INTRODUCTION

This section provides an overview of the background to the project. It is followed by a literature review that focused on four main areas:

- The nature of practice education and its effectiveness
- The role of the practice educator and preparation for this role
- Interprofessional learning and practice education
- Intercultural issues in practice education

In reviewing the literature on the effectiveness of practice education, there is a paucity of evidence from any of the professions with most dependent on policy documents and recommendations for good practice from regulatory bodies.

Finally, account of the scoping exercise undertaken by the project team follows. This exercise followed the principles of case study methodology to collect information that would address the project aim of identifying and documenting good practice on how practitioners are prepared for their educational role within the five health care disciplines: dietetics, nursing, occupational therapy, physiotherapy and radiography.

A separate report was produced for each discipline that collected information from a range of sources using different methods, including literature, questionnaires and focus groups; triangulated collected data during data analysis and provided a description of the phenomenon within the selected health care discipline.

CONTEXT OF PRACTICE EDUCATION

An Overview of the Nature of the Preparation of Practice Educators in Five Health Care Disciplines

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The Nature and Effectiveness of Practice Education

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Practice education

Practice education is a generic term to cover placement learning in the five professions involved in this project. The QAA (Quality Assurance Agency for Higher Education) uses the terms practice learning and student placement to cover the complete range of placement experiences provided by higher education institutions (HEI). Within the NHS (National Health Service) the term clinical placement is used. In the introduction to Placements in Focus (ENB/DoH 2001) a number of phrases are used interchangeably i.e. education for practice in health, practice experience and practice placements. Other terms like work based learning have also been used.

Practice educator

The identified practitioner in the practice placement who facilitates the student learning face to face on a daily basis and generally has responsibility for the formative and/or summative assessment of competence. Throughout the literature this role is described by a number of terms, including work based supervisor; mentor; preceptor; practice learning facilitator; clinical tutor; and trainer. The potential confusion of these varying descriptions of this role has been recognised with Wilson-Barnett (1995) advocating the need for a consensus definition of the role and function of the mentor.

Lecturer

A variety of descriptions are used to describe HEI lecturers when they are undertaking a practice education support role. To identify them as distinct from the practitioners who are working directly with the student in the practice placement the personnel from the HEI will be referred to as lecturers.

Interprofessional education

The terms multiprofessional, interdisciplinary, interprofessional and crossprofessional appear in the health and social care literature. The definition chosen for this project follows closely that set by CAiPE (CAiPE 1997) and refers to students from two or more health and social care professions learning together whether in an academic or a practice setting.
The three year project commenced in January 2003 and the first year has been focused upon scoping five professions: Dietetics, Nursing, Occupational Therapy, Physiotherapy and Radiography as to the nature of the roles, responsibilities, preparation and professional requirements and standards for the practice educator. This investigation has now been completed and the following Case Studies outline the findings.

The following document provides a literature review, methods used to collect data and five case studies that provide an overview of the nature of practice education in the discipline identified and those areas of commonality and difference within and between disciplines in how and why practice educators are prepared and supported for their role. This work will be built upon in the next phase of the project and learning resources will be developed to support and prepare the practice educators across the different professional groups.

The Project aims to make practitioners more effective at supporting & supervising students in the workplace across a range of healthcare disciplines. The professions involved in the project are:

- Dietetics
- Nursing
- Occupational Therapy
- Physiotherapy
- Radiography

Background

The Department of Health document “Meeting the Challenge” (Department of Health 2000a) calls for more flexible and accessible education for its employees based on a strategy of continuous staff development to regularly update staff for supervision and management. In another document, “Investment and Reform” (Department of Health 2001) the government renews its commitment to modernising staff education and training. Since the contribution made by clinical staff to education programmes is vital, this must be underpinned by appropriate opportunities for preparation (English National Board / Department of Health 2001). Furthermore, preparation of mentors and teachers should be based on the principles of flexibility in education provision and accreditation of previous learning, ensuring optimum use of resources.

University programmes in healthcare disciplines require students to integrate theory with practice to ensure the optimum quality of healthcare (Farrington, 1995). The NHS Executive and the CVCP (now UUK) require student placements to be of good quality, provide relevant learning, give adequate support to students and have jointly agreed learning outcomes (CVCP 2000).

Much dedicated effort and expertise is required by academics, practitioners and students to ensure the attainment of placement objectives. The major issues to address are:

- Potential diversity of placement experience;
- Need for consistency of preparation and support within and across disciplines;
- The avoidance tensions between service and educational requirements;
- Integrating cultures of working and of learning;
- Pressures of time and means for dispersed practitioners to engage with each other;
- Urgent need to support practitioners new to the UK culture in their academic role (Department of Health 1999, Spouse 2001, Teichler 1996 and UKCC 1999).

Successful work based learning needs practitioners able to recognise learning opportunities and able to communicate their professional knowledge. Many practitioners have not acquired the necessary language to describe their practices and need opportunities to help them in preparation for sharing their practice. Supervision can be one medium for learning such skills but has mixed success in healthcare settings. This may be because it is often seen as an add-on activity resulting from insufficient numbers of suitably experienced and prepared staff expected to cope with clinical workloads that often fail to reflect their educational responsibilities (Spouse 2001).

Government expects all NHS organisations to put measures in place to ensure that practitioners are supported (Department of Health 2000b) and that flexible learning approaches and interdisciplinary education are provided. The LTSN Centre for Health Sciences and Practice needs analysis identified multi-professional education and a practice-driven curriculum as two of the top four issues deemed important by study participants (LTSN 2001). In addition, McGrath (1991) believes efficiency, effective service provision and greater job satisfaction are the main advantages of interdisciplinary working.

Open learning, “a method of delivering learning where learners use people, materials, equipment as their resources” (Forsyth et al.1999, p.13), offers flexibility to meet the needs of both practice educators and employers. Many forms of delivery are available including E-learning, workbooks or supported study. Models of professional development will be analysed by the project team and will draw from the work of the North Central Regional Educational Laboratory (NCREL) Professional Development Model and the five models suggested by Sparks and Loucks-Horsley (1989).

A result of the shortage of Registered Nurses in the UK has been an unprecedented increase in international recruitment. This trend is likely to be replicated in other health professions. While the literature recognises the need for nurses and other healthcare workers to be educationally prepared in order to be able to meet the needs of multi-ethnic patients and clients, there is little evidence of empirical research or projects into the educational needs of multicultural workforces.

Drawing on previous conceptual and empirical work in the field of culture (Hofstede 1991, Kim1992 and Campinha-Bacote1999), a model for the development of intercultural competence within learning relationships will underpin a programme of educational activities. This will facilitate learners to move from a position of ethnocentrism to one of ethnorelativism. This programme is intended to move beyond learners simply developing their knowledge about specific cultural values, behavioural patterns and rules for interaction in different cultural contexts. Rather, it is anticipated that learners acquire generic skills that prepare them to confidently enter into diverse cultural contexts and interactions and communicate sensitively and effectively.

Therefore, production of an open learning approach to professional development within a multidisciplinary context would be a timely project to address the issue of making practice based learning work.

Overall Structure of the Report

This report provides an account of the exercise undertaken to meet the outcome for Phase One of the project:

- Identify and document good practice on how practitioners are prepared for their educational role.
The literature overview is organised and presented fewer than four broad headings to include:

- The nature and effectiveness of practice education
- Interprofessional learning and practice education
- Intercultural issues in practice education
- The role and development of the practice educator

Throughout the overview, summary points arising from interpreting the literature have been bulleted and are itemised in the final summary section.
The Nature and Effectiveness of Practice Education

For the purposes of this review, the term ‘practice education’ subsumes ‘practice learning’ and ‘practice teaching’. ‘Effectiveness’ is used here to demarcate quality issues related to the provision of practice learning.

