Appendix B

Summary of Interviews with Staff at Leeds

Alison Ledger

This report summarises key findings from interviews undertaken with twenty-one staff involved in the clinical training of healthcare students between July 2011 and March 2012.

Staff involved in clinical placement teaching of undergraduate audiology, medicine, or nursing students were recruited for interview. In all three professions, university staff members served as gatekeepers to potential participants. In audiology, potential participants were sent a recruitment email by the audiology clinical placement co-ordinator. In medicine, recruitment emails were sent out by the hospital and primary care placement leads. In nursing, university staff passed out information about the study at meetings, emailed personal contacts, and placed an advertisement in a newsletter for student mentors on the nursing practice placements website. Across professions, staff were asked to contact the researcher (Dr Alison Ledger) if they wished to participate in an interview. It should therefore be acknowledged that interview participants were most likely people who volunteer and who were enthusiastic about teaching students.

Two audiology educators, nine medicine educators and ten nursing educators volunteered to be interviewed. Interviews were arranged at times and places convenient to the participants (either at the university or at the participants' place of work). All interviews were conducted by Alison Ledger, a research fellow independent of the healthcare training courses. All except one interview was conducted on an individual basis. Two nurse mentors expressed a preference to be interviewed at the same time, so they could continue carrying out work on the day unit (the researcher remained at the nursing station while the interviewees moved about).

The purpose of the interviews was to gain further background to the information provided in student interviews, and to determine whether there were any major differences between students' and staff members' understandings about placement. Interviews were narrative in style to allow staff to talk about what they considered most important in clinical placement learning. Alison asked interviewees an open-ended question to stimulate conversation - "tell me about your involvement in placements". Follow-up questions were asked to gain additional information and clarification, such as "Can you tell me about a specific time when students were really involved?". All interviews were audio-recorded and later transcribed, with the exception of the pair interview. As the pair interview took place on a hospital ward, the researcher took notes and made a more detailed summary of the interview immediately afterwards.

Individual interview transcripts were read repeatedly and summarised by way of 1-2 page case summaries (1 per interview). First, members of the research team read the case summaries independently to identify critical issues in early clinical placement learning. The team then came together to discuss and determine key research findings.

This summary document summarises key findings in relation to two of the original four research questions: Are there any differences in what students say they are doing and what staff members say that students are doing? and how can we help facilitate clinical placement learning? Key findings are presented by profession.

Audiology

In audiology, two interviews were undertaken with qualified audiologists who supervised third year audiology students. One worked in a large city teaching hospital (Meg), the other worked in a smaller district hospital (Hanna).

Audiology staff interviewees verified what the students had said about their clinical placement activities. Interviewees explained how students progressively took over parts of their appointments and were included as members of their audiology departments. Both interviewees reported close relationships with students and described students as "colleagues", "friends", or even "family". Students were valued for their contributions to the team and were included in meetings, rotas, and social outings.

Both interviewees reported that they invested significant amounts of time and effort in the first few months of a student placement, as early efforts paid dividends in the long run. Meg explained:

"we find that if you do that [work with students] intensively for the first 6 months you get them to a much better stage of competence and confidence so that you can actually get more out of them in the second 6 months... because they are more ready then to pass their assessments first time, instead of having to do them 2 and 3 times 'cause they are not quite up to it and they're more ready to then be used as another pair of hands, so you waste a lot of clinical time in some ways in the first 6 months because you are having to have longer appointment times because you're with a student and you know, you're not seeing as many patients because of that but then you gain that back big time in the second 6 months because you've got 2 students that are useable whereas if you are not with them very much in those first 6 months, they can sort of do the clinical work, probably just about competently but there's, they are not confident doing it and they are maybe not at as a higher level as they should be"

Hanna also explained the benefits of allocating extra time in the beginning to students' learning:

"when I schedule somebody together [a qualified audiologist], they are always given an extra 15 minutes doing that process for filling in the log book and discussion, and at the very beginning, the appointments are often made a bit longer to allow time for you've done the appointment and then feedback - this is what was good, this is what was bad, this is why I did this, this is why I did that, so to begin with erm you know there is certainly enough time for discussion. Again, as the student gets more proficient there is less need for that discussion, but it was feedback from my mentors a few years ago that they were finding they were doing appointments but not able to talk about why so we just added in, it might be 15 minutes to half an hour in that morning or afternoon session that they get to discuss."

