyse the data? In response to their second goal, others were commenting on the need for leaflets to be simply written as apparently the health literacy – i.e. "the personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health" (WHO, 2015) – of many people are very low (Manning & Kripalani, 2007). Furthermore, they queried whether the person who was going to produce the leaflet needed to

be trained; how were they actually going to produce the leaflets; did they need money and who would print them?

Although, all comments were very relevant and helpful, Siri could not help, but feeling disheartened. She suddenly felt the energy fading away and the anxiety rising. How would they respond to and deal with all these concerns?

After each group had presented their goals related to: staff illness; bed blocking; homes that were not appropriately equipped. Siri appreciated how their goals had become very linked and felt a sense of revived excitement. Perhaps they would actually make a difference in the end – both to patients and staff. Ragnhild had noticed Siri's slight dip in energy earlier, but also the fact that she had picked up at the very end of the session. She gave Siri a book by Brent and Dent (2010) "The Leaders Guide to Influence". Ragnhild said that she would enjoy reading this book, as it highlights the importance of empowering the group and presents ways in which a leader can role model behaviour that will help the group achieve the desired outcomes together.

The groups were now actively embarking on the change, by taking a step at the time, supporting each other – with Ragnhild acting as the lead facilitator. Siri felt re-energised and her group agreed to pilot the training, as well as the leaflet idea, using a Plan-Do-Study-Act (PDSA) cycle for each goal (Gillam & Siriwardena, 2014). By following a PDSA cycle, their interventions will be planned carefully, tested out small scale, re-evaluated and revised as necessary before they agree (act) on a way forward for their two goals. Between the four group members, they divided out the tasks and decided to meet up at regular time points before they were all meeting with the whole group again to report on their progress. Ragnhild asked Siri to share the PDSA model with the larger group in case someone else wanted to also use this.

At the third meeting, Siri's group presented an outline of their training together with their leaflet, which they circulated in the larger group for their comments. Everyone were very complementary on how they had dealt with the feedback from the previous meeting. They were some additional suggestions put forward, which Siri welcomed and took on-board in a positive manner. After the meeting, Ragnhild praised Siri on how she had created a safe and open environment for everyone to share constructive feedback. Siri was very pleased with

this praise and that she had managed to apply what Brent and Dent (2010) emphasised in their book as a key leadership skill. Collins and Lindqvist (2013) had also mentioned this, and Siri learnt that this can be particularly challenging when a group comprises of different professions with perceived higher, or lower, rank. She found it helpful to recognise the importance of all team members actively contributing to achieving the goals – albeit the leader plays a key role in supporting open and effective communication, by creating a safe learning environment.

Ragnhild ended the meeting by suggesting that the final meeting would be held in four months' time and that the focus of this meeting would be to present data from their goals – as applicable – in order to evaluate where they were at, in relation to their vision. She also suggested that this would be a good time to share their project with others in the hospital and in the community. They decided that Ragnhild would invite staff to celebrate success and agree a plan forward.

*Stage Three*

The third 're-freezing' stage has been criticised by some, since it can be interpreted as a phase where things become too static and not open for new changes (Burnes, 2004). Instead, it should be viewed as an opportunity to consolidate what has been achieved and what steps should be taken from that point. Change always involves learning, but it is imperative to have end points where goals will be evaluated to assess if they were successfully completed, or not. If they were, then new ones may be set - if the vision is still not achieved. If they were not completed, the team needs to decide if they should explore ways to overcome the hurdles, or if perhaps their? goal(s) is no longer deemed relevant. The key here is to make decisions together, by involving all relevant stakeholders in the process, so that everyone has ownership in the new way of working.

The third stage should be a phase where people feel an element of stability, until there is a reason for things to change again. In modern times, this is likely to happen and practitioners need to be dynamic and open to further changes to meet patient and care expectations. However, if this stage is omitted - change is likely to become a burden, as people feel disempowered and less motivated to alter their practice. In this case, Ragnhild ensured everyone that the team would celebrate success and share their progress with other colleagues. This innovative IPL project involved 12 staff members who had worked together over a period of six months towards an agreed vision. Not only had they successfully

managed to shift their philosophy of care to become more “enabling”, but they had also reduced staff illness through re-distributing their resources and enhancing the general spirits on the ward. Bed-blocking was still a challenge, but the project demonstrated significant impact on the process of discharge, mainly due to the ward team working much more effectively with Eva and her colleagues in the community.

