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'THINKING LIKE A NURSE'. CHANGING THE CULTURE OF NURSING STUDENTS' CLINICAL LEARNING: IMPLEMENTING COLLABORATIVE LEARNING IN PRACTICE.

Abstract

This article reports a study evaluating the implementation of Collaborative Learning in Practice models at a university School of Nursing and Midwifery with practice partners across the South West of England. We conducted four focus group interviews with 40 students with experience of Collaborative Learning in Practice placements, and two focus groups with eight clinical practice staff with responsibility for implementing and supporting such models in their areas. Data were transcribed and analysed using the Framework Method. Key themes were 'Real time' Practice of Collaborative Learning Implementation, Collaborative Learning as Preparation for Registrant Practice, and the Student/Mentor Relationship. We conclude that Collaborative Learning in Practice utilising models of coaching and peer support, offers benefits to students who are exposed to the reality of nursing practice from the beginning of their placement experiences, enabling them greater responsibility and peer support than under normal mentoring arrangements. Furthermore, there are benefits to the registrants because the burdens of supervising students are spread more widely. This is timely given the review of Nursing and Midwifery Council standards for programmes and student support and the need to increase placement capacity as a response to global nursing shortages.

Highlights

- Collaborative Learning in Practice can increase placement capacity for students.

- Collaborative Learning in Practice offers benefits to students learning.
- These include greater responsibility for patient care, better preparation for registrant practice and peer support.
- Coaching can replace mentoring and should reduce their burden in relation to student support.
- This matches new UK Nursing and Midwifery Council standards for programmes and student support.

Key words

Collaborative learning, practice education, undergraduate nurse education, adult nursing, focus groups.

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1. Introduction

As there is a global shortage of nurses (Marć et al., 2019), one solution being explored is to increase student numbers in training places. This requires an increase in placement capacity to facilitate students' practice learning (Grealish et al., 2013). It has long been known internationally that clinical

practice can be difficult and stressful for students (Levett-Jones et al., 2015), that good placement support is key (Jack et al., 2017), but also that new graduates are sometimes not at the standard required to be effective in their first employment (Christensen et al., 2016). In this paper, we discuss a regional project designed to increase placement capacity and improve student readiness for registrant practice through peer-learning and coaching.

2. Background and literature

The United Kingdom (UK) professional regulator, the Nursing and Midwifery Council (NMC), has developed new standards for education that include some significant changes to the supervision and assessment of students in clinical practice (NMC, 2018a) to be implemented in reapproved education programmes from 2019. Contextually, the revised standards for nurse education reflects new standards for registered nurses ('Future Nurse': NMC 2018b), that arose from The Willis Commission (2015) and Royal College of Nursing (RCN, 2016) findings, who reported on issues of student placement learning and support as part of the response into care catastrophes at the Mid-Staffordshire NHS trust Inquiry (Francis, 2013). The NMC has revised standards concerning mentoring (defined as a pedagogical, individual relationship for clinical learning in practice (Jokelainen et al., 2011) for student nurses, in favour of a more supervisory relationship (NMC, 2018a), coaching and peer learning. In the United Kingdom (UK), students of nursing undertake clinical placements as 50% of their programmes, working with nurses and other healthcare professionals to care for patients. Students are supernumerary but, even so, report variously being 'used as a pair of hands' (Jack et al., 2018); or cast into a passive 'observational' role that can hamper their exposure to more complex aspects of care (Allan et al., 2011). For mentors, close personal relationships with mentees can sometimes feel difficult (Bennett and McGowan, 2014; Black et al., 2014), overwhelming (Wilson, 2014), and can hamper decisions about placement assessment (Black et al., 2014; Duffy, 2013).

Although the new UK standards for student support (NMC, 2018a) do not specifically endorse Collaborative Learning in Practice (CLIP), this model does operationalise the philosophy embodied in those standards, requires peer learning and coaching, and separates supervisor and assessor roles.

