An Interprofessional Simulation Promoting Collaboration and Problem Solving among Nursing and Allied Health Professional Students

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Abstract: An interprofessional simulation was developed to improve collaboration and problem solving among nursing, radiologic technology, respiratory, and occupational therapy students. The learning objective of the simulation was to facilitate a mutual and professional respect among health care professionals in an educational setting that would be modeled in clinical practice. Instructors from each discipline collaborated on the learning objectives for the simulation. Each discipline specified the expectations and the perceived roles their student would have within the simulation. The simulation allowed students the opportunity to interact with each other to provide safe and effective care for a patient with multiple health care needs. The postsimulation debriefing allowed students to discuss how patient care was prioritized and coordinated by the health care team. The study results indicated that students felt the simulation provided for interdisciplinary team work and an environment that supported working in a clinical situation involving peers. Students reported that they were permitted to explore various paths of delivering patient care during the simulation and that independent problem solving was facilitated.


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Introduction

The cost of health care has risen to an unsustainable level without a sequential increase in patient safety. Cost is growing at a 7% rate; however, patient safety is improving by only 1% to 2% annually (National Quality Forum, 2009). Neither the cost nor the safety records are at acceptable levels. A major barrier to improving health care safety and reducing costs is ineffective communication and collaboration among health care professionals (Institute of Medicine [IOM], 2003).

A call to action has been sounded in the health professions. Improved communication, collaboration, and problem

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solving among health care teams through interprofessional education (IPE) are necessary (IOM, 2003). Teamwork and collaboration should be taught to students in prelicensure nursing programs to improve health care quality and patient outcomes. These pedagogic goals were identified by the Quality and Safety Education for Nurses (QSEN) consortium (American Association of Colleges of Nursing [AACN], 2010). The IOM (2003) also recognized that patient safety and outcomes addressing health care providers collaboration and communication were needed. The Committee on the Health Professionals Education Summit, which included leaders from allied health, nursing, medical, and pharmacology, recommended restructuring health care education. The summit vision concluded that “All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics” (IOM, 2003, p. 3).

The purpose of this article is to describe an interprofessional simulation exercise conducted involving students enrolled in four professional programs. Three learning outcomes of the simulation were assessed: (a) students’ perception of simulation as an interprofessional teaching strategy focusing on collaboration and problem solving, (b) student’s perception of the importance of simulation as a teaching strategy for collaboration and problem solving, and (c) student’s perception of each discipline’s role in health care. This paper describes the results of the interprofessional simulation.

**Literature Review: Use of Simulation in Interprofessional Education**

Simulation technology offers students an opportunity to actively engage in learning. Simulation intertwines evidence-based practice and patient safety to engage students. During the simulation, integration of safety principles and active participation occur as the scenario progresses (Galloway, 2009).

Simulation has been used successfully to implement active learning strategies among health care professionals. Medical students showed an improved understanding of clinical anatomy after participating in simulation (Johnston & McAllister, 2008). Simulation has been used for orienting surgical nurses to cardiac surgery (Rauen, 2004), developing nurse’s confidence in making emergency department triage decisions (Wolf, 2008), and enhancing nursing skills necessary for a bone marrow transplant unit (Kuhrik, Kuhrik, Rimkus, Tecu, & Woodhouse, 2008). Integration of didactic information and relationships among presenting conditions is often synthesized during simulation scenarios (Rauen, 2004). Although simulations have been successful, each of these studies described a simulation focused on a specific profession and did not involve IPE.

Teamwork between interprofessional health care providers is essential. The Agency for Healthcare Research and Quality (AHRQ) developed an evidence-based teamwork system to improve communication and teamwork skills with the goal of producing effective health care professionals who can potentially improve patient outcomes (2010). The United Kingdom’s Nursing and Midwifery Council recognized that nursing students need interprofessional standards to work with and learn from social and health care professionals (2010). An interprofessional health care team working toward the goal of providing the right services to the right patient at the right time improved patient outcomes regarding acute pancreatitis (Headrick & Khaleel, 2008). The Washington, DC American Health Education Consortiums (AHEC) developed an interdisciplinary curriculum targeting the medically underserved that involved four universities, 15 disciplines, and 16 clinics (Lambert, Stone, Cameron, & Hoar, 2010). To address the management of chronic conditions, coordinate care, and think collaboratively, several universities offer an interprofessional health science degree (Saint Joseph, 2010; Western Michigan University, 2010). The University of Maine offers an interdisciplinary training program for rural health care (University of Maine, 2010), and the University of Washington collaborated with AHEC to produce an interdisciplinary curriculum targeting nurse practitioners, nurse midwives, and physician assistants (Robert Wood Johnson Foundation, 2007).