Both Meg and Hanna recognised that students sometimes struggle with variations in practice and with sensitive and unexpected situations. However, both agreed that it was important for students to have these experiences, so they would be capable of working with a range of people in the future. Hanna further explained how it was important for students to encounter differences and to consider why these occur. She said that in practice, there is not necessarily a "right" and "wrong" and students need to learn to practice in "grey areas".

Medicine

In medicine, a variety of educators were recruited to reflect the range of possible placement scenarios. Five were hospital doctors, one was a placement co-ordinator at one of the major teaching hospitals (with a nursing background), and two were GPs with additional leadership responsibilities at the university.

Medicine educators' responses were similar to students' reports of their placement activities. Hospital-based educators described how students carried out histories and examinations, interacted with patients and carers, practiced procedures on and off the wards, and attended tutorials on various topics. William (general medicine consultant) explained how 3rd year students were expected to be honing their "generic" clinical skills and learning "how to get things done on a ward".

GP educators described how students observed consultations, spent time with various professionals, practiced procedures, attended tutorials on topics relevant to their stage of training, and visited long-term patients in their homes. Stephen (primary care placement lead) indicated that the specific areas of focus for early GP placements were communication skills, knowledge about the NHS, and professional behaviour. Meredith (GP) expressed a view that the GP practice was a particularly supportive environment for students:

"You can't be lost in a big system when you're in a small practice... It's coming to somewhere they feel welcome, they feel... they are a part of it, they know they are coming back so we get to know them a bit and that, you know, informal chatting with the staff and coming into the coffee room and that in itself is that community of practice-type experience really which is very important."

(1st year students return to the same GP practice in year 2.)

Medicine educators described how they had helped students to develop their skills through modelling, talking through strategies, offering praise, giving feedback, role-playing, debriefing, and intervening when students become stuck. Callum (surgeon) explained how he exposed his vulnerability in order to reassure and encourage students:

"You don't get to be a consultant by being perfect. You get to be a consultant by making lots of mistakes but getting back up and trying again... I think a lot of medicine is like that – watching, learning, seeing other people make mistakes and hope that they are not making the same mistake... you can stop somebody learning the hard way by saying this is what I did, it all went wrong."

Although medical student interviewees expressed a strong desire to be involved, it was clear that medical educators didn't expect much from 1st or 3rd year students. Students

were frequently described as "nervous" or "apprehensive" and educators perceived that they needed a certain amount of direction and support. However, not all educators saw this as a bad thing. Brian (surgical consultant) observed that students were reluctant to touch and talk to strangers, but:

"you expect it at 3rd year levels and it's probably good and normal that they're not very confident"

Brian also explained how he didn't expect 3rd years to be making significant contributions to clinical work:

"I'm not too bothered... providing they concentrate on the bits they need to pick up, I don't think it's important that they 'help' from our point of view certainly... I mean [I] appreciate from their point of view it might be nice to feel useful, but I suspect in practice they don't do very much."

Medicine educators pointed to a number of factors which may enhance the student experience. These factors included small team environments (e.g. GP practices), small group sizes, enthusiastic and encouraging supervisors, repeated contact with staff and patients, opportunities to become involved, to be challenged and to debrief, and organizational support for teaching. Medicine educators also emphasized the importance of small gestures, such as greeting students, knowing students' names and showing them a place to put their bags or hang their coats. Misba (paediatrician) also suggested that a designated support person is crucial:

"what makes placement work would be someone who they can identify with and someone that they can actually go and see and who is present"

Several interviewees emphasized the significant contributions of junior staff and interprofessional colleagues in teaching medical students. Robert (student placement director at a district hospital) was particularly concerned that other staff received insufficient credit for teaching medical students. He expressed embarrassment that junior doctors and nurses do much of the teaching, yet receive comparatively little reward for their efforts:

"The best I can do... would be to write somebody a letter, an email, going 'this person was very, very helpful to me in helping to teach.' Bit wet isn't it?"