Collaborative Learning in Practice models have already been discussed in the UK and elsewhere (Health Education England, 2017; Hill et al., 2016; Lobo et al., 2014) but the research literature is limited. The concept evolved from the Amsterdam Model (Hill et al., 2016), because of its association with VU Medical Centre, Amsterdam (VU indicates the hospital's affiliation with Vrije Universiteit). A similar model, Dedicated Education Units (DEUs), has been reported in New Zealand (Crawford et al., 2018) and USA (Hannon et al., 2012; Jones and Chesak, 2016; Murray et al., 2011). Student support becomes a team approach, intended to facilitate growth and development towards registrant practice with collaboration between nurses who supervise and coach students, and greater collaboration between students because there are more students in placement areas. This is particularly useful for third year students who can lead small teams for care management, and those teams ought to include more junior students, as well as unqualified nursing staff, and other learners such. This has been discussed as improving students' learning and satisfaction with placement (Health Education England, 2017; Huggins, 2016). Such peer learning fosters is supportive, confidence, psychomotor and cognitive skills in clinical practice (Secomb, 2008; Bennett et al., 2015), encourages self-directed learning, relationship building, providing emotional and educational support, and developing collaboration and leadership skills (Andersen and Watkins, 2018; Carey et al., 2018a; Irvine et al., 2018). Coaching can foster students' development of professional identity (Brannagan et al., 2013; de Lasson et al., 2016), and improve quality and safety (Pronovost and Hudson, 2012).

This study presents analysis of our regional project implementing CLIP models across acute and community hospital adult nursing.

3. Methods

Aim: To investigate the views of student nurses and the placement staff about the similarities and differences in clinical placement experiences in CLIP areas compared to non-CLIP areas.

3.1 Justification of methodology

Qualitative research aims to analyse people's perceptions of the world, behaviour, motivations and events within it, using an inductive approach characterised by building theory from in-depth data collection with people who have properties of interest to the researcher, whether that is illness, knowledge or exposure (Neergaard et al., 2009). Thus, we chose qualitative research to give us a deep understanding of the issues concerning the implementation of CLIP, from the participants themselves however, rather than use a particular school of qualitative research, we used a generic approach (Kate et al., 2003). Focus groups (FGs) were chosen in order to capitalize on group dynamics to stimulate discussion, as they capture unique, interactive events to produce data that might not be gathered from a single respondent (Guest et al., 2017).

3.2 Recruitment

Ethical approval was secured from the Faculty Research Ethics Committee. In early 2018, staff and students received email invitations, including the Consent Form and the Participant Information Sheet (PIS), to focus group interviews. Ethical principles concerning confidentiality, anonymity, right to withdraw data and protection from harm were guaranteed. All student nurses in first, second and third years of a BSc programme specialising in adult nursing (in the UK, students specialise in either adult, mental health, child or learning disability from the beginning of their degree programmes) who were undertaking CLIP placements in four NHS 'host' trusts in the Southwest of England were invited, as were NHS practice placement staff with honorary university contracts with some responsibility for implementing CLIP in their clinical areas.

3.3 Data collection

The groups were conducted by experienced qualitative researchers in all locations, and in all but one location there was a second person 'co-moderating' the group. All FGs were undertaken by researchers who were not well-known to students or staff to avoid potential bias and were recorded on a secure device, anonymised at source, and transcribed.

Table 1 shows the sample frame for invitations to the FGs and the numbers that eventually took part.

Table 1: Invitations and participation in the focus groups

TRUST NUMBER	STUDENTS INVITED TO PARTICIPATE	STUDENT ATTENDEES	NUMBER OF STUDENT FOCUS GROUPS CONDUCTED	PRACTICE STAFF INVITED TO PARTICIPATE	PRACTICE STAFF ATTENDEES	NUMBER OF PRACTICE STAFF FOCUS GROUPS CONDUCTED
1	32	11	1	20	4	1
2	27	11 and 6	2	0	0	0
3	19	12	1	9	4	1
4	5	0	0	7	0	0
TOTAL	83	40	4	36	8	2

We used a schedule of questions asking similar things from staff and students, concerning their views and experiences of CLIP, similarities and differences between CLIP and other placements, coaching versus mentoring, and differences in relationships accruing from additional student numbers.

