International Network for
Health Workforce Education

ABSTRACT BOOK

INNOVATING TOGETHER: THE FUTURE OF IPE

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2026306
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Objectives
Background & Rationale: Interprofessional education (IPE) enhances healthcare professionals' ability to provide quality care, resolve complex issues, think critically, and foster collaborative practice. Evidence supports that well-designed IPE experiences improve patient outcomes and teamwork (WHO, 2010; Guraya & Barr, 2018; Reeves et al., 2010). Effective IPE requires educators to facilitate interactive learning rather than traditional didactic teaching, necessitating faculty development in IPE facilitation skills.
While the importance of training educators to engage in best practices in IPE is recognized by most academic programs, there has historically been a lack of consensus regarding what constitutes best practices in this area, such as frequency, content, and length of training (Babin et al., 2023). IPE faculty development programs must appeal to educators by being relevant to their needs, consider their schedules and workloads, and offer some flexibility (Hean et al., 2012; Zagoloff et al., 2025).
The purpose of this study was to evaluate the effectiveness of an IPE facilitator training program developed by the Center for Interprofessional Innovation at Stony Brook Medicine. The program aims to improve faculty competencies in designing, delivering, and facilitating interprofessional learning experiences.

Method
Design: Mixed-methods approach combining quantitative and qualitative data.
Participants: Faculty enrolled in the IPE facilitator training program.
Intervention: Online modules covering IPEC competencies, IPE pedagogy, barriers and solutions, assessment strategies, and debriefing techniques; plus four synchronous sessions (two in-person, two virtual) that provide participants with.
Data Collection: Retrospective pre- and post-surveys to measure competency acquisition; post-course survey to assess program components and delivery; qualitative data from open-ended survey questions and participant reflections.

Results
Analysis: Descriptive statistics for course process evaluation and paired sample t-test for Facilitator competencies self-assessment; thematic analysis for qualitative responses.

Conclusions
Conclusion data is not yet available. Our hope is that the course components and delivery worked well for the participants, paired sample t-test of retrospective pre- and post self-assessment of competencies will show a statistically significant improvement from pre to post course; and qualitative data will provide us with further insights about participants experience of the course and feedback for the training faculty about what worked well and what could have gone better.

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2026307
Clinical Placements and Mentorship in Context: Shaping Career Identity and Aspirations among Nursing Students

Presenting Author(s)

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Background:
Clinical placements represent a critical phase in nursing education, shaping students' professional identity, confidence, and career intentions. Evidence across the literature demonstrates that mentorship quality and placement context significantly influence students' aspirations and early retention. However, structured mentorship models that optimise these experiences remain inconsistently embedded in pre-registration programmes.

Aim:
To explore how mentorship and placement experiences influence the career aspirations and identity formation of nursing students, and to examine how placement context can enhance workforce preparedness.

Methods:
This scoping review followed Joanna Briggs Institute (JBI) methodology and PRISMA-ScR reporting guidelines. Thirty-five studies published between 1986 and 2025 were mapped across multiple databases. Thematic synthesis was undertaken using the PAGER framework, informed by Social Cognitive Career Theory and Benner's Stages of Clinical Competence to interpret how mentorship and placement environments shape career trajectories.

Results:
Findings highlight that effective mentorship within supportive clinical environments enhances self-efficacy, role clarity, and belonging. Placements that foster positive professional relationships and exposure to competent role models strengthen confidence and career direction. Conversely, inadequate mentorship or unsupportive environments were associated with uncertainty, reduced motivation, and misaligned expectations. The interaction between mentorship, placement environment, and learner readiness emerged as a critical determinant of how students internalise professional identity and envision future roles. Students who experienced psychologically safe learning environments and consistent feedback demonstrated higher career certainty and stronger commitment to nursing practice. In contrast, fragmented supervision or exposure to workplace incivility disrupted learning continuity and weakened professional confidence, reinforcing the importance of structured, nurturing mentorship throughout clinical education.

Implications:
Embedding structured, evidence-informed mentorship within clinical education could enhance learning outcomes and long-term engagement. By designing placements that promote positive professional socialisation, educators can foster confidence, adaptability, and flexible career aspirations, ultimately contributing to a more sustainable nursing workforce.

2026310
Evaluating student learning outcomes and facilitator effectiveness in a Virtual IPE elective course

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Delivering planned interprofessional collaborative learning opportunities for students across health professions to learn with, from, and about each other through team-based activities and case simulation prepares them to be more effective in providing services, solving problems, and improving future job satisfaction (Carney et al., 2018; WHO, 2010, 2016). When developed and delivered in a collaborative spirit and supportive academic environment, interprofessional learning promotes the foundation of a culture in which mutual respect and psychological safety are modeled by faculty (Cohen Konrad et al., 2022, in personal communication).

Studies on the impact of IPE demonstrate that well designed and delivered collaborative learning opportunities increase students' knowledge of professional roles, interprofessional attitudes and confidence, and teamwork skills and communication (IPEC, 2023; McGuire et al., 2020; Peterson & Brommelsiek, 2017; Reilly et al., 2014). IPE enhances healthcare professionals' ability to provide quality care, resolve complex issues, think critically, and foster collaborative practice.

To prepare health professionals for IP collaborative practice, faculty educators must have the knowledge and skills to design, deliver and facilitate interprofessional collaborative learning (Ratka, 2013). Interprofessional education faculty development is noted as a key component of successful learner experiences (Davis et al., 2015), and effective IPE faculty development provides faculty with tools to successfully teach, facilitate, and role model behaviors to interprofessional students (Egan-Lee et al. 2011).

The purpose of this study is to evaluate students' attainment of Interprofessional Education Collaborative (IPEC, 2023) competencies and interprofessional identity development as outcomes of completing an interprofessional education elective course. In addition, the study will explore the skills, knowledge, and attitudes of IPE faculty facilitators that have the most positive impact on learners' understanding of collaborative practice and IP identity. Course will be delivered virtually during summer semester 2026.

Study Design: Mixed-methods approach combining quantitative and qualitative data. Retrospective pre- and post-surveys to measure competency acquisition; post-course survey to assess program components and delivery; qualitative data from open-ended survey questions and participant course reflections to further explore the attributes, behaviors, attitudes, and skills faculty facilitators demonstrate that have the most positive impact on students' acquisition of the competencies.

Data analysis: Descriptive statistics for course process evaluation and paired sample t-test for IPEC competencies and course learning outcomes; Cronbach alpha to test the instruments for validity; thematic/content analysis for qualitative narrative responses on survey and student reflections.

Participants: Students enrolled in an Interprofessional Education elective course, Summer 2026.

Intervention: 16 synchronous zoom class meetings, asynchronous online modules covering IPEC competencies, telehealth, motivational interviewing, social determinants of health, etc., 2 telehealth sessions with standardized patients, and course assignments. Students will be placed on IP teams and each team will have an IP educator/facilitator who has been trained IPE best practices.

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2026313
Preparing Collaborative Practice-Ready Graduates - Exploring Practice Educators' and Clinical Tutors' Perceptions of Practice-Based Interprofessional Education

Presenting Author(s)

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Objectives

The World Health Organisation (WHO) has endorsed interprofessional education (IPE) to facilitate the development of a collaborative-practice ready workforce and recommended the integration of IPE in undergraduate health care curricula (WHO, 1988, 2010). IPE is necessary to ensure health care professionals have learned how to work in an interprofessional team and are competent to do so. IPE can take many forms but falls broadly into two categories: classroom-based (in the university setting) and practice-based (in a clinical setting). While the IPE provided by university programmes can improve graduates' preparedness for interprofessional practice, the focus of many programmes is on increasing knowledge about other professions rather than development of the skills required to work interprofessionally. There can be disconnections between campus-based learning and clinical realities which pose conceptual barriers between what students learn in IPE curricula and what methods and practices are applied in real-world settings.

Practice-based IPE, where students from two or more professions learn together in a clinical setting, offers an excellent opportunity to apply collaborative working skills in a real-world setting. However, practice-based IPE can be complex to implement because it necessitates the interaction of different professions to achieve educational objectives in busy clinical settings.

The aim of this research project was to explore the experiences and perceptions of practice tutors and clinical educators of facilitating practice-based IPE for healthcare students. It is intended that the knowledge gained from this project will be used to design and develop a practice-based IPE programme for healthcare students which will be implemented and evaluated in a future action research study. The research questions were:

• What are the experiences of practice tutors and clinical educators of implementing practice-based IPE for healthcare students?
• What are the factors that support/challenge the implementation of practice-based IPE for healthcare students?
• What are the training needs of practice tutors and clinical educators to prepare them to facilitate practice-based IPE for healthcare students?

Method

Three focus groups discussions (FGDs) were conducted, each one in a teaching hospital in Ireland. The FGDs were semi-structured. Topics for the FGDs included: current involvement in practice-based IPE, ideas for introducing IPE opportunities in the workplace, perceived challenges in implementing practice-based IPE, and assessment approaches for practice-based IPE. The discussions were audio-recorded and transcribed verbatim.

The dataset was independently coded by four researchers to ensure a collaborative and reflexive approach. The research team followed the six stages of reflexive thematic analysis as described by Braun and Clarke. Reflexive thematic analysis is an interpretative approach to qualitative analysis that enables the identification and analysis of patterns in a dataset (Braun and Clarke, 2021). A constructionist epistemology was adopted in the coding process whereby the researchers acknowledged the importance of recurrence of patterns in the dataset but meaning and meaningfulness were the central criteria when coding and developing themes (Byrne, 2022). As the aim of the study prioritised the participants' own accounts of their attitudes and experiences, an experiential orientation to data interpretation was adopted (Byrne, 2022). An inductive approach to coding was taken in the analysis which meant that the data was "open-coded" without trying to fit a pre-existing coding frame. The data was coded at both semantic and latent levels meaning that it included both the explicit meaning of the data and the researchers' interpretations of the underlying assumptions, ideas or ideologies that may inform its descriptive content. The analysis was not a linear process but instead was recursive and iterative requiring the researchers to move back and forwards through the six phases of reflexive thematic analysis.

Results

There were 22 participants in total from a range of professions including physiotherapy, occupational therapy, podiatry, nursing, social work and speech and language therapy. Three themes were developed through analysis of the data: Workplace culture lays the foundation; Staffing matters; and Enhanced and authentic learning through clinical practice. The first theme demonstrated that the culture of the clinical site greatly impacts interprofessional collaboration and thus the value placed on practice-based IPE. The second theme highlighted that clinical educators face ongoing logistical barriers to implementing practice-based IPE including a lack of resources, limited teaching space, staffing issues and problems with timetables. However, efforts have been made by clinical educators to overcome these barriers and develop strategies to implement IPE that are feasible in their workplace. Providing training for clinical educators in delivering practice-based IPE was not perceived to be a useful approach to improve delivery of practice-based IPE due to time pressures and existing high training demands for clinical educators. Instead, forming an interprofessional network of clinical educators was reported to be effective in helping to overcome logistical issues and in providing the support needed to successfully implement practice-based IPE. The final theme recognised that clinical placement provides an opportunity for enhanced learning in interprofessional collaboration and teamwork; however, participants

noted that students may benefit from more classroom-based preparation on this topic before their clinical placement. The lack of formal assessment in this area was perceived to impact the value and emphasis placed on it by some educators and students.

Conclusions

Practice tutors and clinical educators face many challenges when trying to deliver and facilitate practice-based IPE including logistical difficulties, lack of resources, staffing issues and organisational culture. While providing training on delivering practice-based IPE may be useful, it may not be feasible or desirable for clinical educators to attend more training. Instead, developing interprofessional education networks within teaching hospitals and providing resources that can be used in interprofessional tutorials may be more helpful in setting up IPE programmes within the clinical education setting.

2026317
From Pedagogical Research to Practice: Educator Led Approaches in Health Professions Education

Presenting Author(s)

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This presentation reflects on research in health professions education, with particular attention to the study approach and the findings generated through it. The focus is on how learning is examined within educational research, and how different methodological approaches shape understanding of teaching practice, staff development, and student experience.

The work draws on three interconnected topic areas: shared decision making in audiology, the influence of role models in healthcare education, and learning from failure. These topics were selected because they address key dimensions of professional development that are often underrepresented in traditional research designs. Together, they allow exploration of not only what students learn, but how learning occurs, and how educational practices shape professional identity and clinical judgement. The topic areas also support consideration of learning across different levels, from discipline specific contexts, to cross college activity within health and life sciences, and to initiatives operating at a whole university level.

To explore these areas, a range of methods was employed, including online focus groups and surveys. Methodological choices were made with awareness of survey fatigue and the limitations of relying solely on questionnaire based approaches. The studies therefore prioritised approaches that attend to depth, context, and participant experience, rather than surface level data alone. Students were actively involved in shaping and refining the research questions, ensuring alignment with their lived experiences and educational priorities. Online focus groups enabled participation across geographical locations and supported flexible, inclusive dialogue. Bringing together multiple sources of data and sustained student involvement allowed examination of learning processes alongside reported outcomes across topics and contexts.

Across the three topic areas, the studies were united by a shared approach to research design that prioritised collaboration, reflexivity, and practical relevance. The work was developed through collaboration across the university and included contributions from students, professional services staff, and educators, rather than being confined to academic teams alone. As teaching focused staff, the presenters draw directly on their educational roles to inform study design and implementation.

This presentation illustrates how educators, particularly those on teaching focused tracks, can lead pedagogical research in healthcare related topics that supports staff development and results in tangible learning that enhances the student experience. The presentation shows how involvement in pedagogical research supports the use of research findings in everyday teaching and training practice for healthcare students.

2026318
Self-Compassion in Pedagogy

Presenting Author(s)

Dr Maiedha Raza, GP, NHS and University of Manchester, UK

A short presentation on the important of self-compassion in pedagogy for all early career academics and AHPs. This session will explore the power of self-compassion in medicine and teaching, highlighting how it supports wellbeing, resilience, and compassionate patient care. Drawing on evidence from Kristin Neff and others, we will discuss the three pillars of self-compassion. Self-kindness, common humanity, and mindfulness and consider their application in clinical and educational practice. Participants will reflect on their own inner dialogue, learn practical strategies for self-compassion, and examine how this aligns with professional standards.

2026320
Strengthening Clinical Leadership in Complex Healthcare Systems: The "DEVELOP for Leaders" Programme

Presenting Author(s)

Dr Ali Sanders, Associate Medical Director, Imperial College Healthcare NHS Trust, UK

Objectives
Many doctors enter leadership roles by circumstance rather than intentional development, often without preparation for the managerial, financial and governance responsibilities required. Evidence consistently shows that strong clinical leadership improves patient outcomes and system efficiency. The Messenger Review highlighted the urgent need to strengthen NHS clinical leadership and ensure consistent support for clinicians stepping into these roles. Imperial college healthcare NHS Trust has launched an executive sponsored, bespoke programme “DEVELOP for Leaders”, designed to equip clinical directors and heads of specialties with the competencies, confidence and support needed to lead effectively within an increasingly complex healthcare environment.

Method
A needs analysis was conducted using semi-structured interviews with 10, purposively sampled, medical leaders from Imperial College Healthcare NHS Trust, with a combined total of 109 years in leadership experience range (1-20 years). Interviews explored: leadership experience, leadership competencies, leadership development and individual feedback as a leader. Transcripts were thematically analysed by one researcher. Findings informed the creation of a five-day medical leadership development series covering:

Managing self, managing and working with others
Personal resilience and developing myself as a leader
Financial management and business planning
Leading a service that is safe for patients
Embedding improvements for all and delivering high quality education

Feedback was collected after each event using Likert-scale ratings for organisation and impact alongside qualitative free-text Reponses. Two researchers conducted thematic analysis of qualitative data.

Results
Interviews identified a development cycle of leadership competencies. Early-career leaders sought to develop specific competencies, whilst experienced leaders focussed more on identifying and addressing competency gaps though feedback. Across all stages, self-awareness and self-development emerged as core competencies underpinning effective medical leadership. Bespoke, local leadership courses were thought to be more effective and provide additional benefits of peer networking and support.

Out of 122 doctors in leadership positions, there were 107 attendances the 5 events held between October 2024 and May 2025. 67% rated the sessions as either “very good” or “excellent”. Qualitative feedback highlighted, improved confidence, enhanced team management skills, greater clarity on governance and financial responsibilities, and increased cross-divisional collaboration. Participants consistently praised the interactive, case-based teaching and the psychologically safe environment. Medical leaders value the engagement of the executive team which fostered a sense additional support. Executive colleagues described gaining valuable insights and ideas.

Conclusions
“DEVELOP for Leaders” emerged from a clear organisational need to strengthen medical leadership capability at a time of growing system complexity. A participant noted the programme brought “compassion towards the roles we do and the challenges we face that is often not shown”, highlighting its cultural as well as developmental value.

The programme demonstrates that executive sponsored, values-led medical leadership development can be delivered effectively at organisational level, strengthening peer connection, psychological safety and leadership competence. Early evidence suggests improved confidence, cross-divisional collaboration and engagement among medical leaders. The programme supports the workforce of the future by strengthening leadership capacity, fostering a culture of continuous development and ensuring clinical leaders are equipped to guide teams through evolving health service. As the NHS continues placing clinical leadership at the centre of governance, this model offers a scalable and impactful approach for building a diverse and equipped generation of medical leaders.

2026321
“I see you, I hear you, I feel your distress”: Developing empathetic engagement in healthcare students

Presenting Author(s)

Prof Jade Sheen, Associate Professor of Clinical Psychology, Deakin University, Australia

Empathy is an integral common factor for a range of therapeutic outcomes and a foundational clinical skill for healthcare workers. Well developed empathetic engagement can reduce patient anxiety and improve wellbeing (Bikker, Mercer & Reilly, 2005; Guidi & Traversa, 2021), build a sense of trust (Ashouri et al., 2018) and a stronger therapeutic alliance between healthcare workers and their patients (Neinhuis et al., 2018). Empathetic engagement has also been associated with higher positive client change over time (Anderson et al., 2016; Watson et al., 2014), improvements in health related quality of life (Howick et al., 2018) and, reductions in negative client outcomes such as dropout, relapse and non-adherence (Mohammadreza et al., 2011; Moyers & Miller, 2013). Benefits are also evident for the healthcare workers themselves, as empathetic engagement has been associated lower rates of burnout and stress (Lakioti et al., 2020; Linley & Joseph, 2007; Wagaman et al., 2015).

Empathetic engagement is a skill that can be developed through targeted education. Research to date has typically relied on active, experiential teaching methodologies such as group discussion, case analysis and simulation, to improve healthcare students’ empathetic engagement (da Silva et al., 2022). An umbrella review of 25 published reviews of empathy, compassion and person-centred communication training in healthcare suggested the most effective components of empathy training, regardless of educational pedagogy, were repeated practice, feedback, debriefing and guided reflection combined with opportunities to engage with lived/living experience perspectives (Byrne et al., 2024). Byrne et al. (2024) also noted that empathy interventions must target participant attitudes, knowledge, skills and behaviour to accomplish a real change. These conclusions are tempered however, by concerns regarding the methodological rigor of existing research.

This workshop will i) discuss the application of experiential teaching methodologies to improve empathetic engagement in healthcare students; ii) present the findings of several recent studies applying a novel methodology, deliberate practice, when attempting to improve empathetic engagement amongst paramedic, nursing and psychology students in Australia; and, iii) provide recommendations for educators and practitioners seeking to improve this fundamental clinical skill. Key considerations when integrating lived/living experience perspectives in healthcare training to improve empathetic communication will also be reviewed.

2026322
Oral Health Education Preparedness among Undergraduate Medical Students: A Systematic Scoping Review

Presenting Author(s)

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Objectives
Oral health is a gateway to overall well-being and can affect systemic health. Hence, recognizing the importance of oral health education in undergraduate medical curricula is essential. However, integrating oral health education into undergraduate medical curricula remains inadequately addressed. This scoping review aims to systematically explore literature on the preparedness of medical undergraduates in oral health education, focusing on their knowledge, training, self-confidence, and assessment. Additionally, it will identify barriers and enablers to achieve integration of oral health in medical curricula.

Method
The PRISMA scoping review (PRISMA ScR) guidelines and the Joanna Briggs Institute (JBI) methodological framework were followed. Using the PCC framework, four databases (PubMed, Scopus, ERIC, and Embase) were searched for studies involving undergraduate medical students that examined oral or dental healthcare preparedness, education, knowledge, awareness, and training within the context of undergraduate medical curricula. Miller's Pyramid was used as an analytical framework. The extracted data were analyzed using thematic analysis and a 5-point Likert scale.

Results
From forty studies, undergraduate medical students demonstrated limited knowledge and self-confidence in oral health education. Curricula often targeted short-term knowledge acquisition and lacked structured training. Moreover, assessments of OH knowledge mostly used inconsistent methodologies and unvalidated instruments. Lack of faculty trained in OH provision, low faculty awareness, and overloaded curricula were barriers to adequate oral health education for medical students. Conversely, collaborative interprofessional education offers opportunities to address gaps in medical students' oral health education.

Conclusions
This is the first systematic scoping review of the literature on undergraduate medical students' preparedness for oral health education. It revealed that medical students' oral health knowledge is only at knows and knows how level, felt underprepared to provide oral health advice, underscoring the need to improve oral health education through structured clinical experiences and interprofessional collaboration, as well as to cultivate new relationships with dental colleges.

2026323
OPTIMAL - Creating Opportunities of Practices for Teamwork to Improve Advancements of Learning - Saudi Arabia

Presenting Author(s)

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Interprofessional Continuing Education (IPCE) is defined by the World Health Organization (WHO) as “when members from two or more professions learn with, from, and about each other to enable effective collaboration and improve health outcomes”.

The main objective of IPCE is to promote collaboration among healthcare professionals and encourage the implementation of IPCE-based education programs within hospital departments. These programs aim to address patient-related issues through effective communication within the multidisciplinary team.

In our approach to achieve this goal, we formed an IPE education team consisting of individuals from various disciplines. This team, which possessed T3 certification, collaborated on developing educational activities based on the principles of IPCE, targeting a diverse audience representing multiple healthcare professions.

The development of these activities was guided by specific learning objectives. These objectives aimed to highlight the significance of IPCE in healthcare, identify and address potential conflicts that could hinder patient care, and promote an understanding of the roles and responsibilities of different healthcare professions.

Patient-related issues, medical errors, and safety alerts reported to the patient safety team in Quality Management were shared with the IPE team for review. The team analyzed these cases to identify aspects that could be resolved through IPCE, aligning with the aforementioned learning objectives.

It was discovered that ineffective communication and poor collaboration among the multidisciplinary team caring for the patient resulted in patient dissatisfaction, misdiagnosis, delayed treatment, medication errors, and premature discharge, among other issues. Therefore, there was an urgent need to establish communication standards and foster collaborative practice through IPCE across healthcare professions.

Based on this analysis, the initiative centered around presenting case studies through educational sessions titled "Patient Care through Collaborative Practice." The ultimate aim was to change the dynamics within the healthcare team by advocating for proper communication and collaboration. We measured annual changes in team dynamics related to patient care to assess the impact of IPCE on improving collaboration.

The target audience for these sessions consisted of attendees who analyzed real reported cases, drew conclusions, and learned with and from each other about how these errors could have been avoided. A total of Twenty-One focused sessions were conducted, with 336 hospital staff in attendance, including department heads and chairmen. The attendees represented more than12 different professions.

Prior to the sessions, only 6% of the attendees were familiar with the concept of IPE education and collaborative practice. However, after the sessions, awareness of these concepts increased to 93%.

Throughout the scheduled sessions, attendees learned about the roles and responsibilities of ten different professions. Long-term feedback from participants indicated that 71% agreed that the sessions had positively impacted team dynamics. Participants also acknowledged that the IPE-based sessions had improved communication, team empowerment, trust-building, and had the potential to enhance patient satisfaction.

The designed activities also played a vital role in improving communication channels and fostering anticipatory thinking to prevent errors or damages that could impact patient safety. Furthermore, the activities enhanced the behavioral skills of attendees, contributing to their overall competencies in IPCE.

Supporting Documents:
https://inhwe.org/system/files/webform/OPTIMAL%20data.pdf

2026326
Design and Implementation of a Low-Barrier International Interprofessional Student Club: A Pilot Study

Presenting Author(s)

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Background

In higher education, extracurricular activities (EA) support student growth beyond formal curricula1. EAs may be categorized as indirect extracurricular activities (IEA), such as team sports, academic clubs, social events, and performance arts or direct extracurricular activities (DEA), which align with the student's program of study and may include health fairs/clinics, healthcare quality improvement student groups, and interprofessional clubs1. Interprofessional clubs offer students from diverse healthcare programs opportunities to interact, fostering early development of interprofessional identity3. EAs enable students to begin practicing those interprofessional skills they will need in professional practice2.

The literature reveals several positive outcomes associated with EA participation in healthcare education. Students report enhanced knowledge, improved time management skills, increased skills in communication, teamwork, organization, and self-esteem1-2,4. Studies also indicate that students experience enhanced learning regarding health systems science, research skills, critical thinking, and higher academic performance1-2,4.

Despite the many potential benefits of participating in extracurricular activities, evidence is mixed regarding which healthcare professions students are likely to engage. Reported barriers include time constraints, competing academic and personal responsibilities, concerns about academic performance, limited faculty support, fatigue, and distance1-2, 4. Some faculty express reservations about student participation, sharing concerns that engaging in extracurricular activities may increase students' risk for declining academic performance4.

Methods

Despite these barriers, more than half of the students surveyed in two separate studies expressed a desire to participate in extracurricular activities1,4. The pilot project aimed to design and pilot a low-barrier, low-commitment asynchronous interprofessional activity for healthcare students. Ideally, the selected platform would be low-cost or free, enabling students to engage in real-life discussions in an online, asynchronous format that was not time- or distance-intensive.

Padlet, an online collaboration platform, was selected as the delivery modality5. Three monthly activities were developed, including a mini book club, an Interprofessional Education Collaborative Competencies quest6, and an interprofessional case discussion available on YouTube7. Padlet was selected due to its free access, ease of use across web and mobile platforms, and ability to maintain participant anonymity through autogenerated pseudonyms. Ethical approval was obtained through the University of Nottingham. Upon completion of the pilot, participating students complete a reflection and feedback survey. Preliminary student statements highlighted motivations to participate aligned with the literature, including interest in international networking, professional development, and opportunities to develop interprofessional identity, communication, and collaborative practice skills. Final results will be presented, focusing on learner perceptions, engagement patterns, and feasibility outcomes.

Objectives

1. Summarize the structure and implementation of a multi-institutional, online interprofessional education (IPE) club.
2. Analyze barriers to student participation in the online IPE club.
3. Assess strategies used to overcome barriers to participation in the IPE club.
4. Evaluate student outcomes and reported benefits from participating in the pilot program.

Supporting Documents:

https://inhwe.org/system/files/webform/Reference%20List%20Curtis%20Hynson%20Plows%20INHWE%202026.docx

2026328
Rethinking How IPE Lives in the Curriculum: A Decentralized, Credentialed Framework

Presenting Author(s)

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Interprofessional education (IPE) is widely recognized as a foundational strategy for preparing a collaborative health workforce capable of addressing complex patient, population, and system-level challenges. Despite this recognition, many institutions continue to struggle with operationalizing IPE in ways that are scalable, equitable, learner-centered, and meaningfully connected to interprofessional collaborative practice (IPCP). These challenges are often compounded in geographically large, rural states and in institutions serving diverse and underserved populations. The University of New Mexico (UNM), a Hispanic-Serving Institution and the state's flagship health sciences campus, has adopted a novel, systems-oriented approach to IPE that emphasizes decentralization, longitudinal engagement, and visible recognition of learner competence.

Central to this approach is UNM's Interprofessional Education (IPE) Honors Program, which functions as a decentralized, institution-wide IPE curriculum rather than a single course or centrally delivered experience. Learners from multiple health professions engage in interprofessional learning through discipline-embedded coursework, co-curricular activities, simulation, community engagement, and clinical experiences that are intentionally aligned with shared interprofessional competencies. This decentralized structure allows IPE to be woven into existing program curricula while maintaining common expectations, outcomes, and assessment standards across disciplines. As a result, learners experience IPE as an integrated and longitudinal component of professional formation rather than as an episodic or add-on requirement.

As enrollment in the IPE Honors Program expanded, a key challenge emerged: learners entered the program with highly variable understandings of what IPE is, why it matters, and how it translates into IPCP. To address this variability while preserving the flexibility inherent to a decentralized curriculum, UNM developed IPE 101, an asynchronous, self-paced online course designed to onboard learners into the Honors Program and establish a shared foundational understanding of IPE. The course is discipline-agnostic and accessible across programs, enabling standardization of foundational knowledge without imposing additional scheduling or curricular burdens.

IPE 101 is structured around four modules: (1) The Inceptions of IPE: A Historical and Global Perspective, which situates IPE within its international origins and evolving role in health professions education; (2) The Theory and Science of IPE, which introduces learners to theoretical frameworks and empirical evidence supporting IPE and IPCP; (3) Interprofessional Collaborative Practice: Bridging Education to Clinical Practice, which explicitly connects educational experiences to team-based clinical and community care; and (4) Wrap-Up and Integration, which prompts reflection on professional identity, collaborative readiness, and continued engagement within the IPE Honors Program.

Successful completion of IPE 101 results in the awarding of a digital badge that verifies foundational knowledge of interprofessional education. Within UNM's decentralized Honors model, digital badging serves as a unifying mechanism to recognize and communicate learner achievement across programs, while providing a portable and visible credential that extends beyond traditional academic transcripts. Importantly, digital badging also supports learner identity formation by signaling readiness for more advanced interprofessional learning and practice.

Building on this foundation, the UNM IPE program is expanding its digital badging ecosystem to recognize progressive levels of interprofessional knowledge, application, and impact. One example is the development of a Substance Use Disorder (SUD) 101 course that integrates IPE principles with urgent workforce and public health needs. Given New Mexico's ongoing substance use crisis, this course is designed to address gaps in interprofessional education and interprofessional collaborative practice related to prevention, screening, treatment, and referral, while reinforcing the relevance of IPE to real-world clinical and community settings.

This presentation will describe the design, implementation, and early outcomes of UNM's decentralized IPE Honors Program, its IPE 101 onboarding course, and its evolving digital badging strategy. Attendees will gain practical insights into how decentralized curricular models can support scalable, equitable, and practice-relevant interprofessional education, while allowing institutions to respond flexibly to local workforce and population health priorities. The UNM model offers a transferable framework for institutions seeking to move beyond centralized, episodic IPE toward a cohesive, credentialed, and longitudinal interprofessional education ecosystem.

Supporting Documents:
https://inhwe.org/system/files/webform/Dublin%202026%20Abstract.pdf

2026329
Irish Medical Student Perspectives on Internationalization at Home

Presenting Author(s)

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Objectives
Internationalisation in medical education is typically studied through the lens of international student experiences and outcomes. However, local student perspectives remain uncharted. This study examines the benefits and challenges of internationalisation according to graduate-entry medical students in their home country. It explores the influence of internationalisation and identifies areas for improvement.

Method
Irish students from the University of Limerick School of Medicine and the Royal College of Surgeons in Ireland University of Medicine and Health Sciences were invited to participate in World Cafés to discuss internationalisation experiences within their respective programmes. Innovative, prompt-based sessions encouraged open dialogue and shared understanding. Written reflection thematic analysis captured key insights.

Results
Strong, common themes to represent the impact of internationalisation at each medical school formed from the coded data including The Academic Environment, Career Planning, Global Outlook, Cultural Competence, Relationship-building & Belonging and Representation & Support. Both positive and negative connotations were acknowledged in student commentary.

Conclusions
This unique, two-centre study provides evidence that attending an internationalised medical school offers an enriched, transformative, and more challenging educational experience for local students. Learners are prepared to engage more effectively in dynamic, diverse environments. Medical schools play a pivotal role in fostering intercultural competence and expanding professional horizons.

Supporting Documents:
https://inhwe.org/system/files/webform/Tables%20and%20figures%20INHWE%20abstract%20CC.docx

2026330
Beyond Leadership Styles: Memory-Shaping Micro-Skills for Healthcare Workforce Retention

Presenting Author(s)

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Objectives
Healthcare leadership education often emphasizes leadership styles and principles, yet it rarely specifies the cognitive mechanisms through which everyday leader behaviors become durable drivers of nurses' stay–leave decisions. This submission introduces "memory-shaping leadership" as a behavioral-science training concept explaining how routine leader–nurse micro-interactions can produce lasting effects on global work attitudes and retention-related decisions, with an emphasis on trainable micro-skills for health workforce development.