The scope of the literature in this area covers issues around the following sub-divisions:

- The nature of learning through, for and at work
- The role and needs of the learner
- Organisational issues in practice learning

The Nature of Learning through, for and At Work

All learners involved in completing a programme of study for a healthcare professional qualification are required to spend a proportion of their course time, often up to 50%, learning in a practice setting (Chartered Society of Physiotherapy 2002, NMC 2002, College of Occupational Therapists 2003, College of Radiographers 2003). It is important therefore to examine the issues surrounding the nature of practice learning.

A core concept related to practice learning has been adopted by the majority of healthcare professions over the past two decades. Professions have championed the central premises of ‘reflective’ practice with particular reference to the seminal work of Schön (1983, 1987). In a recent publication, Redmond (2004), a social worker, refers to the citation of Schön’s work by the majority of health care professional groups to include medicine (Ming Tang 1998; Higher Education Academy Health Sciences & Practice Subject Centre 2004). Nursing in particular has a history of having adopted Schön’s work as a core element of facilitating learning in and from practice experience since the late 1980s (Clarke 1986, Janes 1992, Palmer et al 1994, Stockhausen 1994, Burnard 1995, Greenwood 1998, Durgahoe 1998, Malik 1998, Graham et al 1998).

Schön based his theories and their application on earlier work by Dewey (1916; 1933) and along with Argyris (Argyris & Schön 1978; 1996) has had a major influence on the development of a body of conceptual and empirical work around the nature of practice learning. Dewey (1953) recognised the social nature of learning and the importance of the continuity of experience. Concrete experiences in the practice setting can be reflected upon leading to new insights and application of new learning (Kolb 1984). However, learners need to engage with the experience, reconstructing it in order to learn from it and build their own unique body of knowledge. It should be acknowledged that, to promote effective learning, the neophyte learner needs support and guidance from the practice educator in undertaking this process.

Schön’s ideas on reflective practice include an element where time and space is needed for the skilled practitioner and the learner to review and appreciate the interconnections between theory, intuition and practice. The practitioner working alongside a learner needs to have good coaching skills in order to make the implicit, often tacit, knowledge embedded in skilled practice, explicit for the learner (Schön 1983: 49 – 54). Blackwell et al (2001) reported that it has repeatedly been suggested that the quality of the student’s reflection is fundamental to the quality of learning. Dutton (2003) and Dewar & Walker (1999) include the encouragement of the student’s reflective process in the practice educators’ role function.

It could be argued that, for effective practice learning, using a reflective practice model, practice educators should have the knowledge and skills to coach learners through triggering reflective learning periods on-the-job where there is a shared knowledge of the context and events (Eraut 2004).

A claim for the effectiveness of the ‘reflection’ model in the arena of practice learning has included reference to its ability to integrate theory and practice. The design of ‘tools’ to use to facilitate reflection has proliferated in the literature with the most common being that of the reflective account written up in a learning log or ‘diary’ (Moon 1999). Promotion of structural frameworks for these written accounts (Johns 1995, Boud et al 1985, Gibbs 1988) has provided a way for academic institutions to assess and accredit practice learning (Burns et al 1994, Malik 1998, Bournemouth University 2001).

The more recent developments in the accreditation of work-based learning through the examination and grading of portfolio learning has incorporated elements of reflective learning as well as judgements on competence to practice (Sumsion & Feet 1996, Chaliss et al 1997, Taylor et al 1999, MacMullen et al 2003). Making sense of the relationship between theory learned in the classroom and their practice learning experiences is important to learners. The practice educator needs to assist students in reflecting on and recording their experiences, encouraging them to relate those experiences to theory already learnt in the classroom. Spouse (1996) refers to this as the ‘sense making’ role of the mentor.

- In order to integrate theory and practice, practice educators need knowledge and skills in promoting reflective learning; have ability and authority to facilitate time and place for the learner to record their learning; and have insight into the knowledge provided within the academic curriculum

The Role and Needs of the Learner

In facilitating learning in a practice environment, the student is viewed as an active participant. The model of ‘cognitive apprenticeship’ (Brown, Collins & Duguid 1989, Taylor and Dean Care 1999) reflects the current role of learners in healthcare placements in the UK and Ireland. Although supernumerary, they are active participants and continue to learn through the apprenticeship mode of observing, being coached by an expert and practicing in the authentic context. They not only gain explicit knowledge and skills in communication, psychomotor and clinical decision making but also need to develop the processes of integrating the knowledge with the conditions under which that knowledge applies and the culture in which that knowledge is used. A key skill required of students is that they learn to integrate into the culture and “communities of practice” (Lave and Wenger 1991, Wenger 1998, Spouse 1998, Eraut 2003).

Professional socialisation of neophyte health practitioners has been the subject of considerable debate in the literature during the mid to later part of the 20th century. Key studies in this area include the socialisation of medical students in the USA (Merton et al 1957, Becker et al 1961) and Melia’s work on the socialisation of nursing students (Melia 1987). The worldview perpetuated by these earlier studies considers students to be passive in the socialisation process. Whilst this has since been challenged (Clouder 2003), evidence continues to be presented by researchers of the power of socialisation processes, particularly in the practice setting, to be able to transform students to meet the ‘ideal’ expectations of the profession (Du Toil 1985, Howkins & Ewens 1999).

Clouder (2003), in her longitudinal study of occupational therapy students, argues that, although students learn to ‘play the game’ in the practice setting they are self aware and will retain their own personal agency, learning to find a route through the professional socialisation process. Clouder’s (2003) learners highlighted their need to get ‘things right’ and to know that they were getting it right; for example performance has to be validated by designated practice educators.

Practice educators, who are in an obvious position of power vis-a-vis the learner, need to be aware of not only of their performance as role models (Banaka 1977) but should also be sensitive to their influence on the professional socialisation of the learner.
The apprenticeship model generally assumes a one to one partnership in learning between the ‘master’ and the ‘apprentice’ (Erart 2003). Individual learners have differing intrinsic needs as well as the demands for varying levels of competence as they complete their learning programmes. Successful attainment of predetermined and prescribed competencies is required by professional awarding bodies (HPC 2003, NMC 2002, An Bord Almannais 2000). Learners need to achieve the prescribed competencies and rely on the practice educator to guide their learning, assess their competence and thus effectively act as ‘gate keepers’ to the profession (Woodd 1997; Duffy, 2004).

For effective practice education, learners also need time and attention from practice educators (Spouse, 1996). Turner (2001) describes the pressures on clinical staff and the impact of high patient turnover resulting in little time to devote to the supervision of students; an issue that is exacerbated by the increasing demands on the available practice placements (Bennett 2003).

- It is argued that to be effective in meeting learner needs, the practice educator has to have time and considerable educational skills to ensure recognition of the stage of learning or skill acquisition that needs to be facilitated and/or assessed at the appropriate time for the learner.

Organisational Issues in Practice Learning

In reviewing the length of time spent and the sequencing of practice learning within the curriculum, Blackwell et al (2001) and Torkington et al (2003) describe a lack of quantitative evidence about the impact of different work experience programmes on different groups of learners. Using a variety of data collection tools such as visits, phone interviews and literature reviews, Blackwell et al (2001) consider good practices in work experience placements for teachers. They concluded that for work experience to be effective, it needed to be purposeful and that all stakeholders i.e. students, employers, academic staff and experienced employees should have the ability to articulate what has been learnt.

It is interesting to compare the Australian model for supporting practice learning in nursing. Short, well planned placements are the norm. Students are prepared through extensive skills laboratory practice “on campus”; they are briefed and de-briefed during each placement episode by a Clinical Facilitator who supports a group of up to eight students. Although ‘buddied’ with a service practitioner, their overall progress is monitored and assessed by the Clinical Facilitator (Department of Education, Science & Training 2002, Australian Universities Teaching Committee 2002, Mallik & Aylott 2003). Another pattern is that proposed for the new nursing four year graduate programmes in the ROI (first intake September 2003); third year students will return to the paid workforce for a full salaried ‘apprenticeship year’ (Government of Ireland 1996).