3.4 Data analysis

The FG transcripts were thematically analysed using the Framework Method (Ritchie et al, 2014), which involves construction of initial themes or concepts to build a preliminary picture of the themes that might evolve; indexing, labelling and tagging the data to construct links between categories by sorting them so that themes and subthemes start to emerge. Data were then subjected to descriptive analysis, where the themes were refined, finalised and agreed. The anonymous transcripts were circulated between all six members of the research team and co-authors, who conducted the analysis independently prior to a final meeting at which the themes and subthemes were discussed and agreed.

4. Findings

In total n=83 students were invited and n=40 attended (48% attendance); n=36 staff were invited and eight attended (22%) (See table 1). Four student and two staff FGs were conducted. In two trusts (trusts 2 and 4) we received no interest from placement staff in attending the FGs, and in one trust (trust 4) we received no interest from students in attending. However, in one trust (trust 2), there was such a high degree of student interest in the FGs that we ran two groups.

Data from the staff and student groups were similar, and so are presented themes together however, that does not mean that all data were in agreement and therefore similarities and differences will be explored. In the following analysis the quotes are coded so that each participant and their trust location are indicated but not identifiable: student participant 1 in trust location 1 is coded as STD1T1; practice placement staff participant 3 in trust 3 appears as PP3T3. In trust 2, there were two student FGs, and the second is identified with brackets at the end of the coding as (2).

4.1 Themes

Table 2 shows the themes and subthemes that emerged from the FG data analysis.

Table 2: themes and subthemes

THEME	SUBTHEME
'Real Time' Practice of Collaborative Learning Implementation	Preparation for Collaborative Learning in Practice Supernumerary status Rostering
Collaborative Learning as Preparation for Registrant Practice	Team Work Accelerated Student Development by 'Working as a Nurse'
Student/Mentor Relationship	Mentoring Versus Coaching Assessment Anxieties about Interrater Reliability

4.1.1 'Real Time' Practice of Collaborative Learning Implementation

In this first theme, students and staff discussed their experiences concerning the implementation of CLIP in their areas, and what worked well or badly.

4.1.1.1. Preparation for Collaborative Learning in Practice. This first subtheme relates to the preparatory input undertaken and issues of operationalisation. The capacity of CLIP placements increased from perhaps one or two student nurses, up to in some cases 12. Preparation included visits to areas where CLIP was running successfully elsewhere in England, local workshops, training materials and teaching sessions for placement staff and students. Staff indicated that extensive planning and preparation was required and had been undertaken:

The wards put themselves forwards to be chosen for CLIP so there was the buy-in from the start. The introductions and training was mostly carried out by myself with some support as well from the University. We had one clinical area who bought into having a Practice Educator to support as a secondment, one day a week. Staff were quite engaged about it. (PP2P1).

However, despite introductory sessions provided for students in university and placement locations, these processes appeared not to be remembered as they described staff and themselves as not aware of the meaning or practice of CLIP:

I had no idea what CLIP was about at all, so going into it, I didn't know what was to be expected of me and likewise, the staff members didn't know what was expected of them or so, I think there was lack of communication about what the whole procedure was and what was expected of everyone.

(STD1T2).

The statement above received general agreement in that group and similar sentiments were repeated elsewhere.

4.1.1.2 Supernumerary Status. In the UK, student nurses learn in the clinical area but are not counted in the area's establishment of permanent nursing staff). Students raised several concerns about this, including being 'counted in the numbers' when it suited daily workforce demands, and how that impacted on their learning. Several students noted that unregistered nursing staff (called Health Care Assistants, or HCAs) were frequently moved to other areas, leaving the students to 'do their work'. Moving HCAs was noted by placement staff, but not registered nurse staff (RNs) which would have implications for the appropriate mentoring and supervision of students. This exchange between students in trust 2 was typical of data from all the student FGs:

...and I've heard them say before that they were a HCA down and then the Ward Manager was like, "No, don't worry, we've got students". (STD2T2).

