Collaborative Learning in Practice (CLiP) for pre-registration nursing students.

A background paper for delegates attending the CLiP conference at UEA on Thursday 18th September.

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Aim

This purpose of this paper is to provide delegates with contextual information about the Collaborative Learning in Practice (CLiP) Project. The project is at a pilot stage, exploring whether aspects of an established model used at VU University Medical Centre Amsterdam (VUmc) to support student learning in practice have potential in a UK setting. The project is being undertaken jointly by UEA School of Health Sciences; NHS Practice Education Partners and NHS Health Education East of England (HEEoE) in consultation with VU University Medical Centre Amsterdam (VUmc).

Further information about the CLiP project pilot study will be presented during the conference.

Introduction

Learning in practice is a vital and substantial component of all health professional preparation programmes, comprising some fifty percent of dedicated learning time. It is through learning in practice that students develop many of the competencies, attitudes and values as well as the skills of person centred caring. The organisation and provision of effective learning in practice relies on strong partnerships between health and care providers and Higher Education Institutions (HEIs) and, in the UK, with Health Education England and the professional regulatory bodies. From the perspective of students, each practice placement is designed to support learning and achievement at a particular point in the programme. For placement providers, supporting students is a responsibility but a welcome opportunity to grow the health care workforce. HEIs that provide health professional programmes are not only attuned to the challenges of the real world of health care and the commitments of the NHS Constitution to the public, but are deeply invested in the co-development of successful models of practice learning.

The first Independent Inquiry of The Mid Staffordshire NHS Foundation Trust (Francis 2010) raised questions about the quality of care provided by nurses and their competence. This has resulted in closer scrutiny of pre-registration nurse education. A subsequent report on pre-registration nurse education commissioned by the Royal College of Nursing stated that "The commission did not find any major shortcomings in nursing education that could be held directly responsible for poor practice or the perceived decline in standards of care." (Willis Commission 2012:6). However the authors identified a number of areas in need of strengthening to reinforce the value of nursing as a profession. A key theme within the report was 'learning to nurse', and the importance of situating practice learning as central to developing a competent and compassionate nursing workforce. Thus the challenge of providing appropriate practice settings, mentorship and leadership skills have been issues that both HEIs and practice education partners have grappled with for many years. This paper

describes a pilot project that introduces a new way of practice learning for pre-registration nurse education that directly addresses some of these challenges.

Background

Locally, in response to the early findings of the Mid Staffordshire NHS Foundation Trust, we worked to strengthen further our methods for collating and feeding back practice evaluations from students and mentors to practice education providers. With some exceptions, most student feedback relating to their practice placements described positive learning experiences with mentorship delivered by mentors who were committed, inspirational, and 'went the extra mile'. Where experiences were reported as being less positive they were often associated with staffing constraints, the time available for learning, increased workload of staff, and the impact of organisational re-structuring. The feedback from mentors suggested that most mentors valued their role but were sometimes put in situations with competing priorities whereby they were often unable to exercise their role to the best of their ability. These emerging themes were not different from any of the parallel research on student experiences in the practice setting and the quality of the practice learning (Willis Commission 2012). However, we were struck by an emerging sense from mentor evaluations that mentorship was experienced by some as a 'burden' even though our approach locally has been of one student per mentor (Figure 1). It was becoming apparent that from the perspectives of both students and mentors, that although our organisations were focussed on the NMC Standards for Learning and Assessment in Practice (NMC 2008) and the requirement that at least forty percent of student time must be spent with their named mentor, there were opportunities for new approaches to enhancing practice teaching and learning. In a climate of greater skill mix, a shrinking pool of qualified mentors and increasing student numbers, this model of mentorship has arguably become unaffordable and unsustainable.

VU University Medical Centre Amsterdam (VUmc)

The University of East Anglia had an existing memorandum of understanding with VUmc to facilitate collaborations in research and teaching. During a visit to VUmc in 2013, we had the opportunity to see their approach to managing practice learning. Following the initial visit, UEA has facilitated two further visits to VUmc (with funding from Health Education East of England to support the costs of travel) to enable a number of lead nurses, experienced ward managers and link lecturers to see the model for themselves.

VUmc refer to their approach to supporting day to day learning in practice as the 'Real Life Learning Ward'. The approach is intensely student centered and based on coaching principles. Typically up to 20 students are placed together in a learning environment. On each 'shift', two to three students are supported by a 'coach' to provide the total care of a group of patients. The coach who is a registered nurse and mentor is entirely freed up from their clinical responsibilities on that day to support the students to plan the care and to be present as the students as provide the care. The learning is attuned to the level of experience of the students and they have found this a very valuable way to learn. The quality of the interactions that we observed between coaches and students appeared to be excellent. Each ward has a learning resource room for students and a full time Clinical Educator employed to support coaches and mentors in two ward areas. We understand that patients value the increased contact they have with students who have time to care for them.

