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Could students' experiences of clinical placements be enhanced by implementing a Collaborative Learning in Practice (CliP) model?

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GUEST EDITORIAL

COULD STUDENTS' EXPERIENCES OF CLINICAL PLACEMENTS BE ENHANCED BY IMPLEMENTING A COLLABORATIVE LEARNING IN PRACTICE (CLiP) MODEL?

There has been much scrutiny of United Kingdom (UK) nursing in the face of allegations of a decline in the standards of care delivered by nurses and systematic failings in care in one NHS trust (The Willis Report, 2012; Francis, 2013). More specifically, The Willis Report (2012) argues for closer partnerships between higher education institutions and practice providers to ensure that student nurses receive the best preparation and support during their placement learning, with an emphasis on flexibility to meet the changing demands of patient care in the 21st century.

The UK nurses' professional regulator, the Nursing and Midwifery Council (NMC) has recently reviewed and consulted on its standards for pre-registration nurse education, with the stated aim of modernising nurse education and preparing UK nurses for the future of care (NMC, 2017a). The NMC's role is to set standards for UK nurse education, as well as regulate the conduct and performance of all registered nurses in the country. This statutory role first began in 1919 and has been revised and updated periodically (Williamson *et al,* 2010). The NMC holds a professional register meaning that only those graduating from approved programmes of study, normally degrees, are eligible for initial registration, and only those maintaining their registration annually and revalidating every three years can maintain their status as registrants and continue in employment. In 2015 the NMC announced plans to regulate staff with preparation programmes other than degrees,

using the term ‘nursing associates’, and these roles would typically operate as a subsidiary to the ‘qualified nurses’ already on the NMC register (See NMC website for further details https://www.nmc.org.uk/). In contrast, no such overarching regulatory body exists in the United States (US), where each state is responsible for licensing practitioners via state Boards of Nursing, although there is overarching legislation and cooperation through a National Council (see National Council of State Boards of Nursing https://www.ncsbn.org/index.htm). In the European Union, there have been attempts at harmonisation of education standards and recognition of qualifications between member states, but national legislation still takes precedence with regard to registration, and practitioners must still register in each nation state (see Directive 2013/55/EU of the European Parliament and of the Council of 20 November 2013 http://eur-lex.europa.eu/eli/dir/2013/55/oj).

As the new UK NMC standards are yet to be finally released, with release recently delayed, a detailed critique of their implications is difficult, but they are likely to have profound implications for how students are supported, as the consultation contains proposals that may alter the current mentoring requirements (NMC, 2017a). Students are currently allocated to a practice placement requiring a mentor with an NMC approved mentorship course (NMC, 2015), which can be problematic if there are insufficient mentors to supervise students (Murray and Williamson, 2008). In addition, mentors are required to directly or indirectly ‘mentor’ each student for 40% of the placement period (NMC, 2008) which has been widely interpreted to mean directly for the majority of the time rather than indirectly working with other professionals (NMC, 2017b). The NMC also states that mentors can mentor up to 3 students (NMC, 2008) which is rarely operationalised due to the pressure mentors feel in supporting students (Bennet and McGowan 2014).

In England, The National Student Survey (Higher Education Funding Council for England, 2017) results for nursing indicated that 86% of students 'received appropriate supervision on my placement(s)' but there is room for improvement and evidence indicates that placement dissatisfaction is an issue throughout the UK; this includes unmet expectations, difficulties with mentors, travel, and ill-defined support (Cameron et al., 2011; Hamshire et al., 2011). Furthermore, there are reports that placement dissatisfaction is a considerable source of student nurse attrition (Eick et al., 2012), and students can feel that they are under-prepared for their new role post-qualifying and some report feeling poorly equipped for it (Muir et al., 2013; Snow, 2013). Although preceptorship programmes ought to help overcome these concerns, newly qualified nurses still report anxiety, stress, uncertainty and lack of confidence, so much so that the desire to leave the profession is widespread (Pasilaa et al., 2017).

The NMC draft standards propose a shift from students having a named mentor who is responsible for planning and enabling their development and assessing performance and competence (NMC, 2008), to a new model where all registrants are enabled to supervise and contribute to the assessment process reviewed by a named assessor at the end of each year (or stage). This would enable an increase in student numbers within a clinical area and remove the conflict that can occur in the relationship between of mentor and assessor that has been known to exacerbate the issues of 'failure to fail' and the emotional guilt that can occur (Black et al, 2014). The NMC rationale for these changes to mentoring appears to be that evidence has not demonstrated current mentoring models to be successful and that there is much variability in the quality of student learning, support and assessment in clinical practice (NMC, 2017b), as well as being limiting placement capacity.

Both the RCN (2016) and NMC (2017b) have highlighted and endorsed international models of student support using Collaborative Learning in Practice (CLiP), or the 'Amsterdam Model', both of which are, broadly speaking, about 'real life learning wards' (Lobo et al, 2014; Health Education England, 2017). A summary of potential benefits of the CLiP is shown in table 1 below, and these appear to address several current concerns, particularly regarding enhanced partnership working (Willis Report, 2012), increased staff retention and preparation for registrant practice (Pasilaa et al., 2017).