We've had staff members taken and put into other departments because they've got enough students but we're not supposed to be counted as part of the staff numbers. (STD3T3).

Placement staff did their best to make sure that students were able to learn, and this may involve learning some skills of assertiveness:

We had a few difficulties. We had a housekeeper that asked [students] to go and feed the patients while they were actually completing a project under instruction from the Band 6 and they said, "I'm really sorry, we're supernumerary; we're doing this project; we've been told to do this project"...

which, actually, caused the students to get quite upset and go out and seek the Band 6 [who rectified the situation]. (PP1T1).

4.1.1.3 Rostering. The last subtheme was Rostering, which was a particular issue in making sure that the daily student skill mix was appropriate. This was a difficult feat to accomplish given myriad demands. Some areas utilised a 'short shift' pattern of lates and earlies to have a lunchtime overlap which could be used for learning activities, but this occasionally meant that there were too many students in placement, and some students struggled to know what they ought to be doing:

There was so many people on the Ward. That was one thing we found on ours as CLIP, because there was a mass amount of students – I'd say there was usually seven of us most days...it meant that on the handover period where the early staff don't go home 'till 1500 but the late staff come in at 1230, there was 'hundreds'; – it felt so cramped – at one point, there was more staff than there was patients. (STD4T1).

Almost all the areas reconsidered the 'short shift' patterns, and move to doing 'long days' (where nursing staff work perhaps from 0730 to 2100) in a move that made continuity of care clearer.

Students were asked to construct their own rosters to make sure that patient care was covered, and this worked well, according to staff, but limited learning opportunities as the overlap period was lost.

4.1.2 Collaborative Learning as Preparation for Registrant Practice

The second major theme centred on CLIP as preparation for registrant practice and, in contrast to the implementation issues discussed above, a number of clear benefits were noted by staff and students.

4.1.2.1 Team Work. Students articulated greater problem solving skills in working together and learning from other students, forming strong bonds between themselves and lasting friendships:

Seeing the process for us it really does [work]...me and a third year – it gives us a chance to problem solve [for ourselves]. (STD4T2)

And in another student **focus group**:

Normally you don't work closely with other cohorts so it has been quite nice. (STD3T1).

Staff made similar remarks:

I think it worked really well... supporting each other ... it's lovely to have them 'cos they really look out each other. If one [has] a problem, the others are all there sorting it out for them and ... they're all interested in each other. (PP2T3).

4.1.2.2. Accelerated Student Development by 'Working as a Nurse'. Third year student nurses articulated a more active role in patient care and clinical leadership than in previous placements. This second subtheme Accelerated Student Development by 'working as a nurse' involved taking responsibility for small groups of patients (usually in 'bays'), organising more junior students and unregistered staff, and delegation (under the supervision of their mentor). This exchange indicates staff consensus:

[Currently] our preceptees feel out of their depth, but these students doing CLIP won't realise at this time that they're getting more learning opportunities doing what you need to do when you qualify. (PP1T1).

The realities of the job isn't it? (PP4T1).

[Students] did comment through the process of de-briefs every week... "actually, I feel more prepared now to become a staff nurse"... which was great to hear. (PP1T1).

Similarly, students remarked that:

We worked well as a team, which has helped, working well together to know strengths and weaknesses and [my mentor] lets you actually run the bay, then you do get a lot of opportunity but I

managed to actually ‘think like a nurse’ which is something that is taken away to a certain extent [with an intrusive mentor]. (STD5T2)(2).

And:

It was the first placement that made me feel like a nurse because I wasn’t following someone around; I wasn’t watching... you were able to take ownership: forward think, make decisions – Honestly, I think we got to do everything. (STD7T1).

These data indicate the overwhelming potential benefit of CLIP for student development. Two students in one FG articulated the accelerated development like this:

I think, as well, [CLIP is good] especially for the 1st years because you progress. By the time you get to 3rd year [your clinical] thinking is brilliant. (STD2T2)(2).