Nursing

A range of nursing educators were also recruited for interview. Two were community nurses who supervised students in GP practices, three were nurse mentors in outpatient/day surgery wards, two were nurse mentors in elderly care, one was a nurse mentor who worked on a respiratory ward, one was a practice learning facilitator who co-ordinated nursing placements at a large city teaching hospital, and one was a university nursing lecturer who was recommended as a reliable informant about undergraduate placements in elderly care.

Nurse mentors explained their understandings of their role. They explained how they assisted students to develop their confidence and skills, through encouraging participation and reflection, explaining practice, "passing on" their experience, challenging students, and providing appropriate support. Nurse mentors also indicated that it was their responsibility to structure placements, by selecting appropriate patients and professionals for student to see, limiting information overload, striking a balance between repetition, variety, straightforward and complex cases, and adapting the placement according to individual students' needs. Some interviewees explained how they prompted and assisted students with their university course requirements and notified the university when concerns about individual students arose. Interviewees appeared to take their mentor role seriously and saw it as their role to ensure patient safety now and in the future.

Nurse interviewees described how first year students work alongside healthcare assistants and qualified nurses, observing practice and practicing procedures under supervision. Sophie (nurse mentor, outpatient ward) explained how the purpose of early placements was to give students an overview of how things work, to provide them with a "window into the hospital", and to focus on the "gist" not the detail. Nurse educators indicated that they didn't expect much from 1st year students, though some students exceeded expectations. They reported wide variability in 1st year students' levels of confidence and "preparedness", due to factors such as the student's age, and previous work and training experience.

Nurse interviewees further highlighted the complexities of students' participation in "basic care" tasks and interactions with healthcare assistants. Some interviewees explained how through providing "basic care", students gained valuable opportunities to develop their communication, observation, and history taking skills and to contribute to the work of the clinical team. However, it was evident that there were times when students were placed with healthcare assistants because wards were under-staffed and qualified nurses were "too busy" to work with students. Mathilde (nurse mentor, elderly care) emphasized that it was important to acknowledge this situation when it occurred:

"when say the staffing is really bad, [when] there is only me and a healthcare assistant to one side and the student is there as an extra pair of hands, I always acknowledge that and say to the student you know, 'How do you feel about your shift today? How do you think it went?' and they will say something like, 'Well I don't know, I didn't really learn much, I didn't really do much today. I just sort of bed-bathed and toileted and just sort of hoisting patients into bed and stuff like that.' and I said, 'Well you know I am conscious of it and I'm sorry about today, but erm you know you've just got to... I'm really sorry about the staffing but I've not had that time to give you the one on one sort of tuition if you like or the support that they might have needed.' It does make you feel bad but sometimes you just can't do it."

Isabelle (nurse mentor, respiratory ward) shared an example of a time when a student refused to do "healthcare work", leading to a disagreement between the student and a healthcare assistant. Though she viewed this students' behaviour as unacceptable, she also referred to times when healthcare assistants may not be the best people for nursing students to be working with. She described how healthcare students may not "challenge"

students enough, or be unfamiliar with first year students' levels of experience. In one example, a student had been asked by a healthcare assistant to stay with a recently deceased patient without receiving adequate preparation.

Nurse interviewees provided examples of situations which may have been difficult for students. These included students' first exposure to naked bodies, emergency situations, death, and sensitive issues (e.g. pregnancy terminations). While nurse interviewees recognised that these situations were potentially difficult, they also stressed the need for students to experience aspects which they would later encounter in their careers. They perceived that it was most important that they provided students with adequate support, supervision, and debriefing opportunities when difficulties occurred. For example, Kayla (community nurse) explained how she and students discussed difficult situations in the car between appointments.