With the annual commissioning of increased student numbers from all the health care professions in the UK (DoH 2000) and the consequent impact on providing sufficient and good quality practice placement areas, the reliance on skills laboratory learning is also a growing trend in the UK. The current emphasis is being placed on interprofessional learning using quite sophisticated simulation models and ‘actors’ to develop and test not only practical clinical skills but also communication, clinical reasoning and decision making skills (Edwards et al 1995, Nicol & Glen 1999, Ladyshewsky et al, 2000, Ker et al 2003, Peteani 2004). It could be argued that countries need to monitor and evaluate these developments through future comparative studies.

Individual learner support is the approach reported in the majority of literature on practice learning and reference to the apprenticeship model in the previous section alludes to a 1:1 relationship where one learner works alongside and learns from one ‘master’. As stated above, there are tensions in providing sufficient and effective practice learning placements for the increasing numbers of health care students. This has stimulated debate about the continuance of the dominant 1:1 model in practice learning.

Comparisons across professions and internationally reveal alternative models that include: learner allocation to consultant teams (medicine); allocation of 1 : 2 in physiotherapy; allocation of one Clinical Learning Facilitator to eight learners (nursing in Australia) (Malik 1998, Malik & Aylott 2003, Baidy Cummins 2000, 2003). In the UK, although there may be pressure, particularly in nursing, to be responsible for a number of different learners at any one time, QAA and professional standards expect that practice educators facilitate learning and undertake practice assessment on a 1:1 basis.

The continued exploration and critical appraisal of the effectiveness of different sequencing and patterns of placements along with proposed alternatives to the 1:1 model of practice educator support for health professions may provide innovative models for practice learning effectiveness in the future.

Structured organisational support or ‘brokerage’ for the ‘coal face’ practice educator is usually undertaken by an appointed named individual either employed by the Health Care Institution (HCI) or by the Higher Education Institution (HEI). Historically, in nursing and the therapy professions, the ‘link lecturer’ role has been the subject of scrutiny and generally considered ineffective (Cohn & Frum 1988, Neville and French 1991, Neville & Crossley 1993, Cross 1995, Clifford 1993, Day et al 1998, Aston et al 2000, Malik & Aston 2003).

For nursing in particular, a proliferation of ‘new’ support roles has been created following the recommendations of the Peach Report, with a consequent strengthening of partnerships between the HEIs and the HCl's (UKCC 1999, DoH 1996). Various titles have been given to these roles by the different professions (see Case Studies). Post holders generally provide a co-ordination, advisory, and supportive role for both the learners and the practice educators. They liaise and negotiate between the HEI and the HCI providing placements for the learner, problem solving any issues and advising on placement capacity and quality.

Erart (2003) is critical of the effectiveness of these roles in relation to the direct learning experiences of students, arguing that they are allocated to senior staff that have relatively little contact with the learner. However, early evaluation studies in Ireland and the UK indicate that they have value particularly in relation to their key stated functions (Department of Health and Children 2001, Clarke et al 2003, Ellis & Hogard 2003). Overall, it could be argued that because learning now takes place in a practice environment that is increasingly complex and challenging for all health care practitioners, that commitment to developing a learning organisation and creating a supportive learning environment by whatever means is acceptable.

Collaborative partnership systems between HEIs and health and placement providers that sustain and support the role and function of practice educators should be retained and continuously evaluated for their effectiveness.

A supportive learning “environment” is an area alluded to in the literature with various interpretations of how it is created and sustained. A focus on key personnel dominates the nursing literature particularly in relation to placements in acute hospital wards. Past evidence, at a time when the learner was an integral part of the nursing workforce, demonstrates that the role of the clinical leader (ward sister) was considered the most influential (Ogier 1981, Orton 1982, Freightwell 1982).

Clouder’s (2003) recent study on the socialisation of occupational health students is more relevant today for all health care learners. Her evidence testifies to a diffuse source of influence with the key individual being the allocated practice educator. Increasingly the policy agenda to foster inter-professional learning (see next section) promotes a team approach to practice learning. This, coupled with an increasing focus on encouraging the...
creation of a learning organisation (DoH 2000, DoH 2001) presents a case for multiple influences on creating an effective practice learning environment. Exploration of the concept and operationalisation of team and organisational learning and their relationship to each other and individual learning is still relatively new. It is argued that service quality and team performance is improved as a consequence of team and organisational learning (Chan 2001; 2003). The conceptualisation of organisational learning by Goh and Richards (1997) provides possible benchmarks in five areas that would allow any organisation to assess its commitment to a supportive learning environment. These areas include; clarity of purpose and mission; leadership commitment and empowerment; transfer of knowledge; experimentation and rewards; teamwork and group problem solving. Although the nursing profession in particular audits the quality of practice placements (DoH/ENB, 2001), the focus is on examining each individual area’s learning environment. Included in these audits is a summary evaluation of the quality of practice educator support. However there is often no reference to team learning or the influence of the organisation’s commitment to supporting practice learning.

- In auditing the learning environment and in providing any learning resources to support practice educators, the relative impact of team and organisational learning needs to be considered.

**Interprofessional Learning and Practice Education**

The current health and social care policy agenda in the UK recommends a refocusing on education and training arrangements, which are genuinely interprofessional (DoH 2000). As the operationalisation of the policy agenda on Interprofessional Education (IPE) is still in a relatively early stage of its implementation, this section provides an overview to include definition, developments and evaluations to date. IPE subsumes the terms interprofessional learning and teaching.

Interprofessional education was originally conceived as a means to overcome ignorance and prejudice among health and social care professions; the aim being that by learning together the professions would work more effectively together and thereby improve the quality of care for patients (DoH 2000). The much quoted definition by CAIPE (CAIPE 1997 Bulletin 13) indicates that interprofessional education occurs when two or more professions learn from and about each other to improve collaboration and the quality of care. It is seen as a subset of multiprofessional education during which professions learn side by side for whatever reason. The perceived benefits of IPE are an increased ability to share knowledge and skills, enhanced personal confidence and professional development, greater respect between professions and encouragement of reflective practice (Wood 2001). However, according to Barr (2000 p3) "a balance needs to be struck between installing common curricula and developing interactive learning, so that the professions not only secure a common foundation for practice, but also appreciate the distinctive contribution that each brings to collaborative practice".

Supporting Barr’s need to retain a balance argument, Hindi et al (2003) considered the interprofessional perceptions of health care students. A total of 853 questionnaires were sent to first year students in medicine, nursing, dietetics, pharmacy and physiotherapy in one university (response rate 55%). Results demonstrated that even at this early stage in their programmes, students not only showed signs of identifying with their professional group, but also a strong willingness to engage in interprofessional learning.

However, in commenting on evidence from an earlier study commissioned by the English National Board for Nursing and Midwifery and Health Visiting, Miller et al (1999) concluded that common curricula were established to reduce duplication in educational programmes, as opposed to utilizing and valuing professional differences, to inform collaborative working (Miller et al 1999).

As many of the ‘new’ IPE developments in pre-registration curricula are currently being planned and implemented there is still a relative paucity of evidence on the processes and outcome effectiveness of IPE in the UK. Much of the work to track developments have been completed by the Centre for the Advancement of Interprofessional Education (CAIPE) and is published on their web site (www.caipe.org.uk).

A systematic review of the literature (mainly pre-2000) (Freeth et al 2002) indicates that most of the evaluations of IPE published are from studies undertaken related to post registration education and training in the workplace and are often linked to patient care improvement initiatives. The majority of good quality evaluation studies were undertaken in North America and fewer than 30% included pre-registration students. Freeth et al (2002) report that the outcomes measured in most studies focused on: learners’ reactions; changes in their attitudes and perceptions; individual behavioural, knowledge or skill changes; organisational changes; and benefits to patient/client.

In the UK, employers do engage in providing IPE at postgraduate level and evidence does indicate that services are improved as a result of these initiatives (Tope 1999 and 2001). In concluding their review, the research team advocated that, in commissioning future studies in the UK, a smaller number of comprehensive evaluations of different types of IPE with a focus on prospective studies with longer follow up periods were essential.