Didactic and clinical educations are considered traditional teaching methods and are effective in teaching discipline-specific knowledge and skills. Yet students may not experience the collaboration and problem solving that takes place among disciplines until they work independently as licensed professionals. Even new nurses may experience limited critical experience during orientation. Simulations in a controlled environment that provide nurses opportunities to experience clinical situations involving team dynamics, communication, and problem solving enhances future performance and patient safety (Strouse, 2010).

In their position statement on Interdisciplinary Education and Practice, the American Association of Colleges of Nursing (AACN, 1995) recommended that educational programs seek IPE models and evaluate the outcomes. Despite the AACN’s recommendation, studies validating the combination of teamwork, interprofessional education, and simulation are lacking. Nursing and medical students used interprofessional simulation on a limited basis to improve communication during a mock code (Dillon, Noble, & Kaplan, 2007) and used an algorithm to treat pancreatitis (Headrick & Khaleel, 2008). Wilhaus (2010) recently reported collaboration among nursing, sports medicine, radiology, and criminal justice students. The simulations involved nursing in preparation, implementation, and data collection; however, the simulations did not allow for collaboration and interaction among multiple disciplines.
The literature provides little evidence that nursing and allied health professionals have jointly used simulation to enhance communication, collaboration, and problem solving. Although IPE is clearly needed and offers substantial benefits, simulation implementation faces several challenges. The challenges include additional physical space to accommodate a multidiscipline simulation center, the coordination of multiple schedules, and meeting each program’s specific accreditation requirements, particularly when considering clinical hours (Lambert et al., 2010). Another challenge is cost. High-fidelity simulators can be quite costly depending on the technological features chosen. Frequently, because of cost constraints, a start-up laboratory can afford only essential equipment (Nagle, McHale, Alexander, & French, 2009; Rauen, 2004). Maintaining small student groups during simulation uses the most effective teaching method, but staffing small sections presents an additional burden on limited faculty time and preparation (Gordon, Wilkerson, Shaffer, & Armstrong, 2001).

### Background

A recent employer survey conducted by the Baccalaureate Nursing (BSN) program at the University of Southern Indiana (USI) indicated that the program’s graduates performed well in the practice setting. Although the employer survey results were positive, one comment noted that the students lacked confidence in the acute care setting collaborating and prioritizing patient care as a member of a health care team. Based upon employer survey results, an interprofessional team of health care faculty developed a simulation scenario targeting collaboration and problem solving among nursing and allied health professional students.

During the same semester, the university offered a creative teaching enhancement award (TEA) to support the teaching—learning process. The team recognized that the award provided an opportunity to expand the use of simulation while focusing on student learning using interprofessional methods. The team applied for and received the TEA to create a designated simulation laboratory that would specifically enhance the student’s simulation experiences. The TEA made it possible to expand existing simulation laboratory and audiovisual capabilities. Budget restraints limited resources to actively include a large number of students for interprofessional simulation. With TEA funding, the faculty team purchased equipment that provided remote classroom viewing of live simulations, thereby increasing the number of student participants.

### Framework

The framework for the simulation exercise was derived from Benner’s theory (1984). The theory describes the use of paradigm cases or example case studies and previous experiences to create concrete learning situations. The expert nurse or health care professional assesses the patient holistically and problem solves based on previous experiences (Benner, 1984). When using paradigm cases, an opportunity to make independent decisions or to actively collaborate with the patient and other health care professionals is not present. “Simulations can be more effective because they require action and decisions from the learner” (Benner, 1984, p. 9). Benner’s theory, although focused in nursing, can be applied to allied health professional roles. During simulation activities, students of all disciplines interact collaboratively in a safe environment and opportunities to initiate the transition of a novice to a discipline’s expert are present. Limiting the student’s exposure to interprofessional experiences delays the novice to the expert transition, potentially compromising patient care (Benner, 1984).