Method
A conceptual framework was developed through an integrative synthesis of four research areas: (1) Affective Events Theory, modeling leadership as sequences of emotionally meaningful micro-events; (2) research on remembered experience, including the peak–end rule and retrospective evaluation; (3) cognitive neuroscience evidence on emotional memory encoding and consolidation; and (4) resource-based perspectives from positive psychology. These literatures were translated into a sequential explanatory model linking leader behavior to retention-relevant decisions via remembered work experience.

Results
The framework proposes that emotionally salient "peaks" and workday "endings" are preferentially encoded and later reconstructed into accessible remembered summaries of work. These summaries function as cognitive evidence shaping global work attitudes and guiding stay–leave decisions more strongly than averaged moment-to-moment affect. For leadership education, the model specifies low-cost, trainable micro-skills: (1) shaping constructive peaks through timely recognition, competence-affirming feedback, and support during high-stakes moments; (2) shaping constructive endings through brief structured shift closures and debrief routines that highlight key moments; and (3) relational repair following friction or setbacks to prevent negative episodes from dominating remembered experience. An online course is under development (planned for September 2026 across eight European universities), complemented by a private-sector leadership training delivery planned for 2026 and a hospital-based pilot of an enhanced version planned for 2027.

Conclusions
Memory-shaping leadership reframes retention-oriented leadership education from teaching styles to teaching mechanisms and everyday micro-skills that influence what staff later remember as representative of their work experience. The approach is positioned as a scalable, low-cost complement to structural workforce interventions and offers testable propositions for longitudinal evaluation that separates momentary affect from reconstructed remembered experience when assessing training impact on workforce outcomes. It has clear potential for integration into healthcare leadership education.

2026332
The COUNTER Study (Counterfactual Online UKMLA Novel Testing for Enhanced Reasoning): AI Generated Counterfactual Questions to Improve Conceptual Transfer in UKMLA Preparation

Presenting Author(s)

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Objectives

Large language models (LLMs) have shown promise in medical education in AI-generated multiple choice questions (MCQs) with high factual accuracy and student acceptance. However, standard AI MCQs reinforce rote recall rather than deeper clinical reasoning. Counterfactual questions, which involve modifying one clinical parameter (e.g., patient age), demand more advanced reasoning to explain the resulting change in an answer. This may promote conceptual transfer and flexible knowledge application. This pilot study sought to test AI-generated counterfactual MCQs' potential for preparation of the UK Medical Licensing Assessment (UKMLA). The primary outcome was accuracy on standard MCQs followed by counterfactual variants. Secondary outcomes include confidence answering UKMLA MCQs (5-point Likert), cognitive load (9-point Paas) and counterfactual reasoning (3-item 5-point Likert composite).

Method

An 11-part cardiovascular UKMLA-focussed online teaching series was delivered by medical students. Each session consisted of a lecture followed by paired MCQs. After each standard MCQ, participants answered its corresponding counterfactual variant, in which one clinical variable was altered while all the others remained constant. Questions were generated using Llama 3.5 via Perplexity with a standardised prompt across each pair. Two independent medical students (SN, JS) reviewed factual accuracy. Participants were medical students in years 2 to 4. Following each session, participants completed a post-session survey. Participants who completed the post-session survey but not the polls were excluded from paired analysis.

Results

Of 127 attendees, 37 participants completed 52 post-session surveys (41% response rate) across 11 sessions. The mean confidence to answer MCQs increased from 2.63 to 3.98 (+1.34, 95% CI 1.06-1.62, $t(36)=9.39$, $p<0.0001$). Cognitive load was moderately high (5.97) and ability to counterfactually reason was moderate (3.83). Analysis of paired entries showed improvement (normal incorrect to counterfactual correct) in 11.5% (n=130) and deterioration (normal correct to counterfactual incorrect) in 20% (n=130). Notably, 20% deteriorated however it should not be interpreted as failure of approach, rather it reflects the intended difficulty of counterfactual reasoning, exposing the gaps in which standard MCQs may mask. Among 24 participants who contributed 33 observations in which both MCQs and post-session survey were completed, mean confidence increased from 2.57 to 4.19 (+1.55, 95% CI 1.16-1.95, $t(23)=8.13$, $p<0.0001$), with similar cognitive load (6.02) though reasoning scores were lower (3.12). Further analysis of the complete dataset is planned to be completed to assess trends.

Conclusions

There was significant improvement in confidence in both full set and subset analysis suggesting exposure to AI-generated counterfactual questions supports students in UKMLA preparation. Future iterations may consider counterfactual MCQs across other UKMLA topics and whether repeated exposure to counterfactual questions improves performance in formal assessments.

2026333
Two Hemispheres, One Vision: co-creating the future of interprofessional education

Presenting Author(s)

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Interprofessional education (IPE) is at a critical juncture as global healthcare systems confront increasing complexity, demographic change, workforce pressures, and rising service user expectations. The conference theme, 'Innovating Together – the Future of IPE' invites educators to reconsider how interprofessional education is shaped, delivered, and enhanced through global collaboration. This abstract outlines a proposed Visiting Faculty initiative from the University of Northampton (UON) in the United Kingdom (UK) to Edith Cowan University (ECU) in Perth, Western Australia, designed to explore how transglobal engagement can drive pedagogic innovation and strengthen international IPE networks.

The planned visit has three aims:
1. To observe IPE within ECU's health and social care programmes
2. To build strategic partnerships with academic colleagues
3. To identify opportunities for long term collaboration in curriculum development, delivery, and research.

Experiencing IPE within a different cultural, organisational, and geographical context is expected to generate insights that support more adaptable and inclusive pedagogies at both institutions.

Anticipated areas of learning include ECU's approaches to embedding IPE across programmes, shaped by Western Australia's workforce landscape, Indigenous health priorities, and distinctive models of care. Observing these practices is expected to prompt critical reflection on UK assumptions while highlighting how innovation emerges when diverse perspectives intersect. Potential transferable practices include culturally safe IPE design, simulation-based teamwork development, and authentic assessment of collaborative behaviours. In return, UON's strengths in digital learning, student-led peer education, and practice-based assessment may offer reciprocal value.

The initiative aims to lay foundations for sustainable collaboration, including co-authored research, comparative studies of student readiness for collaborative practice and virtual IPE events. Ultimately, this proposed UK–Australia partnership illustrates how intentional cross-cultural engagement can foster dynamic, globally informed models of IPE and demonstrates the transformative potential of working together across hemispheres to shape the future of IPE.
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2026334
Breaking Down Silos, Sustaining Change: Evaluating the Impact of Student IPE Champions as Agents of Interprofessional Collaboration

Presenting Author(s)

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This abstract reports the outcomes of the Student IPE Champions initiative presented at the INHWE Online Conference 2026. The initiative, funded by the University of Northampton's Student Success Innovation Fund, sought to enhance engagement with the Faculty's Interprofessional Education (IPE) 'Collaborative Curriculum' through a peer-led model of advocacy and leadership.

Four Student IPE Champions were successfully recruited from across health and social care programmes (midwifery, podiatry, occupational therapy, mental health nursing). Although recruitment proved the most significant challenge (reflecting the academic and placement pressures students experience), the project progressed well once the team was established. The IPE Champions worked as an effective interprofessional unit, modelling collaboration, challenging stereotypes, and demonstrating the value of shared learning in practice.

A key strand of their work involved supporting and promoting Schwartz Rounds (interprofessional reflective forums). Through targeted peer-to-peer engagement, the IPE Champions encouraged greater student attendance, contributing to an observable increase in participation. Their involvement helped normalise reflective, interprofessional dialogue and highlighted the importance of psychological safety and collective learning in professional identity development.

The IPE Champions also played a central role in organising and presenting at the Faculty's IPE Conference 2026. Their contributions shifted the conference dynamic from faculty-led to student-empowered, showcasing how student leadership can elevate the profile and relevance of IPE. Their visible presence reinforced the value of interprofessional teamwork, demonstrating to peers that IPE is not an academic add-on but a foundational element of collaborative practice.

An unexpected and particularly powerful outcome was the external recognition of one IPE Champion, who was nominated for a Nurse of the Year award. This achievement illustrates the leadership potential fostered through the initiative and highlights the wider professional impact of student-led advocacy.

Whilst it is too early to determine long term sustainability or secure funding for future cohorts, the positive engagement, increased student attendance, and strengthened interprofessional culture suggest strong potential for continuation. Findings indicate that student-led models can effectively dismantle siloed thinking, enhance peer engagement, and build capacity for collaborative practice within undergraduate programmes.

This project extends the limited evidence base on student-led IPE initiatives and demonstrates that empowering students as IPE Champions can generate meaningful cultural and behavioural change within health and social care education.

2026335
Awareness First: Addressing Vicarious Trauma and Building Resilience in Healthcare Workforce Education

Presenting Author(s)

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Introduction
Healthcare professionals, particularly nurses, are frequently exposed to emotionally challenging situations that can lead to vicarious trauma (VT), burnout, and other negative psychological outcomes. Despite its prevalence, awareness of VT remains limited, putting the workforce at risk and threatening retention and quality of care. Leadership plays a crucial role in mitigating these risks, yet strategies to prepare the workforce proactively are scarce. This presentation will showcase the study 's prevalence of VT among addiction nurses across Europe and explores how awareness and leadership interventions can support resilience and sustainable workforce development.

Methods
A mixed-methods explanatory sequential design was employed. Quantitative data were collected via a survey of addiction nurses in multiple European countries to assess exposure to VT and its psychological consequences. This was followed by qualitative interviews to explore nurses' experiences, coping mechanisms, and perceptions of leadership support. Data integration informed the development of evidence-based guidelines for education and workforce policy.

Results
Findings indicate that nearly 9 in 10 addiction nurses in Europe are potentially vulnerable to VT and its associated negative outcomes. Leadership support, structured reflection, and interprofessional collaboration were identified as key protective factors. The study emphasises that the first critical step is raising awareness of VT early in professional education. Evidence-based guidelines developed from this research provide practical strategies to embed awareness, resilience training, and leadership support into healthcare education programs, fostering a more sustainable, emotionally resilient workforce.

Conclusion
Proactively addressing VT through early awareness, interprofessional education, and leadership engagement is essential to prepare the future healthcare workforce. Embedding these strategies from the start of training strengthens resilience, supports mental wellbeing, and ensures delivery of safe, compassionate care. Innovation in healthcare education must therefore include emotional preparedness alongside clinical skills, aligning with global priorities for workforce sustainability and interprofessional collaboration.

2026337
Listening to the Workforce: Bridging the Gap between Interprofessional Education and Collaborative Practice Needs

Presenting Author(s)

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Background
Studies find that health professions graduates who participate in campus-based interprofessional education (IPE) translate their collaborative learning into future workforce practice including advanced skills in communication, teamwork and team-based leadership (Shrader, et al, Crampsey, et al). These findings parallel those from studies with workforce stakeholders who agree that graduates who engage in IPE while in their professional programs have a positive impact on interprofessional collaborative practice and workplace culture (Crampsey et al). Despite these encouraging findings, there continues to be contemporary critique from researchers and practitioners about significant disconnections between campus-based learning and clinical realities that pose conceptual and implementation barriers to interprofessional collaborative practice. As collaborative team-based practice evolves, addressing the inconsistencies between what students learn in IPE academic settings and what methods and practices are applied in real-world settings is central to improving health outcomes for individuals, communities, and populations (Rubin et al.; Salfi et al.) and bettering the experiences of practitioners and workers in today's complex health systems.

Presentation
This oral presentation describes a cross-institutional collaborative research project in the U. S. that is exploring the impact of interprofessional education on practice and interprofessional team-based needs of the healthcare workforce from the perspectives of clinical employers, managers, and supervisors. These roles are critical drivers of interprofessional collaborative practice (ICP) and as such, their buy-in is essential if ICP is to be significantly and effectively deployed in healthcare of the future (Dow et al). In order to improve fidelity between the education of future healthcare workers and the needs of healthcare employers, our research team is speaking with workplace leaders across the U. S. to identify common characteristics, competencies, skills, and the cultural necessities they view as indispensable to improve collaborative workplace experiences for providers and better health outcomes for patients across clinical settings, professions, cultures, and geography.
During the presentation, members of the team will provide a brief summary of their work to date and invite discussion on the following topics: why they came together, the composition of the team and how, by working together from multiple positional perspectives the research process was enhanced; the collaborative processes associated with this multi-institution project; the benefits and limitations of single region studies; the process of selecting theories and methodologies; and preliminary findings.

Design
This cross-institutional study deployed a qualitative methodological approach conducting focus groups with workforce employers and managers in four different U. S. states. A collaborative approach was used to establish a shared script for the focus group sessions, targeting the research questions. The script was refined following two pilot focus group sessions to ensure effective research outcomes. Thematic analysis of transcribed data will be used once all researchers from each institution have completed their focus group sessions. Each institution received Institutional Review Board approval prior to conducting focus group sessions.

Participants
As per study inclusion criteria, all participants worked in healthcare organizations or entities and must have worked with their organization for at least 1 year.

Data Collection
Each institution had the goal of conducting three to five focus group sessions with one to five participants from varied health professions in each focus group. Data collection will take place between June 2025 and March 2026, with the goal of reaching data saturation. Transcripts from these focus group sessions and a demographic survey will be culled and analyzed.

Data Analysis
Structured thematic analysis of focus group transcripts confirmed for accuracy will be deployed once all focus group sessions have been completed. The thematic analysis will be conducted by members of the research team who did not serve as focus group facilitators.

Results
Fifteen focus group sessions with 38 participants have been conducted to date across the four institutions. Formal structured thematic analysis will take place once all focus group sessions have concluded. Anecdotal themes thus far noted include a disconnect between what is taught in health education

and what is needed for contemporary clinical workforce practice; varying levels of familiarity and engagement of ICP between healthcare professions and practice settings; disparate acknowledgement of the role of systems factors for ICP; the patient as central to ICP; the need for intentional student training on professionalism, communication and other affective skills; and the need for continuing professional ICP education for workforce employees.

Conclusion

Our collective intention is to provide conference attendees with key reflections from our early findings that can inform curricular and co-curricular IPE, practical guidance on how to develop multi-institution scholarly projects, and personal observations on the challenges and joys of interprofessional, cross-institutional inquiry.

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2026338
Peer-assisted learning in workplace settings: How the hidden curriculum and organizational culture might affect this form of learning

Presenting Author(s)

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Peer-assisted learning (PAL) is considered an effective form of learning in the training of healthcare professionals (e.g. Feng et al. 2024; Zhang et al. 2024), especially in the clinical workplace context, where learners work together to accomplish complex tasks (e. g. Penman et al. 2024) and benefit from each other through social and cognitive congruence (Lockspeiser et al. 2008; Loda et al. 2019/2020a/b; Herinek et al. 2024/2025). At the same time, it is well documented that learning processes in clinical settings are strongly influenced by cultural and organizational factors (e.g. van der Zwet et al. 2011; Nuño-Solinís 2025), particularly in contexts where there are overlapping work and learning expectations. The hidden curriculum is a concept used to denote implicit socialization influences that impact learning. The norms, power structures, and unspoken role expectations, have a significant influence on how students take on responsibility, how secure they feel, and what forms of PAL are actually realized (Apiraksakorn/Howden 2019; Hafferty/Franks 1994; Lu/Kumar 20224; Martimianakis et. al 2015, McKenna/Williams 2017). International studies show that, particularly in workplace learning, subtle hierarchies and time logics structure learners' scope for action and can both promote and restrict learning (e.g. van der Zwet et al. 2011).

The workshop aims to systematically reveal these interactions. After analyzing two exemplary cases in a plenary session, participants will work with a structured power mapping approach. In doing so, they will identify supportive, inhibiting, and invisible forces that influence PAL in their respective clinical contexts. The method enables the derivation of context-specific, realistically implementable strategies that can strengthen PAL in everyday clinical practice. The workshop is aimed at teachers, clinicians, researchers, and curriculum developers who want to design PAL in a reflective manner in the workplace setting and take cultural and structural dynamics into account more consciously.

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Supporting Documents

https://inhwe.org/system/files/webform/Workshop%20Plan%20PAL%20INHWE_Submission.pdf

2026339
The Discipline of Team Learning. Interprofessional simulation is a conduit through which team learning becomes organisational learning, enabling safer care and supporting the system transformation required for integrated care

Presenting Author(s)

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Healthcare is a dynamic, high risk, multi team environment where performance emerges from the interactions between people, processes, technology and context. In that setting, organisational learning is not primarily an individual capability. It is a team capability that must scale across professions, sites and services. Senge argues that teams are the fundamental learning unit in organisations and that sustained improvement depends on developing the discipline of team learning so that people can think together, surface assumptions, and build shared understanding that informs coordinated action (Senge, 1990). This matters for integrated care, where safe and reliable services depend on teams learning across boundaries rather than improving in parallel within professional silos.

Team learning is more than good communication. It requires structured practices that enable dialogue, the testing of assumptions, inquiry into reasoning, and the capacity to work with difference without defaulting to hierarchy, defensiveness or premature closure (Senge, 1990). In healthcare these challenges are amplified by status gradients, time pressure, and fear of blame. Psychological safety is therefore a practical precondition for team learning because it enables speaking up, challenging mental models, and learning from error (Edmondson, 1999). If we want organisational learning in healthcare, we need reliable methods that repeatedly create these conditions in real clinical teams.

High quality interprofessional simulation is one of the few educational modalities that deliberately engineers the conditions for team learning. It brings professionals into the same learning space around shared tasks and goals, and uses established structures to support the learning conversation. Prebriefing prepares participants, establishes ground rules, and supports psychological safety and a shared mental model (INACSL Standards Committee, 2021). During the simulation event, coordination, escalation, leadership, and decision making become visible and discussable rather than implicit. Learning is then consolidated through debriefing. Debriefing grounded in a basic assumption of participant capability shifts the climate from judgement of persons to curiosity about performance, reasoning and context (Rudolph et al., 2006). Advocacy inquiry links observed actions to underlying mental models and invites participants to test and refine those models (Rudolph et al., 2006). Debriefing provides a structured approach that helps maintain psychological safety while still addressing performance gaps and system constraints (Eppich and Cheng, 2015). Interprofessional simulation therefore operationalises team learning as a repeatable practice rather than an aspiration. It also adds a distinctive advantage for interprofessional education: the trained debriefer, who can flatten hierarchy, manage power dynamics, and sustain collegial inquiry when discussions would otherwise fragment or avoid the hard issues.

Interprofessional simulation becomes uniquely valuable when designed as translational simulation. Translational simulation links learning to service priorities by diagnosing system issues, testing changes, and supporting implementation (Nickson et al., 2021). Using an input process output lens, it connects system inputs such as staffing, equipment, pathways and environment to team processes such as coordination and escalation, and then to outputs such as reliability, safety events and patient outcomes (Nickson et al., 2021). This moves simulation beyond education for competence to simulation for improvement, where teams identify latent safety threats and co design changes that can be implemented and measured in practice (Nickson et al., 2021). For interprofessional education to be valuable to the organisation, it must contribute to outcomes healthcare values, particularly safety, quality, and experience. The World Health Organization frames interprofessional education as a mechanism to strengthen collaborative practice and improve health system performance when it is embedded and supported, rather than delivered as isolated events (World Health Organization, 2010). Translational simulation strengthens this value proposition by connecting interprofessional learning directly to measurable change in care delivery.

Implementing this at scale requires coordinated resourcing, governance and strategy. In Ireland, a national strategic guide for implementing simulation on clinical sites set out the need for coordinated implementation and strategic planning, with an explicit focus on interprofessional education and patient safety (Byrne et al., 2021). The case for strategy has strengthened as reform has progressed. Department of Health policy on HSE Health Regions emphasises regional accountability for aligning hospital and community services to deliver integrated care in line with Sláintecare (Department of Health, 2022). A simulation strategy must therefore work with, and add value within, these regional structures. The HSE National Simulation Office Strategic Plan sets out a nationally coordinated approach delivered through regional leadership, shared standards and metrics, and partnerships that can translate shared learning into improvement and patient safety (Health Service Executive, 2025a). To embed interprofessional simulation into an integrated care model rather than running alongside it, the education and improvement workforce must itself be interprofessional and system facing. This includes educators from multiple professions working with quality improvement partners, human factors expertise, technical staff and design capability so that insights from simulation become implemented change (Nickson et al., 2021). Strategy also needs clear goals, measurable outcomes, and governance that align local initiative with national standards and regional priorities.

Interprofessional team based simulation is therefore more than a method for shared education. When delivered to high standards, facilitated skilfully, and designed translationally, it is a practical conduit through which team learning becomes organisational learning, enabling safer care and supporting the system transformation required for integrated care.

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2026340
An Innovative Interprofessional MSc Program to Strengthen Leadership Capacity in Swiss Healthcare

Presenting Author(s)

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Objectives
The Swiss healthcare system is undergoing a profound structural and cultural transformation, characterized by increasing multimorbidity, staff shortage, cost pressure, digitalization, and shifting professional roles. Healthcare professionals are expected to assume leadership and management responsibilities in interprofessional, dynamic environments. The objective of this contribution is to present the concept, structure, and competency-based design of the new Master of Science in Healthcare Leadership at the Bern University of Applied Sciences (BFH). The program aims to equip healthcare professionals with evidence-based leadership competencies to manage complexity, foster interprofessional collaboration, and shape sustainable organizational transformation.

Method
The MSc Healthcare Leadership was developed based on (1) a systematic review of international leadership competency frameworks and empirical studies, (2) alignment with EQF Level 7 requirements, and (3) close collaboration with healthcare providers. The curriculum integrates subject-specific modules (e.g., leadership and management, strategic management, public health and global leadership, organizational and team development), interprofessional modules, research methodology training, and transfer modules enabling direct implementation in practice. A competence-oriented didactic concept combines theory-based, exchange-based, simulation-based, and action-based learning formats, including real-world laboratory approaches and “bring-your-own-project” integration. The program comprises 90 ECTS and is offered in full-time and part-time formats.

Results
The program defines six core competency areas: (1) healthcare system knowledge, (2) scientific expertise, (3) communication, (4) business skills, (5) transformation and change management, and (6) leadership and self-leadership. Interprofessional education is a central pillar that fosters mutual role understanding, collaborative competencies, and patient-centred care. The close integration of research and practice strengthens evidence-based leadership and supports applied research projects, including Master’s theses embedded in healthcare organizations. The modular, competence-oriented assessment strategy emphasizes reflective, methodological, and applied skills rather than purely theoretical knowledge.
The first cohort of students started in 2024, and the full-time students finished this spring with their master's theses. The second cohort started in 2025. The evaluation results of the study programme are very good, and students are satisfied.

Conclusions
The MSc Healthcare Leadership represents an innovative response to the increasing leadership demands within the Swiss healthcare system. By integrating interprofessional education, research-based teaching, and strong practice partnerships, the program contributes to the development of resilient, evidence-informed leaders capable of shaping transformation processes in complex healthcare organizations. The program also strengthens applied leadership research and supports the long-term professionalization of healthcare management in Switzerland.

2026341
Becoming regulator ready through interprofessional education and collaborative practice

Presenting Author(s)

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Background
Interprofessional collaborative practice (IPCP) is well-recognised as improving healthcare experiences and outcomes (1). However, a persistent challenge is embedding IPCP into education and practice throughout the workforce (2). Healthcare regulators represent a potentially powerful lever to address this challenge. For regulated professions, training programmes and healthcare professionals must adhere to standards to legally practice in the profession (3). As such, healthcare regulators can have a powerful impact on the development and implementation of IPCP.

Traditionally, the focus has been on preregistration interprofessional education (IPE), with much less attention paid to continuing professional development (CPD). A lifelong learning approach is preferable, focusing not only on “preparing students in the pipeline” but cultivating clinical environments supporting IPCP (4). To truly embed IPCP and maximise its effectiveness throughout the continuum of health and social care education, training and lifelong learning there is a need for interprofessional CPD in areas such as care coordination, population health management and health coaching (4).

Internationally, evidence of interprofessional curricula is increasingly being sought by accreditation bodies as a mechanism to ensure the introduction of interprofessional learning opportunities. However, standards and expectations differ by health professional group, sending mixed messages to those responsible for implementation.

Therefore, the aims of this research were to:
1. To document the status of IPCP competencies and requirements within Irish health and social care regulatory documents.
2. To generate recommendations for IPCP within Irish health and social care regulatory documents.

Methodology
A document review methodology was used to carry out a comparative content analysis of IPCP requirements across regulatory documents in January 2025 (5). Data was sourced via online Internet searches and email requests to healthcare regulators. With the support of the IPCP Group of the Irish Health & Social Care Regulators, comparative content analysis of IPE requirements was undertaken. Two researchers reviewed 27 documents from six regulators representing 20 health professions – the Nursing and Midwifery Board of Ireland, Pharmaceutical Society of Ireland, Medical Council, Dental Council, Pre-hospital Emergency Care Council (PHECC) and CORU. PHECC represents Emergency Medical Technicians, Paramedics and Advanced Paramedics. CORU is a multiprofessional regulator for 13 professions: Dietitians, Dispensing Opticians, Medical Scientists, Occupational Therapists, Optometrists, Physical Therapists, Physiotherapists, Podiatrists/Chiropodists, Radiographers, Radiation Therapists, Social Workers, Speech and Language Therapists, Social Care Workers.

Results
All regulated professions referenced interprofessional learning as a requirement of pre-registration education. Paramedicine represented the highest coverage. IPCP terminology varied and included interprofessional, inter-professional and interdisciplinary and multidisciplinary. Some documents outlined specific learning activities or outcomes required to achieve interprofessional competency, with varying specificity. The PSI was the only regulator that specified interprofessional learning in the CPD context.

Conclusions
The need for IPCP was referenced in formal documents of all regulated professions. The PSI was the only Irish regulator to explicitly reference CPD. The international interprofessional terminology quagmire (6) was replicated in our results, despite recent efforts to standardise terminology (7). No reference was found to interprofessional competency frameworks in the Irish setting. The pursuit of a single interprofessional competency framework would benefit both those required to design interprofessional curricula, and accreditation bodies seeking evidence of implementation.

Focus to date has mainly been on pre-registration education. Yet, CPD is essential to meaningfully influence clinical practice. Encouraging, and where appropriate mandating, development and implementation of CPD models for all relevant professional groups now needs to become a priority, to ensure progress made in undergraduate/pre-registration education carries through to practice. Emerging interprofessional CPD pathways such as the Project Extension for Community Healthcare Outcomes (an online interprofessional CPD program) provide models for development (8). However, there is a need for Regulators to identify opportunities to incorporate IPCP into their CPD models and realise the potential of CPD on IPCP workplace culture.

In Ireland, there is the now an opportunity for the IPCP Group of the Irish Health & Social Care Regulars to work together. Priorities include harmonisation of expectations through a shared use of interprofessional terminology and frameworks (9), and shared curricular expectations.

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2026342
Palliative Care Education: A Collaborative Interdisciplinary Approach to End-of-Life Management in Children and Young People

Presenting Author(s)

Ms Karen O'Sullivan, Nurse Tutor/Specialist Coordinator, RCNME Dublin & South East, Ireland

Background
The Clinical Governance and Operational Arrangements for Supporting a Model of Care for Children with Life-Limiting Conditions towards End of Life in the Community in Ireland (HSE, 2021) highlighted the need for structured education and training to strengthen governance and operational frameworks supporting children at end of life. In response, a national working group was established to develop an interdisciplinary education programme to enhance the competence and confidence of healthcare professionals in delivering high-quality, family-centred end-of-life care to children and young people across care settings locally, regionally, and nationally.

Aim
To design, implement, and evaluate a continuing professional development (CPD) programme that advances healthcare professionals' understanding and management of end-of-life care for children and young people with an integrated care perspective.

Methods
The interdisciplinary collaborative curriculum design incorporated the perspectives of paediatric and adult palliative care teams, paediatric home-care teams, and educationalists. Using a descriptive, problem-solving approach the team developed a blended learning model, comprising six short online modules and a classroom-based component, ensuring equitable access and a national-to-local reach reflecting Ireland's geographical spread. Evaluation of the programme was completed following each classroom session via an online survey using a mix of closed-ended questions using a Likert scale and opened ended questions allowing for deeper insight to the participants experience.

Results
The blended approach enabled consistent, cost-effective delivery and accessible learning for all participants nationally. Participants were recognised as adult learners, encouraged to identify individual learning needs and apply knowledge within interdisciplinary teams. To date there has been 121 responses to the survey, collation of the responses demonstrated the following results;
• Participants were from a mix of specialities and grades, including medical, nursing and health & social care professionals, with positive feedback on the interdisciplinary attendance.
• A total of 91% were very positive and positive regarding the use of a blended approach.
• Prior to programme completion 33% rated extremely and very confident in their knowledge and competency in end of life care and management of the child and young person.
• Areas of concern and challenging for participants included; medication management, supporting parents and families of the child/young person, correctly recognising signs of dying.
• Post programme completion 93% felt it extremely & very valuable in improving their knowledge and confidence in end of life care and management of the child and young person.

Conclusion
Recognising the challenges in developing an interdisciplinary, inter-agency programme such as; differing organisational cultures and accountability structures and using strategies including setting clear goals and creating an environment based on trust and collaboration helped address these. The programme outcome demonstrates how collaborative curriculum design and blended delivery can enhance professional capability, promote equitable access, and improve care for children and young people at end of life.

2026344
Delivering the CAIPE Strategy: Advancing Faculty Development for Interprofessional Education

Presenting Author(s)

Dr Melissa Owens, Director of Nurse Education, University of York, UK

Background
The Centre for the Advancement of Interprofessional Education (CAIPE) is the leading United Kingdom (UK) authority on interprofessional education and collaborative practice (IPECP), contributing to the work of Interprofessional.Global (IPG) and Interprofessional.Research.Global (IPR.G). In 2022, CAIPE launched a four-priority Strategy focused on research, standard setting, translation of evidence into practice, and faculty development. A significant milestone was achieved in 2025 with the launch of the Quality Standards for Pre-registration Programmes, establishing a national benchmark for interprofessional competence development. As co-leads of the Faculty Development Working Group, we now approach the final year of the Strategy. This presents a timely opportunity to reflect on progress, evaluate impact, and identify priorities for the next phase of development.

Aim
To present the achievements of the CAIPE Faculty Development Working Group and outline future priorities in strengthening interprofessional educator capability.

Methods and Activities
The 4 priorities of the Working Group are:
Implementation of the CAIPE Standards
Assessment guidance
Curriculum and interprofessional course design
Defining the competencies of the interprofessional educator

Our recent work has prioritised numbers 3 and 4. Initial work involved a focused review of the literature and the development of concept maps identifying (a) core facilitator capabilities and (b) essential curriculum components for facilitator training. These findings informed the development of a national 'Train the Trainer' package to support leaders in preparing IPE facilitators, with the ambition of establishing a UK wide 'gold-standard' training programme. The review of the literature also informed the development of a UK and Ireland based survey which was conducted between October and December 2025. Survey outcomes identified significant variability in facilitator preparation and strong demand for structured training. These findings will underpin the development of a structured and sustainable CAIPE training provision.
These findings have underpinned the development of a number of international workshops including a three-day workshop in Qatar and a one day workshop in Ireland, on training IPE Facilitators, demonstrating global engagement and knowledge translation. Recognition of our expertise has also led to an invited book chapter on the training and deployment of IPE facilitators (Blumenthal et al., in press).

Moving Forward
Delivering strategic faculty development for interprofessional education requires sustained collaboration across institutions, professions and national boundaries. Progress has depended on collective leadership, partnership working, and the voluntary contribution of experienced educators alongside full-time academic roles. Despite these constraints, the Faculty Development Working Group has made substantial advances in defining, standardising and strengthening the preparation of IPE facilitators.
Our work reinforces a critical message: high-quality IPECP does not occur by chance. It is enabled by skilled facilitators who have the knowledge, skills, behaviours and attitudes to promote collaborative working through the navigating of professional identities, managing group dynamics, creating psychologically safe learning environments, and translating IPE theory into meaningful practice. By developing evidence-informed guidance, mapping facilitator competencies, and designing a structured 'Train the Trainer' workshop package, we are contributing to a more coherent and sustainable approach to educator preparation across the UK and Ireland, with growing international reach.
As the CAIPE Strategy approaches review, the next phase will focus on piloting and evaluating the train the trainer workshops, expanding CAIPE'S training and workshop provision, strengthening implementation of the Quality Standards, and expanding global collaboration through shared learning and scholarship. Ultimately, this work seeks to enhance the quality and consistency of IPECP, thereby contributing to improved collaborative practice and better outcomes for the populations our graduates serve. This presentation will describe the work of the Faculty Development Group, whilst also providing practical, transferable insights for others seeking to enhance their IPEPC delivery and in particular, IPE Facilitation.