- The role of the clinical supervisor role is valued
- Partnership working is encouraged and increased between practice and educational environments
- Supports inter-professional approaches to care
- Increased student led supportive environments
- Increased ratio of students to 'mentor'
- Increased job satisfaction and staff retention
- Increased preparedness for registrant practice

Table 1. Benefits of Clinical Learning in Practice Model.

Implementing a Collaborative Learning in Practice (CLiP) model, is becoming increasingly popular in the UK (Lobo et al, 2014; Health Education England, 2017), and somewhat dispenses with one-to-one mentors in favour of a 'team' approach. This allows nursing students to be facilitated or 'coached' by registered health care professionals incorporating peer and tiered mentoring where senior students coach junior students in a ward-based environment. It is reported that this model has been

shown to improve students' learning and placement enjoyment, with positive benefits reported for mentors and patients, this all accruing from enhanced student-focused learning (Huggins, 2016; Health Education England, 2017). CLiP allows students to have greater input into their own learning through working collegiately with other students to help run clinical areas whilst being supervised by a Registered Nurse (RN) for the shift. As distinct from a 'mentor', the RN is seen as a 'coach', maintains accountability and responsibility for care of patients in a particular part of the ward or department (for example a 'bay'), and is the 'go to' person if the student requires individual support (Huggins, 2016). As per NMC standards (NMC, 2008) students still have a designated mentor who manages and directs the learning and assessment processes.

Clinical Learning in Practice uses established models of peer-to-peer teaching and learning, described as 'people from similar social groupings, who are not professional teachers, helping each other to learn and learning themselves by teaching' (Bennett et al., 2015, p596). A systematic review found that peer learning was an effective educational intervention for health students on clinical placements (Secomb, 2008), with mostly positive outcomes reported including increasing students' confidence, psychomotor and cognitive skills in clinical practice. Other pragmatic benefits including expanding placement capacity and learning opportunities, reducing clinical staff workload in relation to student support, and increasing students' clinical time with patients. However, these benefits were not seen where students' personalities or learning styles were problematic in some way (Secomb, 2008).

Peer-to-peer learning is supported by Bandura's (1997) theory that learning is a result of interactions with one's environment, personal characteristics and

behaviours in relation to their experiences (Brannagan et al. 2013). Students learn best when there is active engagement and experiential learning through doing (Hope et al., 2010), which a CLiP model can facilitate.

The coaching techniques that inform the CLiP model have previously been used successfully in medical training, and have been reported to provide a major contribution to junior doctors' development of their own personal and professional identity (Brannagan et al. 2013; de Lasson et al. 2016). Furthermore, such coaching has been shown to improve quality and safety where peer assessment has been implemented (Mort et al., 2017). Coaching, unlike mentoring, can be seen as short term and skill-specific, focusing on development and improvement (Huggins, 2016). In a CLiP model, all healthcare professionals and care workers, not just nurses, may have input into students support (Health Education England, 2017). It seems clear that the demands of clinical care can impact on successful 'mentoring', as mentors may not have enough time to balance good quality mentoring with their clinical workload (Health Academy, 2017), and CLiP may alleviate the pressures on mentors who otherwise feel responsibility to look after their own patients as well as students (Huggins, 2016).

Having all members of the multidisciplinary team supporting students could broaden the range of clinical input that students receive and enable interprofessional learning that crosses traditional role demarcations. However, to implement CLiP coaching into a practice area that already has a well-established mentor programme of support requires a restructure of established modes of student support and thinking. Convincing staff that this new model is of benefit to both them and their students, should be seen as an opportunity for a resourced change management strategy rather than a 'quick fix' solution to increase capacity where mentors are not

available. None the less it must be remembered, that at the time of writing, the NMC (2008) mentorship standards remain in place, although this may alter in 2018/2019.

Students can use learning logs to assist their recognition and reflection on clinical learning opportunities, and these logs might help to overcome the theory-practice gap if they require referencing to relevant literature and form part of students' clinical assessment. This could help to demonstrate that nurses are reflective learners once registered and might inform three-yearly revalidation (NMC, 2015). Reflective logs can be discussed with a mentor/coach and an action plan created to help students to develop skills and grow as practitioners when particular clinical scenarios reoccur, also enhancing their written and verbal communication including conversational, questioning and listening skills (Huggins, 2016). Students have offered some positive criticism of peer-on-peer learning as an effective learning environment making learning not so much effortless, but enjoyable (Bandura, 2012) and there is evidence from areas where CLiP has been implemented (Health Education England, 2017) that it improves staff recruitment and retention, although much remains unpublished.

Although the CLiP model is still in its infancy in UK, clear benefits to student learning seem possible through coaching and peer-on-peer learning in clinical environments. If this model were to be more widely implemented following revision of the NMC standards for nurse education, students may be able to enjoy a more holistic learning experience, accruing greater confidence from the additional control over their learning and development, increasing their preparedness for registrant practice, bridging the theory-practice gap between student and registrant practice that is still evident today (Irwin et al 2018).

To date it would appear that there is minimal evidence of the benefits of implementing CLiP and coaching models in practice; however, in order for the model to become successful and well-established, a sound research evidence-base will be required to evaluate and substantiate claims for improvements, and to inform wider national and international implementation.

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