### Methods

#### Participants and Setting

The clinical simulation center is located at USI within the College of Nursing and Health Professions and was opened in 2007. The center includes six adult and one infant patient high-fidelity simulators. The interprofessional simulation used a staged patient room equipped with a high-fidelity SimMan®, portable radiography unit, medications, and oxygen. The SimMan® was equipped with a two-way microphone allowing patient—student communication. Remote viewing of the live simulation was possible using an audiovisual camera.

Four health professional programs were involved in the simulation, including 79 baccalaureate nursing students, 15 baccalaureate radiologic technology students, 27 baccalaureate occupational therapy students, and 10 associate respiratory therapy students. The students’ previous simulation and clinical experience varied. The radiology students had four semesters of clinical and two semesters of simulation experience. Nursing students had one semester of clinical and simulation experience. The respiratory therapy students had one semester of simulation experience, but no clinical experience. Occupational therapy students had no simulation or clinical experience. To accommodate four program schedules, it was necessary to combine students with varied clinical and simulation experience. The faculty in each discipline chose the specific course for participation based upon the simulation content, the student’s academic level, and the simulation time and schedule. See Table 1 for the clinical experience summary.

Faculty simulation experience varied. Of the four disciplines involved, the nursing faculty had the most hands-on experience implementing simulation scenarios. Nursing faculty received two days of formal Laerdal® simulation training in Baltimore, MD. Respiratory faculty
attended an on campus one-day Laerdal® training. Radiology and occupational faculty had no formal training and had limited simulation experience. Because of the varied simulation experience, nursing faculty took the lead in simulation implementation.

Permission was obtained from the university’s institutional review board to collect data following each simulation. No grades were given for the simulation; however, the laboratory experience was counted as clinical hours, and attendance was therefore required. Students were informed that they would be asked to complete an evaluation after the debriefing period and that the results would be used to assess the interprofessional simulation. The sample included freshmen to senior level students, 87.7% females, one associate degree program, and three baccalaureate programs.

After the group debriefing, students were asked to complete the Educational Practices in Simulation Scale (EPSS) and the Healthcare Provider Priority Survey (HPPS). Students were given 20 minutes to complete the questionnaires. All student participants completed the evaluation tools.

### Teaching Strategy

The student activities essential for patient care in each discipline were identified by the team’s faculty. The faculty recognized that the students may have a limited understanding of each profession’s role. Therefore, a video presentation was developed outlining each professional role involved in the simulation. All students viewed the video via the Blackboard® online learning system. During the simulation briefing, the learning objectives, the debriefing schedule, and a clinical simulation center orientation were reviewed. At this time, students could ask the faculty questions concerning the simulation expectations, roles, and scenario. Students who had limited simulation experience asked questions concerning the patient’s communication ability. Other questions focused on when students could be expected to enter the simulation scenario.

In order to accommodate all students within the four courses, the simulation experience was repeated four times throughout a 16-week semester. Seven students were physically involved in each simulation. Participants included two nursing students, two radiologic technology students, two occupational therapy students, and one respiratory therapy student. The remaining students, who served as observers of the simulation, numbered 20 nursing students, 2 radiologic students, 5–8 occupational therapy students, and 1–2 respiratory therapy students.

Because of the large number of students attending each simulation, the faculty in conjunction with the university instructional technology team created a hospital-like environment that could be remotely viewed in a classroom. Remote viewing accommodated the large number of students who would have otherwise been unable to participate. The students not physically present in the simulation were actively involved in the simulation by completing an observer checklist and postsimulation debriefing participation. Appendix A includes the observer checklist details.