Supporting Documents
https://inhwe.org/system/files/webform/Dublin%202026.docx

2026345
Listening Together: How Tiered Learning Prepares Students for Holistic Person-Centred Care

Presenting Author(s)

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This presentation outlines a tiered educational approach designed to strengthen communication skills, Deaf Awareness and shared values across healthcare training at Aston University, UK. Beginning with introductory sessions in Year 1 and progressing to more discipline specific teaching in Year 2, audiology staff deliver deaf awareness and hearing loss teaching to nursing students, while nursing staff provide audiology students with education on dementia. These two foundational teaching components act as essential prerequisites for the subsequent interprofessional education activity later in Year 2, ensuring all students enter the session with a shared baseline of knowledge and readiness for collaborative learning.

Aligned with the conference themes of communication, person centred practice and holistic care, the initiative focuses on best practice when working with individuals who may be living with dementia, hearing loss or both. A central aim is to empower nursing students to communicate more holistically and confidently by understanding the impact of hearing loss on healthcare interactions across professional groups. The teaching highlights signs and indicators that practitioners should look out for, offering guidance on differentiating when observed behaviours may relate to cognitive decline, unmanaged hearing loss or overlapping presentations. Students also explore practical approaches for supporting friends and family members to communicate more effectively with individuals who have dementia or hearing loss, extending learning beyond the clinical setting.

Interactive elements form a key part of the programme. Students practise inserting hearing aids, learn how to maintain and troubleshoot them, and experience simulations and activities that demonstrate the communication barriers created by hearing loss. Through peer learning, audiology students guide nursing students in hands on skills, reinforcing the importance of cross disciplinary understanding for safe and compassionate patient care.

This work directly contributes to Aston University's commitment to preparing graduates who are life ready and work ready, and supports the local community by improving frontline awareness of two highly prevalent health conditions. It also aligns with wider NHS workforce priorities by strengthening the capability of future clinicians to meet the needs of ageing populations, deliver person centred communication and work effectively within multidisciplinary teams.

By bridging the gap between two professional programmes, the initiative fosters shared skills, shared values and mutual understanding. It lays the foundation for the subsequent interprofessional education session between audiology and nursing, creating a coherent learning journey from discipline specific foundations to meaningful interprofessional collaboration. The presentation will demonstrate how this model can be adapted across other healthcare professions to enhance communication, promote inclusive practice and improve patient outcomes.

2026346
Beyond 'Pilotitis': A Systems-Thinking Synthesis of Multi-Level Implementation Dynamics in LMIC Interprofessional Education

Presenting Author(s)

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Objectives

Interprofessional education (IPE) is increasingly promoted in low- and middle-income countries (LMICs) as a pragmatic response to workforce shortages, fragmented care, and weak collaborative practice. These pressures are intensified by the triple burden of disease and severe health worker maldistribution, which together magnify the mismatch between episodic, uniprofessional care and the growing prevalence of multimorbidity and chronic disease. Although IPE is positioned as essential for strengthening collaborative practice in resource-constrained settings, the LMIC evidence base remains overwhelmingly concentrated in pilot-phase work. Most studies report only proximal implementation and educational outcomes, acceptability, appropriateness, feasibility, learner attitudes, knowledge gains, and self-reported teamwork, while offering limited insight into the conditions required to sustain, institutionalise, or scale IPE once external grants or local champions fall away.

This review addresses this persistent evidence gap by applying a systems-thinking, causal-chain framework to IPE implementation research in LMICs, a novel analytical lens that moves beyond static inventories of barriers and facilitators to map cross-level feedback loops and identify structural leverage points where targeted intervention can generate disproportionately large downstream effects on implementation trajectories. In doing so, it responds directly to the conference call to "Innovate Together," reframing innovation not as the introduction of new instructional content or technologies, but as the redesign of governance architectures that make collaborative practice structurally inevitable rather than individually dependent.

Method

A PRISMA-guided systematic review and narrative synthesis were conducted across nine electronic databases (PubMed, Embase, PsycINFO, ERIC, CINAHL, LILACS, AJOL, and IMSEAR), supplemented by grey literature and snowball searching, yielding 52 peer-reviewed empirical studies reporting IPE implementation in LMIC settings. A hybrid analytic framework drawing on CFIR 2.0, Bronfenbrenner's socio-ecological model, ERIC implementation strategies, Proctor implementation outcomes, and Meadows' systems-thinking concepts guided structured data extraction. A causal-chain lens (inputs → activities → process mediators → outcomes) was applied to test 30 a priori propositions examining how implementation factors clustered and interacted across ecological levels. Feedback-loop analysis (minimum two-link rule) and robustness testing using MMAT high-quality and higher-sustainment subsets were used to develop an explanatory model of multi-level implementation dynamics.

Results

Across 52 studies, the evidence base is heavily skewed toward early-stage implementation: 26 studies (50%) were pilots, providing rich accounts of planning, stakeholder engagement, and immediate learner reactions, but offering almost no empirical visibility on penetration or sustainability, outcomes that require longer time horizons, institutional routine, and structural integration. This imbalance generates a pervasive pattern of "IPE pilotitis," in which programmes appear highly successful in controlled pilot environments yet rarely transition to mandatory, system-wide adoption.

The distribution of Proctor implementation outcomes underscores this structural distortion. Acceptability, appropriateness, feasibility, fidelity, and adoption are reported consistently and often positively; cost, penetration, and sustainability are largely absent. This asymmetry creates a condition of "pilot optimism," whereby IPE appears deliverable and well-liked despite the evidence base remaining silent on what programmes cost to run or what institutional conditions support their persistence. Case evidence from Lebanon and Egypt further demonstrates how dependence on unbudgeted faculty labour and unpaid individual champions ("endless champions") enables short-term survival while virtually guaranteeing programme collapse in the medium term. Implementation cost, the very factor determining long-term viability, is the outcome most consistently omitted, as programme labour is routinely absorbed through uncompensated staff overtime.

Feedback-loop analysis situates the core balancing loop at the meso (inner-setting) level, where timetable clashes, siloed faculties, and entrenched professional hierarchies block the transition from pilot activities to curricular integration. Three reinforcing mechanisms emerge as central to implementation trajectories: a curriculum formalisation cycle, in which credit-bearing, timetabled, protected IPE generates self-reinforcing institutional commitment and delivery quality; a professional hierarchy trap, in which hierarchical dynamics systematically degrade interprofessional learning quality unless actively dismantled through intentional facilitation; and an iterative adaptation cycle, in which structured feedback and continuous programme refinement build the resilience necessary for institutionalisation. Across the dataset, meso-level governance, rules, resource flows, scheduling structures, and interdepartmental coordination, emerged as the principal transmission channel through which macro-level policy ambitions either translate or fail to translate into sustained micro-level engagement.

Conclusions

These findings call for a fundamental reorientation of how IPE is funded, implemented, and governed in LMICs. Replicating attitudinal pilot studies without addressing the structural determinants of sustainability represents a critical misalignment of research investment with field maturation needs, and an immediate moratorium on small, ad hoc pilot projects that merely remeasure short-term student attitudes is warranted. Three strategic priorities follow.

First, permanent cross-faculty governance must be established through centralised Offices of Interprofessional Education with authority over cross-departmental mandates, budgetary coordination, and timetabled IPE delivery. Second, grant funding must shift toward structural integration, supporting scheduling coordinators, timetable-synchronisation systems, and curriculum redesign to establish mandatory "green zones" of shared, protected interprofessional learning time. Third, facilitator capacity-building must be explicitly targeted at dismantling professional hierarchies through iterative adaptation cycles anchored in structured, longitudinal feedback.

By shifting resources from fragile pilot experiments to meso-level governance, institutional structures, and costed implementation roles, LMICs can transition IPE from a champion-dependent initiative into a durable component of health system strengthening, with measurable gains in penetration, sustainability, and collaborative practice outcomes. These findings offer scalable strategies for global and Irish-led North–South partnerships, directly supporting SDG 3.8 and WHO Health Workforce 2030 goals, and demonstrate that meaningful innovation in IPE lies not in new pilots, but in governance models that make collaboration sustainable, visible, and equitably resourced across global health systems.

2026347
12 Leadership Capabilities Every Clinician Needs, But Medical School Never Taught You

Presenting Author(s)

Dr Ali Sanders, Associate Medical Director, Imperial College Healthcare NHS Trust, UK

Introduction

Evidence consistently shows that health systems with strong clinical leadership achieve improved patient outcomes and greater efficiency. However, many doctors assume leadership roles without sufficient preparation for managerial, financial, and governance responsibilities that accompany senior roles. This transition is particularly challenging for new consultants, who move abruptly from highly structured training environments into roles with significant decision-making authority and organisational influence.

To address this gap, Imperial College Healthcare NHS Trust developed the Frontier Programme, a five-month leadership programme for new consultants (0-5 years in post). Frontier focuses on developing leadership of self, service, and system, combining evidence-based content with practical application. Since its inception, 17 cohorts comprising of 261 participants have completed the programme with the 19th cohort recently launched. Importantly, participants represent 62 different specialties within the Trust, creating a deliberate inter-specialty learning environment that brings together diverse clinical perspectives and fosters cross-disciplinary understanding and collaboration. Over time, Frontier has evolved iteratively in response to participant feedback, expert educator input, and ongoing organisational learning.

Methods

Frontier's development has been guided by continuous evaluation. During each cohort, participants provided both quantitative and qualitative feedback immediately following every session. This feedback reflected insights from multiple specialties, allowing the programme team to capture varied clinical viewpoints and leadership challenges across services. At the conclusion of each cohort, this data was thematically analysed, enabling the programme team to identify recurrent themes, refine session structure, adapt content, and strengthen areas requiring further development.

A retrospective synthesis of thematic analysis from 17 cohorts, combined with input from experienced clinical leaders and medical educators, developed a set of twelve leadership capabilities that clinicians consistently identified as essential for skills for effective clinical leadership. These capabilities represent the core leadership skills required across self-management, service improvement and navigating organisational systems.

Results

Three overarching domains of leadership were identified, Self, Service and System, each containing four specific capabilities.

Self-leadership capabilities reflect the personal foundations necessary for clinicians to lead with awareness and authenticity. These include self-awareness (understanding your strengths, performance risks and blind spots), living our values (leading in alignment with what really matters), emotional intelligence (managing one's emotions effectively under pressure), and resilience (developing the capacity to recover, adapt and grow following challenges).

Service leadership capabilities related to how clinicians influence care delivery and team culture. These include improvement and patient safety (driving innovation, learning and safer care), coaching (enabling others to identify their own solutions), communication (engaging colleagues and stakeholders in constructive dialogue), and feedback (fostering development, appreciation and accountability)

System leadership capabilities reflect the wider organisational and structural understanding required to lead effectively with complex health systems. These include, system thinking (seeing the broader NHS picture and interdependencies), culture building (creating an inclusive, psychologically safe workplace), NHS finance (understanding money flows and financial decision-making), and medico-legal (navigating legal responsibilities and organisational governance).

The identification of these twelve capabilities has shaped the current structure of the Frontier programme. Each domain is now represented in two full-day session, each dedicated to two of the four capabilities integrated through reflective practice. This clear and coherent structure has improved participants' understanding of programme objectives and confidence in enhancing their ability to translate learning into practice.

Conclusion

The Frontier Programme has not only identified twelve essential leadership capabilities for clinicians, but also demonstrated that an internally designed, executive-supported leadership development programme can be a scalable, replicable, and impactful model for strengthening the medical leadership pipeline. As NHS organisations continue to face escalating pressures, cultivating leadership capability at the point of consultant transition is a strategic investment with wide-reaching benefits for patient care, staff wellbeing, and organisational resilience.

The Frontier Programme offers a practical blueprint for health systems seeking to embed leadership development early in clinicians' careers, ensuring that those stepping into senior roles are equipped not only with specialist expertise, but with the self-awareness, team-leadership skills, and system understanding required to navigate the modern NHS.

2026348
Enhancing responsiveness of home support services in Ireland: Opportunities and barriers to interprofessional education

Presenting Author(s)

Dr Elizabeth Morrow, Senior Research Fellow, Faculty of Nursing and Midwifery, Royal College of Surgeons in Ireland, Ireland

Introduction
In Ireland, reforms are underway to develop a statutory home support scheme. The responsiveness of home support is crucial to enabling older adults to age well at home and in their communities in an age friendly Ireland. The aim of the Attune Project is to enhance home support through gaining the experiences and views of older service users, carers, and advocates and translating these insights into recommendations for policy, practice and education. The need to shift care toward home and communities creates opportunities and barriers for interprofessional education.

Methods
The mixed-methods design includes (i) national survey of older service users (ii) semi-structured interviews with older adult service users and (iii) focus groups with providers of home support. The project will work with sector stakeholders, professional bodies and volunteer organisations to contextualise and implement the findings. A framework analysis will consider multiple factors that influence service users' experiences e.g. individual factors, service delivery/provision and socio-economic-cultural factors. A Service user, Carer and Advocacy Panel (SCAP) has a key role in shaping and influencing the research at every stage.

Discussion
The Attune Project bridges policymakers and the lived experiences of service users to better inform decision-making. Using a policy-focused, engaged research approach and an innovative "Tiger Team" method, the project supports capacity-building and development within home support services. This presentation highlights key challenges and barriers for interprofessional education, particularly in the context of the urgent need to expand and strengthen person-centred assessment and home support provision for older adults.

Conclusion
Robust research that focuses on service users, is needed to inform an age friendly health system in Ireland. The Attune Project is a model of evidence for policy that can be applied in different contexts to guide and inform workforce development, training and education that aligns with changing population needs.

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Supporting Documents
https://inhwe.org/system/files/webform/INHWE%20abstract.pdf

2026349
Bridging the Divide: Co-designing a Virtual Interprofessional Simulation

Presenting Author(s)

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Objectives
Interprofessional competency is required by all healthcare professionals in the pursuit of person-centred care. However, despite its noted importance, students continue to be primarily educated in profession specific silos across the island of Ireland, as elsewhere. The introduction of in-person interprofessional simulation-based education is cited as an appropriate approach to address this challenge. However, due to multi-dimensional barriers such as timetabling and large learner numbers, the implementation of interprofessional education (IPE) remains inconsistent. By designing a virtual IPE simulation, this project aims to address these barriers and introduce the foundational concepts of interprofessional working to pre-registration health and social care students.

Method
While the project was informed by a scoping search of the literature, to develop a user-centric, meaningful interprofessional virtual simulation, the project is adopting a co-design methodology grounded in the Double Diamond framework. While the initial Discover and Define phases were established by recent Irish research, this project focuses on the Develop (i.e., creating choices) and Deliver (i.e., refining solutions) stages. By facilitating two co-design workshops (January and April) with diverse stakeholders, this project fosters interactive cycles of ideation and rapid prototyping.

Results
15 cross-disciplinary stakeholders (students (n=7), healthcare faculty (n=7) and a patient representative) are engaging in the two co-design workshops. Iterative discussions during workshop 1 emphasised the importance of grounding the virtual simulation in a patient's lived experience of interprofessional care. Consequently, the resource's structure includes three interrelated phases: 1) Reflection, building individual and shared metacognitive awareness; 2) Discovery, investigating interprofessional dynamics through an authentic patient case; and 3) Application, employing an interactive, decision-making simulation to bridge the theory-practice gap relating to IPE.

Conclusions
By adopting a collaborative, co-design approach, this project is generating actionable and accessible design solutions grounded in the needs of students, faculty, and patients. Elements of this co-designed output will be presented during INHWE 2026 with the core insights gained through the interprofessional co-design process.

2026350
Interprofessional Continuing Professional Development for Healthcare Professionals: A Scoping Review Protocol

Presenting Author(s)

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Introduction
Interprofessional Continuing Professional Development (IPCPD) has significant potential to enhance interprofessional collaboration. IPCPD is essential for collaborative learning, which contributes to team building, better job satisfaction and safer and higher quality care for the patients and patient safety. Despite its potential to improve communication, teamwork, role clarity, and patient safety, IPCPD remains variably implemented and inconsistently evaluated across healthcare contexts. The aim of this scoping review is to map existing IPCPD initiatives for practicing healthcare professionals, examining how programmes are designed, delivered, and evaluated, identifying reported outcomes, barriers, and facilitators, and highlight research and policy gaps.

Method
Following the Joanna Briggs Institute (JBI) methodology and PRISMA-Scoping Review guidelines, the review used the PCC framework to generate the search strategy. Seven databases (CINAHL, Embase, MEDLINE/PubMed, Scopus, Web of Science, PsycINFO, ERIC) was searched for primary studies (2000–to present) describing interprofessional post-licensure CPD interventions. Eligible studies include quantitative, qualitative, and mixed-methods research describing post-licensure interprofessional CPD interventions. The scoping review started in January 2026 and is ongoing. A total of 11693 records were identified for review with title and abstract.

Discussion
This review will provide a comprehensive map of IPCPD interventions internationally, highlighting diverse educational strategies (e.g., simulation, micro-credentials, online and blended models), key outcomes (teamwork, collaboration, professional practice change, patient care), and systemic barriers to implementation. Findings will inform future research priorities and guide policy and educational planning to strengthen IPCPD. The plan is to complete the review by August 2026.

Conclusion
This scoping review will clarify how IPCPD is currently conceptualised, delivered, and evaluated across healthcare systems. By mapping existing initiatives and identifying persistent gaps the review will support the development of more robust, evidence informed IPCPD strategies.

2026351
Current Trends in Integrated Behavioral Health: A Bibliometric Analysis of 2025–2026 Literature

Presenting Author(s)

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The current study is in progress and will be completed in July 2026

Introduction

Integrated care (IC) is broadly defined as the systematic coordination of behavioral health care with primary medical care and serves as an umbrella term encompassing multiple professionals working together within a unified care plan (Giresunlu et al., 2025). Within integrated behavioral health (IBH) delivery systems, primary care providers and behavioral health clinicians collaborate with patients and families using coordinated, team-based, and cost-effective approaches. A growing body of research demonstrates that IBH improves both physical and mental health outcomes, increases utilization of behavioral health services, and reduces healthcare costs.

However, the literature describes IBH delivery models in diverse ways such examples include care behavioral health (PCBH), the collaborative care model (CoCM), coordinated care, co-located care, and fully integrated care. models differ in structure, degree of integration, professional roles, and levels of collaboration (e.g., minimal coordination, coordinated care). While this reflects the adaptability of integrated care across contexts, it can contribute to conceptual and terminological ambiguity (Giresunlu et al., 2025)

This ambiguity may influence implications for interprofessional education (IPE) and workforce development. Recent work in health professions suggests that variability in how integrated care is defined and operationalized can influence training experiences, supervision practices, and professional identity development within IBH settings (Garton et al., 2025)

While prior bibliometric studies have examined the historical development of integrated care, there is limited evidence on how integration is being conceptualized in the most recent literature (Sun et al., 2014). Given the rapid evolution of the Integrated Behavioral Health including, workforce development (e.g., population and diagnosis being served), educational models, a recent mapping of terminology is needed to better understand how integrated care is currently framed and how this framing may shape the future of interprofessional education.

Research Aims

The purpose of this study is to conduct a bibliometric analysis of the trends used to describe integrated care, with emphasis on behavioral and mental health care literature published between January 2025 and June 2026. We wanted to examine current publication patterns and trends including disciplinary and geographic distribution, as well as leading journals and authors. Map the conceptual structure of recent terminologies using co-word and co-citation analyses to identify themes, analyze current and new terminologies used (e.g., “integrated behavioral health,” “collaborative care) and evaluate which these terms are used interchangeably.

By focusing on recent literature, this study seeks to inform the audiences of recent trends in the IBH field that may support the development of workforce education and practice by highlighting the recent themes. This study will also what is going on innovations in interprofessional education by presenting the diversity of terminologies and topic trends.

Methods

We will use bibliometric analysis to systematically analyze recent scientific literature related to integrated care and behavioral/mental health. Bibliometric analysis provides quantitative tools for examining large bodies of scholarly work and is useful for identifying, research trends, and patterns of knowledge production within a field (Passas, 2024)

Data Sources and Search Strategy

We used Scopus database, selected for its comprehensive coverage of health, social science, and interdisciplinary journals. An initial exploratory search was conducted using Lens.org to refine keywords and inclusion criteria. The final Scopus search included the following terms in titles, abstracts, and keywords:

(“integrated care” OR “collaborative care” OR “co-located care” OR “coordinated care”) AND (“mental health” OR “behavioral health”).

Inclusion and Exclusion Criteria

Articles were included if they met the following criteria:

- Peer-reviewed journal articles
- Published in English
- Conducted in the United States
- Published between January 2025 and June 2026
- Included an abstract
- Focused on integrated care with relevance to behavioral or mental health

We excluded articles that are not directly related to IBH such as articles identifying IBH in conclusion sections. We also excluded articles that does not include focus on behavioral and mental health. The study is currently in progress, as we are analyzing the 2025 dataset with 559 articles. As 2026 articles are published, we will continue our review and complete the final analysis in July 2026.

Data Analysis

We will conduct the Bibliometric analyses using VOSviewer software (Eck & Waltman, 2023). Specifically, we will complete descriptive analysis to examine publication volume, leading journals, authorship patterns, and institutional affiliations, co-word analysis based on author keywords and indexed terms to identify conceptual clusters and dominant research themes, co-citation analysis to explore topic trends shaping IBH research and overlay mapping to examine relationships among key terms and to identify emerging conceptual emphases.

2026352
Introduction: Innovating Together Including Counseling Programs

Presenting Author(s)

Prof Yesim Giresunlu, Associate Professor, Johnson & Wales University, USA

Introduction

While interprofessional education (IPE) is widely implemented in health sciences programs (e.g., medicine, nursing, other allied health disciplines), counseling programs often are not part of IPE. This is relevant especially when institutional infrastructure is limited in having representation of counseling in team-based educational activities/trainings (Giresunlu, 2024; Martin, 2017). Additionally, educators in other health disciplines may have limited familiarity with counselors' scope of practice and clinical contributions, which can further hinder meaningful collaboration and inclusion in IPE initiatives.

As counselor educators, we are actively seeking to collaborate with other health disciplines. In this short paper, we share faculty-led efforts to include counseling students in various IPE initiatives within a small teaching-focused institution. Our aim is practical and collaborative; to make counseling visible while strengthening partnerships across health professions. We discuss the importance of including counselors in behavioral health settings, faculty-led IPE initiatives within the counseling department that expanded peers' understanding of counseling and its role in the behavioral health system, and implementation challenges. During the presentation, we will engage colleagues in interactive discussions about IPE initiatives and strategies to address challenges.

Background

Training students in interprofessional education (IPE) fosters essential competencies such as teamwork, role clarification, and communication, while also supporting professional identity development (Giresunlu et al., 2025; Grace, 2020). IPE is critical for preparing health professionals to collaborate effectively in addressing complex patient needs (Johnson, 2021). Although widely implemented in medicine, nursing, and allied health programs, counseling students often receive fewer structured IPE opportunities despite increasing expectations for interprofessional collaboration (Giresunlu et al., 2024). The literature highlights both the benefits and implementation challenges of IPE initiatives (Martin, 2017), including barriers such as limited faculty awareness of counseling roles, difficulties aligning schedules across disciplines, ensuring equitable program representation, and sustaining faculty engagement.

Interprofessional Education (IPE) Initiatives

We initiated and collaborated with several disciplines (Occupational Therapy, Physician's Assistant, Nursing, Dietetics) in different formats of Interprofessional Education initiatives. These initiatives include Interprofessional Education and Practice (IPEP), a research initiative, volunteering in community events and curriculum-based initiatives that connects various topics that connect topics relevant across disciplines (e.g., wellness, trauma.

Below are the selected IPE activities involving counseling students:

Interprofessional Education and Practice Training for Counseling Students (IPEP): This program aimed to integrate IPE into the M.S. Mental Health and Addiction Counseling programs and provide training on topics relevant to counseling and allied health disciplines (the Occupational Therapy, Dietetics). Students first completed online webinars on Introduction to IPE, Motivational Interviewing and Social Determinants of Health (SDOH). The they applied their learning during the experiential component, which involved working with a role-playing patient to address SDOH concerns as a team.

Dietetics and Counseling students completed the full study. Two counseling students and seven dietetics students participated in the in-person component; additional students from occupational therapy and other disciplines completed the online webinars. Recruitment across programs proved challenging, yet participants reported increased understanding of professional roles and value in collaborative learning. This program highlighted the feasibility and challenges of implementing a research program. Lessons learned includes the need for institutional support and flexible scheduling.

Rally for Recovery

The Rally 4 Recovery free community annual event celebrating recovery from addiction. This recovery event features information about various wellness activities and resources for individuals interested in recovery. Students from the Master of Mental Health and Addiction Counseling program collaborated with Physician Assistant students at this event. Counseling students educated attendees on mindfulness and progressive relaxation strategies to reduce stress while the Physician Assistant students provided health education. Students from both programs reported positive experiences learning about each other's roles while providing services to attendees in a community-based event.

Dimensions of Wellness

Dimensions of Wellness is a collaborative learning initiative for Occupational Therapy Doctorate (OTD) and Master of Mental Health and Addiction Counseling program (Counseling) students at Johnson & Wales University (JWU). Through this pilot wellness program, OTD students explore community-based mental health and wellness practices, while first-semester students in the Counseling program benefit from peer-led wellness programming. This program combined in-class activities and asynchronous online collaboration, centered around the 8 Dimensions of Wellness (Myers & Sweeney, 2005). Counseling students completed the 8 Dimensions of Wellness assessment, set personal wellness goals, and participated in short wellness workshops

developed by the OTD students. The goal of this program is to support student well-being at JWU, while providing students with first-hand experience of assessment tools and intervention strategies they will eventually utilize with clients in practice. This program supported counseling students' awareness of wellness and setting wellness goals for themselves. Each workshop they attended, they submitted their takeaways and looked at the feedback, which was very helpful for them. Counseling students reported positive experiences and noted that they gained exposure to components of the wellness model (e.g., financial literacy) for which they had not previously received formal training, and found this information useful.

Challenges and Lessons Learned

While highlighting the value of these initiatives, it is also important to address implementation challenges. Research across health professions education identifies barriers to IPE implementation, including scheduling conflicts, uneven faculty engagement, curriculum and accreditation constraints, particularly in non-medical disciplines (Giresunlu et al., 2025). These barriers can affect programs like counseling that may not be housed within colleges with other health professions programs.

Within our initiatives, challenges varied depending on the type of the activity. For example, challenges for the research based IPE program, student recruitment and cross-program scheduling despite institutional support. Challenges for community-based event included scheduling challenges. The learning initiative faced class scheduling conflicts, which limited it to a single-semester implementation. Lessons learned include the importance of early coordination across programs, ideally by incorporating such initiatives into the curriculum rather than offering them as separate one-time events.

2026353
Organizational trust as a foundation for interprofessional collaboration: Implications for the healthcare workforce post-pandemic

Presenting Author(s)

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Objectives
The COVID-19 pandemic profoundly disrupted healthcare systems worldwide, intensifying workforce shortages, moral distress, burnout, and erosion of organizational trust. These disruptions were not only experienced by practicing healthcare workers but were also highly visible to health professions students embedded within interprofessional clinical learning environments. As healthcare systems struggled to respond to unprecedented demands, the quality of interprofessional practice, supervision, communication, and learning was significantly affected. Organizational trust—an essential foundation for effective teamwork, psychological safety, and learning—was challenged across clinical and educational contexts.

Interprofessional education (IPE) relies on stable, supportive practice environments where learners can observe and participate in collaborative, ethical, and person-centred care. When organizational trust is compromised, learners' professional identity formation, wellbeing, and expectations of collaborative practice may be negatively shaped. Emerging evidence suggests that students' perceptions of healthcare systems and organizations are closely aligned with those of practicing clinicians, highlighting the importance of examining trust through an interprofessional and systems-level lens. Understanding how trust is disrupted and rebuilt within interprofessional learning environments is therefore critical to strengthening healthcare workforce resilience and preparing future practitioners for collaborative practice in post-pandemic systems.

The overall aim of this study was to explore healthcare workers' perceptions of organizational trust in post-pandemic healthcare settings. Secondary objectives for the purposes of this presentation include: to describe the current state of healthcare worker trust in one Canadian province, identify multilevel factors that undermine or foster trust within interprofessional teams, and explore the implications of findings for interprofessional education, workforce wellbeing, and collaborative practice readiness.

Method
This study employed a mixed-methods design incorporating a scoping review, an online survey, and focus groups. The scoping review synthesized existing literature on organizational trust pre and post pandemic across global healthcare settings. The survey was distributed to regulated and unregulated healthcare workers, including health professions students and early-career practitioners, in one Canadian province. Survey items explored perceptions of organizational trust in relation to colleagues, direct supervisor, senior management and the health system. Survey respondents were invited to join focus groups, which included participants from multiple health disciplines and levels of training. Focus groups explored experiences of trust and mistrust in clinical and educational settings, including interprofessional relationships. Data collection and analysis were guided by systems and ecological frameworks, enabling examination of individual, interpersonal, organizational, and system-level influences on trust.

Results
Across professions, participants reported a perceived erosion of organizational trust, intensified by the COVID-19 pandemic and ongoing human resource challenges. Key factors undermining trust included staffing shortages, workload pressures, inconsistent or unavailable supervision, communication breakdowns, and perceived misalignment between organizational values and enacted practices. Moral distress was frequently described, particularly when participants felt unable to provide safe, ethical, or collaborative care due to system constraints.

Interprofessional learners reported that these challenges directly affected their clinical learning experiences, psychological safety, and perceptions of collaborative practice. Students and early-career practitioners described observing strained interprofessional relationships, limited opportunities for meaningful collaboration, and reduced support for learning. Learners' accounts closely mirrored those of practicing healthcare workers, highlighting the visibility of system-level trust challenges within interprofessional learning environments and their influence on professional socialization and identity formation.

Conversely, participants identified several trust-enhancing factors within interprofessional contexts. Ethical, relational, and accessible leadership; transparent and consistent communication; supportive and well-resourced practice learning environments; and structured interprofessional supervision were central to fostering trust. Feeling heard, valued, and meaningfully included in interprofessional teams supported both learning and wellbeing. Participants emphasized that psychologically safe environments—where questions, uncertainty, and reflection were welcomed—strengthened trust and enabled effective interprofessional learning and collaboration.

Conclusions

This study advances understanding of the importance of organizational trust for quality health services delivery through an interprofessional education lens, demonstrating how trust is co-constructed through everyday interprofessional practice and learning experiences. Findings suggest that trust deficits within healthcare systems are readily perceived by learners and shape their expectations of collaborative practice and future workforce participation. Embedding trust-enhancing strategies within interprofessional education and clinical learning environments may mitigate moral distress, support learner and workforce wellbeing, strengthen collaborative competencies, and contribute to healthcare system resilience and sustainability.

By foregrounding trust as a foundational element of interprofessional learning, this work aligns with a focus on innovating together to prepare a resilient, collaborative, and future-ready health workforce. The findings, in collaboration with practice partner SWITCH BC (Safety, Wellbeing, Innovation, Training and Collaboration in Healthcare), offer actionable insights for educators, clinical leaders, and policymakers seeking to strengthen interprofessional education and rebuild trust in post-pandemic healthcare systems.

2026355
Supporting Interprofessional Education in the Practice Environment for Students and for Staff

Presenting Author(s)

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Interprofessional education (IPE) is widely recognised as a cornerstone of high-quality health and social care education. There is wide recognition of IPE in the university sector, and there is equal importance of IPE in practice. When working collaboratively it can be assumed that IPE is occurring, yet the value of learning with, from and about each other is overlooked. By learning with, from, and about each other, professionals develop the collaborative competencies necessary to deliver safe, effective, and person-centred care. The recently published CAIPE Quality Standards for design, management, and delivery of pre-registration IPE in the UK stipulate that IPE should be undertaken in the academic environment and the practice environment so that students can develop the knowledge, skills and attitudes to become interprofessional practitioners. While higher education institutions introduce students to the theoretical foundations of interprofessional collaboration, it is within the practice environment that these principles are truly tested, refined, and embedded. The clinical and community setting offers authentic, complex, and dynamic contexts in which learners can observe, participate in, and reflect upon collaborative practice in action.

IPE is also an educational concern not just at pre- registration level but also for the workforce in all health and care settings. IPE initiatives within practice for health professionals who work together can improve collaborative practice and address issues within the workplace such as burnout, fragmented care and quality of care delivery. However, supporting interprofessional education in practice presents both opportunities and challenges. Competing service pressures, differing professional cultures, variable supervision models, logistical constraints, lack of staff confidence, limited faculty development training, differing funding models and limited time can hinder the intentional facilitation of interprofessional education. At the same time, the practice environment offers rich, naturally occurring learning opportunities; simulation, Shwartz Rounds, grand rounds, ward rounds, joint assessments, discharge planning discussions, and case conferences that can serve as powerful platforms for collaborative development when approached with educational intent. Collaboration amongst educators in this educational intent could address some of the logistical and resource issues hindering IPE in this setting.