The team was empowered to move forward and together with members of the audience, they agreed an action plan for how this type of project would take place in other wards to address other areas that was perceived as “not working well”. Within the team, some agreed to get together to write an abstract to disseminate their work to the wider audience by presenting their work at an international conference. Siri was so excited about it all and felt that she had learnt so much during this first year as nurse. From the moment she saw Amund being upset about not being able to do up his buttons to now realising how much they had been able to improve practice, she really appreciated the importance of effective communication and how this can be particularly difficult between professionals as discussed by Lindqvist (2016). The author highlights a number of challenges involved with interprofessional communication, including:

- awareness of own role in communication;
- understanding of, and ability to deal with, rank dynamics between professions;
- understanding of different professions’ roles and responsibilities;
- courage and being proactive;
- skills in dealing with conflict and emotional stress;
- common language and consistency in the interpretation of confidentiality;
- respect towards, and trust in, the abilities of other professions;
- time.

Although Siri is now a qualified nurse and an excellent communicator, she still had to develop ways in which she communicated with her group members, especially when taking on the leading role for her group. Working with Nanna, helped Siri understand how difficult it can be for professionals who have successfully worked for many years to deal with new staff arriving with new ideas, some of which may conflict with their own practice.
Being part of this IPL project taught Siri about how her own profession and Ragnhild’s complements each other. It helped clarify similarities, differences, and the limitations to their respective professions e.g. Ragnhild would never need to insert a cannula and Siri may not be responsible for the assessment of Amund’s Activities of Daily Living (ADL). By recognising the meaning of assessment of ADL, Siri now has a much greater appreciation for how unsafe a home can be if not adequately equipped. Through completing this project, Siri also gained

an increased understanding of how the ward team could support Eva's work to be even more effective, by simply letting her know - in a more timely fashion - what the patient needed in order to safely return back home. Also recognising that of course some time they were not going to ever be able to.

Siri was very proud of having had the courage to approach Ragnhild in the first place. She also admired Nanna's for challenging the idea of "enabling" patients, yet being open-minded enough to try a new way of working – after many years of practicing in the same way. Siri dealt with that situation very well, and learnt to respect the power of communication and how it can break down if handled badly. There had been deep and vivid discussions throughout the project, and staff had realised how many professions often speak in "riddles" by using acronyms and jargon that only their profession understands - leaving colleagues and patients feeling left out, and often confused.

This project not only helped Siri value the contribution of other professions, but also to consolidate the importance of her own. She now recognises the need to remain pro-active and to actively attempt to empathise with everyone – in any given situation – before making any conclusions. This all takes time, but Siri and the team all agreed that this initial investment had a real impact in ways that would not be possible, had they not all worked together, across professions and care settings. For many professionals and teams, time is a significant and limiting factor to any project. By involving different professions, based at different settings will add to this challenge and for many, this is where many initiatives like this come to a halt. Therefore, it is vital to get buy-in of senior management so that staff can invest the time necessary to engage in working towards their vision and their respective goals. In order to get this buy-in – there need to be a clear reason to why the proposed change and time investment will make an actual difference to patients and/or staff. Furthermore, once a project is underway, it needs to be facilitated by skilled and committed staff in order for staff to safely and effectively progress along the chosen pathway through the different stages of change. Finally, on completion of the project, celebration and dissemination is key – as it will further energise the team and for others to see that they too can make a difference.

*Concluding remarks*

Becoming and being a healthcare professional is an ongoing journey. After successful completion of final exams, you will be given the opportunity to care for people on your own. Regardless of your input to the overall care delivery of one patient, you are likely to contribute a key component of a greater picture. By standing back and looking at this picture, reflecting on what you see and how you feel, you will increase your understanding of what is happening and whether there is anything you act upon to improve what you see.

In this case, Siri decided to act by approaching Ragnhild. Many people would have chosen not to as it takes effort and skill. Some people have the skills, but are not willing to make the effort whereas others are keen to make the effort, but lack the skills. By mutually supporting and empowering each other, Siri and Ragnhild engaged the wider team in IPL that led to real improvements in practice.

> *"In organisations real power and energy is generated through relationships.*
> *The patterns of relationships and the capacities to form them*
> *are more important than tasks, functions, roles, and positions."*
>
> Margaret Wheatley (1992), as quoted in *100 Ways to Motivate Yourself* (2004) by Steve Chandler

**Question to reflecction**

1. From reading this chapter, what do you think is the greatest challenge for you to initiatie an IPL project in practice? How could you overcome this challenge?
2. What are your strengths and weaknesses when it comes to working as part of a team and interacting with others?
3. What is important in rolemodelling interprofessional practice?
4. How will you maintain a pro-active approach to improving practice for your patients

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