Conceptualising a new model of learning in practice.

Our experience from visiting VUmc identified two key differences between what was being delivered in Amsterdam and what we delivered in the UK. The model is distinct from the traditional mentorship model (Fig.1) in both the way practice learning is organised and in the

philosophy that underpins how students learn in practice. Organisationally, under the new CLiP model (Fig.2), rather than working individually with a mentor, students work collaboratively alongside other students under the guidance of a day coach. Typically, on any particular shift, one day coach will be responsible for a group of patients, the care of whom is primarily delivered by students. Coaching underpins the philosophy of learning so that students are supported to take on greater responsibility for their learning and the learning environment embraces a culture of valuing student-focused solutions to care.

Organisation of learning. This is underpinned by the notion that coaches deliver care to patients but this is done through the students.

- A key principle is that the coach should be a registered professional, not necessarily a qualified mentor, and that for each particular shift, their responsibility is restricted to coaching and excludes any other ward management activity. In this way only one nurse might be involved with student supervision thereby freeing up other registered nurses to focus on patient care, ward management or other tasks.

- One coach usually supports up to three students. A mixture of students at different stages of their course are allocated to wards encouraging peer learning among first, second and third year students working together. This also increases the capacity for the number of students per shift with wards taking up to twenty students. However, this is variable depending on the type and size of ward, dependency of patients, and complexity of care.

- Normally students are allocated 1-3 patients but this is commensurate to their level of training, their stage of personal development and the learning outcomes expected to be achieved. This approach not only has a strong person-centred care focus but also gives students time to learn.

- As the coach's only focus for the shift is to supervise students, they have the time to teach.

- The day is highly structured with analytical case discussions at the beginning, through the day and at the end of the shift. Students are able to access the resource room during their

shifts to develop their knowledge in relation to the care they are delivering. They are expected to select case studies and present these jointly or individually to their peers and practice staff.

Philosophy of Coaching. There is much debate about the similarities and differences between coaching and mentorship but for us there are some key differences which stand out:

- We observed that coaches deliberately 'stood back' to create a student led learning culture. Simple measures such as encouraging the student to introduce themselves to their patients first and then the coach following behind five minutes later reinforced this approach. Students are expected to come prepared for the shift identifying the learning outcomes they wish to achieve and are encouraged to articulate how these might be met.

- We noticed the student/coach conversation was less 'telling and teaching' and more 'questioning, enquiring and prompting', encouraging students to provide solution focussed care and to assume responsibility for the care they plan and deliver.

- Coaches created a positive learning environment underpinned by a culture of valuing, encouraging, learning by doing, positive reinforcement enhanced by consistent and timely feedback.

- Coaching is embedded within the ward culture, all nurses have the opportunity to coach but this is not mandatory for individual members of staff. There is recognition that for some nurses, supporting students is not a strength and unwilling coaches do not make good coaches.

- Students were aware they were being observed and were expected to articulate their learning needs.

- Coaches are supported by a Clinical Educator who effectively 'coaches the coaches'. They help the coaches assess the right allocation of patient commensurate with the level of student development. They support coaches in applying the appropriate coaching style to student developmental level and facilitate the assessment process. They are visible to actively contribute to the ward learning environment.

Transferring the Model to the UK

In 2013 we established a steering group led jointly by ourselves and Health Education East of England with representative membership from our six main NHS Trusts. This set the context for a collaborative project. The steering group has a role in ensuring the integrity of the project, that terminology is agreed, that the key elements of the model are rolled out consistently across all Trusts informed by an evaluative component, and that best practice is identified and shared. Whereas at VUmc the model is applied in the hospital setting, we are also interested in testing the approach in community settings.

Each Trust first identified a potential practice area for the initial pilot phase. The identified area was predominantly self-selected and in that way ensured the lead person was enthusiastic, motivated and committed to the project. A very detailed project plan was then initiated, developed by the practice area and the university link lecturer.

Key Roles

One of the first steps of the project was to identify key roles and describe the remit of each role within the context of the project.

The Clinical Educator. This new role is seen as pivotal to the success of the project and in exercising this role clinical educators would directly influence the quality of the learning environment. The clinical educator needed to be an experienced mentor with strong facilitating skills who would oversee the project in a particular practice area and could provide on-site support and guidance to coaches, mentors and students. The importance of this role was enhanced by HEEoE which provided shared funding with each of the Trusts. The role of the clinical educator is to:

- oversee a maximum of two wards or practice areas.
- provide training and support to the day coaches and named mentors.

- work with HEIs in supporting practice areas to ensure learning opportunities are compatible with learning outcomes.
- support the practice areas in allocating students to patients
- support student formative and summative practice assessments through upskilling mentors and acting as a source of expert advice.