This interactive 90-minute workshop is designed for practice/clinical educators, clinical supervisors, placement coordinators, service leads, and academic partners who are committed to strengthening interprofessional learning in workplace settings both for students learning in these environments, and staff working in them. It will explore how everyday clinical activities can be reframed as structured interprofessional learning opportunities. Through a combination of evidence based theoretical considerations, facilitated discussion, case-based exploration, and structured reflection, the workshop will examine:

• The theoretical foundations and core principles underpinning interprofessional education
• The relationship between interprofessional education and collaborative practice
• Identification of potential opportunities that could enable interprofessional learning.
• Practical strategies that promote interprofessional learning in the practice environment.
• Approaches to overcoming common barriers within busy practice environments

A key focus of the workshop will be on moving from incidental IPE exposure to intentional facilitation to promote interprofessional learning. While learners may be present during multidisciplinary activities, meaningful learning requires guided observation, structured debriefing, and opportunities for shared reflection. The workshop will introduce simple methods that can be integrated into daily routines without significantly increasing workload. By the end of the session, participants will have developed a practical, context-specific action plan to enhance interprofessional learning within their own practice environments. Session Aim: to equip practice educators, clinical supervisors, and service leaders with evidence-informed, practical strategies to intentionally support, facilitate, and sustain high-quality interprofessional education within the practice environment.

Learning Outcomes
By the end of the workshop, participants will be able to:
1. Identify how interprofessional education is distinct from multidisciplinary education
2. Articulate the core principles of interprofessional education and emphasise the value and importance in relationship to collaborative practice, patient safety, and quality of care.
3. Analyse their own practice environment to identify existing interprofessional learning opportunities, as well as barriers that may limit collaborative engagement.
4. Develop a toolbox of practical strategies that could transform routine clinical activities into meaningful interprofessional learning experiences.
5. Develop a tailored action plan to enhance and sustain interprofessional education within their own workplace context.

2026356
Simulation-Based Training to Improve Drug Calculation Competence in Nursing Students

Presenting Author(s)

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Objectives

Medication calculation errors are a major cause of preventable adverse events and represent a critical patient safety issue. Nursing students often struggle to apply mathematical knowledge to clinical contexts, increasing the risk of error. Simulation-based education has been shown to enhance practical skills, self-efficacy, and learning through experiential approaches in safe environments.

To evaluate the effectiveness of a simulation-based training programme in improving nursing students' drug calculation, preparation, and dilution skills, and to assess the retention of these competencies after three months.

Method

A pre–post experimental study with a three-month follow-up was conducted among second-year undergraduate nursing students at the University of Pisa. Participants attended a structured clinical simulation laboratory focused on drug preparation and administration. Self-perceived knowledge, preparedness, attitudes, and objective calculation skills were assessed at three time points (pre-intervention, post-intervention, and three-month follow-up). Data were analysed using repeated-measures ANOVA and McNemar's test

Results

Significant improvements were observed over time in self-perceived knowledge, preparedness, and attitudes toward drug calculation ($F(2,132) = 129$, $p < .001$), with scores remaining higher at three months despite a slight decline from immediate post-test values. Objective calculation performance also improved significantly ($F(2,132) = 30.0$, $p < .001$) and continued to increase at follow-up, indicating consolidation of learning over time

Conclusions

Simulation-based training is an effective educational strategy for strengthening nursing students' pharmacological calculation competence. The sustained improvement observed supports the role of simulation in preparing a resilient and safety-oriented nursing workforce, contributing to patient safety and high-quality healthcare education.

2026357
Improving ICU Nurses' Knowledge and Attitudes Toward Delirium Through a Video-Based Educational Intervention: A Pre–Post Study Using the ICU Delirium Playbook

Presenting Author(s)

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Objectives
Delirium is a frequent and serious complication among critically ill patients, associated with increased mortality, prolonged length of stay, and long-term cognitive impairment. Despite international recommendations supporting routine delirium monitoring with validated tools such as the CAM-ICU, delirium remains under-recognized in clinical practice. Educational gaps, time constraints, and inconsistent training approaches continue to limit effective delirium assessment across healthcare teams. Innovative, scalable educational strategies are therefore needed to strengthen health workforce competence and to support interprofessional education (IPE) in high-complexity care settings. The ICU Delirium Playbook is a video-based educational intervention designed to enhance clinicians' knowledge and promote evidence-based delirium care through standardized, multimedia learning resources

Method
A quasi-experimental pre–post study was conducted among intensive care unit (ICU) nurses at a large Italian university hospital. Participants completed a validated delirium knowledge quiz (44 multiple-choice items) and the Attitude Tool of Delirium (ATOD; 26 items rated on a 5-point Likert scale) before and after participation in a structured educational programme based on the ICU Delirium Playbook. The intervention consisted of short, scenario-based educational videos delivered during a face-to-face training session. The educational content focused on delirium risk factors, systematic screening using the CAM-ICU, and evidence-based prevention and management strategies. Paired t-tests were used to compare pre- and post-intervention scores.

Results
Fifty-three ICU nurses participated in the study (mean age 41.1 years; mean ICU experience 11.8 years). Statistically significant improvements were observed across both outcomes following the intervention. Delirium knowledge scores increased substantially from pre- to post-training ($t = -12.21$, $df = 52$, $p < .001$), with a very large effect size (Cohen's $d = 1.68$). Nurses' attitudes toward delirium, measured using the ATOD total score, also improved significantly ($t = -4.92$, $df = 52$, $p < .001$), demonstrating a moderate-to-large effect (Cohen's $d = 0.68$) and reflecting increased awareness, perceived professional responsibility, and confidence in delirium assessment and management.

Conclusions
The findings indicate that a brief, video-based educational intervention can produce not only statistically significant but also educationally meaningful improvements in ICU nurses' delirium competence. The very large effect observed for knowledge acquisition and the moderate-to-large improvement in attitudes suggest that standardized multimedia education can effectively address both cognitive learning and professional readiness to engage in delirium assessment and management. The use of concise, scenario-based video content may help overcome common barriers to workforce education in critical care settings, such as limited training time and inconsistency in educational delivery. Although this study focused on nurses, the educational approach is inherently transferable to interprofessional education contexts, supporting shared understanding and more consistent delirium management practices across multidisciplinary ICU teams.
The ICU Delirium Playbook represents an effective, scalable, and transferable digital educational strategy to strengthen health workforce preparedness for delirium recognition and management. Its integration into continuing professional development and interprofessional education programmes may support more consistent evidence-based practice, enhance team collaboration, and ultimately contribute to improved quality of care in intensive care settings.

2026359
An Innovative Interprofessional Education Session Integrating Policy and Practice for Health-Related Professions

Presenting Author(s)

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Background
IPE predominantly focuses on collaborative practice and direct patient care although the provision of non-patient-facing services, such as policy development, is equally amenable to interprofessional collaboration. Traditional IPE and interprofessional practice (IPP) activities may be missing the important contributions of non-clinical health-related disciplines. To fill this gap, we designed and implemented an IPE policy practice pilot ("IPE triple P"; IPE3P) exercise that is flexibly designed to allow students from any profession to participate, as policy is the umbrella under which all clinical practice occurs. Thus, the purpose of this presentation is to describe the implementation of the IPE3P activity and lessons learned for improvements.

Methods
IPE3P was piloted in the Spring 2026 semester during two separate class sessions. The first iteration consisted of students enrolled in the Social Welfare, Health Sciences, and pre-dental/Dental Medicine programs, while the second iteration consisted of Social Welfare, Public Health, and pre-dental/Dental Medicine students. Students were randomly assigned to groups that had representation from at least two professions. Students were required to complete readings on policy practice and IPE prior to the activity. During the two and a half hour in-person class, students in their IPE groups participated in an ice breaker, analyzed a policy vignette, produced policy recommendations, and then debriefed together as a group. At the end of the activity, students were required to complete an individual reflection assignment, and were asked to voluntarily complete Archibald et al.'s (2014) Interprofessional Collaborative Competencies Attainment Survey (ICCAS), a retrospective pre-post survey that assesses student learning outcomes.

Outcomes
In total, 110 students participated in one or both of two sessions. The first session included the following students: 3 Pre-Dental track, 5 from the School of Dental Medicine, 24 from the School of Social Welfare, and 42 from the School of Health Professions. The second session included the following students: 3 Pre-Dental track, 5 from the School of Dental Medicine, 15 from the Program in Public Health, and 21 from the School of Social Welfare. The IPE teams produced a group-generated written policy analysis with recommendations on policy implementation. Students were expected to apply competencies related to IPE (Interprofessional Education Collaborative [IPEC], 2023) and those related to their own degree programs. Evaluation of student learning outcomes is underway. We expect there to be improvements in learning outcomes from pre- to post participation. Although not the primary focus of this activity, we expect the activity to have important second-order effects: because policy practice training is uneven both across professions and within specializations, students (especially clinical students, the beneficiaries of much IPE to date), may think of policy as something 'not for them', leaving the policy decisions to some other profession's practitioners (e.g., accountants, MBAs, health administrators, etc.), belying the IPE tenet of collaborative equality in professional importance, legitimacy, and decision-making responsibility. This activity provides students with exposure to policy practice, thus strengthening policy-related skills. Lessons learned include: streamlining student check in-process and group assignments, lengthening time during the activity for team cohesion building, incorporating into the policy case study the defined roles of participating professions (given the level of educational attainment), and expand the health-related professions in the interprofessional groups.

Significance
This IPE activity has the potential to be innovative and timely, as there is a need for policy practice training for health professions and within the context of IPE. In addition, the healthcare environment is rapidly evolving, with an increasingly complex care environment often shaped by healthcare policy on the macro, meso, and micro levels. This activity was intentionally designed to allow for replication among any IP group, given its flexibility in the use of relevant case studies from any participating health-related profession. Thus, the non-traditional IPE approach of this policy activity has the potential to foster forward-thinking collaboration across health disciplines, in congruence with the goal of more traditional IPE.

2026360
The Gamification of Collaborative Care: Evaluating a gamified Escape Room concept health science IPE study

Presenting Author(s)

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Prof Christina Burke, Clinical Associate Professor, Stony Brook University, USA

Introduction and Background
Interprofessional Education (IPE) has become a cornerstone of modern healthcare training, driven by the World Health Organization's mandate to cultivate a "collaborative practice-ready" workforce. Educators are increasingly turning to innovative pedagogical tools like educational escape rooms. These gamification technologies immerse teams in physical or digital environments where they must solve puzzles and complete challenges within a strict time limit. By shifting away from traditional lecture-based models, these activities offer a dynamic platform for students to practice essential soft skills in a high-stakes, yet controlled, setting.

Moore and Campbell (2019) found that escape room activities were enjoyable, encouraged participant engagement, and showed promise as an interprofessional learning platform. Similarly, Friedrich et al. (2018) reported that an interprofessional escape room promoted communication and positive attitudes among healthcare students. Such activities have shown potential in promoting teamwork, communication, and critical thinking skills among participants. Moore and Campbell (2019) conducted a pilot study using an escape room as an interprofessional learning activity for healthcare students.

Fusco et al. (2022) found that escape rooms can positively influence both knowledge acquisition and interprofessional collaborative skills among health professions students. Foltz-Ramos et al. (2021) used a quasi-experimental design to test the use of an interprofessional escape room as a method to improve teamwork prior to interprofessional simulation. Roman et al. (2020) compared the use of escape rooms to traditional objective structured clinical evaluations for assessing nursing students' clinical skills and found that escape rooms were a useful tool for evaluation and were well-received by students, thus highlighting the potential of escape rooms not only as learning activities but also as alternative assessment methods. Furthermore, Morrel and Eukel (2020) evaluated the impact of a cardiovascular escape room on nursing students' knowledge and perceptions revealing several tenets about escape room IPE activities: increased student knowledge that was positively received, encouraged engagement in learning, increased content application, increased peer communication, and improved healthcare practice skills.

The measurement of the impact of IPE on student attitudes and perceptions has been a growing focus. For example, Bethea et al. (2019) used the Readiness for Interprofessional Learning Scale (RIPLS) to measure changes in student attitudes towards IPE. A systematic review of escape room studies in nursing education highlighted the need to expand their use and improve the quality of studies across a greater number of contexts. Schmitz et al. (2017) reported on the relevancy of the Interprofessional Collaborative Competency Attainment Survey (ICCAS). As a 20-item self-report instrument, the ICCAS was designed to assess behaviors associated with patient-centered, team-based, collaborative care. Most importantly, the ICCAS has been used in various interprofessional education (IPE) programs. A replication study at the University of Minnesota found the ICCAS to be sensitive to course content, with the largest effects seen in areas emphasized in the curriculum.

The Extended Professional Identity Scale (EPIS), a 12-item instrument based on Extended Professional Identity Theory (EPIT), measures interprofessional identity, which is a social identity that is superordinate to a professional identity. EPIS measures three interrelated characteristics of interprofessional identity: belonging, commitment, and beliefs. Research suggests that interprofessional identity, as measured by EPIS, is related to intrinsic motivation towards interprofessional collaboration and can predict group effort and equal communication. By using these two scales in different ways, a stronger standards-based to attitudes and perceptions regarding IPE can be accomplished.

To date, existing literature suggests that escape rooms can be effective tools for promoting interprofessional collaboration, enhancing knowledge retention, and improving teamwork skills among healthcare students. However, further research is needed to fully understand the impact on the experiences of health professional students using both Interprofessional Collaborative Competency Attainment Survey (ICCAS), and Extended Professional Identity Scale (EPIS).

Objectives
This escape room IPE half day event followed a Wizard of Oz theme that guided students through a sequential "Yellow Brick Road" representing stages in a patient care journey. Each station included case based activities that required interprofessional collaboration as well as team building activities that focused on the IPEC Core competency of Teams and Teamwork. The research question guiding this study asked, "How does participation in a university-sponsored IPE escape room workshop impact healthcare students' experiences, knowledge, attitudes, beliefs, and behaviors related to interprofessional collaboration and practice?

Participants and Setting

A total of 287 students representing seven academic programs—including athletic training, physician assistant, respiratory care, physical therapy, speech-language pathology, occupational therapy, and clinical laboratory sciences—participated in a half day immersive experience developed and facilitated by faculty and staff from the School of Health Professions.

Data Collection and Instruments

The evaluation incorporated a retrospective pre and post test format using the Interprofessional Collaborative Competency Attainment Survey (ICCAS) and the Extended Professional Identity Scale (EPIS). Students completed a preparatory reading on teamwork principles and submitted reflective responses after the activity.

Results

Results indicate strong positive outcomes across four areas: satisfaction, motivation, communication, and professional identity.

• Students reported higher satisfaction with the escape room format compared to traditional IPE sessions.

• Students perceived significant improvement in communication skills, particularly in using closed loop communication.

• EPIS findings suggest that students developed a stronger sense of their professional roles and value.

The Wizard of Oz themed escape room concept demonstrates that gaming is an effective method for teaching complex teamwork competencies. Unlike lectures, escape rooms require students to enact collaborative behaviors, promoting experiential learning. The narrative structure reinforced the concept of the patient care journey, highlighting how teamwork can impact outcomes across stages. The scale of the event also illustrates that immersive IPE activities are feasible and impactful when supported by institutional collaboration.

Conclusions

This study contributes to growing evidence supporting innovative IPE strategies. Escape rooms offer a dynamic, practice aligned approach to cultivating interprofessional skills and improving knowledge retention. As healthcare systems increasingly prioritize integrated, patient centered care, educational models must reflect these shifts.

2026363
Innovating Together for AI-Ready Nursing: An Interprofessional Competency Framework, Validated Multilingual Assessment Tool, and Immersive Learning Model (NursingAI)

Presenting Author(s)

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Objectives

Health systems face persistent workforce shortages, rising care complexity, and accelerating digitalisation. As AI, robotics, and other autonomous technologies enter care delivery, interprofessional education (IPE) must evolve to prepare nurses not only to use these technologies safely, but also to engage in their co-design, implementation, and evaluation alongside other stakeholders. However, nursing education and workforce development often lack a shared competency language, practical tools to assess readiness, and learning formats that support meaningful interprofessional dialogue around technology adoption. The Erasmus+ NursingAI project addressed this gap by developing: (1) a technology-related competency framework for nursing practice (TCNP); (2) a multilingual self-assessment instrument for autonomous technology-related competencies in nursing practice (ATNP); and (3) an immersive interprofessional learning prototype to strengthen AI-readiness and co-creative capability in nursing education and practice.

Method

Using a multi-phase, international design across Hungary, Germany, and the Netherlands, the project combined expert consensus, framework development, multilingual instrument adaptation, and pilot educational evaluation. First, an evidence-informed expert process developed the TCNP framework aligned with domains of nursing practice and interprofessional collaboration. Second, framework-based item generation used a culturally sensitive decentring approach, followed by multilingual adaptation (English, German, Dutch, Hungarian), cognitive interviewing, and psychometric testing. The questionnaire was administered to hospital nurses and nursing students (n = 804; Hungary n = 700, Germany n = 104), resulting in a final 16-item ATNP scale. Third, a theatre-pedagogy-inspired immersive storytelling workshop was piloted to foster interprofessional reflection and dialogue (n = 82, with n = 39 participants completing pre–post evaluation).

Results

The project produced a concise, multilingual 16-item validated ATNP instrument suitable for educational needs assessment, baseline mapping, and monitoring technology-related competency development over time. The TCNP framework provided a structured, practice-oriented and interprofessionally relevant language for discussing nurses' roles in AI- and robotics-enabled care. Pilot testing of the immersive workshop showed that this format supported constructive interprofessional dialogue and was associated with improved self-assessed technology-related competencies among participants. Together, the three outputs formed a coherent, reusable educational toolkit that can support curriculum development, continuing professional education, and workforce preparation in areas such as digital documentation, telehealth-supported community care, and technology-enabled patient monitoring.

Conclusions

NursingAI offers an IPE-aligned, scalable, and practice-oriented model for preparing the nursing workforce for AI- and robotics-enabled care. By combining a shared competency framework, a validated multilingual assessment tool, and an immersive co-creative learning model, the project moves beyond general digital ambition toward implementable educational infrastructure. The findings are highly relevant to the future of IPE because they show how innovation can be translated into measurable, collaborative, and patient-centred workforce development across professional and national boundaries.

Supporting Documents

https://inhwe.org/system/files/webform/AI%20absztrakt%20Ujv%C3%A1rin%C3%A90301.pdf

2026364
Student perceptions of a competency-based medical education (CBME) approach to teaching during clinical placements: Mixed-methods evaluation

Presenting Author(s)

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Objectives
A competency-based medical education (CBME) approach has been shown to encourage learners to take an active role in their learning, preparing them for lifelong learning in medicine. This approach supports habits required as future clinicians, ensuring skills learnt during undergraduate training can continue into postgraduate practice. While the literature has shown this to be an effective approach, this project evaluated student perceptions of a CBME approach to teaching sessions, using quizzes, practical sign-offs and simulated scenarios. Using evaluation forms, we were able to assess students' feedback on content relevance, confidence and perceived preparedness for practice.

Method
Final year medical and physician associate students who received CBME-formatted teaching sessions were invited to complete post-teaching evaluation forms. Evaluation forms anonymously collected both quantitative and qualitative data.

Results
38 students completed the evaluation form, although not all questions were answered by respondents. Of the students who responded to the question on content relevance, 97% (n=29) felt the content was extremely or very relevant, with the remaining 3% rating it as somewhat relevant.
Using a 5-point Likert scale, self-reported confidence improved amongst students, with 86% (n=28) of students scoring ≥4/5 and 14% scoring 3. Free-text comments emphasised students' appreciation of the interactive and practical format of the teaching sessions, applying knowledge while receiving real-time feedback to gauge their competence.

Conclusions
Students appreciated a CBME approach to teaching sessions during clinical placements, providing an opportunity to implement knowledge and skills learnt in a measurable and examinable format. An outcomes-focused approach helped students evaluate their competence, improving their perceived confidence and preparedness.

Supporting Documents
https://inhwe.org/system/files/webform/Dublin%20conferece.Med_.Ed_.docx

2026365
Usability Evaluation of Histology Educational Mobile Apps for the Android Operating System

Presenting Author(s)

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Prof Marina Santiago de Mello Souza, Professor at Souza Marques Medical School, Centro Universitário Souza Marques, Brazil

Objectives
To analyze four usability criteria of histology educational mobile apps available for the Android operating system.

Method
The search for histology educational mobile app was conducted on the Google Play Store in February 2026, using the keywords “histologia” or “histology” in the app title. Free apps available in Portuguese and English for Android devices were included. Four usability criteria were evaluated for the selected apps: (1) clarity of visual information, (2) consistent navigation, (3) absence of technical errors, and (4) user retention. A Likert scale was used to assess usability criteria by two independent evaluators, achieving 95% inter-rater agreement. Subsequently, statistical analysis of the results obtained was performed.

Results
Eleven apps were included in the evaluation. Regarding clarity of visual information, almost half (n = 5) were rated as excellent, presenting high-quality images and facilitating accurate identification of histological structures. Concerning consistent navigation, nine apps demonstrated satisfactory performance, with intuitive organization and straightforward access to content. In terms of absence of technical errors, the majority of apps (n=10) showed stable performance; however, one app presented episodes of freezing and slow loading, partially compromising its usability. With respect to user retention, eight apps included interactive quizzes, some with immediate feedback and a diverse range of histological images, demonstrating greater potential for user engagement. In contrast, seven apps were considered less motivating and less attractive due to limited image availability and restricted educational resources in the free version. Additionally, the presence of long and intrusive advertisements interrupting content access negatively impacted user experience and discouraged continued use.

Conclusions
The findings showed a limited number of histology educational mobile apps for Android, with 27,3% of those apps demonstrated excellence in the four usability criteria analyzed. Evaluating the usability of educational histology mobile apps is essential for the learning process of the cellular and tissue structure of human body organs, since the clarity of information is directly related to the quality of the images, the correct identification of histological structures, and the organization of the content. Furthermore, the absence of technical errors, consistent navigation, and user retention contribute to greater user engagement and facilitate the study of tissue biology. Evaluating those criteria helps to identify limitations and guides users in selecting the app, enabling the selection of a mobile app that is appropriate to academic demands and improves knowledge acquisition in histology.

2026366
Level Up: From Good to Great - Developing a Workshop to Strengthen Interprofessional Collaboration at Toronto Rehab

Presenting Author(s)

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Objectives
Interprofessional collaboration is essential to safe, high-quality rehabilitation care, yet many clinical teams continue to work in parallel rather than in fully integrated ways. Evidence links strong interprofessional collaboration to improved patient satisfaction (up to 95%), fewer medical errors (up to 77%), and reduced length of stay (Cadet et al, 2023). Toronto Rehab (TR), part of the University Health Network (UHN), Canada's No. 1 hospital and the world's No. 1 publicly funded hospital with over 20, 000 staff. TR is comprised of in-patient and outpatient rehabilitation programs, transitional care and complex continuing care where care is provided by diverse groups of health professions. In response to a UHN wide patient experience survey, in which 61% of patients rated communication among staff as “always good”, and a needs assessment identified interprofessional collaboration as the top priority for future educational investment. Three interprofessional educators identified a need to strengthen collaborative practice. Although many Toronto Rehab teams collaborate effectively, advancing from good to great collaboration requires intentional skill development and support to overcome persistent structural and relational barriers.
To address this gap, we developed a pilot workshop to enhance clinicians’ intentional collaborative practice. The workshop clarified distinctions between multiprofessional and interprofessional work, supported participants in recognizing and addressing collaboration barriers, and offered practical tools—including language prompts, reflective activities, and micro-behavioural strategies—to strengthen psychological safety and shared understanding in daily team interactions. By emphasizing relationship-focused care and positive team climate, the workshop introduced simple, scalable habits that can enhance patient experience, team effectiveness, and overall care quality across care environments.

Method
The 60-minute workshop, delivered virtually during UHN’s Teaching and Learning Week 2026, used a highly interactive, learner-centred approach grounded in the CIHC Competency Framework. Facilitated by three interprofessional educators, the session drew on real patient and team scenarios to anchor learning in participants’ lived clinical experiences—an adult-learning principle that enhances relevance and immediate applicability. Participants engaged in polls, word clouds, open discussion, and reflective activities to surface team norms, collaboration barriers, and role-related assumptions. Evidence-based concepts such as psychological safety, interdependent teamwork, communication, and role clarity, were reviewed while practice activities supported skill application through identifying jargon, reframing uncertainty, and articulating scope. A gamified design increased engagement, and the session concluded with a commitment exercise in which participants identified one actionable behaviour to strengthen collaboration—reinforcing self-directed learning and problem-centred change.

Results
Participants demonstrated strong engagement, underscoring the workshop’s direct relevance to their clinical realities. Word-cloud analysis exposed wide variation in discipline-specific acronyms and terminology, revealing a persistent need for explicit clarification practices. Participants identified key barriers to asking questions—fear of appearing uninformed, hierarchical dynamics, and time pressure—highlighting the importance of creating psychologically safe norms. Through sharing examples of role overlap, clinicians reported gaining clearer insight into each other’s scopes and identifying new opportunities for cotreatment and coordinated mobilization to better support patient goals. Reflection on relationship-focused care emphasized how subtle behaviours—validation, curiosity, and kindness—shape both team climate and patient experience. The closing commitment exercise generated concrete, practice-ready strategies, including aligning goals during rounds, using shared language, pausing to clarify jargon, and embedding gratitude in daily communication—demonstrating clinicians’ readiness to translate learning into meaningful behavioural change.

Conclusions
This workshop shows that targeted, scenario-based interprofessional education can rapidly strengthen clinicians’ collaborative skills and equip them with practical, immediately actionable strategies to improve team functioning. By centering shared patient goals, clarifying roles, enhancing communication, and fostering psychologically safe team climates, teams can shift from parallel task-oriented work to intentional, integrated collaboration. Participants’ reflections underscored that small relational behaviours—curiosity, validation, transparency, and kindness—are powerful drivers of collaborative culture and directly influence patient experience. Building on this early success, future work will expand delivery to in-person, program-specific settings to address unit-level barriers in greater depth and further embed collaboration competencies into daily practice. Ongoing evaluation across Toronto Rehab will examine the workshop’s impact on team climate and patient-centred outcomes, supporting broader organizational efforts to elevate collaborative care from “good” to truly “great.”

2026367
Making criticality and relationality explicit: augmenting competency-based IPE with criticality and relationality to prepare for non co-located collaborative work

Presenting Author(s)

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Much contemporary health and social care work is characterized by temporality (i.e. brief interactions), non-familiarity between shifting providers, non-co-location (i.e., where providers are located across geographic distance) or be between providers who are differentially located within a hierarchy (e.g., an unregulated provider collaborating with providers from regulated professions). These characteristics are particularly prevalent in community-located health and social care work; work that also might cross boundaries of the system (e.g., between primary and tertiary care) and engage multiple organizations. Ongoing increases in complex, chronic and continuous illness means that even more people access community-located care and even more non co-located providers will be tasked with non co-located collaboration (Bodenheimer et al., 2009; Engeström, 2020; Milani & Lavie, 2015). At the same time, the uptake of virtual conferencing technology makes such collaboration more accessible.

While it is within the scope of IPE educators to prepare providers to collaborate across diverse ways of working together, IPE interventions tend to orient towards the development of teamwork competencies (Kaas-Mason et al., 2024; Reeves, 2010a, 2010b). While IPE educators direct their attention to developing teamwork competencies, it leaves the educational preparedness of providers who navigate dynamic, temporal and non-co-located interactions underdeveloped (Dow et al., 2017; Reeves et al., 2018; Xyrichis et al., 2018). One way to strengthen and broaden IPE to ensure learners are prepared for a complex array of collaborative practice configurations, is to augment the established reliance on interprofessional competency frameworks with an explicit focus on relationality and criticality.

This presentation responds to the theme “innovating together in interprofessional education” by sharing an interprofessional education approach that responds to the diverse nature of interprofessional work across the health and social care system, particularly dynamic and temporary work that involves collaboration with non co-located colleagues. The approach intertwines competency-based interprofessional education with explicitly foregrounded criticality and relationality. By making criticality and relationality explicit, the approach prepares individual providers to engage themselves beyond their technical skills.

Following an introduction to the theoretical underpinning of the approach, we introduce its three components: competency-based interprofessional education (e.g., the Canadian Interprofessional Health Collaborative’s Competency Framework for Advancing Collaboration (CIHC, 2024), relationality (i.e., drawing on the extensive work by Anne Edwards ((Edwards, 2010)) and criticality (drawing on Foucault (1982)) .The approach includes the following sub-components: location the self; relational navigation; responsive and adaptive critical reflection; implication of self; contextual awareness and standardization awareness. By making the three components explicit, the approach creates space for critically reflective conversations about working together in complex configurations. We then describe how we have operationalized the interprofessional approach into a curriculum for an Ontario-based educational program of advanced care paramedics to practice with an interprofessional lens. Here, we describe how the theoretical foundation informed the development, delivery and assessment of the learners.

By leveraging relationality and criticality explicitly, our interprofessional approach provides educational preparation that develops reflective and responsive providers who can employ interprofessional competencies with awareness of their own critical footprint and relational impact. With a flexible enactment, we suggest that the approach is relevant across settings, for interprofessional educators who wish to prepare context-aware health and social care providers to collaborate with critical awareness of their own impact and relational attention to the contributions that their colleagues bring.

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2026368
Educational Inequities in Europe: What Mixed-Methods Evidence from ECHOES Tells Us About the Future of education and CPD

Presenting Author(s)

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Objectives
To identify and examine expertise gaps in healthcare professional education across Europe using integrated quantitative and qualitative findings to inform a more equitable and inclusive education system

Method
A mixed-methods study was conducted as part of the Erasmus+ ECHOES project. A cross-sectional survey (n = 230) assessed perceived gaps in knowledge, practice, research, and teaching across four competency domains: hard, transversal, digital, and green skills. Reliability and construct validity were evaluated using Cronbach's alpha and confirmatory factor analysis. Qualitative data were collected through four online focus groups and two semi-structured interviews involving 28 healthcare professionals and educators from 12 European countries. Quantitative and qualitative findings were analysed in parallel and integrated during interpretation

Results
Quantitative findings revealed pronounced gaps in digital (mean = 5.04, SD = 2.10) and green skills (mean = 6.16, SD = 2.30) across all the professions with regional variations. Gaps in research methodology and innovative teaching methods were frequently reported in Eastern Europe. Qualitative analysis contextualised these results, identifying five key themes: limited access to structured educational opportunities, fragmented learning pathways across professions and countries, insufficient integration of evidence-based practice, variability in digital readiness, and limited curricular attention to sustainability and green healthcare.

Conclusions
The findings highlight persistent and systemic inequities in healthcare education across Europe, affecting both access to expertise and the development of emerging competencies. Within the ECHOES project, these mixed-methods findings informed the development of a digital platform aimed at facilitating collaboration between European institutions and professionals, supporting more equitable access to educational resources, and fostering innovation in healthcare education. Such evidence-informed approaches may contribute to more inclusive and sustainable educational systems in line with the United Nations Sustainable Goal N.4.

2026369
Integrating Team-Based Learning into Clinical Simulation to Enhance Nursing Students' Knowledge: A Randomized Controlled Trial

Presenting Author(s)

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Objectives

To evaluate the early effectiveness of Team-Based Learning integrated into clinical simulation on nursing students' knowledge acquisition, compared with simulation-based training alone.

Method

A randomized controlled trial was conducted among undergraduate nursing students enrolled in a clinical simulation laboratory. Participants were randomly assigned to either a simulation-only group or a TBL-integrated simulation group. The TBL intervention included pre-class preparation, individual and team readiness assurance tests, and structured application exercises aligned with the simulation scenarios. Outcomes included objective knowledge scores assessed after the educational intervention. Secondary outcomes included students' perceptions, transversal competencies, and observed performance indicators. Group differences were analysed using independent samples t-tests and chi-square tests, as appropriate.

Results

Students in the TBL-integrated simulation group achieved significantly higher knowledge scores compared with those who received simulation-based training alone ($t = -21.9$, $p < .001$). Differences were consistently observed across individual knowledge items, indicating a robust advantage of the TBL-integrated approach in supporting conceptual understanding. No statistically significant differences between groups were observed at this stage for transversal competencies, perceptions, or observed performance indicators.

Conclusions

Integrating Team-Based Learning into clinical simulation significantly enhances early knowledge acquisition among nursing students compared with simulation alone. These findings suggest that TBL may strengthen the cognitive foundations required for subsequent development of clinical and transversal competencies. Ongoing follow-up will explore whether these early gains translate into sustained improvements in performance and professional readiness over time.

2026370
Memory-Shaping Leadership: A Behavioral-Science Framework for Nurse Retention

Presenting Author(s)

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Objectives
Healthcare leadership education often emphasizes leadership styles and principles, yet it rarely specifies the cognitive mechanisms through which everyday leader behaviors become durable drivers of nurses' stay–leave decisions. This submission introduces "memory-shaping leadership" as a behavioral-science training concept explaining how routine leader–nurse micro-interactions can produce lasting effects on global work attitudes and retention-related decisions, with an emphasis on trainable micro-skills for health workforce development.