That’s right, ‘cos I remember when I was a 1st year, I didn’t have the experience of running a ward or anything – I literally followed my Mentor, like a sheep. (STD3T2)(2).

4.1.3 Student/Mentor Relationship

The last theme concerned the different relationship between students and their mentors under a CLIP model compared to other placements. In the CLIP model, there was not more than three students to registered mentor, even so, students and staff perceived a change in how this ‘arms’ length’ supervision worked, with responsibility shared more widely across clinical nursing teams. This was an emotive area, particularly for students, who found it difficult to see how mentors could make appropriate judgements about them sufficient for their placement grades to be accurate.

4.1.3.1. Mentoring versus Coaching. Some students and staff explored the differences between mentoring and coaching, saying:

In the old mentoring style you’re the Mentor and the student’s behind you, you’re protecting them from the work that needs doing but now with CLIP, you’re putting the student in front of you and

expecting them to do their job and it's come as a shock to some of them...A 2nd year Student said to me [at the beginning of a CLIP placement] "They've given me a patient to look after"; I said "yeah, that sounds like a really good idea". (PP3T3).

And:

If they brought a clinical case to us I would then coach them through their approach and how they would manage that, and how they would go to the doctor: "Well, how do you want to manage that?"... students that had done that came back and said ... "I got all of the care of that patient changed; it was really good and I feel like I've learned a lot. I can make clinical decisions now; I feel empowered". (PP1T1).

This illustrates how some students perceived the difference between mentoring and coaching:

[My mentor] said "I've got to learn to stand back and let you just get on with it"... it's a new thing for them as well, sometimes they forget and so have to remind themselves to stand back. It's hard, 'cos they're used to just getting on with it themselves. (STD4T2)(2).

4.1.3.2. Assessment Anxieties about Interrater Reliability. A student said:

The biggest difference I found is the relationship between your Mentor...we felt like we hadn't worked with our Mentor that much and I know that some of the staff were unhappy having to sign off some of their students that they'd only worked one shift with. Normally, you made such a good relationship with your Mentor [but] with CLIP, we're working with so many different nurses, it gets passed down the chain about how you actually are, and it feels like maybe they haven't got the full picture of you. (STD5T3).

A staff member said:

Mentors [felt] scared that they were signing off a student that they hadn't directly worked with, 'cos they're used to "that's my student, I work with them and they follow me everywhere" – literally – and suddenly we're saying "your students are here today, but they're not working with you 'cos they're working with a different Mentor in a different bay" ...But I think as time's gone on... they've got more confidence in the students. (PP2T3).

In another staff **focus group:**

The students also couldn't understand how a Ward Manager would know what they were doing 'cos they hadn't actually worked alongside of them...we knew what every student was doing at any given point but, because they didn't have that close scrutiny, they couldn't see how we knew they were improving..."trust me, we know what you're doing well – you will be graded appropriately(PP1T1).

5. Discussion

The aim of this study was to investigate the views of student nurses and the placement staff involved in the implementation of CLIP in their clinical areas, and our findings indicate that the key issues were how CLIP facilitated students' learning through 'Real time' practice, helped them to prepare for registrant practice, and altered the Student/mentor relationship to one more akin to coaching and the assessor/supervisor relationship extant in the revised NMC standards (NMC 2018a). Our 'real time' theme resonates with the work of others (Lobo et al., 2014; Lobo, 2018), where CLIP is described as giving students an insight into the 'real world' of nursing. We argue that this is of global importance because it helps to address the findings from international studies that indicate many graduates are not 'work ready' in their own and their employers' views (Wolff et al., 2010). This appears particularly important in students' last practice placement before graduation (Kaihlanen et al., 2020) because they can take on clinical care and leadership roles similar to those expected of them when they are employed. Partly, these benefits seem to accrue from the enhanced potential of CLIP to enable peer learning and peer support, which has been shown

elsewhere to help students to cope in challenging practice placements, provide effective role modelling, develop confidence and reduce anxiety (Carey et al., 2018a). Our students formed new friendships in CLIP areas, which is likely to benefit their learning (Carey et al., 2018b), overall satisfaction (Brynildsen et al., 2014) and influence their retention on programmes of study (Williamson et al., 2013).