Of perhaps more relevance to the aims of this project is the publication of a case study report, commissioned by the DoH, of current IPE initiatives being conducted in the UK (Barr & Goosey 2002). The criteria for inclusion were that the programmes included common learning in all or part of the curriculum; involved three or more health and social care professions; involved the NHS; higher education and, where appropriate, other agencies as partners; addressed current NHS developments; was subject to robust evaluation.

(Barr & Goosey, 2002 p 2)

Fifteen case studies are presented with eight of these focused on pre-registration IPE. The report acknowledges that all of these case studies pre-date the government initiatives to include IPE in foundation programmes (DoH 2000); however data from the Southampton University pilot for the ‘New Generation Project Curriculum’ due to commence in September 2003 was included. Case studies reported on both HEI organised courses and initiatives in practice based learning.

A practice learning example included the IPE training ward set up by St. Bartholomew’s Hospital and City University in London for medical, nursing, physiotherapy and occupational therapy pre-registration students (Peeves and Freeth 2002). Barr (2001) does acknowledge the constraints in providing practice placements where learners are exposed to examples of good collaborative practice. A concurrent issue is the feasibility of including
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Intercultural Issues in Practice Education

For the purposes of this project intercultural is taken to mean people from different cultures working alongside one another, engaged in a common endeavour. The context of this review is practice education of qualified practitioners as well as those preparing for professional registration.

The scope of the literature in this area covers issues around the following sub-divisions:

- The context for intercultural healthcare workforces
- Intercultural mentorship
- The nature of culture and difference in practice learning
- Implications for practice-based learning in health care

The Context for Intercultural Healthcare Workforces

The UK is a multicultural society and the composition of healthcare workers reflects this. The promotion of cultural diversity throughout health care organisations and across health care professions is a key policy area (DoH 2003) for equal opportunity employment reasons as well as to address concerns that health care is insufficiently culturally sensitive. Stereotyping and prejudice may result from exposure to different cultures. MacLachlan (1997) writes that their role as practitioners of health care does not make professionals immune from such reactions. Awareness of this should be fundamental to practitioner education as a key clinical skill. However, Gerrish (1997) writing about nursing reported ‘a lack of cultural awareness in British healthcare’. Similar issues are raised in relation to dietetics education (Suarez & Shanklin 2002) and occupational therapy (Black 2002).

An additional significant factor in this debate relates to the globalisation of health care workforces. Migration is certainly not a new phenomenon. What is new is the extent of migration of healthcare professionals, as travel becomes easier and educational frameworks become more consistent and interchangeable. Much has been written about nurse migration mainly because this is the largest professional group in healthcare. However, the issues raised by migration can be applied to most health professions. Staff shortages exist currently and are predicted in a range of other health care professions in the western world, for example in radiology (Reiner et al 2002) and medicine (Dowie & Langman 1988).

Focusing then the nursing literature, as a result of the shortage of registered nurses in the western world, there has been an unprecedented increase in international recruitment in developed countries (Kline 2003, Buchan 2001). The processes of economic globalisation and the increased mobility of labour in health care have resulted in a workforce which appears ethnically and culturally more diverse than in previous decades when globalisation and migration were less prominent. In the UK for example, more than 30 000 new non-UK nurses have registered in the UK since 2000, with the number growing each year (RCN 2003). This trend is replicated in other professions in health and social care.

Growing demands for skilled nurses has motivated international recruitment by developed countries. However, their availability is rapidly reducing which has been the result of an ageing nursing workforce while demographics and the opportunity for different career choices has reduced the numbers of student entries to the profession. The ‘import’ of nurses is seen as a quick solution to shortages at the same time as the problem of nurse shortages is ‘exported’ elsewhere (Buchan 2001, Kingma 2001). Kingma (2001) reports that nurse migration is motivated by the search for professional development, better quality of life and concerns for personal safety in areas of political instability.

The NHS has relied on overseas nurses at various points during its lifetime. Nurses from the Caribbean migrated to the UK in the 1950’s and 1960’s. Irish women were the second major group of migrant nurses, though this trend has been reversed in recent years (Buchan and Edwards 2000). Today the migration of nurses to the UK occurs within the context of regulatory structures governing migration and career entry. Professional regulation through the Nursing and Midwifery Council, EU treaties on the free movement of labour across the European Community, and government guidance on international nursing recruitment (DoH 2001a, RCN 2002) are shaping the way nurses are recruited internationally.

However, these efforts do not address the issues that overseas nurses who are recruited to the UK face. Some research is beginning to emerge concerning the experience of internationally recruited nurses (IRNs). Allan & Larsen (2003) explored the motivations and experiences of IRNs working in the UK. 67 participated in focus groups across 3 sites in England and Wales. It was found that the experience of coming to work in the UK was personally demanding. They had to cope with different working practices, integrate into nursing teams and some experienced a severe drop in status. Whilst not always the case some were faced with hostile and unsupportive colleagues. Although adaptation programmes go some way to inducting international recruits to UK health care culture, induction programmes which aim to provide UK nurses who work with international recruits with greater understanding and capacity to work with professional and social differences are yet to be established (Allan and Larsen 2003).

Gerrish & Griffith (2004) report on selected findings of an evaluation of an adaptation programme for overseas Registered Nurses. Data were collected from various stakeholders, including 17 overseas nurses plus mentors and managers involved in the adaptation programme, concerning their perception of the success of the programme using focus groups and in-depth interviews. Five meanings of success were identified: the achievement of professional registration, ‘fitness for practice’, reducing nurse vacancy factor, retention and finally promotion of an
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organisational culture that values diversity. One significant factor identified by the study to influence success was whether there was a positive interpersonal relationship between overseas nurse and mentor. The study also found that whilst sharing of expertise was evident, like Allan & Larsen (2003) some experienced hostility from a minority of British nurses. Both these studies indicate that whilst RN’s bring valuable nursing experience to the UK, their ability to function to their potential is in part determined by an acceptance of the value of cultural diversity by the individual and the employing organisation.

- While there is much recognition in the literature that it is essential for nurses and other workers in health and social care to be educationally prepared in order to be able to meet the needs of multicultural patient and client groups, there is little evidence of projects examining processes of problem-solving and learning in multicultural workforces.
- The contributions and challenges of such diverse workforces in health care for professional education, mentorship, preceptorship, practice education and clinical supervision have yet to be identified.

Intercultural Mentorship

Mentorship would appear to be a key mechanism to facilitate the adjustment and integration of overseas recruited health care staff into their role. However there would appear to be few studies of intercultural mentoring. Morales-Mann & Smith-Higuchi (1995) describe a study of Canadian mentor nurses and Chinese students in which cultural issues were found to have considerable impact on the mentorship relationship. For example each party shared different concepts of time, health, educational needs, customs and lifestyles. In a similar study Koskinen & Tossavainen (2003) describe Finnish nurses and British undergraduate nursing students during international placement experience in Finland. Strategies used to improve intercultural competence included mediating between the students and the Finnish culture in several ways. Koskinen & Tossavainen (2003) concluded that acting as an intercultural mentor was a complex and energy-consuming role, particularly given other clinical responsibilities. However it also provided opportunities for personal professional growth.

- Intercultural working is a feature of health care workforces and intercultural mentoring is inevitably part of this. All mentoring takes time and effort but the evidence seems to indicate that intercultural mentoring involves additional commitment.

The Nature of Culture and Difference in Practice Learning

The concept of culture has been touched upon earlier and it is apparent that it can be defined and interpreted in many ways. It may be useful therefore to explore the discourse around the concept in order to develop an understanding that any definition of culture is grounded in a particular time, place and perspective. In relation to practice education, it may be helpful to think about culture as difference. Difference comes in many forms, but the most overt may be that of skin colour and language, ethnic background, cultural practices and nationality. It is this overt form of difference that is spoken about when, for example, referring to cultural diversity or multiculturalism.