Method
A conceptual framework was developed through an integrative synthesis of four research areas: (1) Affective Events Theory, modeling leadership as sequences of emotionally meaningful micro-events; (2) research on remembered experience, including the peak–end rule and retrospective evaluation; (3) cognitive neuroscience evidence on emotional memory encoding and consolidation; and (4) resource-based perspectives from positive psychology. These literatures were translated into a sequential explanatory model linking leader behavior to retention-relevant decisions via remembered work experience.

Results
The framework proposes that emotionally salient "peaks" and workday "endings" are preferentially encoded and later reconstructed into accessible remembered summaries of work. These summaries function as cognitive evidence shaping global work attitudes and guiding stay–leave decisions more strongly than averaged moment-to-moment affect. For leadership education, the model specifies low-cost, trainable micro-skills: (1) shaping constructive peaks through timely recognition, competence-affirming feedback, and support during high-stakes moments; (2) shaping constructive endings through brief structured shift closures and debrief routines that highlight key moments; and (3) relational repair following friction or setbacks to prevent negative episodes from dominating remembered experience. An online course is under development (planned for September 2026 across eight European universities), complemented by a private-sector leadership training delivery planned for 2026 and a hospital-based pilot of an enhanced version planned for 2027.

Conclusions
Memory-shaping leadership reframes retention-oriented leadership education from teaching styles to teaching mechanisms and everyday micro-skills that influence what staff later remember as representative of their work experience. The approach is positioned as a scalable, low-cost complement to structural workforce interventions and offers testable propositions for longitudinal evaluation that separates momentary affect from reconstructed remembered experience when assessing training impact on workforce outcomes. It has clear potential for integration into healthcare leadership education.

2026374
From Intention to Impact: Building Blocks for Sustainable Collaboration with a Nurse in General Practice - A Five-Step Implementation Framework for Integrated Primary Care

Presenting Author(s)

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Objectives

Primary care systems are facing increasing pressure due to ageing populations, multimorbidity, rising complexity of care, and workforce shortages among general practitioners (GPs). In Belgium, as in many countries, the integration of nurses into general practice is considered a structural strategy to enhance accessibility, quality, continuity of care, and workability. International evidence demonstrates that nurse-led care in primary care settings is safe and effective, particularly in chronic and preventive care, provided that roles, responsibilities, and supervision structures are clearly defined. However, implementation in daily practice remains challenging and extends beyond a simple staffing decision.

This practice-oriented study aimed to identify and systematize key implementation conditions for the sustainable integration of the Nurse in General Practice (NGP) and to translate these findings into a structured, phased implementation framework tailored to the Belgian primary care context.

Method

A qualitative, exploratory design was used within a practice-based research and development trajectory. Data triangulation was achieved through multiple sources: practice-oriented case analyses (n = 44), stakeholder meetings (n = 3), practice quick scans (n = 4), and semi-structured waiting room interviews with patients (n = 12). Field notes and written reports were anonymized and analyzed using thematic analysis. Open coding was followed by clustering into overarching themes and subthemes, with particular attention to needs, success factors, and implementation pitfalls. Findings were iteratively refined against practice realities and existing literature. Results were structured into a five-phase implementation model covering the full lifecycle of NGP integration.

Results

The analysis resulted in a five-step model: considering, searching, finding, starting, and growing. Although not strictly linear in practice, the phases provide a structured framework for addressing implementation challenges.

1. Considering focuses on strategic decision-making. Practices require clarity regarding legal scope of practice, competence profiles, supervision and escalation lines, liability, financing models, and organizational structures. Financial uncertainty and lack of role clarity were identified as major barriers. Early alignment of mission, vision, financial flows, and task distribution reduced later role conflicts.
2. Searching involves a thorough practice analysis. Successful practices mapped patient population characteristics, chronic and preventive care needs, existing competencies, and future developments. Merely adding “extra hands” led to underutilization of nursing competencies. Sustainable integration required translating identified needs into a forward-looking competence-based role profile.
3. Finding emphasizes recruitment and selection. Sustainable matches were associated with structured interviews that assessed not only technical skills but also soft skills such as initiative, clinical reasoning, autonomy, teamwork, communication, and evidence-based practice. Transparent discussion of expectations, growth pathways, employment conditions, and long-term vision increased alignment.
4. Starting highlights the importance of structured onboarding. Practices that implemented phased mandate expansion, mentorship, regular supervision, checklists, and protocol-based working reported higher satisfaction and reduced uncertainty. Explicitly defined care pathways, red and orange flags, and digital support (e.g., electronic medical record functionalities for proactive care) strengthened safe integration.
5. Growing shifts focus toward sustainable embedding and impact. Practices operating within shared leadership models reported stronger outcomes. Clear role delineation combined with psychological safety enabled nurses to take initiative while ensuring appropriate consultation and escalation. Structured reflection moments, feedback cycles, growth conversations, and investment in training and coaching supported role maturity, team stability, and quality improvement. Active population management and protected time for quality projects further enhanced impact.

A central insight concerns the dynamic interplay between role clarity and psychological safety. Clear agreements on responsibilities and escalation pathways empower nurses to act proactively while maintaining patient safety. Conversely, ambiguity increases stress, defensive behavior, or overstepping boundaries. For GPs, the transition toward shared care implies an explicit leadership role characterized by delegation, feedback, and trust-building. Timing emerged as critical: granting autonomy too rapidly without supportive structures generated resistance and insecurity, whereas overly cautious expansion led to frustration and underutilization of competencies.

Conclusions

The integration of a Nurse in General Practice offers significant opportunities to strengthen accessibility, quality, proactive population-based care, and sustainable work organization. However, successful implementation requires a strategic, phased organizational approach addressing legal, financial, cultural, and leadership dimensions. The proposed five-step model provides a practical framework to guide practices from intention to sustainable impact.

2026376
Development and validation of the Clinical Leadership Contextual Factors Analysis (CLeaFA) tool for use in diverse healthcare settings

Presenting Author(s)

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Objectives
Healthcare professionals who actively engage in clinical leadership contribute to a culture of continuous improvement. However, the enactment of clinical leadership strongly depends on contextual conditions. Although previous research has identified several enabling factors, no validated tool exists to systematically measure these contextual factors.
The aim of the research is to develop and validate a self-reporting tool that identifies contextual factors influencing the development of clinical leadership among healthcare professionals.

Method
The Clinical Leadership Contextual Factors Analysis (CLeaFA) tool was developed and validated through a three-phase process: (1) item development informed by a literature review and qualitative data from focus groups, (2) content validation via a Delphi procedure with experts, and (3) psychometric validation via exploratory factor analysis and internal consistency reliability analysis. The tool was tested in a sample of 1,023 healthcare professionals from diverse disciplines and levels of seniority working in Belgian hospitals.

Results
The Clinical Leadership Contextual Factors Analysis (CLeaFA) tool consists of 28 items across four dimensions: (a) leadership style of the formal leader, (b) team dynamics, (c) departmental culture, and (d) organizational context. Together, these dimensions capture how both interpersonal and organizational conditions shape the development of clinical leadership: from the coaching role of formal leaders (a) to trust and collaboration within teams (b), a learning-oriented departmental culture (c), and, finally, the structural conditions of the wider organization (d). The total scale demonstrated high reliability (Cronbach's $\alpha = 0.93$).

Conclusions
The CLeaFA is a valid and reliable tool for assessing contextual factors that influence clinical leadership development. It holds potential for use in training, evaluation, and research. Future studies could focus on further exploring the organizational context dimension, given its lower internal consistency, and examine the tool's applicability across diverse healthcare settings.

2026377

Development and preliminary validation of a nursing delegation instrument - The Delegation Scan: a Delphi and pilot study

Presenting Author(s)

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2026378
Delegation in Nursing Practice: A Concept Analysis of Delegation and Delegation Competence

Presenting Author(s)

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Objectives
Delegation is recognised internationally as a core professional competency within nursing and is embedded in regulatory and professional standards. In increasingly complex healthcare systems characterised by diversified skill-mix models and interprofessional collaboration, registered nurses are required to delegate aspects of care to licensed practical nurses, unregulated assistive personnel and other healthcare professionals. While delegation practices differ depending on regulatory frameworks and scope-of-practice boundaries, the registered nurse retains professional accountability for delegated care.

Despite its central role in practice, delegation is described inconsistently in the literature. Some publications conceptualise it as task redistribution, others as a clinical decision-making process or as a leadership behaviour. Similarly, delegation competence is variably framed as preparedness, confidence, communication skill or supervisory ability. This conceptual ambiguity complicates curriculum development, continuous professional development and the development of valid measurement instruments.

The objective of this study was to clarify the concepts of delegation and delegation competence in nursing through a systematic concept analysis following the method of Walker and Avant.

Method
A concept analysis was conducted using the eight-step approach described by Walker and Avant. The steps included:
(1) selecting the concept;
(2) determining the aims of the analysis;
(3) identifying all uses of the concept in the literature;
(4) determining defining attributes;
(5) constructing a model case;
(6) identifying additional cases (borderline and contrary cases);
(7) identifying antecedents and consequences; and
(8) defining empirical referents.

A structured review of international peer-reviewed literature was undertaken, including empirical studies, integrative and scoping reviews, and relevant professional and regulatory documents addressing delegation within nursing and interprofessional care contexts. Definitions, descriptions and applications of delegation were extracted and compared. Conceptual similarities and distinctions were analysed iteratively to identify core attributes and boundaries of the concept.

Results
Analysis of the literature revealed that delegation in nursing practice consistently involves the transfer of responsibility for performing a defined component of care while accountability for outcomes remains with the delegating registered nurse. Beyond this foundational element, conceptualisation varies in scope and emphasis.

The defining attributes of delegation identified through analysis include:
1. Transfer of responsibility for task performance within a defined scope of practice;
2. Retention of professional accountability by the delegating nurse;
3. Clinical judgement in determining appropriateness of delegation;
4. Assessment of the competence and scope of the receiving professional;
5. Explicit communication and expectation-setting;
6. Supervision and follow-up.

A model case illustrated delegation as a structured clinical decision in which a registered nurse assesses patient acuity, evaluates the receiving professional's competence, communicates clear instructions and monitors outcomes while retaining accountability.

Borderline cases reflected situations where tasks were allocated without adequate assessment or supervision. Contrary cases included simple task assignment without retained accountability or autonomous professional practice without oversight.

Antecedents identified in the literature include clarity of scope of practice, regulatory frameworks, organisational support, interprofessional trust and educational preparation. Consequences include enhanced patient safety, improved workflow efficiency, strengthened team collaboration and professional development. Conversely, ineffective delegation may contribute to missed care, role ambiguity and increased workload.

Delegation competence emerged as a related but distinct concept, referring to the integrated capability of a registered nurse to enact delegation appropriately. It encompasses clinical reasoning, communication, supervisory skills and understanding of regulatory accountability.

Empirical referents in the literature include measures of delegation preparedness, confidence, communication practices and observed delegation behaviours, although operational definitions remain heterogeneous.

Conclusions

Using Walker and Avant's structured method allowed systematic clarification of delegation and delegation competence within nursing practice. The analysis demonstrates that delegation is not merely task distribution but a regulated clinical decision-making process characterised by retained accountability, judgement and supervision.

Clarifying defining attributes, antecedents and consequences provides greater theoretical coherence and supports future educational design and empirical research. Conceptual refinement is particularly relevant in contemporary healthcare systems where safe and accountable delegation across intra- and interprofessional teams is essential for quality care delivery.

2026379
The global doctor: the evidence and need to prepare doctors for work internationally, a quantitative study

Presenting Author(s)

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Objectives

Growing numbers of students attend Transnational Medical Education Programmes (TMPs), pursuing their Primary Medical Qualification outside of their home country. Many of these students are motivated by factors such as cost, availability of places, and quality of education (1). Many plan to transition back to their home country – or a third country – after graduation (2). However, medical education is rooted within local contexts, and a potential mismatch exists between graduates' place of training and place of practice in terms of the knowledge, skills and values required to practice safely within different contexts (3).

This study aimed to identify:

1. Specific areas in which graduates perceived being more/less prepared when they began practice
2. Whether or not preparedness differed by location of practice
3. Whether there was any difference in preparedness in graduates beginning practice elsewhere, compared to those remaining in the country of training
4. Whether there was any difference in preparedness of those completing a placement in the place of practice, compared with those who have not.

Method

A descriptive cross-sectional study was conducted in January-February 2025 among graduates from RCSI Dublin and Bahrain, and RUMC Malaysia. Participants completed an anonymous survey, rating themselves on a five-point Likert scale across 62 items grouped according to one of seven facets of 'preparedness': clinical skills, communication skills, knowledge, personal development, prescribing, teamwork, and work environment. A total of 113 survey responses were recorded (n=19%).

The psychometric properties of the survey were evaluated using Rasch analysis with the Rating Scale Model. Inferential statistics (t-tests and ANOVA) were used to compare groups. Data analysis was conducted using the Winsteps computer programme.

Results

Participants perceived more preparedness in areas such as knowledge and patient-centeredness and less preparedness in prescribing, complex communication, and managing challenging behaviours from patients and colleagues.

Perceived preparedness did not differ according to the country of eventual practice, or amongst graduates beginning practice elsewhere compared to those remaining in the country of training. There was no difference in perceived preparedness between those completing a placement in the place of eventual practice, compared with those who have not.

Conclusions

To support the transition to practice we recommend greater opportunities for experiential learning within the medical curriculum and destination of work, alongside greater emphasis on the acquisition of transferable skills to assist graduates to navigate uncertain and unfamiliar situations.

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Supporting Documents

https://inhwe.org/system/files/webform/Supporting%20data.pdf

2026380
Pioneering Evidence-Based, Interprofessional Online Education for Safer Radiotherapy

Presenting Author(s)

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Rationale and Aim

The primary aim of this presentation is to showcase our experience in designing and developing a high-impact, fully online course through European funding (Erasmus+ Cooperation Partnership in Higher Education).

The OPTIMIZE-RT project addresses a critical gap in modern oncology: while Cone-Beam Computed Tomography (CBCT) is vital for accurate patient positioning in radiotherapy, it introduces additional radiation exposure that must be optimised, which means ensuring doses are as low as reasonably achievable (ALARA) while maintaining sufficient image quality. This requires knowledge of the image quality needed for different clinical tasks and the appropriate radiation dose to achieve these. By scaling this education across Europe, the project is designed to ensure appropriate radiation exposure for thousands of cancer patients annually.

Discussion

At the heart of OPTIMIZE-RT lies robust interprofessional collaboration. The course is developed by a multidisciplinary team of experts, including Diagnostic Radiographers, Radiation Therapists (RTTs) and Medical Physicists.

To ensure the curriculum is grounded in reality, the project follows an evidence-based approach. The research phase (WP2) includes a Systematic Literature Review (SLR) to identify the latest optimisation methods and a pan-European survey to map current clinical practices and needs. This research ensures that the training content is tailored to resolve actual challenges faced in radiotherapy departments today. The project leverages modern digital technologies to ensure accessibility and sustainability. A fully asynchronous micro-credential course will be hosted on an e-learning platform (Moodle), allowing healthcare professionals to engage with the material without disrupting their clinical responsibilities.

The pedagogical backbone of the programme is the Constructive Alignment model. This ensures the seamless integration of target learning outcomes, teaching methods, and assessment. The learning outcome of “being able to optimise radiological protection aspects for the use of imaging in radiotherapy” is achieved through self-paced learning materials, followed by application in clinical practice and constructive feedback from experts. The assessments are also aligned, effectively measuring the learning outcome.

Conclusion

Upskilling medical professionals in this specialised area provides a multifaceted value proposition. For professionals, it offers high-level specialisation (5 ECTS at EQF Level 7) and the ability to spearhead optimisation initiatives within their departments. For healthcare systems, it fosters a culture of safety and interdisciplinary efficiency, which is currently rare in daily practice. Ultimately, the most significant beneficiary is the general population. By reducing unnecessary radiation exposure, we can reduce the risk of secondary cancers and enhance safety standards for this vulnerable group across Europe and beyond. Through this presentation, we invite the educational community to explore how European cooperation can transform niche clinical needs into broad-reaching, life-saving educational initiatives.

2026381
Developing research to advance pharmaceutical care practice across the NHS in Scotland: A case study

Presenting Author(s)

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Dr Clare DePasquale, Director for Research and Collaborative Practice, Equity Lighthouse, UK

Research is now considered an integral part of a pharmacist's scope of practice. The Royal Pharmaceutical Society's credentialing curricula for post-registration foundation, core advanced and consultant levels incorporate five broad domains that align to four 'pillars of practice'; research is one of these pillars [1]. Research supports the profession's core purpose - ensuring safe, effective and efficient person-centred care through the evidence-based use of medicines. Furthermore, research enables pharmacists to identify medicines-related problems, collaborate with multidisciplinary teams, demonstrate the impact of pharmaceutical care and innovate service provision. It is essential to advancing practice and shaping policy. However, published literature highlights that research capacity, competency and confidence within the pharmacy profession requires development [2, 3]. Performance in this 'pillar' most frequently impedes credentialing success at core advanced and consultant levels [4].

The Scottish Pharmacist Clinical Academic Fellowship (SPCAF) programme - a collaboration between Higher Education Institutions and NHS Education for Scotland – was created to develop a network of Clinical Academic Pharmacist posts. These were designed to generate an evidence base for healthcare practice development through a robust programme of research which in turn, would help establish a national network of research-focused practitioners. The recruitment process which commenced in February 2021, resulted in the successful appointment of 6 candidates to the first cohort of the 2-year SPCAF programme. These posts allowed fellows 0.6WTE spent on health service-based activities and 0.4WTE spent on research activities related to their clinical area of practice.

The presentation will provide an overview of a study conducted in 2024-2025 evaluating the SPCAF programme cohort 1 (2021-2023) with the overarching aim of determining its impact on developing research to advance pharmaceutical care practice across the NHS.
A case study approach was deemed appropriate to developing a holistic understanding of the programme. A multi-modal design incorporating both qualitative and quantitative methods was employed, with each method aligned to specific study objectives. Data collection comprised an archival review, online semi-structured interviews with key stakeholders, a cross-sectional questionnaire, and the VICTOR (Visible Impact of Research) tool questionnaire [5]. The Theoretical Domains Framework (TDF) [6] informed the study. Ethical approval was granted by the Robert Gordon University School Ethics Review Committee; NHS approval was confirmed as not required.
The findings present an overall positive view of the SPCAF programme, as a structured approach to develop practice development and research capacity, competence and confidence in the pharmacy workforce. The findings can be used to guide further development and delivery of practice-based research programmes within a wider national remit to increase the value and visibility of research; to further advance pharmaceutical care within the NHS in Scotland.

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Supporting Documents
https://inhwe.org/system/files/webform/2026381.docx

2026382
The lived experiences of junior hospital doctors in the Irish public health system during the COVID-19 pandemic: a qualitative study

Presenting Author(s)

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Background
COVID-19 placed exceptional demands on hospital doctors and exposed longstanding weaknesses in health systems. In Ireland, the pandemic reached a public hospital system already affected by understaffing, excessive working hours, constrained resources, difficult working conditions and high junior-doctor turnover. Although early pandemic measures brought additional staffing, investment, faster decision-making and stronger clinical support, it remained unclear whether these changes would endure and how doctors experienced the later phases of the emergency.
Evidence on junior doctors during COVID-19 has largely emphasised occupational stress, infection risk, reduced well-being and intentions to resign. Less is known about how positive and negative experiences changed across successive waves, particularly in an already strained health system. This study explores the lived experiences of junior hospital doctors in the Irish public hospital system during and after the later waves of COVID-19. It asks how doctors interpreted changes in working conditions, support and workplace relationships, and what these experiences imply for routine health-service management, workforce retention and future emergency preparedness.

Theoretical Framework
The study is grounded in an interpretivist understanding of lived experience: doctors construct meaning from events through their individual, professional and organisational contexts. The analysis also draws on concepts of professional commitment, vocation and hope to interpret how junior doctors continued to provide care under pressure and how temporary organisational improvements shaped their expectations of the health system. These concepts illuminate both the strength and the limits of relying on personal resilience when structural conditions remain difficult.

Methodology
An exploratory, cross-sectional qualitative design was used. Thirty-one junior hospital doctors from diverse specialities, demographic backgrounds and urban and rural hospitals were recruited through social media and snowball sampling. All participants had at least one year of service. In-depth semi-structured video interviews were conducted between August 2021 and April 2022, lasted approximately 40-45 minutes and examined working conditions, satisfaction, turnover intentions, community embeddedness and experiences of frontline work. Interviews were audio-recorded, transcribed verbatim and analysed using Braun and Clarke's reflexive thematic analysis, supported by NVivo. Coding was primarily inductive and was refined iteratively as data collection and analysis proceeded concurrently.

Findings
Doctors described a phased experience. Early in the pandemic, many perceived better staffing, greater consultant availability, faster decisions, reduced bureaucracy, stronger teamwork and visible organisational support. These changes fostered purpose, fulfilment and hope that meaningful reform was possible. As the pandemic progressed, however, these benefits weakened. Infection and quarantine intensified staffing shortages and workloads, while prolonged restrictions on interaction reduced collegial support. Participants described guilt when illness or quarantine shifted work onto colleagues, isolation from co-workers and family, and emotional strain when protective equipment and distancing disrupted patient relationships. International doctors living alone and doctors protecting high-risk relatives appeared especially vulnerable. Professional commitment helped doctors persist, but their accounts show that commitment cannot sustainably compensate for systemic shortcomings.

Practical Implications
The findings indicate that preparedness for future health emergencies should address psychological and social consequences alongside clinical capacity. Health services should preserve the organisational practices that doctors experienced as beneficial and ensure that workforce policies do not depend on individual resilience alone.
• Maintain safe staffing levels and reliable access to senior clinical support, including consultant supervision for junior doctors.
• Retain timely decision-making, streamlined administrative processes, visible leadership and stable team structures beyond emergency periods.
• Protect opportunities for collegial interaction, peer support and psychologically safe debriefing, even when infection-control measures constrain normal contact.
• Provide targeted support for doctors who live alone, are internationally recruited, must isolate from family, or experience guilt and moral distress after infection or quarantine.
• Use staff hope, trust and perceived organisational support as indicators of whether reforms are being sustained, and connect improvements to retention strategy.

Limitations and Future Research

The cross-sectional design captures retrospective accounts rather than following individual doctors throughout the pandemic. The sample of 31 participants supports depth and diversity of experience but limits statistical generalisability. Future research should use longitudinal interviews to examine whether hope, organisational trust and intentions to remain change as emergency measures recede. Comparative studies across jurisdictions and quantitative studies could test the wider applicability of the themes and identify which organisational practices most strongly support well-being, commitment and retention.

2026383
Interprofessional Medication Safety Session - Promoting Safe Prescribing through Interprofessional Education Workshops

Presenting Author(s)

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Objectives

Worldwide, medication errors occur frequently in the hospital setting, with the five main types of medication errors relating to prescribing, preparing, dispensing, administering, monitoring. The Interprofessional Education (IPE) Medication Safety workshops aim to provide students with an opportunity to learn from, with and about each other to understand each other's role in medication safety in the hospital setting. The aim was to investigate whether the workshop would result in a change in student confidence in self-reported interprofessional collaboration-related competencies using the Interprofessional Collaborative Competency Attainment Scale (ICCAS) tool.

Method

Three IPE workshops took place in an Irish university setting, involving approximately 440 medical, pharmacy, nursing and midwifery students (February-April 2025) facilitated by experienced discipline specific facilitators and a hospital Medication Safety Pharmacist. A case-based learning approach was adopted, and the content was developed interprofessionally by university faculty and reviewed by practitioners. One patient case and hospital drug chart (Kardex) was reviewed by students in mixed profession groups. Students collaborated on a review of the drug chart, reviewing the indication and prescribing of each medication, spotting errors and then transcribing a new drug chart. The workshop explored various aspects of medication errors, including prescribing and administering issues, and reporting incidents. The session was grounded in contact theory, with students working on a shared goal with equal status, cooperating on the medication review, working on an authentic patient case and simulating tasks that are core to medication safety in hospital practice. Feedback was collected, with consenting students also completing a pre- and post- ICCAS survey to self-report on interprofessional and teamwork competencies. Ethical approval was obtained.

Results

There were 117 matched pre and post-workshop survey responses (86.3% female, 101) from across all student groups (nursing 41.9% n=49; medicine 29.1% n=34; pharmacy 17.1% n=20;, midwifery 12% n=14). Statistically significant improvements ($p<0.05$) in all ICCAS subscales of Communication, Collaboration, Roles and Responsibilities, Collaborative Patient/Family-Centered Approach, Team Functioning and Conflict Management showed. All twenty ICCAS items demonstrated a significant improvement in score after the workshop ($p<0.05$). Students reported positively on the workshop format, with more than 75% rating their ability to collaborate interprofessionally as improved afterwards. Students reported developing skills in medication prescribing, benefited from the interprofessional experience to understand the roles of other healthcare professionals and found the interactive and practical nature of the workshop beneficial.

Conclusions

The study has demonstrated that interprofessional collaboration, through authentic, active case-based learning methods strengthened students self-reported interprofessional competencies. Through interprofessional medication safety workshops, medical, nursing, midwifery and pharmacy students learned with, about and from each other regarding the importance of safe prescribing. This IPE session supports the development of interprofessional competencies, patient safety competencies and will continue to form a key component to scaffold IPE in the curricula of these students.

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2026384
The Northern IPE Strategy: Creating a Regional Community of Practice to Advance Interprofessional Education

Presenting Author(s)

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Introduction
In 2021, the Collaborative Newcastle Universities Agreement was established which set out to increase partnership activity for the benefit of Newcastle and local areas. Interprofessional Education (IPE) was recognised as an educational activity well aligned to this ambition, with an established foundation of cross-organisational collaboration and longstanding expertise across the northern region. From this, the goal was set to create a regional IPE Strategy. This innovative IPE approach is a UK first with co-creation of a regional strategy for multiple universities across diverse geographical regions.
The Northern IPE Strategy – launched in March 2026 - has been developed through collaboration between five universities (Newcastle, Northumbria, Teesside, Sunderland, and York) following stakeholder consultation and analysis. The purpose of the strategy is to create a regional community of practice to advance IPE across the North, drawing on expertise, locally agreed principles, and shared goals.

Method
The Northern IPE Group set the following objectives to:
• Co-develop a regional strategy for IPE
• Foster a collaborative learning environment across institutions
• Align with NHS workforce and education priorities.
A multi-institution consultation event was facilitated involving university and healthcare stakeholders. Data was collected from facilitated workshops, group discussions and subsequent thematic analysis.

Results
The Northern IPE Strategy is structured around five foundational pillars drawn from stakeholder analysis:
• Regional collaboration
• Leadership and governance
• Faculty development
• Research and evaluation
• Quality assurance
To achieve regional priorities, the Northern IPE Group will drive the advancement of IPE through the following key priorities over the next five years:

Short term:
Developing working groups: Establish and sustain dedicated groups to support progress, including a regional IPE coordination group, a faculty development group, and a research group to strengthen scholarship and innovation in IPE.

Medium term:
IPE faculty training: Provide structured training and development opportunities for faculty across partner institutions to ensure educators are well-equipped with the skills, knowledge, and confidence to design and deliver high-quality IPE activities.

Long term:
Dissemination and sharing of best practices: Establish and sustain a culture of collaboration and continuous improvement in IPE by actively disseminating best practices, sharing resources and case studies across institutions, and contributing to national and international IPE networks to influence policy and practice.

Conclusion
The Northern IPE Strategy was successfully launched in March 2026, and it provides a cohesive framework to strengthen collaboration, enhance education quality, and prepare a workforce ready for integrated care. Together, these priorities will help embed IPE more systematically across the region, supporting faculty and student engagement, and ensuring that the Northern IPE Strategy continues to deliver meaningful impact on education and practice.

2026385
Innovating Together for Safer, Sustainable Care: Interprofessional, Peer Led and Cross Sector Collaboration in the ScotGEM Agents of Change Curriculum

Presenting Author(s)

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Background

As healthcare systems grow more complex, fragmented, and resource strained, the need for clinicians who can collaborate effectively across professional boundaries has never been greater. Interprofessional education (IPE) is increasingly recognised as central to developing a healthcare workforce that is capable of delivering safe, person centred, sustainable care. The Scottish Graduate Entry Medicine (ScotGEM) Agents of Change (AoC) curriculum was specifically designed to prepare future doctors to work in this environment by embedding interprofessional collaborative practice early leadership development, and systems thinking throughout undergraduate training. Uniquely, AoC combines peer led learning, experiential prescribing safety projects, and strong NHS–academia partnership to create an innovative model of collaborative practice that both supports learner development and delivers meaningful improvements to real clinical services. Co produced by NHS boards, pharmacists, GPs, academic faculty and community partners, the AoC curriculum aims to address national patient safety priorities, expand students' understanding of professional roles, and build capability for collaborative quality improvement from the outset of medical training.

Aim

This work evaluates how the AoC curriculum uses interprofessional collaboration, peer learning structures, and joint NHS–university delivery to enhance prescribing safety, leadership capability, and sustainable, person centred service improvement among early stage medical students. We examine both the educational benefits for learners and the measurable contributions to clinical practice produced through experiential projects and change initiatives.

Method

AoC is delivered as a spiral curriculum integrating classroom based teaching, workplace experiential learning, and structured reflective practice. Interprofessional collaborative practice is embedded through several key mechanisms:

• Prescribing Safety

Throughout all 4 years of the undergraduate course, students undertake healthcare improvement projects within NHS general practices. They work directly with pharmacists, GPs, practice nurses, and wider interprofessional team to explore high risk areas such as inhaler optimisation, polypharmacy, and anticoagulant monitoring. Students receive joint mentorship from clinical and academic staff, enabling them to engage in shared decision making, data interpretation, and the co development of improvement recommendations.

• Peer Led Learning and Collaborative Sense Making

Peer learning is intentionally embedded throughout AoC. Students present findings to peers, teach one another audit methodologies, and contribute to cross cohort peer support networks. These activities foster horizontal learning, build confidence in communication and teaching skills, and reinforce a shared culture of inquiry and collaboration.

• Collaborative Change Methodologies: Students apply shared tools—process mapping, driver diagrams, stakeholder analyses, and PDSA cycles—within NHS placements and community settings which focus on interprofessional collaborative practice and QI teams in practice.

• Collaborative Mentorship: NHS colleagues and clinical mentors provide joint supervision, helping students understand differing professional roles, perspectives, and contributions to patient care.

• NHS–Academia Partnership

The AoC curriculum is co designed and co delivered by the Universities of St Andrews and Dundee alongside NHS partners and community organisations. This ensures alignment with service needs, national safety strategies, and local priorities. NHS clinicians actively guide project selection, mentor students, and support the implementation of student generated recommendations, bridging the gap between educational objectives and practical system improvement.

• Person Centred and Sustainable Practice

Students examine how prescribing decisions and improvement interventions affect not only safety and clinical outcomes but also environmental sustainability, equity of access, and patient experience. This aligns with Scotland's commitments to Realistic Medicine and value based care, helping learners to consider health system impact from a broad, holistic perspective.

Results

Since 2018, students have completed 503 improvement projects across 80 NHS general practices and have resulted in supporting transformational change. These activities have produced measurable improvements in the accuracy, safety, and sustainability of quality of care, leading to targeted interventions around systems redesign, medication reviews, and monitoring pathways. Students reported significantly enhanced confidence in communicating with healthcare professionals, raising safety concerns, and understanding the interplay between different professional roles.

• Peer learning was identified as a highly influential part of the process, with students noting that sharing experiences with peers demystified audit work, normalised uncertainty, and built a sense of collective responsibility. By teaching each other, students consolidated their knowledge, developed early leadership skills, and contributed to a culture of collaboration across the programme.
• NHS clinicians expressed that student audits frequently provided useful insights and actionable recommendations that aligned with local and national priorities. The NHS–academia partnership was seen as instrumental in enabling students to work on genuinely meaningful, system relevant problems while ensuring that supervision, data governance, and quality assurance standards were upheld. Academic staff observed improved engagement, deeper learning, and greater readiness for clinical placements among students participating in AoC.
Students reported that working directly with pharmacists, nurses, GP, patients and the wider practice team was one of the most influential learning experiences of their training, shaping their professional identity and reinforcing the importance of interprofessional collaborative practice.