One anxiety-provoking aspect for our participants was the reduced contact with 'mentors'. Where student capacity increases there will be a reduction in the amount of time students spend with a mentor, and therefore this is likely to be of international importance where areas are increasing training places to overcome shortages of qualified nurses. This was clear elsewhere (Hill et al., 2016) where there was a statistically significant reduction in supervisory relationship scores in the Clinical Learning Environment, Supervision and Nurse Teacher scale (CLES+T) (Saarikoski et al., 2008) items between CLIP and non-CLIP areas, but not for the pedagogical atmosphere of placement environment items: students perceived different relationships, less contact and feedback in CLIP, but this did not appear to alter their perceptions of CLIP areas as learning environments compared to non-CLIP areas. Although reduced time with a mentor might appear to be a negative element, the new supervisor and assessor roles extant since the UK implemented new standards for nurse education (NMC 2018a) allow students to experience a wider variety of care activities and professions than currently. This may impact positively on registered nurse student assessors, reducing their feelings of mentoring overwhelm (Wilson, 2014) as responsibilities are shared across interprofessional teams; and may reduce inappropriate pass decisions, where student and mentor relationships become too close for objectivity (Hughes et al., 2016). It may also end the perception that student nurses can manipulate mentors' assessment judgements (Hunt et al., 2016), as decisions will become more clearly team rather than individual decisions.

5.1 Rigour

Trustworthiness is a key factor in establishing the rigour of qualitative research and (following Guba and Lincoln). Morse (2015) argues that credibility, transferability, dependability and confirmability are necessary for the reader to assess the trustworthiness of qualitative research. We argue that our research is credible because we have engaged in prolonged exposure and persistent observation with our participants, with six focus groups and 119 people involved. Recognised data analysis processes should be used in qualitative research to ensure dependability and confirmability. We used the Framework method (Ritchie et al., 2014), which is flexible, not allied with a particularly school of qualitative research, relatively simple for different researchers to adhere to in teams, (Gale et al., 2013), and has been well-used in nursing research (Parkinson et al., 2016). We have met criteria for transferability through 'thick description' because we constructed and agreed our themes and their interpretation between the whole research team; have provided extensive quotes to illustrate the themes and subthemes and given local and national context, so that readers can interpret the findings for their own setting. Therefore, we believe that this study meets evaluative criteria for robust qualitative research. (Graneheim and Lundman, 2004).

5.2 Limitations

This qualitative study took place in one English region, and we acknowledge this as a limitation. However, students were in placements in three NHS trusts in two counties, and staff were in two NHS trusts in two counties, meaning this study is not limited to one city but represents the implementation of CLIP in a region.

6. Conclusions

Key issues in the implementation of CLIP models in our region were preparation and on-going support, more effective preparation for registrant practice, and an altered student/mentor relationship. Our participants saw benefits accruing from peer learning (Carey et al., 2018a),

‘coaching’ as opposed to mentoring (Clarke et al., 2018) and support of friendly peers in placements (Williamson et al., 2013). For RNs, an additional benefit should be that they lose the overwhelming, sometimes disabling, responsibility for a student’s learning (Hughes et al., 2016; Wilson, 2014). These developments will be important as UK nurse education moves away from mentoring towards coaching, supervision and assessment roles (NMC, 2018a), may have an impact internationally on preparedness for registrant practice, and require evaluation of the quantifiable benefits with further systematic evaluation. We note the work undertaken by (Hill et al., 2016) in this respect, and argue that further research should investigate the national impacts, using validated tools such as CLES-T (Saarikoski et al., 2008), or designing and testing CLIP-specific tools to provide a robust methodology.

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