Yet culture is not something uniform or homogenous. There is so much individual and inter-group difference and variation that it become difficult to box up and compartmentalise behaviours and practices. There is no essential culture. Rather, it is being enacted every day and is a result of our individual experiences and perspectives. Therefore, it is important to understand that cultural diversity is not always helpful. They can be useful as stepping-stones in our thinking about how we may work and interact with others. However, culturally sensitive care, for example, may be represented exclusively as care that takes religious practices, and rules relating to food or social interaction into consideration. There is a danger of not moving beyond such a reductionist, tick-box type approach (Duffy 2001). Similarly, health care workers from different ethnic and cultural backgrounds may also be at risk from such stereotyping.

Implications for Practice-Based Learning in Health Care

There has always been difference and cultural diversity within health care workforces in terms of, for example, social class, education, religious beliefs or sexual orientation. However, as a result of international recruitment and migration, they have recently come under renewed scrutiny. Difference in health care workforces may rise to the surface in relation to:

- Communication styles
- Attitudes towards conflict
- Approaches to tasks

There is a danger in conflating culture with ethnicity, in other words, using the word culture when we actually mean ethnicity or nationality, and the overt differences of ethnicity and nationality. The term ‘difference’ may be preferable because it immediately begs the question ‘difference from what?’. And it brings to our attention the fact that we as individuals make ourselves the yardstick for difference because the answer always is of course ‘different from me’ or ‘different to what I am used to’. If we belong to a powerful group, say white, male, middle class then we may also say ‘different from me’, and therefore ‘different from what is normal or the norm’.

If we acknowledge difference, then we go beyond ethnicity and look at other ways of living life that may diver from what ‘we’ consider to be the norm. Some definitions of culture are not always helpful. They can be useful as stepping-stones in our thinking about how we may work and interact with others. However, culturally sensitive care, for example, may be represented exclusively as care that takes religious practices, and rules relating to food or social interaction into consideration. There is a danger of not moving beyond such a reductionist, tick-box type approach (Duffy 2001). Similarly, health care workers from different ethnic and cultural backgrounds may also be at risk from such stereotyping.

A consideration of learning in practice must begin with an understanding that these differences will have a profound impact on how students and professionals learn and work together, which in turn will ultimately determine the quality of care to patients. The term ‘intercultural competence’ seeks to describe the attitudes and skills that are necessary in order to function effectively and sensitively in multicultural environments irrespective of whether cultural differences exist between healthcare professionals, or between health care professionals and patients.

Drawing on the work of Bennett (1993) and Camphina-Bacote (1998, 1999), Koskinen (2003) defines intercultural competence as a ‘learning process from lower to higher levels of self-awareness and personal maturation that moves through cognitive, affective and behavioural dimensions and leads to skills of increasing sensitivity toward other people’.

The cognitive dimension of intercultural competence concerns our capacity to be flexible in our thought processes and to be able to move beyond the need to reduce new experiences to familiar and safe categories of understanding. The affective dimension relates to an emotional openness towards the unfamiliar, moving from an emotional response of threat and defensiveness to one
of openness and willingness to engage. The behavioural dimension refers to the ability to express the mental and emotional adaptability described above into our interactions with others whose cultural background is unfamiliar to us (Gerrish et al 1996).

As economic interests within a growing service sector are producing an increasing number of international trade agreements, including a focus on health care, there will be a corresponding increase in the mobility of health care professionals (Kingma 2001). Consequently, the need to prepare health care professionals in the UK to work with colleagues from different backgrounds, to act as their mentors or preceptors, or to support them as clinical supervisors for students will continue to grow. Therefore, intercultural competence will continue to be a prerequisite skill for health care professionals. However, rather than relying on ad-hoc training sessions or individual aptitude and experience, the development of intercultural competence needs to be facilitated and nurtured both in pre-qualification education and in professional development.

- Intercultural competence should be part of the skill set of all health practitioners and therefore evident in the work of practice educators. There is a need to understand the extent to which it features in practice educator preparation and more widely in education for placement.

The Role and Development of the Effective Practice Educator

The term ‘practice educator’ has been specifically selected as the most suitable generic term for use within this interprofessional project (see Glossary). However, the literature cited in this section does refer to the specific terms used by the different professions. These most commonly include the words ‘mentor’ (nursing and teaching), ‘clinical supervisor’ or ‘clinical tutor’.

It is worth noting that the majority of relevant literature on the role of the practice educator is nursing based and there is a relative paucity of publications from the other professional groups involved in this project. The nursing literature is supplemented by publications from midwifery, social work and those in higher education involved in teacher education. The QAA, who undertake the inspection of quality in higher education for all courses, have indicated that HEI’s are responsible for ensuring that all those staff involved in practice learning should be competent to fulfil their roles.

Andrews and Wallis (1999) reviewing the literature on mentoring in nursing concluded that there was confusion both in regard to the concept of mentorship and the role of the mentor/practice educator. This difficulty with role definition appears to be a feature of other roles relating to placement learning. A national evaluation of the role of the clinical placement co-ordinator in the Republic of Ireland (Department of Health and Children 2001) found that 70% of respondents stated that the role was inadequately defined. Jowett and Stedd (1994), in considering the mentoring of teaching students, conclude that there is a lack of a satisfactory understanding of what exactly is involved in mentorship.

Despite difficulties in defining roles, when analysing the activities expected from the practice educator a more coherent picture emerges. Woodd (1997) describes the mentoring process as being about developing the mentee’s learning. The ENB/DoH (2001;2001a) describe the two key responsibilities within the role to include:

- assuming accountability for the student’s learning in the practice setting.
- undertaking the formative and summative assessment of student learning in practice.

This section is presented under the following three sub sections:

- Facilitating practice learning
- Undertaking the assessor role
- Preparation for the practice educator role

Facilitating Practice Learning

In undertaking the practice educator role, Spouse (1996) proposes a quite detailed list of activities that are necessary to be effective. These include: befriending; planning; collaborating; coaching; and sense-making. Similar to Spouse, Evans (1999) describes the main functions of the practice educator to be enabling, teaching and organising placement opportunities. The two main elements of ‘enabling’ are described as being supportive and empowering of the student. The significance of the supportive element of the role of the practice educator is the need for learners to believe they are capable and that their engagement with learning tasks is related to a belief in success (Brennan & Little 1996). This view is also highlighted in a small study by Sloan (1999) who used a convenience sample from six adult mental health teams. Of the 32 good qualities described by respondents, the highest rated quality was that the supervisor made them feel comfortable enough to discuss their own limitations and had the ability to develop supportive relationships.

The relationship between the student and the practice educator is described in the literature as being of key importance (Dick et al 2003), with the reminder that in professional training, students learn not only from absorbing ‘content’ but also from their learning experience (Ward 1999). In a literature review on effective supervision in practice settings for medical students, Kilminster and Jolly (2000) comment on the significance of interpersonal exchanges within supervision roles.

Andrews and Wallis (1999) note that a common theme in the mentoring literature is the significance of the personal characteristics of the mentor. However, in an earlier study, Jacka and Lewin (1987, cited by Brown 2000) revealed that the reality of student nurse clinical placement was complicated by many variables; this did include personalities involved, but also patient dependency, patient illness, skill mix and clinical credibility. Brown (2000) considered 238 end of placement reports from 3 groups of students and similar to Jacka and Lewin (1987), concluded that there were a number of complex variables involved.

The implications for learning in a practice area, if staff are not up-to-date and competent, are obvious and therefore practice proficiency is an important element in supporting effective practice learning. Although good teaching and interpersonal skills are necessary for effective supervision, Kilminster and Jolly (2000), also noted the importance of clinical competence and knowledge. The ENB/DoH (2001) refer to the importance of ensuring that those with practical and recent experience of their professions teach health care students. In support of this argument, they recommended that the practitioner has a minimum of one-year full-time post registration experience prior to taking on the practice educator role. Although practice educator skills are transferable, it is suggested that those who transfer to a new area of practice need time to re-develop and demonstrate sound professional knowledge and skills.