Like staff in the other professions, nurse interviewees highlighted aspects that they believed helped students feel part of the team. They described how they provided introductions and orientation on the first day and allowed students to participate in handovers, ward rounds, and case conferences. Only Kayla (community nurse) expressed reservations about involving students in team meetings, as she felt it limited community workers' abilities to debrief openly and to gain support from each other. Additionally, Isabelle (nurse mentor, respiratory ward) indicated that some clinical environments were more inclusive than others. She reflected:

"I don't know whether it's just like the culture of that ward, we tend to like all work together, the doctors, the nurses and everyone, we form like a nice bunch... so anybody coming in tends to also get into that culture of the ward 'cause that's the way... It's just the way we work and then it makes things work."

Like nursing student interviewees, nurse educators pointed to the value of placement interviews in facilitating placement learning. Nurse mentors indicated that these were useful for providing initial orientation, goal setting and reviewing progress, as well as for adapting placements according to individual students' abilities and interests. Isabelle (respiratory), Mathilde (elderly), Suzie and Jen (day unit) provided examples of how they had arranged for students to meet other professionals or to attend team meetings on the basis of their discussions with students in interviews.

Perceptions about students' placement logbooks appeared to be more mixed. Mathilde (nurse mentor, elderly care) and Sophie (nurse mentor, outpatient ward) suggested that the Nursing and Midwifery Council categorisation of skills reduced overwhelmment and aided in goal setting. However Kayla (community nurse) indicated that the logbooks were repetitive and time-consuming. A larger sample of nurse mentors may have provided greater clarity around the impact of logbooks on students' learning.

Summary

Interviews with Leeds healthcare educators indicated that placements were working well. Although it is likely that staff interviewees were a particularly enthusiastic group, they gave

the impression that students gained valuable opportunities to develop their skills and were supported through new and challenging situations.

In relation to the ways that students participate on placement, staff and student interviewees' responses were remarkably similar. Staff and students' descriptions of student activities and placement aims were reasonably well-matched. The only mismatch detected was the degree to which staff and students expected students to become involved. Students in all three professions expressed a desire to become involved, to contribute to clinical work, and to prove themselves as budding health professionals. However, it was evident that staff held much lower expectations of students' participation in early placements. Staff didn't expect students to know too much or to make significant contributions to the work of the team. This was particularly the case in medicine and nursing, where students enter new placement sites frequently. This mismatch between staff and students' expectations suggests that it may be helpful for staff to communicate their expectations about participation to students. Staff could explain that while they intend to involve students as much as possible, the focus is on the students' learning and not their contributions to patients' care. These sorts of explanations could be provided in nursing placement interviews and in similar meetings in audiology and medicine.

Staff interviewees reported that students experienced new and challenging situations and that these experiences were essential for students' ongoing development. Perhaps for this reason, staff interviewees stressed the need to make time for students, to explain why a situation occurred, to field any questions, and to allow students a chance to discuss their reactions to the work. In medicine, the debriefing role is often performed by a placement co-ordinator, but in audiology and nursing, debriefing times are usually provided by the student's primary supervisor or a helpful member of staff. In all cases, it appeared beneficial for students to have a designated person who they could go to for support.

Across all three professions, an important factor which appeared to facilitate learning was the students' degree of familiarity with the placement environment and staff. Staff interviewees indicated that students developed their abilities and confidence over time and through repeated contact with patients and professionals. Staff perceived that students benefited most from placements when they received individual attention and when they got to know staff well. Although it may not be possible to extend the length of placements or reduce student group sizes, interviewees pointed to simple ways in which students' placement experiences could be enhanced. Small things such as welcoming gestures, encouragement, reassurance, and praise appeared to have a large impact on students' feelings about placement, as well as their motivation to practice and develop their skills.