### Simulation Design

A high-fidelity SimMan® represented a 56-year-old male with a suspected paralytic ileus and history of chronic obstructive pulmonary disease (COPD). All students were given an oral patient report before the simulation concerning the patient’s medical history, chief complaints, and ordered procedures. To create realism, a patient chart was available for students with physician orders and interventions. Orders and interventions were discipline-specific and targeted specific assessments and tasks. Appendix B shows the patient and procedure order details.

The nursing student’s role was to perform a focused patient assessment and recognize patient needs. The physician orders directed the nursing students to insert a nasogastric (NG) tube, request a follow-up radiograph, and administer patient-requested medications. The nursing student’s decisions directed the intervention’s sequence and each discipline’s involvement. As students from each discipline entered the scenario, collaboration and prioritization among the team was necessary to implement appropriate patient care.

During the nursing assessment, the respiratory therapy student entered the patient’s room and explained that a routine breathing treatment for COPD was needed. The nursing student and respiratory therapy student decided collaboratively whether they should continue with the NG placement or stop to give a breathing treatment. After

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### Table 1 Demographic Data

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Program degree</th>
<th>Level of student</th>
<th>No. of previous clinical semesters</th>
<th>No. of students in each discipline</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>Baccalaureate</td>
<td>Juniors</td>
<td>1 semester</td>
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<td>8</td>
<td>71</td>
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<tr>
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<td>5</td>
<td>22</td>
</tr>
<tr>
<td>Radiology</td>
<td>Baccalaureate</td>
<td>Seniors</td>
<td>5 semesters</td>
<td>15</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Respiratory</td>
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<td>Freshman</td>
<td>None</td>
<td>10</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td>131</td>
<td>16</td>
<td>115</td>
</tr>
</tbody>
</table>
several minutes, the occupational therapy student arrived and stated that an assessment of the patient’s activities of daily living and coccyx wound was needed. At this point, three students were present and needed to communicate and decide upon priorities concerning patient care.

When requested by the team, the radiology students responded by bringing the portable x-ray unit to the patient room. Assessment, movement, and positioning of the patient for the desired radiographs required collaboration among nursing, radiology, and occupational therapy students. The students coordinated the medical care, problem-solved, and decided which treatment was of the highest priority. For a successful patient outcome, communication and collaboration among the students proved essential.

One additional role assumed by a student in the simulation was that of the patient’s wife. Students participated in this role and interacted with the simulation’s health care providers. Students acting as the patient’s wife were given cues to use during the simulation. As the family members engaged in the simulation, the students could use therapeutic communication and provide family education.

Students who viewed the simulation remotely completed an observer checklist and made notes. During debriefing, they shared their observations with simulation participants. The observation checklist guided the students’ postsimulation discussion and debriefing focusing on safety and communication. To provide students a nonjudgmental communication environment to debrief, two sessions were held. The first debriefing session was conducted for each specific profession simultaneously. This debriefing encouraged frank discipline-specific group discussion and students an opportunity to communicate their feelings and frustrations.

The second debriefing, an interprofessional discussion among all students and faculty, followed and allowed discussion of the patient’s priority needs, team communication, problem solving decisions, and professional roles. During the group debriefing, students talked openly about the feelings of chaos, confusion, and methods they could use in the future to facilitate communication, collaboration, and problem solving. During this time, the group shared profession-specific knowledge. An example was the knowledge concerning the inclusion of a chest radiograph in an abdominal series. This was new knowledge for non—radiology technology students. Therefore, students discussed how they could appropriately complete the chest radiograph to evaluate the patient’s declining respiratory status. A second example was the respiratory therapy students sharing information concerning the use of a nasal cannula in the oral cavity to maintain oxygen saturation during NG tube placement.

Measurement Instruments

Two tools were used to assess the student’s perception of the simulation. The first tool was the Educational Practices in Simulation Scale (EPSS) provided by the National League of Nursing (NLN) and Laerdal. The second tool, entitled the Healthcare Provider Priority Survey (HPPS), measured qualitative data and asked the students to list their opinions. Each evaluation tool was marked with a number that corresponded to a student. Students were reassured that the evaluation would be kept confidential and used for identification of each discipline.