- An effective practice educator needs good communication and interpersonal skills as well as practice proficiency and the ability to facilitate learning opportunities.
Undertaking the Assessor Role

Going back to the second main function cited by the ENB/DoH (2001) that of practice assessment, the literature also raises issues relating to valid and reliable assessment of students by practice educators (Brown 2000), and arguments both for and against the use of clearly defined learning outcomes (Brennan & Little 1996). Chambers (1998), reviewing the practice assessment literature reinforces the responsibility of the mentor for this role, but indicates that individual mentors may have different perceptions of competence. Practice educators are expected to make valid and reliable assessments of learners’ competence to practice and to validate any written evidence of that competence contained within a portfolio of learning (Norman et al 2002, Watson et al 2000). Where practice educators are supported through joint assessment strategies with the HEI, there may be no problems. There is evidence however, that particularly in nursing, shared assessments do not happen (Wilson-Barnett et al 1998). As they are the ‘gate keepers’ to the profession and as such have a key role in public protection, there is an urgent need to ensure that all practice educators are adequately prepared to confidently assess students.

Reasons cited for this ‘failure to fail’ students include: lack of understanding of the assessment documentation; students not on placement for long enough to gain competence; insufficient time to work with the student to make judgements; fear of the perceived consequences for the student; a sense of personal failure; lack of support in the decision to ‘fail’ from lecturers (Iott 1996, Duffy & Scott 1998, Sharp 2000, Phillips et al 2000, Dufty & Watson 2001, Dolan 2003, Dufty 2004). In her ongoing study undertaken in Scotland, found that all mentors interviewed stated that the topic of ‘failing’ students was not dealt with in their mentor preparation programmes. She goes on to state that ‘The literature supports the view that mentors feel ill prepared for their role (Wilson-Barnett et al 1995, May et al 1997) and there is often a lack of coherent support for mentors from lecturers (Cahill 1997). Given that mentors are ill prepared for their role in failing students it is recommended that mentorship programmes address the issue of accountability. It should also be recognised that the issue of responsibility in relation to ‘failing to fail’ lies not only with individual mentors, but also with individual lecturers’.

Role Preparation

A government briefing paper reported that a significant amount of mentorship is conducted on an ad hoc basis (Damodaran et al 2002). The Department of Health (DoH, 2000) recommend that education and training needs to be responsive to the skills and competencies required for healthcare delivery, an argument that is equally applicable to practice educator preparation. The assumption cannot be made that the experienced skilled practitioner will automatically effectively fulfil the practice educator role.

From the issues outlined in this overview of the literature and the individual case studies presented in this project, is it evident that preparation for the role is essential.

The ENB & DoH (2001) provided a framework of guidance for the preparation of mentors and teachers; the NMC (Nursing and Midwifery Council 2002) published standards for the preparation of teachers of nursing and midwifery. The NMC (2002) set required standards based on the following learning outcomes:

- communication and working relationships
- facilitation of learning
- assessment
- role modelling
- creating an environment for learning
- improving practice, knowledge base and course development

These standards, although with an obvious nursing bias, have been considered as a base for other health related professions. The Case Studies for this project (http://www.practicebasedlearning.org) list learning areas that should be included in preparation programmes.

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NMC (2002) requirements and the most recent discussion document (NMC, 2004) suggest a developmental approach to preparing practice educators. Titles to suit a progressive acquisition of practice educator skills and experience to follow a pattern from ‘associate mentor’ → ‘mentor’ → ‘practice teacher’ → ‘qualified teacher’.

There should be no specific academic level for ‘mentor’ preparation courses and there should be a flexible approach to providing programmes, with preparation both in practice and academic environments. The consultation document advocates that the change in status of the mentor standard enables NMC Visitors (Quality Assurance inspectors) in England and agents in Northern Ireland, Scotland and Wales to require evidence that mentorship outcomes have been met by those undertaking the practice educator role.

Across all professional groups there is evidence of inconsistency in the length and level of preparation courses required and provided for practice educators (see Case Studies at http://www.practicebasedlearning.org).

Andrews and Walls (1999) indicate that in some areas with a shortage of mentors, and an increasing demand for practice placements, that short preparation programmes are provided. They question the value of these programmes.

Wilson-Barnett (1995) & Phillips et al (2000) demonstrate that mentors are still ill prepared and that preparation varies from area to area. Studies, which considered the preparation of clinical supervisors mentoring post-registration students, have also illustrated the importance of preparation for the role and the possibility of developing methods that allow for the measurement of the impact of clinical supervision (Mike & James 2002, Seveninson & Borgenhammer 1997). Overall, there is a lack of literature on the content and outcome effectiveness of courses designed to prepare practice educators for their roles (see case studies).

- Provision of courses and/or learning materials to develop and support the practice educator role need to be reviewed and evaluated for outcome effectiveness
Summary
The following section lists the summary points made throughout the review, presented under the appropriate headings. There is no overall discussion as the literature overview and the results of the profession specific mapping Case Studies will guide the development of learning resources during Stage Two of this project (see Section Eight, Conclusion and Recommendations).

The Nature and Effectiveness of Practice Education
- For effective practice learning, practice educators should have the knowledge and skills to coach learners through triggering reflective learning periods on-the-job where there is a shared knowledge of the context and events.
- In order to integrate theory and practice, practice educators need knowledge and skills in promoting reflective learning; have ability and authority to facilitate time and place for the learner to record their learning; and have insight into the knowledge provided within the academic curriculum.
- Practice educators, who are in an obvious position of power vis-à-vis the learner, need to be aware of, not only of their performance as role models, but should also be sensitive to their influence on the professional socialisation of the learner.
- The continued exploration and critical appraisal of the effectiveness of different sequencing and patterns of placements along with proposed alternatives to the 1:1 model of practice educator support for health professions may provide innovative models for practice learning effectiveness in the future.
- Collaborative partnership systems between HEIs and health and placement providers that sustain and support the role and function of practice educators should be retained and continuously evaluated for their effectiveness.

Interprofessional Learning and Practice Education
- Opportunities for interprofessional learning in the practice setting are still being developed. Practice educators potentially play a key role in the organisation and facilitation of interprofessional practice based learning.
- Practice educator preparation programmes need to include specific learning opportunities to fulfil the specific requirements of facilitating interprofessional practice learning.

Intercultural Issues in Practice Education
- The contributions and challenges of diverse workforces in health care for professional education, mentorship, preceptorship, practice education and clinical supervision have yet to be identified.
- Intercultural working is a feature of health care workforces and intercultural mentoring is inevitably part of this. All mentoring takes time and effort but the evidence seems to indicate that intercultural mentoring involves additional commitment.
- Intercultural competence should be part of the skill set of all health practitioners and therefore evident in the work of practice educators. There is a need to understand the extent to which it features in practice educator preparation and more widely in education for placement.

The Role and Development of the Effective Practice Educator
- An effective practice educator needs good communication and interpersonal skills as well as practice proficiency and the ability to facilitate learning opportunities.
- In order to value and formally recognise the importance of the practice educator role in facilitating and assessing practice learning within health care curricula, there is a need to have clearly defined competencies for practice educators to ensure effective practice education.
- To guarantee public protection, practice educator preparation courses should include the issues of accountability inherent in dealing with the “failing” student.
- Provision of courses and/or learning materials to develop and support the practice educator role need to be reviewed and evaluated for outcome effectiveness.
CONTEXT OF PRACTICE EDUCATION


CONTEXT OF PRACTICE EDUCATION

Literature Review References


www.practicebasedlearning.org

CONTEXT OF PRACTICE EDUCATION

Literature Review References


CONTEXT OF PRACTICE EDUCATION

Literature Review References


United Kingdom Central Council (1999) Fitness for Practice. UKCC. London.


The design of this case study was informed by the principles of case study methodology. A case study approach to collecting information on a phenomenon has been used by a variety of disciplines, e.g. education (Hammersley 1986), experimental psychology (Yin 1994) and nursing (Woods 1998). They involve an in-depth examination of a particular phenomenon by focusing on relationships and processes within a natural setting. Stake (1994) believes differing definitions of the case study exist in the literature, with the consequence that the purpose and nature of case studies may vary considerably. Therefore, it is important to define and describe an actual case study so that the process of collecting information about a phenomenon is transparent.