Discussion
The AoC curriculum demonstrates the power of combining, peer led development, and cross sector collaboration to prepare learners for modern healthcare. Students learn to navigate complex systems, appreciate diverse professional perspectives, and build the leadership skills required to influence change. The close integration of NHS staff and academic educators reinforces authenticity, while peer led structures enhance confidence, autonomy, and collaborative identity formation. This model illustrates how practice learning can simultaneously support workforce development and deliver tangible benefits to healthcare services.
Recommendations for future development of IPE involves students from 2 or more professions learning and working together through delivery of healthcare improvement to become a community of learners.

Conclusions
AoC offers a scalable, future focused model that aligns strongly with national priorities and global calls for collaborative, sustainable healthcare. By uniting students and professionals across disciplines in meaningful, outcome driven activities, it strengthens patient safety, promotes sustainability, and builds leadership capacity. This demonstrates how innovating together enables learners to shape safer, more equitable and collaborative healthcare systems. Key aspects of the AoC curriculum are now embedded in other educational programmes within education.

2026386
Evaluating Medical Students' Experiences with Clinical Bedside Tutorials

Presenting Author(s)

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Objectives
Clinical bedside tutorials are an essential component of medical education providing students with direct patient interaction and practical application of history-taking and clinical examination. The effectiveness of these tutorials can vary based on teaching styles, clinical tutor factors, student factors and learning environment. This research study aims to gain valuable information from the students' perspectives on their experiences of clinical bedside tutorials. The findings of this research may contribute to future improvements in bedside tutorials, clinical skill acquisition and medical education.

Method
A qualitative study was conducted among third- and fourth-year Graduate Entry Medical students at the University of Limerick to explore their experience of clinical bedside tutorials in the discipline of Medicine. Ethical approval was granted by the University of Limerick Research Ethics Committee prior to the study commencing. A 29-item questionnaire was collaboratively developed with clinical tutors from both main and peripheral teaching hospital sites, focusing on three domains: medical bedside tutorials, the learning environment, and student experiences. Items were rated on a five-point Likert scale, and two open-ended questions were included to gain insight into students' experiences. A pilot study was conducted to ensure the questionnaire was relevant and that responses were valid before it was redistributed in October 2025. The final amended version was distributed electronically via Qualtrics XM on the University's Brightspace eLearning platform. Participation was voluntary, and responses were anonymized upon submission. Open-ended responses were analyzed thematically to identify recurring themes and key insights regarding students' perspectives on clinical bedside teaching.

Results
The total number of eligible students was 349. The response rate was 23.5%, with 82 students beginning the questionnaire. Ultimately, 54 students completed it, representing 15.5% of those eligible. Respondents were evenly split as 50% were third-year students and 50% were fourth-year students. The majority were female (84%). Most students (69%) agreed they received an adequate number of bedside tutorials from their assigned clinical tutors, with 81% reporting having bedside tutorials across multiple hospital site rotations, and 72% did not receive tutorials from their assigned medical teams on the wards. Regarding teaching quality, 59% agreed that practical skills, history-taking, and physical examinations were adequately supervised and assessed, and 71% reported that tutorials were structured around relevant learning outcomes and the current curriculum. 67% felt bedside tutorials encouraged critical thinking, and 80% said they helped identify strengths and weaknesses in clinical skills. Some areas for improvement were highlighted, 45% disagreed that they received clear learning objectives for their overall medicine placement, and 38% did not feel comfortable approaching their assigned medical teams for teaching during rotations. Finally, 60% reported differences in how clinical skills were taught by ward teams compared to tutor-led tutorials

Conclusions
As evident by the results of this study, we can see the majority (81%) of the total number of 3rd and 4th year students that responded to our questionnaire received bedside tutorials during their medicine rotation. However, we can also appreciate that 19% of the respondents did not receive any bedside tutorial from their tutor during their medicine rotation. This highlights that this research may contribute to the future delivery of bedside tutorials by ensuring 100% of students receive bedside tutorials during their medicine rotation to maximise the development of their clinical skills. The study also highlighted the importance of having an assigned clinical tutor to deliver bedside tutorials as 72% of respondents reported they did not receive any tutorials from their assigned medical teams on the wards and 38% did not feel comfortable approaching their assigned medical teams for teaching during rotations. This reflects the increasing challenges accessing bedside teaching on the wards with increased staff burdens and also the importance of the support provided by assigned clinical tutors to students. The majority of students who completed this study were satisfied with the quality of bedside teaching with 80% reporting it helped identify their strengths and weaknesses in clinical skills but there are areas for improvement as 45% disagreed that they received clear learning objectives for their overall medicine placement. This emphasizes the importance of reinforcing the learning objectives from the student's core curriculum throughout their placement with a blend of classroom and bedside tutorials. It would be beneficial to repeat this study again with hopefully a larger response rate after implicating changes including ensuring all students receive bedside tutorials and that the core curriculum is reinforced throughout the placement with increased participation in teaching by the medical teams on the wards in addition to the clinical tutor.

Supporting Documents
https://inhwe.org/system/files/webform/Student%20Questionnaire%20Regarding%20Experience%20of%20Clinical%20Bedside%20Tutorials%20%281%29.docx

2026387
Evaluation of a First Year Interprofessional Education session to build Role Awareness and Communication Skills

Presenting Author(s)

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Introduction

Early introduction to Interprofessional Education (IPE) in health and social care pre-registration training is recommended to foster interprofessional communication and collaboration competency development (1). The aim of this session was to provide early exposure for students to understand and consider the perspective of other professions and the importance of effective communication as key enabler of interprofessional collaboration in healthcare.

Methods

First year students from nine pre-registration programmes participated in a two-hour IPE workshop. Students were introduced to other professions and worked in small groups, guided by facilitators, to learn about communication and apply the ISBAR communication tool. The Introduction, Situation, Assessment, Recommendation tool is a standardised approach to communication used in a wide range of clinical contexts (2). Workshop content also introduced students to interprofessional team collaboration and the importance of person-centred care. Students were invited to complete a pre- and post-workshop survey; the validated Readiness for Interprofessional Learning Scale (RIPLS). Ethical approval was obtained.

Results

The response rate was 27.2% (102/374) for paired pre- and post-survey (72.5% female). The mean RIPLS score was 80.91 (SD±11.94) before and 82.89 (SD±12.29) after the workshop ($p=0.058$), on the paired data. A significant increase in self-reported readiness was reported in 11 of 19 of the RIPLS statements ($p<0.05$), primarily relating to Roles and Responsibility, Positive Professional Identity and Teamwork and Collaboration. Students reported positively on the benefits of learning about ISBAR and working with other professions.

Discussion

This evaluation demonstrates that students have a high self-reported readiness for IPE. Our findings indicate that this first IPE workshop resulted in significant improvements in students IPE competencies. This supports the ongoing embedding of IPE early in healthcare student curricula. Further inclusion of additional healthcare programmes in the future will expand the opportunity to more students, resulting in increased awareness of professional roles and improvements in team communication skills.

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2026388
From Silos to Systems: Shaping a Regional Interprofessional Future Together A Thematic Stakeholder Analysis of Postgraduate Educators in the East of England Across the Health Spectrum

Presenting Author(s)

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Objectives

The East of England Multiprofessional Foundation School (MPFS) was established in 2022 to bring early-career doctors, pharmacists, physician associates and other healthcare professionals together to learn with, from and about each other during their foundation years. Alongside this, the School incorporates Enhance, a contextual multiprofessional leadership development programme with an explicit focus on generalism.

Enhance emerged in response to the NHS Future Doctor Report (HEE, 2020) and the NHS Long Term Plan (NHS England, 2019), both of which emphasise clinicians who can think beyond specialty boundaries and understand their work within wider systems of care. It encourages early-career clinicians to see leadership as relational and contextual rather than positional. Work is ongoing to extend this approach across a broader multiprofessional audience, including allied health professionals, reflecting a regional ambition to embed system-aware thinking early in clinical careers.

Interprofessional education (IPE) is well established in undergraduate curricula (Reeves et al., 2016). Less attention has been paid to what happens once clinicians enter postgraduate practice, when responsibility intensifies and professional norms are absorbed through everyday behaviour as much as formal teaching. It is during these early years that patterns of hierarchy, communication and collaboration often become normalised.

The MPFS, including enhance, was not conceived as a short-term intervention but as a sustained regional effort to keep multiprofessional and generalist thinking visible during this formative period. As we approach a new three-year strategy cycle (2026–2029), we sought to understand how educators supervising early-career clinicians view the future direction of this work.

Method

A survey was distributed to educators working with postgraduate learners across the East of England. In total, 110 educators responded, representing medicine, nursing, allied health professions, pharmacy and dentistry. Respondents included clinical and educational supervisors, pharmacy educators, simulation faculty and programme leads.

The survey explored priorities for the School's next phase: future development, constraints on multiprofessional learning, activities perceived to have lasting impact, markers of success at three years, and shared capabilities early-career clinicians should develop together.

Open-text responses were analysed using reflexive thematic analysis. Coding was iterative, allowing themes to emerge across questions. Attention was paid to areas of agreement and to tensions between aspiration and what feels achievable within service realities

Results

Five themes recurred across professional groups.

First, educators emphasised learning grounded in real clinical work. Case-based discussion, simulation and exposure to functioning multidisciplinary teams were valued more than classroom-style teaching. One-off sessions were seen as useful but insufficient alone to shift practice.

Second, silo-working remains visible. Respondents described ongoing uncertainty about roles and scope, particularly among early-career clinicians stepping into new responsibilities. Bringing professions together was viewed as necessary but insufficient; interdependence needs to be explicit and deliberate.

Third, prescribing safety, referral pathways and shared clinical decision-making were repeatedly highlighted. These were framed as areas where misalignment can directly affect patient care. Joint quality improvement work was frequently cited as a practical vehicle for collaborative learning.

Fourth, organisational backing matters. Protected time was the most cited enabler. Educators described tensions between service pressures and collaborative learning. Leadership endorsement and faculty capability in facilitating across professions were viewed as critical.

Fifth, success was defined by changes in everyday practice: clearer communication, smoother handovers and reduced visible hierarchy. Attendance figures or satisfaction metrics were rarely mentioned. Sustainability emerged as a consistent concern.

Discussion

Many findings echo established literature, yet the early postgraduate context warrants attention. Much IPE research centres on undergraduate programmes or established teams (Reeves et al., 2016). The early postgraduate workplace is different. Clinicians are no longer students, but they are still consolidating professional identities (Cruess, Cruess and Steinert, 2019). They are negotiating responsibility and belonging within real clinical systems.

Lave and Wenger's concept of legitimate peripheral participation (Lave and Wenger, 1991; Wenger, 1998) provides a useful lens. As clinicians move toward fuller participation in communities of practice, the norms they encounter shape what becomes taken for granted. If siloed behaviour predominates, it may become embedded. If collaboration is visible and expected, it may similarly become integral to professional identity.

In postgraduate training, the "workplace" extends beyond clinical encounters. It includes supervision meetings, appraisal processes, portfolio requirements and formal teaching structures. The educational infrastructure is therefore part of the workplace. Billett's notion of workplace affordances (Billett, 2001)

reminds us that participation depends not only on individual motivation but also on the opportunities and permissions embedded in organisational systems. Protected time and leadership support are structural conditions for collaborative practice to develop.

A tension remains. Our programme includes structured one-off regional events. Alone, these are unlikely to transform culture. However, within a sustained regional commitment, they may function as catalysts. They can introduce shared language and challenge assumptions that are then reinforced locally. Enhance, as a one-year longitudinal multiprofessional programme, offers one mechanism for revisiting and deepening these conversations over time.
The emphasis on shared risk, prescribing and system navigation aligns with the shift toward integrated care systems outlined in the NHS Long Term Plan (NHS England, 2019). Educators positioned multiprofessional learning not as optional enrichment but as foundational to safer, coordinated care.
This survey has limitations. It reflects self-reported perceptions from a single region and may over-represent those with an interest in education. It focuses on educator views rather than learner experience or measured behavioural outcomes. The findings therefore describe priorities rather than demonstrable impact. Nevertheless, the breadth of representation and consistency across professions offer insight into how early postgraduate IPE is currently understood.

Conclusion
Drawing on 110 educators across medicine, nursing, AHPs, pharmacy and dentistry, this study highlights the early postgraduate workplace, including its educational infrastructure, as a pivotal site for interprofessional formation.
Respondents called for learning grounded in clinical reality, clearer disruption of silos and organisational structures that actively support collaboration. While individual events may catalyse reflection, the longer-term influence lies in sustained programmes. Enhance, as a one-year longitudinal leadership programme, illustrates how interprofessional and generalist thinking can be reinforced over time rather than delivered as a single intervention.
If interprofessional practice is to become routine rather than aspirational, sustained attention to the formative postgraduate years and to the structures that shape them will be as important as any discrete innovation.

2026389
Grow Leader: Building Leadership Capacity for Health Management in an Oncology Research Institute

Presenting Author(s)

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Objectives

Healthcare systems across Europe are experiencing increasing pressure related to demographic ageing, financial constraints, workforce shortages and rising accountability demands. In highly specialised oncology settings, leadership roles are frequently assigned to senior clinicians or technical professionals who possess strong disciplinary expertise but limited formal training in organisational governance and health management. This structural gap between clinical excellence and managerial capability may compromise coordination, decision quality, resource optimisation and long-term sustainability of public healthcare organisations.

Contemporary Health Management literature highlights the importance of distributed and inclusive leadership, value-based governance, and the integration of relational and managerial competencies into everyday clinical practice. In this perspective, leadership development should not be treated as an ancillary training activity but as a strategic investment in organisational performance, public value creation and system resilience.

The Grow Leader programme was designed and implemented within IRCCS IRST “Dino Amadori”, a multidisciplinary oncology research institute operating within the Italian National Health Service. The initiative aimed to strengthen leadership capacity among professionals responsible for coordinating teams and processes in a high-complexity clinical and research environment.

The primary objective of Grow Leader was to enhance leadership and health management competencies among mid-level and senior professionals. The programme specifically sought to strengthen four interconnected domains:
- Strategic direction and shared sense-making (defining and communicating vision aligned with organisational goals).
- Team management competencies (inclusive decision-making, delegation, empowerment and trust-building).
- Relational and communication competencies (active listening, adaptive communication styles, constructive feedback and conflict management).
- Responsible and accountable leadership (integration of equity, inclusion, sustainability and public value into managerial decision-making).

The evaluation aimed to assess perceived competence development, behavioural transfer into practice and perceived organisational impact.

Method

A mixed-method evaluation design was adopted, combining quantitative and qualitative approaches.
The programme was delivered between February and October 2025 and consisted of four structured modules:
- Agile Organisation
- Teamwork Development and Soft Skills
- Overcoming Communication Barriers to Foster Connection
- Leadership for Managerial Skills

The pathway comprised 28 hours of training delivered across six sessions, with a total of 167 participations distributed across modules (79, 30, 22 and 36 respectively). The pedagogical design was grounded in adult learning principles and experiential methodologies, including case discussions, simulations, group exercises and reflective practice. The curriculum followed a progressive logic from process optimisation and agile management to relational and advanced leadership competencies.
The final impact questionnaire was completed by 26 leaders from a multidisciplinary background including physicians, nurses, pharmacists, biologists, technical staff and administrative managers. The majority were female and aged between 50–59 years, followed by the 40–49 age group. Most participants coordinated teams of six or more professionals and had significant seniority in leadership roles (≥4 years).

About data collection, evaluation occurred at three levels:
1) Satisfaction (reaction level)
Module-specific questionnaires used a 3-point scale (1–3) to assess teaching quality, learning climate, organisation and overall satisfaction.
2) Retrospective pre–post self-assessment (perceived learning level)
A 20-item instrument measured perceived competence before and after the programme using a 5-point Likert scale (1 = strongly disagree; 5 = strongly agree). A retrospective format was adopted to mitigate response shift bias, frequently observed in leadership development contexts.
3) Qualitative impact assessment (behavioural transfer level)
Open-ended questions explored concrete behavioural changes, team-level applications, perceived impact on collaboration and sustainability, and contribution to public healthcare governance.

Results

About satisfaction, satisfaction scores were consistently high across modules:

- Agile Organisation: 2.41/3
- Teamwork Development and Soft Skills: 2.90/3
- Overcoming Communication Barriers: 2.62/3
- Leadership for Managerial Skills: 2.84/3

Teaching quality and classroom climate were particularly valued.

About perceived competence development, across the 20 items, mean self-assessment increased from 3.42 (pre) to 4.00 (post) on a 5-point scale. The proportion of high ratings (4–5) increased substantially in core domains:

- Vision definition and sharing: from 38% to 77%
- Team involvement in decision-making: from 38% to 85%
- Constructive and timely feedback: from 27% to 69%
- Attention to equity, inclusion and respect: from 50% to 85%

The consistency of improvement across strategic, relational and managerial domains suggests a broad-based strengthening of leadership capacity relevant to health management functions.

About behavioural transfer and organisational implications, qualitative responses indicate translation of competencies into daily managerial practice. Recurring themes included more structured delegation processes, intentional communication strategies, improved management of difficult conversations and enhanced team engagement.

In the “impact” section, 69% of participants reported high agreement (4–5) regarding the programme’s contribution to managerial capacity-building and reduction of organisational waste. High agreement was also reported regarding improved team wellbeing, more efficient resource use and more sustainable decision-making practices.

Participants explicitly linked leadership competencies to their role as public decision-makers, highlighting increased awareness of accountability and long-term sustainability of the healthcare system.

Conclusions

The findings suggest that a structured and institutionally embedded leadership development programme can generate meaningful perceived improvements in managerial competencies within a complex oncology research setting.

The magnitude and coherence of improvements across multiple domains indicate a systemic learning effect rather than isolated skill acquisition. The qualitative data provide supporting evidence of behavioural transfer into managerial practice, strengthening the interpretation of impact beyond attitudinal change.

The retrospective pre–post design enhances internal validity by partially mitigating recalibration bias. However, reliance on self-reported data represents a limitation. Future evaluations should incorporate multi-source assessment (e.g., 360-degree feedback), objective organisational indicators and longitudinal follow-up to assess sustained impact.

About sustainability and transferability, the modular and experiential architecture of Grow Leader supports scalability and transferability to other complex healthcare organisations. Long-term sustainability may be reinforced by:

- integrating leadership competencies into performance evaluation systems;
- establishing periodic competence monitoring;
- implementing peer coaching or action-learning cycles;
- aligning leadership development with succession planning strategies.

Embedding leadership training within governance structures may reduce the structural gap between clinical expertise and managerial responsibility, contributing to organisational resilience.

In conclusion, Grow Leader demonstrates that leadership capacity-building within a specialised oncology research institute can produce measurable perceived improvements in competencies central to Leadership & Health Management. The programme strengthened strategic alignment, participatory governance, communication effectiveness and responsible decision-making.

Although further validation through objective indicators is required, the results support leadership development as a strategic investment in workforce sustainability, organisational performance and public healthcare governance.

In complex healthcare environments characterised by resource constraints and accountability pressures, structured leadership pathways represent a critical component of sustainable health management strategies.

2026390
TEAMCARE: The Development, Implementation and Evaluation of an Interprofessional European Curriculum for Health and Social Care Staff in Ireland

Presenting Author(s)

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Objectives
The TEAMCARE EU Erasmus Research project developed and implemented an interprofessional educational programme based on a European curriculum for health and social care staff in the community. The main expected output of the TEAMCARE project was an EU Curriculum for “Specialist in Community Based Interprofessional Teams for person-centred care” The Pilot based on this curriculum was implemented via four micro credentials to 54 community based professional health and social care community staff.
The key objective was to educate community-based health and social care staff to work collaboratively for the benefit of service users and improve collaboration among healthcare and social care professionals, the absence of which which can lead to fragmented service user care and poor health outcomes. review of evidence included 94 articles. A recent review shows overwhelming evidence supporting a positive relationship between IPE interventions and several key quality health measures including:
length of stay, medical errors, patient satisfaction, patient or caregiver education, mortality (Cadet.T et al., 2023).

Methods
The curriculum was informed by:
Service users at focus groups to understand the problem from their perspective
- An EU wide contextual analysis
- A review of the international literature and
- An e-Delphi study to identify the core competences, and articulate the knowledge, skills and behaviours needed to support the development of a community-based specialist in interprofessional working.
-The ICAR tool to ascertain the benefit of the course based on teamwork competencies
- A participant survey and focus groups to evaluate the four pilot TEAMCARE micro-credentials in Ireland

Findings
The EU curriculum was completed and was piloted in Greece, Ireland, Italy, and Poland
54 Health and social care staff in 13 teams undertook the four micro credentials in Ireland
Evaluation of these micro-credentials was positive with recommendations for sustainability going forward
In addition each of the community interprofessional teams undertook a quality improvement project that had positive outcomes for service users.

Conclusion
The sustainability for the continuation of the Teamcare micro- credentials including a roadmap to train other professionals was developed. The dissemination of results of TEAMCARE Research Project was undertaken and recommendations for political, policymakers, and regulatory bodies were detailed.
After many years of inquiry, there is now sufficient evidence to indicate that interprofessional education enables effective collaborative practice which in turn optimizes health-services, strengthens health systems and improves health outcomes

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2026391
Beyond the patient story: family/carer voice, compassionate care, and the relational dimensions of leadership in international online interprofessional education

Presenting Author(s)

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Objectives

To explore how patient and family/carer voice can support learning about compassionate collaborative care, inclusive partnership, and the relational dimensions of leadership in interprofessional practice within an international online interprofessional education seminar.

Method

This multi-site educational evaluation draws on quantitative and qualitative data from the 2025 and 2026 Bridging Perspectives seminars, delivered collaboratively by the Maine College of Health Professions, the University of Nottingham, and Cardiff University. Data sources included post-session student questionnaire responses and qualitative data generated through patient and carer lived-experience contributions within the seminars. Data were analysed descriptively and thematically to explore educational and emotional impact. Planned follow-up semi-structured interviews with the patient and carer contributors will supplement and deepen the findings by exploring their experiences of participation, perceived impact, and perspectives on family/carer voice in interprofessional education.

Results

Student feedback indicated a highly positive response to the seminar. In 2026, 56 students attended across the three institutions, with 10 questionnaire responses and a mean satisfaction score of 4.8/5. Students particularly valued the patient and family/carer perspective, the international and interprofessional exchange, and the inclusive, non-hierarchical learning environment. Feedback suggested impact on empathy, active listening, cultural humility, team reasoning, and person-centred collaborative care. Lived-experience data added depth by highlighting the often less visible emotional and practical labour of caregiving, the importance of including family members in communication and decision-making, and the value of continuity, honesty, responsiveness, and coordinated support across professions. Together, these findings suggest that hearing both patient and carer voices helped students connect interprofessional teamwork with compassion, partnership, and the relational work of leadership in practice.

Conclusions

Patient and family/carer voice appears to add substantial emotional and educational value to international online interprofessional education. Combining student feedback with lived-experience narrative data offers a richer understanding of how interprofessional learning can promote compassionate care, inclusive partnership, and leadership as a relational practice grounded in listening, responsiveness, and support. Follow-up interviews will extend this work by further exploring the experience of participating as patient and carer educators.

2026392
Bridging the Gap: New Graduate Doctors' Perspectives on Medical Education in Ireland and Preparedness for Clinical Practice

Presenting Author(s)

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Introduction

The transition from medical student to practising doctor is a challenging period of rapid adjustment. In Ireland, many new graduates report feeling underprepared for the realities of internship. This study explores new graduate doctors' perspectives on preparedness for clinical practice and identifies areas where undergraduate medical training could be strengthened.

Methods

A qualitative design using four focus group discussions was conducted with new graduate doctors working in a large Irish teaching hospital. Purposive sampling included new doctors from multiple medical schools. Discussions followed a semi-structured topic guide exploring preparedness for clinical, procedural, and communication tasks. Sessions were recorded, transcribed verbatim, and analysed using Braun and Clarke's reflexive thematic analysis, supported by NVivo software.

Results

Four main themes were identified: simulation, roles and responsibilities as new graduate doctors, meaningful participation as medical students, and interprofessional dynamics and teamwork. Simulation was valued for confidence-building but perceived as limited in replicating real-world pressures. Graduates felt underprepared for administrative and communication tasks such as discharge planning or pronouncing death. Participants emphasised the benefits of supervised responsibility during placements and reported limited understanding of allied health roles before starting work.

Conclusion

Preparedness for practice extends beyond technical competence. New graduates could benefit from more longitudinal, feedback-based simulation, structured "stepped responsibility," earlier exposure to routine intern duties, and enhanced interprofessional learning. Integrating these elements could smooth the transition from student to doctor, supporting both confidence and patient safety.

2026393
From wilderness to wellbeing: forests at the heart of interprofessional preventative healthcare

Presenting Author(s)

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Background
The NHS England (NHSE) enhance programme and Forestry England (FE) have developed an innovative model of practical nature based interprofessional education (IPE).
Feel Good in the Forest is a social prescribing initiative from Forestry England and Sport England, part of Active Forests, a wider Forestry England initiative, designed to support people with mild to moderate health conditions access the nation's forests through nature-based activities. Forestry England's national wellbeing programmes, including Active Forests, provide evidence based physical and mental health benefits and have been associated with £2.7 million in mental health gains and £18 million in avoided NHS treatment costs (1).

In 2023, the NHSE East of England (EoE) enhance team and FE collaboratively designed and began delivery of an IPE development day based on the enhance programme domain of systems working (2). This learning event focuses on the creation, partnerships, funding routes and outcomes of the national FE Active Forests initiative. The event also integrates nature based experiential learning including reflective walks, disc golf and exposure to green social prescribing pathways, with a structured systems leadership "Dragon's Den" task where learners develop creative nature-based initiatives and pitch their ideas.

Methods
A mixed methods evaluation synthesised survey data from feedback responses (n=71) from these collaborative development days (2023–2025). Participants include foundation doctors, foundation pharmacists and allied health professional (AHP) students. Measures included achievement of learning objectives (2), wellbeing impact, career relevance, confidence, motivation and qualitative thematic analysis.

Results
Learning Achievement
Across the total sample (n=71), many respondents agreed or strongly agreed that their personal learning objectives were met. In the 2024 and 2025 datasets, agreement ranged from 80–88%. Participants also reported strong achievement of the systems working learning objectives - collaboration, population health, innovation and leadership (2).

Wellbeing Impact
Nature based learning consistently improved wellbeing, with a medium to significant impact on wellbeing reported in the range of 70-78%. The feedback similarly reported moderate–high personal impact (86%) from forestry based learning. Participants described the environment as restorative, calming and a needed break from ward pressures.

Career Relevance & Application to Practice
Career impact ratings were broadly positive with 65-72% of respondents reporting medium – significant career impact. Participants reported increased confidence in social prescribing and green care, person centred and preventative practice, the integration of community assets into care pathways, and systems leadership and cross sector working.
Learners also described plans to signpost patients to green activities, integrate reflective outdoor activities into clinical teams, and partner with community organisations.

Systems Thinking & Interprofessional Collaboration
Cross sector learning with FE rangers broadened understanding of organisational interdependencies, community assets and population health models. These findings reflect that learning alongside non clinical professionals strengthens real world systems understanding.

The Dragon's Den task was repeatedly cited as the most effective learning activity across datasets, supporting teamwork, creativity, service design and practical application of systems thinking principles. An AHP student reflected "the "Dragon's Den" task stood out as a significant learning opportunity. Working with foundation doctors was stimulating and collaborative. I felt respected as an equal and noticed areas of personal growth, such as maintaining focus during discussions and encouraging others to take leadership roles."

Barriers Identified
Across all years, the respondents noted and identified common constraints that may prevent patients and communities from accessing forestry and other nature sites. These includes distance and transport limitations, car parking charges, and weather conditions. This demonstrates that learning through the

enhance programme and collaboration with FE is supporting early-career healthcare professionals to think more holistically about individuals' unique circumstances, the wider determinants of health, inequalities and wider system design when considering potential and accessible treatment options.

Conclusion

Evaluation of respondent attending the EoE enhance and FE collaborative development day (2023–2025) demonstrates that nature based interprofessional learning enhances:

• systems thinking capability
• wellbeing and reflective capacity
• confidence in prevention and green social prescribing
• cross sector collaboration
• readiness for integrated, person centred models of care

The enhance and Forestry England partnership represents a cross sector, evidence based model of IPE aligned with workforce transformation priorities supporting the 10-Year Health Plan (3) shift from cure to prevention.

The initial collaborative development day in November 2023 has provided a successful blueprint, with the EoE enhance day due to be hosted for the fourth year running in November 2026. Based on the successful implementation, FE now hosts multiple Health Professionals Network Days across various sites in England. To date they have held 32 successful events over a three-year period with 941 healthcare professionals engaged. Results are broadly similar across all events, with participants expressing commitments to utilise the outdoors more, both for their personal wellbeing, but also as a recommendation to support patients health and wellbeing.

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Supporting Documents

https://inhwe.org/system/files/webform/Dragon%27s%20Den%20Brief%20%26%20scoring%20feedback%20sheets_0.docx

2026394
Evaluation of Outcomes and Sustainability of the PAIRS (Paediatric Acute Illness Resuscitation Skills) Train-the-Trainer Paediatric Resuscitation Programme in Tanzania: A Mixed-Methods Study

Presenting Author(s)

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Since 2016, the PAIRS Group has partnered with Tanzanian healthcare institutions to deliver context appropriate paediatric resuscitation training to frontline healthcare workers at minimal or no cost. Two major centres—Muhimbili National Hospital (MNH) and Kilimanjaro Christian Medical Centre (KCMC)—have established PAIRS Training Centres with dedicated interprofessional faculties. The newly developed two day Train the Trainer (TTT) course aims to build sustainable, locally led paediatric resuscitation training capacity within hospitals and regions.

This multi site evaluation explores the experiences, perceptions, and impact of the PAIRS TTT programme on healthcare professionals in Tanzania. The study examines how TTT graduates deliver PAIRS training, challenges encountered, the sustainability of training activities, and the influence on clinical practice and system strengthening. Baseline demographic and professional information will contextualise findings.

This mixed methods study will be conducted at MNH and KCMC. Participants include graduates from four TTT cohorts (2023–2025). Data collection comprises (1) an anonymous census survey of all graduates (approximately 62) to ensure representativeness across cohorts, and (2) purposively sampled in depth interviews and 2–3 focus group discussions exploring individual and collective experiences. Quantitative data will be analysed descriptively and using logistic regression to identify predictors of sustained training activity. Qualitative data will undergo thematic analysis following Braun and Clarke's six step framework, supported by NVivo software. Saturation will be defined as the point at which no new codes or themes emerge across three consecutive transcripts. Integration of quantitative and qualitative findings will occur through a joint display matrix to identify convergent, divergent, and complementary insights. All survey and interview data will be anonymised, handled via GDPR compliant platforms, and overseen by Tanzanian co investigators. A qualitative methods expert will support coding and analysis to enhance rigour.

The study is expected to generate robust evidence on the uptake, application, and sustainability of the PAIRS Train the Trainer model within selected Tanzanian hospitals. Anticipated findings include the proportion of graduates actively delivering training, the extent to which resuscitation skills are incorporated into routine clinical practice, and the institutional and contextual factors that support or hinder sustained training activities. These insights will inform strategies to strengthen paediatric emergency care training and build long term, locally owned educational capacity.

2026395
Advancing Leadership for Integrated Care Excellence (ALICE): An Interprofessional, Team-Based Model for Strengthening HSCP Leadership and Quality Improvement Capability Across Ireland

Presenting Author(s)

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Objectives
The Advancing Leadership for Integrated Care Excellence (ALICE) programme is a national, interprofessional initiative designed to strengthen leadership, quality improvement (QI), and systems-thinking capability within Health and Social Care Professional (HSCP) teams working across Ireland's health service. This abstract evaluates the impact of ALICE's inaugural cohort and explores how intentionally multidisciplinary, team-based education can build competencies necessary for integrated care. ALICE was developed to address known gaps in siloed practice, variable QI capability, and the systemic need for collaborative leadership to support person-centred, integrated models of care.

Method
ALICE is delivered over six to eight months using a blended model combining in-person workshops, virtual collaborative learning, structured leadership development (including EQ2), team-based coaching, and workplace-embedded QI projects. Participating teams consist of three HSCPs from diverse professions including physiotherapy, occupational therapy, speech and language therapy, dietetics, and psychology, representing all six HSE regions. Team-based eligibility is intentional and foundational, enabling teams to develop improvement skills together in an interprofessional space that mirrors their real-world practice and supports flattening hierarchies and strengthening collaboration.

The curriculum integrates leadership theory, reflective practice, quality improvement methodology, data literacy, co-production, inclusion, and "What Matters" principles. Two facilitated coaching sessions per team support the translation of theory into practice and provide personalised guidance on project design, implementation, and measurement. Evaluation involved pre- and post-programme surveys (RCPI Research Ethics Committee approval: RECSAF216) measuring changes in leadership confidence, QI literacy, data capability, collaborative behaviours, and intention to lead further projects. Workplace-based project outcomes were collected to assess impact on patient care and service design.