Named Mentor and Sign-Off mentor. The role of the Sign-Off mentor (SOM) mirrors that set out in the NMC SLAiP Standards (2006, 2008) whereby the student must have one hour a week protected time with their SOM and the SOM is responsible for determining the students competency and fitness to enter the NMC register. This role will be an adjunct to the CLIP project although the SOM may also act as a day coach or mentor on occasions. In addition, where the Clinical Educator is also a qualified SOM, and where no other SOM is available, there may be a necessity for them to carry out this function. The benefit of CLIP to the SOM is that Daily Feedback sheets and input from Day Coaches, Mentors and Clinical Educators can help support their decision making. As now, students will not always be working with their named mentor and therefore mentors will need to ensure they are up-to-date with their student's learning and progress. The named mentor will need to ensure that they create opportunities to meet with and work with their allocated student to ensure learning opportunities are maximised, learning outcomes met and assessments are robust. The presence of the clinical educator and day coach made this very much a collegiate approach to student learning. The role of the named mentor is to:

- have a role consistent with NMC standards ensuring each student has access to a mentor forty percent of the time.
- have a maximum of three allocated students.
- be responsible for liaising with coaches and other people that their student might have worked with in order to develop an informed assessment of the student's practice.
- be able to request to spend time working with a student on a one-to-one basis

- be expected to meet regularly with the student to ensure they are meeting their learning outcomes.

- Liaise with other coaches and familiarise themselves with feedback through the daily learning logs to support the assessment process

Day Coach. The day coach role is new and can be undertaken by any registered nurse within the practice area who is overtly interested in supporting student learning and willing to take on the role and further preparation. In order to execute this role satisfactorily, day coaches do not have any other responsibilities during that particular shift. The day coach is:

- a registered nurse but not necessarily a qualified mentor.

- a regular ward based member of staff (long-term bank staff may be suitable but short term or agency staff are not). When acting as a day coach they:

o have a maximum of three students per day.

o have a maximum of nine patients to care for at any one time, ideally only having responsibility for the patients directly cared for by 'their' students.

o have no other patient responsibilities.

Students. The model is underpinned by a philosophy of student-led and peer learning. Students need to be prepared for what to expect of their role in this new learning environment. Students will:

- normally have not more than three patients allocated to them but this would be in relation to their developmental stage, their competency and the complexity of the patient's needs.

- be afforded some flexibility in order for them to achieve learning outcomes of management and leadership.

- Second and third year students will be involved in supporting and facilitating learning for other more junior students

Link Lecturers. Link lecturers are identified as key players in supporting partnership working. There is an expectation that they will be involved from the outset in the project plan development. Link lecturers work with the clinical educators in supporting coaches and mentors and play a key role in cascading the coach training to practice level. Link lecturers will:

- organise on-site training in coaching skills
- support practice by attending the student case study presentations
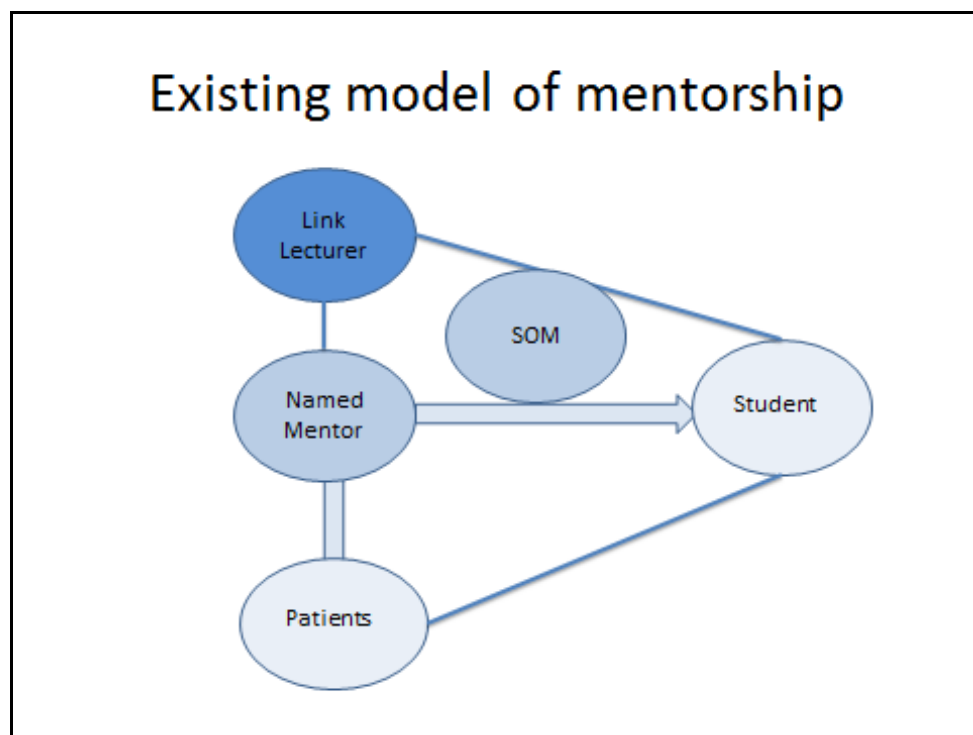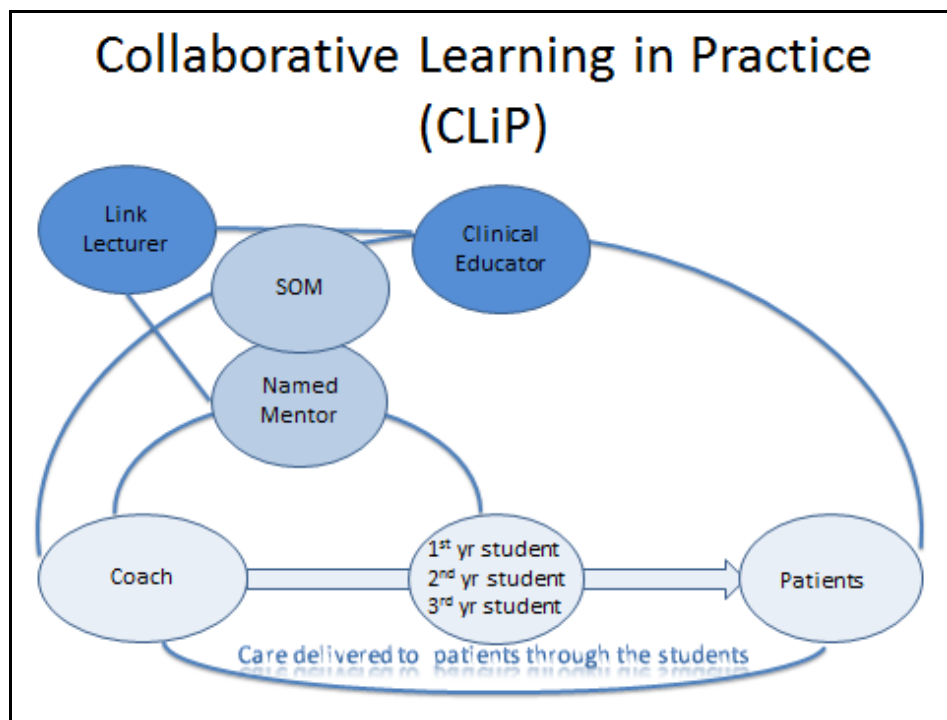- support coaches and mentors in executing their roles by role modelling coaching skills

Fig 1

Collaborative Learning in Practice (CLiP)

Fig 2

Preparing Practice

All members of the practice area need to be aware not only of the significant increase in the number of students to be placed but also of the change in philosophy of learning. This is crucially important if the aim is also to influence, incorporate and embed coaching as a culture of the learning environment. Preparation involves ensuring all levels of the organisation are aware of the proposed changes as well as the multi-disciplinary teams working in the practice area. This practice preparation is part of the project plan.

Training

Training was the final key factor to be considered. The university took responsibility for this aspect with a view to developing a 'training the trainers' programme. Initially a series of short study sessions were delivered in the School to link lecturers, pilot project mentors and clinical educators. This was followed by two master classes delivered by a visiting clinical

educator and coach from VUmc. Subsequently, the training is cascaded to the practice areas delivered by the clinical educators and link lecturers. The two main theories underpinning the training programme are Hersey and Blanchard's (1977) situational leadership and Miller's pyramid of assessing clinical competence (1990). The current programme involves:

- a series of screen casts available on the internet that explains the project, explaining the theory of coaching, role plays depicting coaching in action.
- a number of coaching sessions are delivered in the practice area to all staff of the nursing team before students arrive
- a further series of sessions half way through the student's placement are delivered to the coaches and mentors that enable the application of the theoretical models to practice.
- Students are prepared before going into practice around the expectations of student-led learning
- A resource booklet explaining the project has been developed for students and coaches.

Evaluation of the CLiP model

A formal evaluation of the model has been designed and an application for funding for the study has been submitted. However, we have undertaken early evaluation with our partners to share learning about CLiP that emerges through this pilot phase, including via our regular educational evaluation processes and from the co-ordinating activities of the steering group. Some of this learning will be presented for the first time at the CLiP Conference. A further wave of CLiP pilot sites will commence this month.

Acknowlegdements

We are grateful to members of the CLiP steering group who have been instrumental in developing the model and whose enthusiasm and vision for the project continue. We thank

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