The project team selected the following two definitions of a case study that encapsulated the nature of the approach taken to examine current procedures used to prepare students on practice placement within selected health care disciplines. The first definition for the term case study refers to the collection of detailed unstructured information collected from a range of sources about a particular group or institution, usually including the accounts of subjects themselves that does not attempt to generalise findings (Hammersley 1989).

This definition uses descriptive methods within a qualitative approach that matched the philosophical approach of the project team to the case study. However, this definition did not provide a clear guidance to data collection when the project team had commissioned teams to produce a case study for a specific health care discipline. The following definition of the case study retained this philosophical approach, but also acknowledged a need to predetermine the data collection process:

- Benefits from prior development of theoretical propositions to guide data collection and analysis.

Yin (1994) page 1

The project team used these two definitions to undertake a case study that utilised analysis of the literature to guide data collection; collected information from a range of sources using different methods; triangulated data during data analysis; provided a description of the phenomenon within selected health care disciplines.

The literature review for this report indicated the nature of information to be collected as the basis of the five separate case studies that were undertaken in the following disciplines, dietetics, nursing, occupational therapy, physiotherapy and radiography. These disciplines were chosen as key professional groups using a practice based learning approach as a core component of the educational preparation for the role. The next section provides information about how this information was obtained.

The case study for each discipline was produced by a team of academics from that discipline, recruited by the project team. The teams consisted of a case study writer plus a number of contributors who assisted with collection and analysis of data. The Nursing, Occupational Therapy and Physiotherapy case study teams each had two contributors. However, because of size of the disciplines there was one contributor for Radiography and no contributors for Dietetics. Those case study teams with a writer and two contributors divided the distribution of institutions to be sampled into three geographical areas so that there would be a degree of equity in workload:

- Southern England
- Northern England
- Ireland, Scotland & Wales

• Coping with technically distinctive situations in which there are more variables of interest than data points.
• Relies on multiple sources of data, with data converging in a triangulating fashion.

Data Collection

The other two case study teams sampled the whole of Great Britain and Ireland collectively. Details of the precise distribution of institutions can be found at: http://www.practicebasedlearning.org/case_studies/case_studies.htm

The data collection methods used in all of the case studies were:

- Questionnaire
- Focus Group
- Secondary Data

Questionnaire

A central aim of the case study was to obtain information on current practice in preparing practice-based supervisors within five disciplines in both the Great Britain and Ireland. Limits in available time and resources for alternative data collection methods, such as individual interviews, meant that to collect data from such a large and geographically widespread sample made use of a questionnaire the only feasible choice. Several influences, including the literature review and discussions amongst project and case study team members, informed questionnaire design.

Information to be collected in the questionnaire included:

- Respondent, e.g. institution, discipline, course(s) with practice placement.
- Students, e.g. numbers by course and ethnicity, inter-professional learning, preparation for practice placement(s).
- Placement supervisors, e.g. criteria for appointment, preparatory courses, support mechanisms.
- Assessment of practice, e.g. methods, staff involvement.
- Benefits, problems and areas for development in practice-based supervision.

To ensure that an overview of current practices plus a degree of depth of information of these practices could be obtained from a large diverse sample, the questionnaire consisted of a series of open and closed questions. A draft questionnaire was piloted by a convenience sample of six members of staff working in higher education with an interest in the preparation of practice based supervisors. Following revisions, the final version of the questionnaire (see Appendix One) was made available for completion in a number of ways:

a. Accessed via the Internet, completed on-line and submitted as an e-mail to a named member of the project team.

b. Accessed via the Internet, saved as a Word document, completed off-line and submitted as an e-mail attachment to a named member of the project team.

c. Accessed via the Internet, saved as a Word document, printed out and completed, then submitted as a paper copy to a named member of the project team.

A letter containing information about the project and questionnaire completion instructions, which requested the letter be forwarded to the relevant member of staff, was sent to the head of all departments identified in an analysis of relevant QAA subject discipline website, professional and statutory body websites plus informal knowledge held by members of both project and case study teams, see Appendix Two.
The response of 13 for nursing was far less than expected and as can be seen above represented only 16.7% of the initially identified sample. There was no significant improvement in the response rate despite further telephone or email contact. Of those who did respond, there was variation in the level of detail. Some, for example gave only minimal information; however, in those cases one could criticise the questionnaire or some other aspect of the methodology.

Whilst, it could be argued that such a small response rate could go some way towards compromising the validity and reliability of the data as the number of non-respondents outnumbered the respondents, Bowling (2002) pointed out that an acceptable response rate is difficult to determine. Furthermore, Parahoo (1997) drew attention to the fact that those who did not respond may have had markedly different experiences or opinions than those who did respond.

Quantitative data from the closed questions were entered into SPSS for analysis, whilst qualitative data from the open questions were printed out and collated by the relevant case study team.

### Focus Group

Focus group participants had to complete a questionnaire (see Appendix Three) indicating their health care discipline plus the three questions above. The answers to these three questions were used to inform discussions that were facilitated by either a member of the project team or a member of a case study writing team who had been briefed on the nature of the activity. Paper-based recordings of the discussions within each focus group discussions were distributed to each case study team. Individuals’ written answers to the three questions were distributed to the relevant case study team, determined by the respondents’ discipline.

A second workshop was held three weeks after the first workshop. A similar approach to the focus group was used, with two groups of ten participants meeting to first complete the questionnaire (see Appendix Two). Paper-based recordings of the discussions within each focus group discussions were distributed to each case study team. Individuals’ written answers to the three questions were distributed to the relevant case study team, determined by the respondents’ discipline.

### Secondary Data

Data that had been produced for another purpose was collected to provide contextual information about professional body perspectives on the preparation of supervisors and their role in supervision of students undertaking practice placements. This information was sourced from professional and statutory body reports and/or websites, e.g. Chartered Society of Physiotherapists, Health Professions Council, Nursing and Midwifery Council, Royal College of Nursing. Selected documents.

Whilst these documents give an overview of the standards expected by professional bodies associated, they often do not contain contextual information on the process and debates that may have informed their development. However, even with this caveat, such documents provide insight into professional expectations that can be compared with current practice through triangulation with both questionnaire and focus group data.

### DATA ANALYSIS

The various data collection methods used produced both qualitative and quantitative data. Data analysis merged data by type, i.e. qualitative or quantitative, from all sources and then used specific approaches depending upon data type:

- Qualitative data was analysed by following the principles of thematic analysis as described by (Polit and Hungler 1995).
- Descriptive statistical analysis of the quantitative data involved frequency counts and percentages. Distribution of the demographic composition of the sample limited valid inferential statistical analysis of the data using the chi-squared test in what was essentially a descriptive approach to the case study.

### CONCLUSION

This case study utilised a range of methods to collect information from a variety of sources. It is important to note that the purpose of the case study was not to be a rigorous research study, but instead an exercise to develop insight into current practices in the preparation of practice based supervisors.
APPENDIX ONE: Postal Questionnaire

Dear As the key person in placement provision you have been approached as the individual in your institution most able to provide information about practice placements in a specific discipline.

The practice placement experience of health care students is key to successful education and training of the health care workforce. This Funding Development in Teaching and Learning (FDTL4) project, funded by Higher Education Funding Council England (HEFCE) and the Department of Employment and Learning (DEL) Northern Ireland aims to help educators/mentors become more effective at supporting and supervising students in the workplace across the following range of healthcare disciplines:

• Nursing
• Physiotherapy
• Occupational therapy
• Dietetics

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• Nursing
• Physiotherapy
• Occupational therapy
• Dietetics

The project will develop generic materials to support practice placement educators/mentors taking healthcare students for their pre-registration practice placements. Prior to developing these materials, we need your views as to what is required.

a. Pre-registration Undergraduate Course

1. 
2. 
3. 

b. Pre-registration Post-graduate Course

1. 
2. 
3. 