ALICE includes a subsequent optional continuation phase offering interactive webinars and coaching to support ongoing embedding of learning; the evaluation presented here reflects outcomes from Phase 1 only.

Results
ALICE demonstrated significant improvements across multiple domains essential to integrated care delivery:
Leadership confidence in leading QI projects increased from 38% to 93%.
Familiarity with QI methodologies increased from 52% to 96%.
Ability to use data effectively increased from 35% to 89%.
Confidence to influence change increased from 41% to 86%.
Interdisciplinary teamwork improved for 91% of participants.
Intention to lead future QI projects reached 72%.

Teams demonstrated measurable improvements in communication, patient access, clinical flow, discharge coordination, and cross-site alignment of care. Examples include 100% implementation of personalised communication packages for young people admitted with eating disorders, reduced ophthalmology review delays through redesigned triage and scheduling, timely access for babies under one year through redesigned intake processes, and a standardised MSK pathway improving non-attendance rates and timely access to physiotherapy.

Conclusions
Healthcare is delivered by teams, yet professional education is often siloed. ALICE counters this by embedding interprofessional learning in both classroom and workplace settings. The programme supports shared mental models, psychological safety, collaborative decision-making, and collective accountability, providing a living model of integrated care. Through team-based QI projects and leadership development, participants learn to analyse system problems together, understand each other's roles, and co-design improvements grounded in real-world complexities. ALICE is an effective model for strengthening leadership, collaboration, and QI capability across HSCP teams. Its interprofessional, team-embedded design counters traditional siloed training structures by integrating leadership, systems thinking, human factors, and patient-centred approaches throughout the curriculum. Evaluation findings show substantial gains in confidence, competence, and collaborative behaviours, alongside measurable improvements in patient access, communication, and cross-setting coordination. ALICE offers a scalable template for future interprofessional education initiatives that prepare the workforce for integrated, people-centred care.

2026396
QUICKPAIRS: A Modular, Low-Resource Approach to Paediatric Resuscitation Training in LMIC

Presenting Author(s)

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Objectives
To describe the development, implementation and early outcomes of QuickPAIRS, an innovative, modular paediatric resuscitation training model designed to overcome barriers to traditional full day courses in low resource settings.

Method
QuickPAIRS was developed following over a decade of paediatric resuscitation training experience in Tanzania, during which recurring structural, cultural, and practical barriers consistently limited engagement, feasibility, and sustainability. Working collaboratively with local training teams, the PAIRS faculty identified multiple systemic obstacles to effective training delivery, including: heavy clinical workloads and inability to release staff; lack of study leave or financial incentives; cultural expectations around per diem and catering; limited availability of manikins and teaching equipment; difficulties securing classroom space; hierarchical permission structures; and the absence of interprofessional learning norms, where doctors and nurses rarely trained together. Although traditional PAIRS full day courses were designed to be bespoke, context appropriate, and culturally sensitive, they still required staffing, catering, audiovisual support, and faculty input beyond what partner sites could reliably sustain.
In October 2024, the first QuickPAIRS modules (Paediatric, Newborn, and Safety Huddle) were developed and tested, co designed with Tanzanian faculty to provide short, flexible two hour sessions requiring minimal equipment, minimal audiovisual support, and lower faculty to learner ratios. Each module integrates essential paediatric resuscitation skills (e.g. CPR, ABCDE assessment) with a strong focus on communication, team dynamics, situation awareness, and psychological safety—critical behaviours in settings where hierarchical culture has historically prevented nurses and junior staff from escalating concerns. Modules incorporate tools such as PACE (for speaking up) and ISBAR (for structured communication) and embed safety huddles as a routine mechanism for early detection of clinical deterioration.
To maximise sustainability and local ownership, modules were designed for further subdivision into brief, 5–20 minute micro sessions deliverable opportunistically or at the bedside. These short teaching moments enable teams to practise shared clinical language, reinforce interprofessional cooperation, and integrate resuscitation principles directly into everyday clinical work. This micro learning format also supports staff engagement in contexts where full day training is impractical.
Iterative adaptation occurred through continuous staff feedback, observation of routine clinical practice, and close collaboration with local trainers to ensure cultural alignment, contextual relevance, and feasibility using locally available resources. QuickPAIRS was implemented initially across two Tanzanian hubs, with subsequent uptake in Uganda and emerging partnerships in Sudan, reflecting its adaptability across diverse low resource environments.

Results
Across multiple pilot sites, QuickPAIRS enabled substantial expansion of paediatric resuscitation training in resource constrained hospitals. Over 300 healthcare providers have participated in QuickPAIRS sessions to date, delivered by a growing network of 62 PAIRS Train the Trainer (TTT) graduates across Tanzania, and eight in Sudan. Early feedback from faculty, department heads, and learners consistently highlighted the model's practicality, cultural relevance, and minimal disruption to clinical care—directly addressing long standing barriers associated with full day training formats.
Preliminary observations demonstrate:
• Improved trainer confidence and increased willingness among local teams to deliver training independently.
• Higher learner attendance and engagement, attributable to the short, flexible structure that fits within demanding ward environments.
• Strengthened interprofessional communication, with widespread adoption of ISBAR and safety huddles to coordinate care.
• Reduced hierarchical barriers, with nurses increasingly empowered to speak up, escalate concerns, and participate actively in decision making—marking a significant cultural shift compared with earlier years when escalation to doctors was rare.
• Enhanced clinical readiness, with staff reporting greater confidence in recognising deterioration, initiating structured assessment, and performing CPR where appropriate.
• Early clinical signals, including reports from one hospital of reduced infant mortality following introduction of the QuickPAIRS Newborn module (pending formal evaluation through the separate ethically approved TTT study).
The establishment of QuickPAIRS hubs in northern and eastern Tanzania—with additional hubs planned in western Tanzania, Sudan, and Malawi—demonstrates scalability and early sustainability. Local ownership is further evidenced by independent trainer led delivery, peer mentoring structures, and routine integration of micro teaching opportunities into daily clinical practice.

Conclusions

QuickPAIRS offers a feasible, scalable, and culturally attuned approach to paediatric resuscitation training in low resource environments. By reducing logistical barriers, embedding interprofessional collaboration, and integrating core clinical and communication skills into short, sustainable modules, QuickPAIRS supports meaningful culture change and improved team performance. The model demonstrates strong potential for long term local ownership, expansion across multiple regions, and future integration into national training strategies in LMIC contexts.

Supporting Documents

https://inhwe.org/system/files/webform/CHER2026_Abstract_QuickPAIRSInnovation.docx

2026397
Advancing Interprofessional Education Through International Digital Collaboration: Co-Design of a Pharmacy-Medicine COIL

Presenting Author(s)

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Background

Interprofessional education (IPE) is internationally recognised as essential in developing healthcare professionals who can collaborate effectively across disciplines to deliver safe, high quality and person-centred care. The World Health Organization (WHO) defines interprofessional education as occurring when two or more professions learn with, from and about each other to improve health outcomes. [1] Evidence demonstrates that structured IPE enhances professional role clarity, interprofessional attitudes and collaborative competencies. [2], [3] Sustainable implementation of IPE can be constrained by interpersonal, institutional and structural barriers. [4]

Context and Aim

Accreditation standards and European professional qualification frameworks increasingly emphasise demonstrable competence in interprofessional collaboration and communication as essential components of contemporary healthcare education across pharmacy and other regulated health professions. The development and accreditation of a new integrated Master of Pharmacy (MPharm) programme at South East Technological University (SETU) required design of a longitudinal IPE structure, as both a regulatory requirement and a strategic priority. 5,6 The development team at SETU, assessed and developed a plan for collaborative activities within their established suite of healthcare and science-based programmes. The absence of an on-site medical programme at SETU, however, limited opportunities for sustained pharmacy–medicine engagement. The participation of SETU as a full partner in the European University Alliance EU-Conexus offered potential for innovative, interprofessional education, with a partner University who provided a medicine programme at their site. This initiative therefore sought to develop and jointly integrate structured embedded interprofessional educational activities within EU-CONEXUS partner institutions: SETU and the Catholic University of Valencia (UCV).

Design and Methodology

An EU-CONEXUS mobility award enabled relationship-building and exploratory engagement, through which Collaborative Online International Learning (COIL), as developed by the SUNY COIL Center,[7] was identified as an appropriate mechanism to support internationalised IPE within the partnership. Subsequent EU-CONEXUS seed funding supported systematic curriculum mapping and structured knowledge transfer in COIL design and delivery from UCV to SETU faculty, delivered through online collaboration and in-person co-design workshops involving academic and educational technology staff from both institutions. The COIL model supports Internationalisation at Home by enabling structured international engagement without the requirement for physical mobility, thereby broadening access to global learning opportunities and enhancing inclusivity across student cohorts. The COIL is structured to enable pharmacy and medical students to engage directly in collaborative, case-based interprofessional learning activities designed to strengthen communication and shared clinical reasoning in preparation for collaborative practice. Delivering the IPE activity through a COIL model extends traditional interprofessional learning by incorporating structured international and digitally mediated collaboration, creating opportunities for intercultural exchange and exploration of differing healthcare systems and professional contexts. [8]

Planned Implementation and Implications

The COIL is in late-stage development with implementation planned, following piloting. The in-person aspect of collaboration particularly allowed for mapping of technological and logistical barriers to be explored well ahead of implementation. Structured student volunteer feedback will inform iterative refinement and ongoing curriculum enhancement. The initiative delivers sustainable international IPE through digital collaboration, preparing globally minded healthcare professionals for person-centred, collaborative practice.

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2026398
Innovating Together at Scale: How RCPI Is Building a National Interprofessional Workforce for Quality, Safety and Integrated Care

Presenting Author(s)

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The Royal College of Physicians of Ireland (RCPI) has developed an integrated, interprofessional educational ecosystem that strengthens leadership, quality improvement (QI), patient safety, and systems thinking across the Irish health service. This ecosystem encompasses the Advancing Leadership for Integrated Care Excellence (ALICE) programme, the Being Safe Together (SAFE) collaborative, and the Professional Certificate in QI Leadership in Healthcare (PGCert QILH). Together, these programmes build workforce capability for collaborative problem solving, integrated care, and safer clinical practice. Grounded in Sláintecare and national HSE priorities, RCPI's approach counters traditional professional silos by creating structured, psychologically safe learning environments where clinicians learn, practise, and lead improvement as interprofessional teams.

Interprofessional Design and Rationale

All RCPI programmes described here are explicitly interprofessional and team-based, with eligibility criteria requiring multidisciplinary participation. This design reflects the reality that no single profession delivers integrated care, and that siloed training contributes to fragmented services, communication breakdown, and variability in safety practices. Classroom-based interprofessional learning, combined with team-based workplace application, builds shared mental models, strengthens psychological safety, develops collaborative leadership, and improves the reliability of clinical systems across acute and community settings.

ALICE: HSCP Leadership and Integrated Care

ALICE equips HSCP teams with leadership and QI skills necessary to advance integrated care. Participants demonstrated major improvements in leadership confidence (38% to 93%), QI literacy (52% to 96%), and data capability (35% to 89%), alongside strengthened interdisciplinary teamwork (91%) and intention to lead future QI initiatives (72%). Team projects delivered measurable improvements in communication, access, flow, scheduling, and care coordination across acute and community settings.

SAFE: Safety Culture, Psychological Safety and Teamwork

SAFE is a national multidisciplinary safety collaborative that supports frontline teams to strengthen early warning processes, communication, and situational awareness through <10-minute daily safety huddles. Cohort-after-cohort, SAFE improves teamwork, psychological safety, and cross-disciplinary communication. In the most recent Cohort 9 (February 2026), 100% of teams implemented structured huddles, all used the SAFE script, multidisciplinary participation was high, and most teams continued huddles even in the absence of the original SAFE participants—evidence of culture embedding. All teams demonstrated measurable improvements in processes or outcomes, including acuity recognition, escalation reliability, and early identification of at-risk patients. MaPSaF (Manchester Patient Safety Framework) data across SAFE cohorts shows upward shifts in all ten safety culture domains, including teamwork, communication, learning, and systems awareness, demonstrating progression toward proactive safety culture.

PGCert QILH and System-Level Capacity Building

The Professional Certificate in QI Leadership in Healthcare supports doctors, nurses, HSCPs, and managers to develop advanced QI competence. Learners report improved ability to identify system risks, apply improvement tools, integrate human factors knowledge, and lead service-level change. RCPI collaboratives such as the national Stroke and COPD programmes have demonstrated improvements in door-in–door-out stroke times and timeliness of respiratory specialist review.

Working Group Alignment

RCPI's interprofessional programmes align with multiple INHWE Working Groups, particularly Interprofessional Education and Training; Leadership and Healthcare Management; Research in the Education and Training of Health Professionals; Health Workforce Policy and Research; and Caring for Vulnerable People. Each programme advances specialist educational practice, strengthens global networks for interprofessional learning, enhances knowledge sharing on team-based improvement, contributes to a growing evidence base on QI and safety education, and supports policy-level recognition of the importance of interprofessional workforce capability for integrated care.

Conclusion

Across ALICE, SAFE and PGCert QILH, RCPI has built an educational architecture that enables interdisciplinary teams to develop shared approaches to leadership, safety, and improvement. More than 2,000 staff have participated in structured QI and safety training, delivering more than 1,200 workplace projects with measurable impact on communication, patient access, flow, safety processes, and team functioning.

This integrated ecosystem demonstrates how interprofessional education—embedded in real practice, grounded in human factors principles, and supported by coaching and structured processes—creates the collaborative capability required for the future of integrated, people-centred care.

2026399
The Sodos: A family health history told using a structured IP simulation format

Presenting Author(s)

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Introduction

Meeting the SODOS cases are designed as interactive and experiential simulations, grounded in educational theory which teach both clinical reasoning skills and Interprofessional Healthcare competencies. These simulations focus on chronic health diseases using Social Determinants of Health (SDH) and health inequalities that negatively impact communities around the USA. This approach allows many different health professional student, from first year to more advanced, to participate.

These simulation cases are based on an educational model which scaffolds learning from concrete experience and information through to assessment and understanding of complex clinical IPE. Each case is designed as an IPE clinical progressive simulation that levels the learning playing field for students and has been repeatedly tested in different contexts and piloted at two University campuses in the United States of America (Rosalind Franklin University of Medicine and Science and the University of New England).

Methods

A Four-Stage Interprofessional Cognitive Learning model, incorporating experiential learning theory, metacognition and IPEC competencies was assessed for effectiveness over three studies using mixed methods to test for validity and reliability. The model incorporated peer to peer learning from concrete experience and preparation to student-driven active experimentation and evaluation of patient related information through the lens of health disparities. It was hypothesized that introducing information about health disparities at stage three (roles and responsibilities/metacognitive regulation/respect & diversity) would impact student monitoring, indicating that this was the point in which Metacognition was impacting learning.

Results

Three studies evaluated the effectiveness of the model as an educational framework through student and faculty assessment comprised of IPEC competencies and patient plans of care. Across the three studies four-hundred-and-twenty health professions students (Pharmacy, Physician Assistants, Podiatry, Path Assistants, Psychology, Physical Therapy, CRNA and Medicine) were either assigned to groups (IP, uni-professional, or individual learners) in lab settings or were assigned to IP groups in an educational setting. Results across all three studies showed significant changes in IPEC Competencies including the predicted dip in score when new information was presented to them. This suggests that model facilitates effective IPE learning through metacognition. Post hoc comparisons using Tukey's HSD indicated significant differences between the three groups over time and in the final plan of care. The Four-Stage Interprofessional Cognitive Learning model is effective as a framework for IPE.

Discussion

The educational results are robust and statistically significant suggesting that this simulation can be replicated across programs. Importantly, these are the only interprofessional simulations that we know of that includes and assesses clinical reasoning and IPEC competency skills. These simulations are effective in increasing students' understanding of clinical reasoning, the roles of healthcare professions outside of their own, improve teamwork and collaboration, and refine communication skills.

We currently have distinct, pre-recorded simulation scenarios for 5 family members addressing social isolation and Type 2 diabetes, HIV and domestic abuse, Pre-eclampsia and rural health, pediatric asthma, drug addiction and PTSD. Future simulations may include family members with genetic conditions (e.g. BRACA variants), mental health (e.g. stress, anxiety, depression), autism and/or ADHD and menopause.

2026402
Cultivating Collaborative Global Citizens: An Integrated Connect–Create–Celebrate Framework for Transformative Curriculum Design in Health and Social Care Education

Presenting Author(s)

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In a world marked by inequity, workforce strain and growing global interdependence, the question is no longer what health professionals should know - but who they must become. The complex nature of health and social care systems calls for graduates who can work confidently across disciplines, navigate cultural diversity, apply systems thinking, and demonstrate leadership in tackling global and local health challenges.1,2 Educators therefore have a responsibility to help cultivate graduates who see themselves not only as practitioners, but as collaborative global citizens.
The Connect–Create–Celebrate Integrated Framework offers educators a transformative approach to curriculum design in health and social care education. Underpinned by two teaching philosophies – humanistic3 and compassionate4 - the framework creates a holistic learning environment that nurtures all aspects of student learning – personal, professional and interprofessional. A systems-based framework, which at its heart integrates two pedagogies – global citizenship education and interprofessional education, it aims to position learners as collaborative global citizens. By adopting different pedagogies and teaching methods, it encourages educators and learners to explore key themes – collaborative practice and research, equity and social justice, ethical practice, cultural humility and sustainability.

The Connect phase builds global awareness, shared understanding and relationships across professions and cultures. The Create phase supports innovation, collaboration and transformative change through authentic, real-world tasks that foster co-creation, teamwork and professional and interprofessional identity formation. The Celebrate phase recognises personal, professional and interprofessional growth, impact, and shared achievements through collaborative practice. Together, these three phases provide a dynamic, student-centred teaching and learning environment that prepares future practitioners to navigate complexity, champion equity, diversity and inclusion and contribute meaningfully within local and global communities.

The strength of the Connect-Create-Celebrate Integrated Framework lies in its cyclical nature; allowing learners to move back into the “Connect” phase with new insights, relationships, confidence and relational capacity. This creates a sustainable culture of collaboration and global citizenship across professional programmes.

The 3C Integrated Framework offers a coherent blueprint for transformative change that advances collaborative practice, ethical engagement, and global responsibility. Whether educator or learner, we invite you to engage with the framework and reflect on how connection, co-creation and celebration can shape not only how we learn and teach, but who we become in service of communities.

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2026403
Interventions that facilitate cultural competence in prelicensure healthcare professionals: a systematic review

Presenting Author(s)

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Introduction
Currently, Europe hosts 31% of the global migrant population. Healthcare providers face challenges in meeting the cultural and health needs of diverse patient groups. These patients face additional challenges and barriers in accessing healthcare, resulting in increased morbidity and mortality rates. To address inequality, healthcare organisations need to ensure they have a culturally competent workforce. Given the numerous interventions reported to facilitate cultural competence, there is a need for robust assessment to evaluate their effectiveness. This study aimed to review the international literature to identify interventions effective in facilitating cultural competence among prelicensure healthcare students.

Methods
A systematic review of the international literature was conducted. Seven electronic databases were searched: MEDLINE, PubMed, CINAHL, APA Psy Info, Embase, Scopus, and Health Business and Health Business Elite. In addition, a search of the grey literature, repositories and citations was carried out. The findings were reported in accordance with PRISMA guidelines. Following abstracts review (5082), full text screening (184), 25 articles were quality appraised by two reviewers and analysed. A conceptual frame called “The Activate consciousness, Connect relations and Transform into true cultural care” (ACT) culture model was used to analyse the data.

Results
Twenty-five articles were quality appraised following the JBI criteria. The study designs included randomised controlled trials (n=5), quasi-experimental (n=19), and qualitative (n=1). The majority of interventions were delivered in the USA (n= 14). All studies that relied on self-reporting without a comparator were excluded. A narrative synthesis of the findings identified the following four themes: improved cultural knowledge, awareness, and sensitivity; improved therapeutic relationships; improved behavioural and practical skills; and improved self-perception and confidence.

Discussion
The findings indicated that cultural competency is less meaningful when delivered as a standalone or short intervention. Instead, it should be woven into curricula and revisited to enable the learner’s cultural competency to develop over time.

Conclusion
The overarching aim of the intervention is to ensure healthcare students as the future workforce possess cultural competencies and the ability to apply them in practice when caring for diverse patient groups in the clinical setting.

Supporting Documents
https://inhwe.org/system/files/webform/Support%20docs%206th%20International%20Congress%20of%20Health%20Workforce%20Education%20and%20Research%20%28Dublin%2C%20Ireland%29_0.docx

2026404
Educational experiences of GP trainees in obstetrics and gynaecology: results from a mixed-methods survey

Presenting Author(s)

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Objectives

Hospital-based placements in obstetrics and gynaecology (O&G) are an important component of general practice (GP) training, providing essential exposure to women's health, pregnancy care and reproductive health. The Irish College of General Practitioner's (ICGP) curriculum highlights the requirement for GP trainees to develop the knowledge, skills and attitude required to provide comprehensive care across the spectrum of women's health. Current literature on the experiences of GP trainees' hospital placements in O&G is both limited and outdated, predating significant changes in clinical practice, maternity care, and the GP training structures. Without contemporary data on how Irish GP trainees perceive the relevance, quality and educational value of their rotations, it is difficult to ensure that rotations are appropriately structured and resources align with competencies required for modern general practice.

The aim of this study is to evaluate the educational experiences of GP trainees during their O&G hospital rotations at Cork University Maternity Hospital as part of the ICGP training scheme.

Method

A cross-sectional mixed methods study was conducted and distributed online via Google Forms. All current GP trainees within the Cork ICGP training scheme who had completed a rotation in O&G at Cork University Maternity Hospital since 2022 were eligible to participate. Quantitative data were analysed descriptively, and chi-squared tests were used to examine associations between key variables, with statistical significance set at $p<0.05$. Free-text responses were analysed using thematic analysis, involving inductive coding, and iterative theme development. Quantitative and qualitative findings were integrated at the interpretation stage to inform key recommendations to improve the quality of education for GP trainees at our hospital.

Results

Of the 24 GP trainees that completed the survey, 87.5% had no prior experience in O&G prior to starting their rotation and two thirds reported not being prepared prior to commencing their rotation. Although 83.3% received a formal orientation at the start of their rotation, only one third of these felt that it helped them prepare for the placement. The role of the GP trainee within the O&G hospital system was not clearly defined for most (79.2%) and it was reported in 66.7% that there was an imbalance between service provision and educational opportunities. Post-rotation preparedness for managing women's health conditions in the community as GPs was not significantly associated with receiving formal teaching or feedback during the rotation, however assignment of a clinical supervisor during the hospital rotation, while not statistically significant, demonstrated a trend towards improved preparedness for community practice (68 vs 32%, $p = 0.051$). 83.3% of participants reported frequent symptoms of burnout and a lack of support in managing clinical activities was also highly prevalent, reported by 43.7% of survey respondents.

Thematic analysis identified three over-arching themes within the data: 1) systematic deficits in placement orientation and role clarity; 2) highly-valuable rotation with missed opportunities; 3) significant emotional burden and burnout. GP trainees at our hospital frequently reported that there was an expectation to perform procedures or counsel patients about gynaecological conditions without training or orientation within the service which was compounded by unclear escalation pathways for help. Opportunities for GP-relevant skill development were plentiful however these were often missed due to service pressures and rota shortages. Many participants reported a growth in the skills confidence and recognised this rotation as essential for future GP practice, however learning was often described as opportunistic rather than structured. Experiences of inadequate supervision and a lack of humility at the workplace contributed to feelings psychological unsafety and burnout during the rotation.

Conclusions

Results from this study emphasise that O&G is a highly valuable and clinically relevant rotation during the GP training scheme for future GP practice, yet its educational impact is inconsistent and largely dependent on service design and supervision. Opportunistic exposure to clinical scenarios improves GP trainee's confidence in managing women's health conditions, however improvements in rotation orientation, role clarity and balancing service-provision may enhance learning further. Our results support the implementation of a standardised orientation programme at the beginning of each GP rotation as well as the development of a formal GP-aligned curriculum with clearly defined learning outcomes. Protected access to GP-relevant clinical sessions and embedded supervision during the rotation is also important within our hospital system. Optimising the educational quality and relevance of O&G rotations for future GP trainees is essential to support the development of confident and competent GPs to manage women's health in community practice.

2026406
360o immersive virtual reality (VR): developing a generalist skills learning package for multiprofessional education - mutual gains for educators and learners

Presenting Author(s)

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Introduction

The East of England Multiprofessional Foundation School and Enhance Programme work in tandem to bring together early-career healthcare professionals to learn about, from and with each other. Together we provide a range of educational activities. These include one-off deep learning clinical simulation sessions and a series of development days to selected learners across a 12-month period. Both methods of educational delivery take a considerable amount of time and resources to organise and facilitate, with limits on attendee numbers.

In a bid to ensure that learners have access to meaningful educational experiences alongside and between these impactful face-to-face learning events, faculty from across both teams have collaborated to create blended learning options, including the use of “multiprofessional by design” immersive 360o virtual reality (VR) resources. VR is becoming increasingly accessible for healthcare professionals. With content accessible through various mediums, the creation of VR educational packages supports flexibility for learners, whilst providing the ability to interact with real-world scenarios in a safe environment.

To date we have produced:

- A 5-episode series following the journey of a patient with complex multimorbidity navigating the healthcare system. A key aspect of this series is in episode 2 where learners take the role of the patient to foster empathy and experience healthcare as a patient.
- A 5-part series on person-centred practice, highlighting a range of roles in the primary care workforce. This series features common illnesses which can be managed in the community (chronic diarrhoea, lithium shared care, sore throat, sinusitis and urinary tract infection (UTI)). Each storyline concludes with an expert panel discussion to showcase the range of knowledge and skills available within the healthcare team, supporting learners to understand how to work collaboratively for the benefit of patients.
- Rapid tranquilisation and de-escalation in Mental Health inpatient setting and an emotionally unstable patient journey from home to hospital.
- A standalone episode highlighting the challenges of access to healthcare services for those who live differently as part of the enhance social justice and health equity module.

The resources are freely available for all healthcare professionals to access nationally (1).

VR creation process

All resources have been produced in collaboration with actively practicing healthcare professionals from across the East of England. Collaborators also include subject matter experts from third party organisations, charitable and voluntary sectors, such as waterways chaplains, and input from carers and experts by experience.

The production of resources has consisted of a period of research and storyboarding, ensuring that the topics covered are timely and relevant to early-career healthcare professionals. We work closely during this process with the external production company who also provide advice and guidance, ensuring that recording of all desired aspects is practicable.

“Stop and think” moments are designed into each module providing opportunities for learners to reflect and consider wider aspects, both within and beyond the scenario which plays out in front of them. Examples of stop and think moments include opportunities to further explore the environment, options for differential diagnosis and time to consider other patient groups/populations which may be impacted by the scenario at play, as well as how these aspects relate to their own professional practise.

For each episode/part of a series, following filming and editing, feedback sessions are held with a wide range of stakeholders to collect and collate feedback. This feedback is used to strengthen the educational content by addressing gaps, ensuring accuracy, providing explainers where needed, and supporting the learners to find relevance of the material to their personal context.

Evaluation

Evaluating these resources is not straightforward. Our audience is wide, and most learners access the material in their own time and in different ways — some as part of structured programmes, others for self-directed CPD, and some using selected sections to support local teaching. This flexibility is a strength, but it makes consistent evaluation challenging.

Unlike face-to-face simulation, where we can gather immediate feedback and observe learning in action, asynchronous VR and modular content limit our insight into how deeply learners engage or how the learning translates into practice. Usage data alone does not tell us whether behaviour, confidence or collaborative working has changed. Where modules are adapted by semi-professional educators, the impact is also shaped by local context, making direct attribution more complex.

As the intended outcomes include system-awareness, collaborative behaviours and professional identity development, evaluation needs to move beyond simple completion metrics. A more layered approach, incorporating reflective feedback, follow-up discussions and alignment with wider programme evaluation. This is likely to provide a more meaningful picture of impact.

That said, this work represents an important starting point. Establishing accessible, high-quality multiprofessional digital resources lays the foundation for ongoing refinement and more sophisticated evaluation over time.

Benefits for educators

Whilst creating VR scenarios was done with benefit to learners in mind, importantly, the process of developing and facilitating these resources has also been developmental for our educators. Faculty from different professional backgrounds work collaboratively to script scenarios, shape patient journeys, negotiate authenticity, and make explicit the tacit knowledge embedded within their own practice. This process requires participants to articulate reasoning, challenge assumptions, and translate profession-specific perspectives into shared language. These are skills that extend beyond the educational setting and into everyday clinical practice.

Faculty also gain meaningful pedagogical experience in digital design, alongside new technical skills in VR production and delivery. In this way, the initiative contributes not only to learner development, but to growing faculty capability and confidence in innovative educational practice.

Conclusion

Virtual Reality can be a useful tool for early-career healthcare professionals to learn a range of topics in a safe "environment". Due to the nature of the access and use of VR, often asynchronously, evaluation with learners is challenging. However, amongst educators the learning from content design is deeply impactful for clinical practice, shared understanding and interprofessional working, whilst also supporting development of digital capabilities needed for educating into the future.

(1) Virtual Reality resources can be accessed here: https://learninghub.nhs.uk/catalogue/enhancinggeneralistskills?nodeId=5489 (free account required).

2026408
The Value of Interprofessional Continuing Education and Joint Accreditation

Presenting Author(s)

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Ms Kate Regnier, Executive Vice President, Accreditation Council for Continuing Medical Education, USA

Objectives
The objective of this study was to determine the impact of Joint Accreditation (JA) on accredited organizations. The purpose of this presentation is to disseminate those results and demonstrate how JA drives change through interprofessional education.

Method
Descriptive study based on Joint Accreditation Leadership Summit Reports from 2023 to 2025 and Data Reports from 2023 and 2024 to highlight observations, impact, and value of Joint Accreditation. Additionally, information on Joint Accreditation with Commendation is reviewed, summarised, and integrated with existing literature on interprofessional education to make the case for the value and impact of IPCE and Joint Accreditation.

Results
Across Joint Accreditation Leadership Summit and Joint Accreditation Data Reports (2023–2025), the Joint Accreditation enterprise expanded to 187 accredited providers in 2024 (up from 169 in 2023; +10%), delivering >123,000 accredited activities (vs 113,934 in 2023) and recording 34 million learner interactions in 2024. Providers represented diverse sectors, led by publishing/education companies (31%), hospitals/healthcare delivery systems (26%), and schools of medicine/health sciences (19%), and programming was delivered primarily as live courses and enduring materials (>90% of activities). Outcomes increasingly extended beyond knowledge acquisition, with 21% of activities (26,101) intended to improve patient health outcomes and 7% (8,719) intended to improve community/population health. Interprofessional engagement remained strong, with nurses, physicians, and pharmacists comprising the largest learner groups and 33,980,516 total learner interactions reported by profession in 2024. Since 2021, 48 providers have achieved Accreditation with Commendation, most frequently demonstrating impact related to factors beyond clinical care (39/48), population health collaboration (38/48), positive patient/community impact (32/48), and quality improvement achieved through the overall IPCE program (27/48), along with skills-focused evidence such as optimizing communication (18/48), technical/procedural skills (19/48), and team performance (16/48).

Conclusions
The Joint Accreditation programme has continued to grow and evolve in recent years. This growth and evolution are clearly demonstrated in the Joint Accreditation Leadership Summits, which showed growth in individual attendees and accredited organisations. The Joint Accreditation programme represents a powerful alliance between accrediting bodies and providers of IPCE and CE, driving the future of healthcare learning and practice.

2026409
Responsible Use of Artificial Intelligence (AI) in Accredited Continuing Education (CE)

Presenting Author(s)

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Artificial intelligence (AI)—including generative AI and other machine-based systems—is quickly transforming how accredited continuing education (CE) is planned, delivered, and assessed. This guidance from Joint Accreditation for Interprofessional Continuing Education presents a responsible-use approach that promotes innovation while protecting educational integrity, learner trust, and confidentiality. Key expectations focus on maintaining independence and reducing bias by ensuring AI-assisted or AI-generated outputs stay evidence-based, balanced, and free from commercial influence, with accredited providers remaining fully responsible for all educational decisions and content. The guidance also urges transparent disclosure of AI involvement when it significantly contributes to content creation or analysis (including tool name/version and purpose), and emphasizes strong human oversight to verify accuracy, identify "hallucinations," and detect bias before sharing. To safeguard privacy, the document stresses careful management of learner identity and sensitive information, avoiding PHI/PII on non-secure platforms, and aligning with institutional data governance policies. It also notes prohibited or high-risk uses that require additional scrutiny. Recommendations include internal governance practices—such as approved tool lists, training, auditing, and role-specific policies—to promote consistency and ongoing improvement. Overall, this guidance helps accredited providers incorporate AI as an aid (not a replacement) for human professional judgment, emphasizing transparency, accountability, and integrity as core principles for AI-enabled continuing education.