The EPSS was used to measure the student’s perception of the use of simulation as an interprofessional teaching strategy for collaboration and problem solving and the student’s perception of the importance of the use simulation as an interprofessional teaching strategy for collaboration and problem solving (Jeffries & Rizzolo, 2006). Advanced approval to use the EPSS for the 2009 spring semester was obtained from the NLN. Cronbach’s alpha, measuring the tool’s reliability, was 0.86 for simulation practice and 0.91 for the importance of the items.

Five selected statements were extracted from the EPSS questionnaire to measure the student’s perception of collaboration and problem solving during the simulation and the importance of collaboration and problem solving (Table 2). These five statements specifically addressed collaboration and problem solving. A 5-point Likert scale ranging from 1 (strongly disagree/not important) to 5 (strongly agree/very important) was used to quantify student responses.

Three nursing faculty specifically designed a tool, HPPS, measuring students’ perception of the simulation experience. The HPPS measured the student’s perception of each discipline’s role and priorities during the simulation (Appendix C).

Results

Educational Practices in Simulation Scale

EPSS questions yielded response with a mean of 4.0 or greater indicated that students agreed that the item was present during the simulation. Each item’s importance was measured as high when the mean was 4.0 or greater (Table 2).

The students felt that the simulation provided interdisciplinary teamwork and an environment that supported working in a clinical situation involving peers (M = 4.43). Students noted that during the simulation, they worked together with their peers on the clinical situation (M = 4.40). Students scored lowest (M = 4.12) the statement that the simulation provided adequate information in a clear manner to problem solve the situation; however, they felt that independent problem solving was facilitated (M = 4.33). The statement “I was encouraged to explore all possibilities of the situation” was scored M = 4.18. Students reported that they were permitted to explore various paths of delivering patient care during the simulation even though the statement was scored lower than the others (M = 4.18).
Healthcare Provider Priority Survey

The qualitative results from the HPPS indicated that recurring common themes existed among the student’s perception of the professional roles. Each student, after considering the three other discipline’s activities, listed three priority activities for each discipline. Student responses were then compared across the four disciplines (Table 3).

The nursing students noted that their primary role was assessing the lungs and administering oxygen before inserting the NG tube. Respiratory therapy, radiologic technology, and occupational therapy students felt that the nursing students should insert the NG tube and expected the respiratory therapy students to give a breathing treatment. In addition to giving the breathing treatment, the respiratory therapy student was expected to stabilize breathing and maintain the oxygen saturation levels.

All four professions felt that the radiology student’s primary role was to obtain the needed images and check NG tube placement. The second priority listed by the radiology student was knowledge of radiology exposure techniques, such as using the lead apron and clearing the room of visitors. The other three professions did not address the radiation exposure safety issues.

The most diverse student opinions concerned the occupational therapists’ role. Nursing and occupational therapy students noted that assessing the wound and rendering wound care was the therapist’s primary concern. Respiratory therapy students expected the occupational therapy students to offer their help in whatever was needed at the time. The radiologic technology student expected the occupational therapy student’s assistance moving and positioning the patient for the radiograph. Three nursing students readily admitted that they did not know what the occupational therapy student’s role was during the simulation.

The student’s opinions validate the need for increasing communication, patient safety, and problem solving using interprofessional education (IOM, 2003).

Debriefing

During the debriefing period, the roles and expectations were openly discussed. Students were surprised to learn that radiology uses the term decubitus to describe a position and that an abdominal series included a chest radiograph. Nursing students wanted to intervene in maintaining oxygen levels despite the fact that the respiratory therapist was present.

The students actively involved in the simulation reported a feeling of chaos during the simulation. Discussion ensued that a sense of chaos is not uncommon in today’s health care setting when different health care providers are involved in simultaneously rendering patient care. The students felt that nurses are often the primary provider of patient care and are responsible for the prioritization and coordination of all patient services. The ability to
coordinate care is not based exclusively on individual knowledge of the patient, but is reliant on collaboration among health care professionals to obtain pertinent information to make good clinical decisions (QSEN, 2010). The need to work collaboratively was reinforced after the simulation exercise.