Your experience in this area will form an essential component of this project. For further information you are invited to access the project website. http://www.practicebasedlearning.org/quest.htm

The aims of the this report include:

a. Auditing the university based preparation of practitioners for their educational role in supporting students during

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practice placements.

b. Identifying principles of good practice that emerge from the audit.

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We would be grateful if you would complete the audit on behalf of your HEI. You can complete the audit online at http://www.practicebasedlearning.org and submit it directly to the Audit administrator, Chris Turnock.

Alternatively, you can save the document and either:
- complete and save as a word document, which can be emailed to chris.turnock@unn.ac.uk
- print the document and post a completed printed version to
  Chris Turnock
  H216
  Main Building
  Northumbria University

Please complete separate audits for each discipline if you are reporting on more than one discipline.

Preparation
- Preparatory Workshops
- Handbook
- Web based material
- Prior Visit
- Induction at workplace
- Other

We have a team working on writing the final report for this project and the member of the team working in your discipline will contact you to talk through any issues you may have in/when completing the audit. As a result of completing the questionnaire you will receive a copy of this report and you will be kept informed of developments resulting from the project.

All data will be stored on password-protected computers and will be treated as confidential.

In addition, we are interested in highlighting and sharing good practice in this area. We would be grateful if you would identify any aspects of your institution’s approach to practice based learning that exemplifies good practice and/or innovation.

Yours sincerely

J. Mulholland
Project Director

ALL COMPLETED AUDITS RECEIVED BY 13/10/03 WILL BE ENTERED IN A DRAW FOR £100 BOOK TOKEN PRACTICE-BASED LEARNING AUDIT

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<td>5.</td>
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</table>

Section A: Institutional Data

1. Institution details

2. Your Contact detail
4. Pre-registration courses offered which include practice placements, (Eg Pre Reg Diploma or BSc etc)

**Section B: Student Information**

5. Please indicate, if possible, the total number and gender of students that enrolled on the first year of your 2002 pre-registration undergraduate and postgraduate course(s)

6. Please indicate, if possible, the number students with disabilities for the 2002 undergraduate pre-registration intake

7. Please indicate, if possible, the ethnic breakdown of students by number on your undergraduate and postgraduate pre-registration course(s)

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8a. Do your undergraduate students and/or postgraduate pre-registration students experience any interprofessional education within the university? Yes/No

<table>
<thead>
<tr>
<th>Course</th>
<th>Teachers/trainers</th>
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3. Discipline, tick as appropriate

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<th>Course</th>
<th>Total</th>
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Role, responsibilities and accountability

Programme planning

Learning Contracts

Setting student tasks

Portfolios

Monitoring students progress

Student Assessment

Student Absence

Mentor/educator absence

Insurance issues

Communication skills

Coaching skills

Counselling skills

Teaching styles

Learning styles

Assignment writing

Reflective practice

Special needs

Cultural diversity

Report writing

Mentoring

Facilitation

Discipline

Confidentiality and ethics

Legal requirements

Consent

Rules and Regulations

Health Professions Council

---

education within the university? Yes/No
If yes please give details:

8b. If no, please indicate why not:

8c. Do all pre-registration students receive the same preparation prior to practice placement?
Yes/No/Not applicable
If yes please answer question 8d.
If no please answer question 8d. in relation to preparation of students for the course which has the greatest number of students.

Comment

8d. What preparation do students receive prior to practice placement:

Section C: Roles and Responsibilities

Comment

9. Does your university have someone with specific responsibility for managing the links between the University and clinical placements?
YES/NO

Comment

10. What criteria does the university set with regards to the qualifications and experience mentors/educators must have for mentoring/educating students on practice placement?

<table>
<thead>
<tr>
<th>Method</th>
<th>Yes/No</th>
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<tbody>
<tr>
<td>Portfolio</td>
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<tr>
<td>Observation of professional practice</td>
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<tr>
<td>Recording and reporting</td>
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<tr>
<td>Written reports</td>
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<tr>
<td>Reflective records</td>
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<tr>
<td>Case Studies</td>
<td></td>
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<tr>
<td>Peer discussion</td>
<td></td>
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<tr>
<td>Oral presentation</td>
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<td>Other (please specify)</td>
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</table>

11. To your knowledge are any practice based staff specifically allocated to fulltime practice placement support?
YES/NO

Comment

Section D: Preparation of clinical educators/mentors

12a. What courses do you offer to prepare clinical practice mentors/educators for their role, where are these courses held?

<table>
<thead>
<tr>
<th>Staff involved</th>
<th>Formative (ongoing)</th>
<th>Summative (Final)</th>
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<tbody>
<tr>
<td>Manager or deputy</td>
<td></td>
<td></td>
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<tr>
<td>Named practice supervisor</td>
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<tr>
<td>Senior clinicians as group</td>
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<tr>
<td>HEI Placement tutor</td>
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<tr>
<td>Other (specify)</td>
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Section G Concluding comments

(please continue on a separate sheet if required)

19. List up to 3 benefits work based supervisors have highlighted regarding their experience of supervising students on practice placement

1. 

2. 

3. 

20. List up to 3 problems that practice-based supervisors bring to your attention regarding the supervision of students on practice placement

1. 

2. 

3. 

21. In an ideal world, what measures would help to address these problems? Please list in order of priority

1. 

2. 

3. 

22. Are there any comments you would like to make regarding the support of mentors/educators that you have not covered in the audit?

Thank you for completing this questionnaire

APPENDIX TWO: Postal Questionnaire Covering Letter

Dear
As the key person in placement provision you have been approached as the individual in your institution most able to provide information about practice placements in a specific discipline.

The practice placement experience of health care students is key to successful education and training of the health care workforce. This Funding Development in Teaching and Learning (FDTL4) project, funded by Higher Education Funding Council England (HEFCE) and the Department of Employment and Learning (DEL) Northern Ireland aims to help educators/mentors become more effective at supporting and supervising students in the workplace across the following range of healthcare disciplines:

- Nursing
- Physiotherapy
- Occupational Therapy
- Radiography
- Dietetics

The project will develop generic materials to support practice placement educators/mentors taking healthcare students for their pre-registration practice placements. Prior to developing these materials, we need your views as to what is required. Your experience in this area will form an essential component of this project. For further information you are invited to access the project website. http://www.practicebasedlearning.org/quest.htm

The aims of the this report include:

a. Auditing the university based preparation of practitioners for their educational role in supporting students during practice placements.

b. Identifying principles of good practice that emerge from the audit.

We would be grateful if you would complete the audit on behalf of your HEI. You can complete the audit online at http://www.practicebasedlearning.org and submit it directly to the Audit administrator, Chris Turnock. Alternatively, you can save the document and either: complete and save as a word document, which can be emailed to chris.turnock@unn.ac.uk; print the document and post a completed printed version to Chris Turnock;

H216
Main Building
Northumbria University

Please complete separate audits for each discipline if you are reporting on more than one discipline.

We have a team working on writing the final report for this project and the member of the team working in your discipline will contact you to talk through any issues you may have in/when completing the audit. As a result of completing the questionnaire you will receive a copy of this report and you will be kept informed of developments resulting from the project.

All data will be stored on password-protected computers and will be treated as confidential.

In addition, we are interested in highlighting and sharing good practice in this area. We would be grateful if you would identify any aspects of your institution’s approach to practice based learning that exemplifies good practice and/or innovation.

Yours sincerely

J. Mulholland
Project Director

ALL COMPLETED AUDITS RECEIVED BY 13/10/03 WILL BE ENTERED IN A DRAW FOR £100 BOOK TOKEN PRACTICE-BASED LEARNING AUDIT

APPENDIX THREE: Focus Group Questionnaire

Please write down your answers to the following questions. They will be used to inform the workshop discussions. We would also like to collect the answers at the end of the conference as your answers may be used in case studies on the nature of practice education in health care.

INSTITUTION:

DISCIPLINE:

What is good practice in preparation of practitioners for educating students on practice placement?

What factors influence the quality of practice education?

What materials could be developed to help make practitioners more effective practice educators?
Data Collection References