Supporting Documents
https://inhwe.org/system/files/webform/1099_20251125_Guidance_on_Artificial_Intelligence_in_Accredited_CE_JA_ANCC_0.pdf

2026410
Coloring outside the lines: Blending the borders of climate–health education

Presenting Author(s)

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Introduction

The growing convergence of climate change, environmental degradation, and global health challenges requires health professionals who can think and collaborate across disciplinary boundaries. Planetary Health and One Health frameworks highlight the interdependence of human, environmental, and societal systems, underscoring the need for integrative educational approaches that prepare future professionals to address complex climate–health challenges. University of New England (UNE) in the Northeastern United States responded to this need through collaboration between the Center to Advance Interprofessional Education and Practice (CAIEP) and the Planetary Health Council (PHC) with support from the University of New England College of Osteopathic Medicine (UNE COM), creating shared interprofessional learning events that link Planetary Health and interprofessional education (IPE). These initiatives are documented in two recent studies published in Frontiers in Public Health and Frontiers in Medicine, which describe the design, implementation, and evaluation of interdisciplinary climate-health learning events engaging students and faculty across multiple programs. Together, these studies explore how framing environmental challenges through a Planetary Health lens may strengthen interprofessional readiness by fostering systems thinking, collaborative dialogue, and awareness of the environmental determinants of health.

Methods

During event planning, organizers intentionally designed sessions to reflect widely recognized competency frameworks relevant to collaborative health practice, including the United States' (US) Interprofessional Education Collaborative (IPEC) Core Competencies, Planetary Health education principles, and public health professional competencies. These frameworks guided speaker selection, topic development, and the structuring of panel discussions to encourage systems-oriented dialogue across disciplines.

These events occur as part of a Knowledge Exchange (KE) series; accessible, interactive, exposure-level IPE sessions developed at UNE more than a decade ago. These events bring interdisciplinary learners together for a 50-minute presentation that blends interprofessional competencies with contemporary health related themes such as cultural humility, diversity, ethical dilemmas, power dynamics, social determinants, equity, climate change, and professional identity development. Knowledge Exchanges have proven effective in scaffolding early interprofessional awareness because they intentionally combine the US IPEC Core Competencies with social and cultural learning aligned with established pedagogical frameworks that emphasize the importance of early exposure, experiential engagement, and positive first encounters with collaborative practice. This entry level format has been a reliable modality for introducing learners to complex themes, such as the intersection of climate change and human health.

The majority of attendees at these planetary and human health events have been osteopathic medical students, reflecting a strong, growing interest, and increasing engagement with interdisciplinary, systems-based approaches to health. Osteopathic medical education in the United States emphasizes holistic thinking, with a professional identity grounded in the interconnectedness of body, mind, community, and environment. Within this context, the IPEC Core Competencies align naturally with osteopathic principles by promoting patient-centered care, collaborative decision-making, and respect for diverse professional roles and perspectives. Collectively, these competencies reinforce an osteopathic framework that prioritizes whole-person care, preventive approaches, and shared responsibility for optimizing health outcomes at both individual and population levels.

To evaluate participant experiences, post-event surveys were administered following each session with another scheduled event in Spring 2026 as part of the dataset. De-identified open-ended responses were compiled across events and analyzed using an inductive thematic approach. Responses were reviewed iteratively to identify recurring ideas related to perceived value, interdisciplinary exchange, and engagement with climate–health topics. The analysis focused on understanding how participants experienced these educational events.

Discussion

Event participants consistently emphasized the value of engaging with diverse disciplinary perspectives and accessible delivery formats. Survey responses from the Planetary Health event series indicated that learners appreciated hearing from speakers representing different professional and community viewpoints and valued opportunities to connect environmental issues with health practice. Flexible delivery formats, particularly virtual and hybrid sessions, expanded access and supported participation from learners across multiple programs and professional roles.

The design of these sessions also operationalized core principles associated with IPE and One Health approaches. By intentionally convening participants, both presenters and attendees, from medicine, public health, environmental sciences, and related disciplines, the events created learning environments where complex climate–health challenges could be examined through multiple lenses. Attendees frequently noted that this structure helped them recognize how environmental change, clinical practice, community health, and policy intersect. In doing so, the sessions functioned as practical demonstrations of interprofessional competencies such as shared problem framing, cross-sector communication, and collaborative understanding of systems-level health challenges.

The urgency of climate-related health threats further reinforces the importance of developing adaptable educational models that can be implemented across institutions and disciplines. The event-based format described in these studies represents one feasible strategy for introducing climate–health

concepts into existing educational structures without requiring extensive curricular restructuring. Such models can complement formal coursework by creating shared spaces where learners explore emerging issues collaboratively.

Finally, dialogue generated through Q&A at these events appeared to help participants identify connections that may not emerge within discipline-specific training environments. These discussions often highlighted links between environmental exposures, clinical care, community resilience, and policy responses. These exchanges suggest that structured interprofessional conversations may play a valuable role in helping learners integrate climate and Planetary Health considerations into their emerging professional identities and future practice contexts.

Conclusion

These events and analysis suggest that the CAIEP/PHC model offers a promising and scalable approach for introducing climate–health learning within IPE environments. By convening learners and faculty from multiple disciplines around shared planetary and environmental health challenges, the events created accessible entry points for discussing complex systems that link ecological change and health outcomes. Integrating Planetary Health and One Health perspectives with established IPE structures also appears to provide fertile ground for educational innovation, enabling learners to engage with climate–health issues through collaborative, systems-oriented dialogue. The next step for this work is refinement of educational goals, competencies, and analysis of achieved learning objectives. Continued collaboration among health professions educators, environmental scientists, and community partners will be essential for strengthening this work to prepare future professionals to respond to emerging climate-related health challenges.

2026413
Nephrology Workforce Sustainability in Ireland: A National Benchmarking and Dependency Analysis

Presenting Author(s)

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Objectives

In the context of increasing demand for kidney services, sustainable workforce planning is essential to ensure equitable delivery of kidney care. International workforce analyses demonstrate substantial variation in nephrologist density, with Western Europe reporting a median of 25.01 (IQR 16.37-33.92) nephrologists per million population (PMP), compared with a global median of 11.75 PMP.

Although Ireland has expanded its consultant nephrology workforce in recent years, questions remain regarding workforce structure, the contribution of Non-Training Scheme Doctors (NTSDs), an ageing consultant cohort, and comparatively slower growth in Higher Specialist Trainees (HSTs). This study evaluates national workforce trends and composition, benchmarks consultant nephrologist density internationally, and estimates benchmark-equivalent consultant workforce scenarios to 2040.

Method

We analysed national workforce data from 2021-2025 using secondary data from the Health Service Executive (HSE) and National Doctors Training & Planning (NDTP) medical workforce reports. Parameters included consultant nephrologist headcount, whole-time equivalent (WTE) capacity, age distribution, permanent and non-permanent appointments, NTSD and HST workforce size and trends.

Benchmark-equivalent consultant workforce scenarios to 2040 were estimated using Central Statistics Office (CSO) national population projections and the Western European first-quartile and median nephrologist densities reported by the International Society of Nephrology-Global Kidney Health Atlas, 2023 (ISN-GKHA).

Results

Between 2021 and 2025, consultant nephrologist density in Ireland increased from 9.78 to 13.73 PMP, remaining below the Western European first-quartile (16.37 PMP) and median (25.01 PMP) reference values. Consultant nephrologist headcount increased by 53.1% (49 to 75), while NTSD number increased by 59.5% (37 to 59), indicating an increasing contribution from the non-training medical workforce. HST numbers increased by 17% (35 to 41), substantially less than consultant and NTSD growth. In 2025, 16% of consultant posts were filled on a non-permanent basis, including temporary and locum categories, and 27% of consultants were aged more than 55 years. Under the moderate population projection scenario, the projected population in 2040 correspond to approximately 99 consultant nephrologists at the Western European first-quartile benchmark and 151 at the median benchmark.

Conclusions

Despite substantial recent workforce growth, important sustainability challenges remain, including slower growth in the specialist training pipeline, a growing non-training workforce, and an ageing consultant cohort. Future workforce planning should align specialist training with consultant recruitment, retention and replacement needs, while anticipating population-driven increases in workforce requirements. Planning for the wider kidney workforce and optimising multidisciplinary skill mix will also be important to support sustainable service delivery. Coordinated, forward-looking planning across training, retention and workforce skill mix will therefore be central to sustainable nephrology workforce development towards 2040.

Supporting Documents

https://inhwe.org/system/files/webform/Abstract%20Supporting%20Document.docx

2026415
Development, Implementation, and Evaluation of Interprofessional Disability Education Events

Presenting Author(s)

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Ms Chantal Lewis, Medical Student, University of New England College of Osteopathic Medicine, USA

Introduction
According to 2022 United States (US) Centers for Disease Control and Prevention (CDC) data, approximately 61 million adults (1 in 4) in the US live with a disability, with higher prevalence among adults aged 65 years and older, women, certain racial groups, and individuals with incomes below the federal poverty level.1 Globally, an estimated 1.3 billion people, approximately 15% of the world's population, live with some form of disability.2 The United Nations has described people with disabilities as "the world's largest minority,"2 highlighting persistent inequities in healthcare access and quality that contribute to poorer health outcomes.3 In response to these disparities, global health organizations, medical associations, and academic journals have increasingly called for the integration of disability education into medical and health professions education (HPE).4–6

While some US allopathic medical schools have begun to pilot and implement disability-focused curricula,7-11 widespread adoption remains limited. The Liaison Committee on Medical Education (LCME) does not currently mandate Intellectual and Developmental Disabilities (IDD) curricula for accreditation,12 and similarly, the Commission on Osteopathic College Accreditation (COCA) does not explicitly require IDD content in osteopathic medical education.13 Notably, there is a paucity of published literature examining disability education within US osteopathic medical schools, despite their emphasis on holistic, patient-centered care.

To investigate gaps in disability-related education, the University of New England (UNE) Center to Advance Interprofessional Education and Practice (CAIEP) collaborated with the Maine Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program. LEND is a federally-funded project aimed at expanding resources to individuals with Autism Spectrum Disorder (ASD) and other Neurodevelopmental Disabilities (ND) across the US. Together they developed a series of interprofessional Knowledge Exchange events designed to fulfill the Interprofessional Education Collaborative (IPEC) Core Competencies14 in areas not routinely addressed within individual health professions programs. Beginning in 2024, these events focused on disability, accessibility, and inclusive care through structured discussions, reflective activities, and participant surveys. Given limited research on integrating disability frameworks into HPE, particularly in an osteopathic context, this study provides a timely examination of students' engagement with disability education in an interprofessional setting.

The purpose of this study is to evaluate disability education within HPE through CAIEP and LEND Knowledge Exchange events by 1) assessing attendance across health professions schools; 2) examining the perceived impact of disability-focused events; 3) identifying opportunities for program improvement based on participant feedback; and 4) assessing the IPEC Core Competencies identified by participants.

Methods
This retrospective mixed-methods study analyzes quantitative and qualitative survey data collected from three completed CAIEP events held between 2024 and 2025 (n = 515), with an additional event scheduled for April 2026 (anticipated n = 150). The consolidated dataset will be analyzed to evaluate program impact across a two-year period.
Quantitative survey data will be analyzed descriptively to determine attendance by health professions students and to identify which IPEC Core Competencies participants reported addressing during the events. Qualitative data derived from open-ended survey responses will be analyzed using inductive thematic content analysis to capture participants' perspectives on disability education, accessibility, and inclusive care.

Purposive sampling was used to recruit UNE students enrolled across health professions programs, as well as community participants not affiliated with UNE. Participants self-identified during events and through post-event surveys. This sampling approach was appropriate for the exploratory qualitative focus of the study, prioritizing depth of insight over statistical generalizability.

CAIEP and LEND Knowledge Exchange events were conducted in both virtual and in-person formats and facilitated by UNE faculty or student facilitators. Structured discussion prompts and probes were designed to elicit narratives related to disability integration in educational and clinical training environments, while allowing participants to guide discussion content. Qualitative data will be organized and coded15 using Dedoose or a comparable qualitative analysis platform, with coding conducted iteratively to allow themes to emerge organically across sessions.

Results and Discussion
This study is expected to demonstrate strong student interest in disability-informed education and highlight the perceived value of interprofessional learning environments for addressing disability, accessibility, and inclusive care. Anticipated findings include increased awareness of disability-related health disparities, enhanced appreciation for interprofessional collaboration, and identification of curricular gaps within existing HPE.

Conclusion

Qualitative research offers rich, contextualized insight into learners' experiences and perspectives; however, its findings are inherently context-specific and may not be broadly generalizable. To strengthen the evidence base, future research should incorporate complementary methodologies, including quantitative surveys and longitudinal designs. Findings from this study have the potential to inform the development and expansion of disability education initiatives at the University of New England College of Osteopathic Medicine (UNE COM) and other health professions programs, addressing a critical gap in medical and HPE and supporting more inclusive, equitable healthcare.

Supporting Documents

https://inhwe.org/system/files/webform/INHWE%20Conference%20-%20Final%20Abstract%20-%20March%202026.pdf

2026416
Bridging Digital Skills Gap: Perspectives from Higher Education and Employers in Business and Health Sectors

Presenting Author(s)

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This study investigates the alignment between digital skills taught in Higher Education Institutions (HEIs) and those demanded by employers in the business management and health and social care sectors in the United Kingdom. Drawing on a qualitative research approach using primary data, the research explores how recent graduates and industry professionals perceive digital competencies and identifies strategies for more effectively integrating these skills into university curricula.

A total of 51 graduates and 7 employers participated in the study, contributing insights through surveys distributed via email, WhatsApp, and Microsoft Teams. The findings reveal a persistent gap between graduates' digital literacy and employers' expectations, particularly in data analysis, specialized software use, and digital communication. While basic proficiency in tools like Microsoft Office is common, both groups emphasised the need for more advanced, practice-oriented digital training.

Employers highlighted adaptability and digital fluency as critical yet underdeveloped attributes among recruits. The study concludes that bridging this gap requires a collaborative effort between HEIs and industry, including curriculum reform, simulation-based learning, and certification in emerging technologies. These findings contribute to ongoing debates about graduate employability and digital readiness, offering practical recommendations for educational policy and curriculum development.

2026417
It's a never ending story: Exploring Curriculum Tensions Through Complexity Theory

Presenting Author(s)

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Objectives

Prescriptive instructional design models based on instructional system theory, such as such as Kern's (2022) 6-step approach, envision a continuous quality improvement cycle. The implicit assumption of these models is that with resources and expertise, educators can revise and improve the curriculum to perfection. However from a complexity theory lens – health professions education can be seen as a complex adaptive system (Mennin, 2013; Van Beurden et al., 2011), suggesting that implementation challenges are often interrelated, dynamic tensions rather than problems-to-be-solved.

To explore this perspective further, we analyzed an established and recently revised curriculum: the Maastricht Master of Health Professions Education (MHPE). Founded in 1992, this part-time and largely distance-based MHPE program has consistently attracted an interprofessional and international audience of healthcare professionals aiming for a career in health professions education. In 2020, the UM MHPE program underwent a program redesign that aimed to innovate and align with developments in educational theory while at the same time increasing flexibility for students to adapt their learning trajectory and further stimulating interprofessional and international collaboration.

In 2025 we aimed to explore experiences with the revised curriculum using a complexity theory lens that helps us explore implementation tensions as seen from the perspective of faculty and staff.

Method

This study employed a qualitative case study design to investigate the complexities of curriculum redesign within a Master of Health Professions Education (MHPE) program. The analysis was guided by complexity theory, specifically the lens of paradox theory (Smith & Lewis, 2011). This theoretical framework views organizational tensions not as binary problems to be solved, but as persistent, interrelated contradictions that can yield generative outcomes if managed effectively. Applying this framework enabled a deep exploration of the competing demands inherent in implementing a learner-centered, programmatic assessment curriculum in a global context.

To understand the intended curriculum, we performed a document analysis. In parallel, to explore the enacted curriculum and diverse perspectives on instructional design, we conducted semi-structured interviews with a purposefully recruited sample of 11 faculty members actively involvement in curriculum planning and educational design and holding key responsibilities. The sample represented a broad spectrum of academic seniority, with professional experience in medical education spanning from four years to over three decades. This mix of administrative and pedagogical expertise ensured a comprehensive view of the design process from both strategic and operational levels.

The interview guide explored experiences with the redesign, implementation challenges, and tensions in delivery. Interviews averaged 45 minutes in duration and were audio-recorded and transcribed verbatim. Data were analyzed using an iterative thematic analysis approach, supported by Atlas.ti (web version).

Results

The analysis of document materials and interview data revealed seven implementation tensions experienced by faculty following the MHPE curriculum redesign:

T1: Learner Flexibility and Program Structure
T2: Self-directed Learning and Structured Support
T3: Coaching Relationships and Assessment Requirements
T4: Programmatic Assessment Ideals and Faculty
T5: Cross-Cultural Learning and Cross-timezone learning
T6: Interprofessional Learning and Disciplinary Dominance
T7: Integrated Competency Development and Distributed Coordination

Conclusions

These seven tensions reflect the multi-faceted nature of curriculum implementation, with each tension representing competing priorities (or polarities) that faculty need to navigate. We postulate that curriculum maintenance should focus navigating this complexity rather than aiming for the 'perfect curriculum'. In consequence, quality assurance procedures should not focus on uncovering 'problems to be solved' but rather on identifying tensions that can subsequently serve as basis for a nuanced discussion of advantages and disadvantages of curriculum choices, leading to balanced choices and acceptance of imperfection.

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2026418
Improvement of the Yale Medical School Pre-Clerkship Simulation Curriculum's Coverage of Sex-and-Gender-Based Health Determinants through AI-Guided Review

Presenting Author(s)

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Objectives

Yale Medical School utilizes a simulation curriculum to teach clinical management and communication skills to medical students. Over the course of their four years of education, students visit the Yale Center for Healthcare Simulation and are given over 40 high-fidelity, clinically relevant medical scenarios they must successfully manage. However, assessment of the current curriculum has revealed a need for a tool to efficiently evaluate the comprehensiveness of the content covered. Importantly, to develop skilled medical clinicians, medical school curricula must sufficiently cover the impacts of biological sex and gender as patient health determinants.

Method

In response to this need, the Yale School of Medicine Educational Technology and Innovation Team has worked in partnership with the Women's Health Research, Simulation Curriculum, and Medical Library teams to develop an AI-powered curriculum search assistant. This assistant leverages a multimodal large language model with a retrieval-augmented generation system to pull data from the 21 simulations covered in the Yale Medical School pre-clerkship curriculum. This tool is being used to identify gaps in the coverage of sex-and gender-based health determinants in the pre-clinical simulation curriculum.

Results

The search assistant identified six major areas of improvements to better address sex-and gender-based health determinants: 1) Better integration of sex-specific disease presentations across organ systems, including development of a simulation incorporating atypical myocardial infarction presentation in women. 2) Expansion of gender-diverse patient representation, including development of a simulation centered on a transgender woman experiencing osteoporosis with long-term hormone therapy use. 3) Improvement of sex-specific pharmacology teaching cases, with incorporated teaching about anticoagulants, antidepressants, statins, ACE inhibitors, and opioids. 4) Increased coverage of reproductive health conditions across all simulations, including discussion of the possible impacts of pregnancy, teratogenicity, and lactation safety in all females of reproductive age. 5) Systematic address of gender-based violence and trauma-informed care, including incorporating patient trauma history into existing simulations. 6) Addition of a "Diagnostic Reasoning and Bias" section to the simulation debriefs to allow for more focused discussion on the impacts of sex and gender health determinants after the simulation.

Conclusions

The tool's suggested improvements are being systematically collected and shared with the Simulation Curriculum Team at Yale to guide curriculum revision. This process demonstrates the potential for AI-guided programs to provide feedback on medical school curricula and ensure comprehensive content coverage.

2026420
Innovating Together: Co-Designing a Personalised Digital Resource for Head and Neck Cancer Care in Ireland

Presenting Author(s)

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Objectives
To collaboratively co-design a personalised digital cancer care resource for individuals with head and neck cancer within the Irish healthcare context, informed by patient lived experience and international best practice. The project seeks to demonstrate how collaborative, cross-disciplinary and cross-sector partnership, including engagement with digital health expertise in industry can support sustainable innovation in digitally enabled cancer care.

Method
Semi-structured interviews were conducted with adults in Ireland who had completed treatment for head and neck cancer, including surgery, radiotherapy, chemotherapy, or multimodal therapy. Disease subsites such as sinonasal, oropharyngeal, oral cavity, and laryngeal cancers were included. Interviews explored informational needs, self-management challenges and preferred digital features from diagnosis through survivorship. Thematic analysis identified core priorities. Findings were compared with a global review of cancer information websites to evaluate variability in usability, accessibility and contextual relevance. Insights informed iterative co-design discussions within an Irish interprofessional team including nursing, medicine and allied health, working in partnership with a digital health industry collaborator to ensure technical feasibility, user-centred design, data security, adaptability and scalability.

Results
Participants emphasised the need for trustworthy, jargon-free information regarding diagnosis, treatment pathways, side-effect management and recovery expectations. Key desired innovations included adaptive symptom tracking, integration of patient-reported outcome measures, psychosocial supports, evidence-based coping strategies and clear signposting to reliable Irish and international resources. The international review demonstrated wide variability in quality and accessibility, highlighting gaps in context-specific supports. Collaboration between clinical, academic, patient and industry partners strengthened the platform's usability, technical robustness and responsiveness to real-world care pathways and survivorship needs in Ireland.

Conclusions
Co-designing this digital resource illustrates how innovating together across healthcare disciplines with patients and alongside industry digital experts can generate scalable, equitable and sustainable solutions. Embedding collaborative practice within digital development supports workforce readiness for increasingly technology-enabled care environments. This Irish initiative provides a model for how healthcare, academia, and industry can partner to enhance outcomes across the cancer care continuum.

2026421
Building on What Works: Using Appreciative Inquiry to Strengthen Interprofessional Clinical Supervision

Presenting Author(s)

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Objectives

Interprofessional clinical supervision is central to preparing collaborative-ready graduates in health professions education. However, supervision practices are often developed within profession-specific contexts, limiting opportunities for intentional interprofessional learning. This study aimed to explore supervisors' experiences of effective supervision practices and identify strengths that could inform the development of an interprofessional clinical supervision model for undergraduate health and social science students. This study builds on a preceding systematic review that developed a comprehensive definition of interprofessional clinical supervision using a who, what, how, why, and when framework.

Method

An Appreciative Inquiry (AI) approach was used to explore existing supervision practices that work well in clinical education settings. Semi-structured interviews were conducted with clinical supervisors across departments and schools involved in undergraduate clinical supervision, with one to two supervisors purposively selected. Inclusion criteria required participants to be actively involved in supervising undergraduate students in clinical or community-based settings, while individuals involved only in academic or research supervision were excluded. Interviews explored experiences of successful supervision, strengths and enabling conditions within supervision practices, examples of collaborative supervision, and participants' visions of an ideal supervision model.

Results

Interview data were deductively analysed and organised according to four themes derived from the AI-informed interview guide: appreciating successes in supervision, exploring strengths and enablers, learning from collaboration, and imagining possibilities for an ideal supervision model. These themes highlighted supervisors' experiences of effective supervision practices, the contextual and relational factors that support positive supervision environments, the role of collaboration across disciplines, and opportunities to strengthen supervision practices within undergraduate health and social science education.

Conclusions

By focusing on existing strengths and effective practices, this study provides contextually grounded insights into interprofessional clinical supervision. The findings contribute to the development of a model that supports collaborative learning and strengthens supervision practices within undergraduate health professions education.

2026423
Globalising Chiropractic Education: Transnational Delivery, Regulatory Development, and Workforce Mobility

Presenting Author(s)

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Introduction

As healthcare systems evolve globally, the demand for clinically competent and registrable health professionals continues to grow. While much attention has focused on interprofessional education, less consideration has been given to how single-discipline health programmes can innovate through globalised educational models while supporting emerging regulatory frameworks. This paper presents two complementary case studies demonstrating how innovative education can contribute to both international workforce mobility and national regulatory development.

Transnational Educational Model

The first case study examines a multi-campus chiropractic education framework delivered across five campuses in Hong Kong, the United Kingdom, and Spain. This transnational model utilises blended learning to deliver standardised theoretical instruction through digital platforms while maintaining intensive, locally delivered practical and clinical training. Operating across multiple regulatory environments allows the institution to maintain consistent educational standards while exposing students to diverse healthcare contexts, fostering adaptability, mobility, and professional readiness.

Regulatory Development in Ireland

The second case study focuses on the establishment of the Master of Chiropractic (MChiro) programme delivered through a partnership between McTimoney College and Ulster University in Derry. As the first chiropractic degree programme on the island of Ireland, the programme serves as a proof of concept for domestic professional education during the Republic of Ireland's current risk assessment phase for statutory regulation. By providing clear educational standards and clinical training pathways, the programme contributes to the development of high-quality workforce data and supports government efforts to define professional scope and protected title under future legislation.

Implications for Workforce Development

Together, these models demonstrate how globally connected education systems can support both international workforce mobility and national regulatory clarity. Standardised curricula, blended learning delivery, and early clinical exposure ensure graduates develop the technical competence and adaptability required to provide patient-centred care across diverse healthcare systems.

Conclusion

Globalised educational frameworks have the potential to strengthen both professional standards and regulatory development in emerging healthcare professions. These case studies highlight how education can contribute to workforce planning, professional mobility, and evidence-informed policy development in evolving healthcare environments.

Supporting Documents

https://inhwe.org/system/files/webform/Late%20Submission%20Request%20for%20Consideration.docx

2026428
Towards a Person-centered care model in community mental health services

Presenting Author(s)

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Mental illness is widespread among adults and remains the foremost cause of years lived with disability. Despite its importance, there is a scarcity of research on person-centered care (PCC) from the viewpoints of mental health service users, particularly within clinical community mental health services. This study sought to investigate the potential for enhancing PCC through the lived experiences of individuals with mental health conditions who use local community mental health clinics (CMHC) in Malta. The goal was to obtain a thorough understanding of the current landscape, evaluate its strengths and weaknesses, and identify strategies for evolving the system towards a more PCC-focused model.

A qualitative research design was utilized, following the principles of Interpretative Phenomenological Analysis (IPA) as described by Smith et al. (2009). Ten participants from Malta, including six women, who frequently visit CMHCs, were recruited through intermediaries. Each participant took part in a one-hour semi-structured interview, conducted at a mutually convenient time and location. These sessions were audio-recorded and transcribed verbatim for subsequent analysis.

The analysis identified three main themes: Quality care, emotional support, and partnership and collaborative care, each comprising various sub-themes. The study illuminated both the strengths and shortcomings of the existing system and their implications for a PCC-oriented healthcare approach. While our findings reaffirm research on the critical role of empathy in care and other relevant factors, results also indicate that cultural factors in Malta, such as strong family ties, significantly influence the delivery of person-centered care (PCC), which may be relevant for other small communities. Furthermore, the research offers healthcare professionals (HCPs) a chance for ongoing professional development in accordance with the latest PCC principles.

2026429
Preparing Critical Care Teams: A Critical Care IPE Elective for Collaborative Practice

Presenting Author(s)

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Objectives

Effective critical care relies on teams whose members understand each other's roles, learn from the expertise of multiple disciplines, and collaborate in complex clinical environments. To better prepare learners for team-based critical care practice, an innovative interprofessional education (IPE) critical care elective was developed and offered to learners from multiple health professions disciplines to enhance role understanding, interdisciplinary information synthesis, and readiness for collaborative practice.

Method

A 12-week hybrid interprofessional critical care elective was implemented at a large academic health center and offered to learners from multiple health professions disciplines. The course combined asynchronous learning with experiential activities and was intentionally designed to prepare learners for collaborative practice in high-acuity clinical environments. Content was developed and delivered by an interprofessional faculty team, with discipline-specific instruction provided by experts including respiratory therapists, pharmacists, nurses, physicians, and other healthcare professionals. Weekly "Meet the Interprofessional Team" modules introduced learners to the roles, responsibilities, and scope of practice of each profession while promoting understanding of how disciplines contribute to patient care and team-based decision-making. Experiential learning activities included simulation, clinical shadowing, interprofessional rounds, and team-based rapid response exercises. Outcomes were evaluated using the Interprofessional Socialization and Valuing Scale (ISVS), reflective assignments, and qualitative feedback.

Results

Pre- and post-course ISVS assessments demonstrated improvements in interprofessional socialization, role understanding, and confidence in collaborative practice. Reflective assignments and qualitative feedback revealed an increased appreciation for the expertise and contributions of other healthcare professionals. Learners reported enhanced communication skills, greater understanding of team roles, and improved ability to synthesize information from multiple disciplines to support clinical decision-making in complex patient care situations.

Conclusions

As healthcare systems increasingly rely on collaborative practice models, innovative IPE approaches that strengthen role understanding, communication, and interdisciplinary learning are essential. This critical care elective provides a scalable model for preparing future healthcare professionals to function effectively within high-acuity teams. Findings suggest that readiness for critical care practice is strengthened not by mastering every discipline, but by understanding the unique contributions of team members and learning to work collaboratively toward shared patient care goals.

2026430
Reflecting Reality - Mapping Skin Tone Diversity in Undergraduate Medical Education Materials

Presenting Author(s)

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Objectives
People with darker skin tones remain underrepresented in undergraduate medical education, contributing to disparities in diagnostic confidence and clinical preparedness. This project aimed to (1) evaluate the representation of skin tones in undergraduate clinical teaching materials at the Royal College of Surgeons in Ireland (RCSI), (2) identify opportunities to improve the diversity and educational value of clinical imagery across the curriculum, and (3) develop a sustainable repository of high quality, diverse skin tone images to support more inclusive medical education.

Method
Clinical teaching materials, including lecture slides and educational videos, were systematically reviewed across undergraduate modules. Images depicting dermatological and non dermatological conditions were assessed for apparent skin tone using a modified skin tone classification system. Data collected included module, diagnosis, educational context, skin tone representation, and opportunities to improve diversity. An image repository was developed using evidence based educational resources to support future curriculum enhancement. Engagement with faculty members and key stakeholders informed recommendations for sustainable implementation.

Results
The project identified substantial variation in the representation of skin tones across teaching materials, with darker skin tones consistently underrepresented relative to lighter skin tones. Several common dermatological conditions lacked appropriate examples in richly pigmented skin, despite known differences in clinical presentation. The project produced a curated repository of over 300 clinically relevant images representing a broad range of skin tones and generated recommendations to support more inclusive teaching across the undergraduate curriculum.

Conclusions
Improving the representation of diverse skin tones in medical education is an important step towards reducing diagnostic disparities and preparing future physicians to care for increasingly diverse patient populations. This project demonstrates a practical and scalable approach to evaluating educational resources and provides a framework for integrating more inclusive clinical imagery into undergraduate medical curricula.

Supporting Documents
https://inhwe.org/system/files/webform/3.png

2026431
Purposeful Icebreakers in Interprofessional Simulation to Enhance Non-Technical Skills: A Critical Participatory Action Research Study

Presenting Author(s)

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Background
Full Patient Simulation (FPS) is a high-fidelity simulation which is widely used within interprofessional healthcare education to develop non-technical skills such as communication, teamwork and leadership. As healthcare professionals are often trained in silo's, integrating NTS with medical and practical knowledge is crucial for safe patient care. However, simulation environments can generate anxiety and hierarchical barriers that may limit student engagement. Icebreakers are commonly used in educational settings to build rapport and encourage participation, yet their use within FPS remains inconsistent and poorly defined.

Aims
This study explored how purposeful icebreakers can be incorporated into FPS sessions to enhance the development of non-technical skills among healthcare students.

Methods
A critical participatory action research design was employed across three iterative cycles. Data collection included live observations of FPS sessions and semi structured focus group interviews with interprofessional healthcare students. Reflexive field notes were used alongside qualitative data. Thematic analysis was conducted manually to identify patterns and themes emerging from the data.

Results
Four key themes were identified: interaction and trust, alignment of goals, communication and collaboration, and psychological safety. Initial observations revealed the absence of icebreakers and limited rapport between participants. Subsequent cycles implemented structured icebreakers designed collaboratively with students. These interventions improved engagement, fostered psychological safety and encouraged greater participation in simulation activities.

Conclusions
Purposeful icebreakers can positively influence the learning environment within FPS by strengthening psychological safety and promoting non-technical skill development.

Implications for practice
Structured icebreakers should be integrated into simulation design and facilitator training to enhance student engagement and learning outcomes.

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ABSTRACT BOOK

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