During the simulation, students noted that they had an opportunity to learn, make mistakes, and not fear compromising patient safety. One example included a dilemma for the nursing and respiratory students requiring the students to decide whether the NG tube should be placed or the patient’s oxygen saturation level maintained. A second example was the radiology student’s suggestion that the chest radiograph could be completed without the NG tube placed and the abdominal images could be completed later. While interacting with each other during the scenario, students demonstrated collaboration and problem solving skills. Students stated that during traditional clinical experiences, they are not often given opportunities to use problem solving skills and are frequently excluded from collaboration involving patient care. Reflection on the simulation experience and discussion of improvements that could be made by sharing knowledge and respecting professional roles were considered essential debriefing outcomes.

Discussion and Implications

Acknowledgement and understanding of health professionals’ roles can impact the communication and collaboration that occurs. Collaboration and problem solving skills are imperative and lead to good patient outcomes and reduce health care costs (Joint Commission, 2008; AHRQ Quality Indicators, 2006). The development of these skills needs to be included in the education of student health care professionals. Interprofessional activities can and should be an essential part of nursing and allied health professional educational curriculum. Educational programs and faculty that meet resistance and barriers in the implementation of IPE activities should be diligent to overcome these obstacles. Educators should role model collaboration in the development and implementation of IPE strategies.

This study supports simulation as an effective method for teaching collaboration and problem solving among student health care professionals. The simulation provided students with an opportunity to explore and understand the roles of the other health professionals. The data collected revealed that students perceived that an environment was provided supporting teamwork, collaboration, and problem solving.

The statements that the students scored the lowest addressed having adequate information to solve the problem and that they were encouraged to explore all possibilities of the situation lowest. In future simulations, teaching methods that provide additional information to the student before the simulation should be considered. Faculty must...
also be aware that students felt that they could not explore all possibilities of the situation and critical thinking exercises to assist the student in considering alternative options could be developed.

With budget constraints, interprofessional simulations reduce costs and required physical space. Combined simulation experiences reduce faculty workload related to simulation development and implementation. Interprofessional simulations relieve laboratory scheduling constraints, meeting multiple program needs.

Limitations

Differences in the student’s educational levels posed some challenges to the simulation. Students at the senior level had more clinical exposure and opined that they had a higher comfort level while working among the health care team. Students at the higher educational level readily stated that they found the interprofessional opportunity very important, while students in the early educational stages did not feel that the interprofessional simulation was essential.

Before the simulation, students’ perception of other health professional roles and priorities were not measured. Assessing students’ baseline knowledge of other professional roles may change HPPS results.

Another limitation includes that this is one university in the Midwest that offers specific allied health profession majors. These data may not apply to other settings with distinctly different disciplines and levels of students.

Future studies of IPE simulation could include student comparisons based upon professional discipline, educational ranking, and clinical experience. An opportunity exists for the evaluation of progressive IPE simulations throughout the baccalaureate programs. The evolution of collaboration and problem solving to assess the transition from novice to expert can also be initiated in the educational setting.

Conclusion

An interprofessional simulation was successfully implemented among four disciplines. Students from each discipline participated in IPE, assessed the activity, and concluded that IPE simulation provided an effective learning environment and is valuable in their coursework.

The students provided interesting perspectives concerning individual discipline roles during the simulation, noting that the roles were often different than their general beliefs. The opinions of the students reinforced that interprofessional education is needed to understand each discipline and increase good communication among health care providers. The faculty will continue using the interprofessional scenario’s implementation in future courses.

To facilitate a change in the education of today’s health care professionals, creative interprofessional educational strategies are needed. According to Benner’s theory (1984), nursing knowledge is attained through real life learning experiences. When students are involved in experiential learning and problem solving, the novice to expert transition occurs. Traditional clinical settings do not readily offer students interprofessional experiences. By using common problems frequently encountered in the health care setting, IPE simulation offers critical thinking opportunities. This interprofessional experience offered, to four disciplines, a safe haven to practice communication skills increasing collaboration and share knowledge. Students who engage in interprofessional educational activities will be better prepared as productive health care teams contributing patient care effectiveness, efficiency, and safety.

References


Interprofessional Simulation among Nursing and Allied Health Students


