NET2012

TUESDAY 4 – THURSDAY 6 SEPTEMBER 2012

Robinson College, University of Cambridge, CB3 9AN, UK

NET networking for education in healthcare

23rd International Networking for Healthcare Education Conference

Second group of theme sessions Curriculum innovations and enhancement 2

Second group of theme sessions

Curriculum innovations and enhancement 2

Core and theme papers

Wednesday 5 and Thursday 6 September

Please note:
References are as supplied by authors
Papers included are those being presented at the conference at the time of going to press.

Core paper

Biographical details of core presenter

Curriculum innovations and enhancement 2

Gylo Hercelinskyj

Gylo Hercelinskyj, PhD, is a registered nurse and experienced nurse academic. Her clinical, teaching and research expertise and areas of publication are in mental health, interprofessional learning, innovative educational approaches to learning and teaching identity and social inclusion.

She has extensive experience in teaching at undergraduate and postgraduate levels and is currently an Assistant Professor in Nursing at the University of Canberra.

C12

Learning for real life: a report on the collaborative development of a simulated learning module for nursing and allied health students in the Australian Capital Territory, Australia

Gylo Hercelinskyj, Assistant Professor in Nursing, University of Canberra, Australia

Introduction

Regardless of the health discipline, there is an urgent need to prepare students for the complexities of working in today's multifaceted healthcare system (National Health and Hospitals Reform Commission, 2009). Increasingly-crowded curricula and limited clinical learning opportunities mean that we need to not only select and deliver appropriate content in a finite timeframe but also provide students with the opportunity to experience their practice within a realistic context of clinical practice. Students must make sense of their environment, the consumers and colleagues they interact with, their role, responsibilities and accountabilities. As educators we must also prepare students to be 'global citizens' by ensuring students' skills and knowledge meet professional standards for registration and university-defined 'generic graduate attributes'.

Contemporary health services are also increasing the call for teamwork and cooperation in multidisciplinary group practice (Belanger and Rodriguez, 2008). Multidisciplinary teams are seen to provide the best opportunity for consumers to receive care influenced by a range of professional understandings. The aim is to improve the quality and diversity of care options offered (Dennis, 2006), with effective communication between health professionals viewed as one of the cornerstones of high quality patient care. In Australia, national policy statements around such areas as workforce planning and development, mental health and primary health, all promote the need for multidisciplinary teams to deal with and respond to the increasingly complex needs of patients and their families (Australian Health Ministers, 2009). The National Health and Hospitals Reform Commission (National Health and Hospitals Reform Commission, 2009) also stated that the modern health workforce required 'modern learning and [a] supported workforce' (p.121).

To meet these government policy directions and provide students with the capacity to deliver healthcare within a multidisciplinary framework, it is crucial that students be taught accordingly (MacDonald *et al.*, 2008). The challenge lies in finding space in already-crowded, discipline-specific curricula, to provide such an approach to professional development. These learning opportunities also need to reflect the multi-profession reality of healthcare practice in order to maximise students' understanding of each others' professional roles (Ker *et al.*, 2003).

As a nurse academic I am interested in developing learning opportunities for nursing students to engage with their colleagues from other disciplines, develop critical thinking skills, and experience the collaborative process of multidisciplinary team work in a structured and safe environment. This paper explores a pilot study in providing an interprofessional clinical learning experience for students in a simulated virtual setting, *Second Life*. Interprofessional education, and the novel virtual environment in which it took place in this pilot, is considered to offer rich opportunities for multidisciplinary learning and team work. While the evaluation of the students' experience of the pilot is yet to be undertaken, this paper reports on my experiences and observations as a nurse academic in using this type of pedagogical approach with nursing students to foster an understanding of working as part of a multidisciplinary team. These observations offer lessons for other academics and educators in nursing and for preparing our nursing students for an interprofessional working experience in general.

This paper first considers some of the issues and challenges in developing teaching and learning strategies that provide students with interprofessional learning experiences and opportunities. It then provides an overview of the Australian Capital Territory Clinical Training Subsidies Network, Health Workforce Australia Simulated Learning Project, developed between colleagues from the Canberra Institute of Technology and University of Canberra, before reflecting on the collaborative relationship between the two educational institutions (University of Canberra and Canberra Institute of Technology) in the development, pilot testing and evaluation of CSLEP.

Interprofessional education and practice: opportunities and challenges for teachers

Authentic learning opportunities that replicate the reality of clinical practice (Lave and Wenger, 1991) are considered vital for promoting role socialisation and a sense of professional identity (Hercelinskyj and McEwan, 2011). However, increasingly-limited clinical learning opportunities limit student contact with peers and health colleagues, and can impede their integration into the multidisciplinary context of practice. Interprofessional education is considered a form of collaborative learning from, and about, other disciplines, for the purpose of improving team work and consumer outcomes. Interprofessional education is seen as the means by which clinicians can develop the knowledge and skills to ensure that more effective and efficient service delivery – via a multidisciplinary team structure – can occur (Priest *et al.*, 2008). Some argue that interprofessional learning increases understanding of others' role and scope of practice as well as facilitates collaboration in practice (Ker, Mole and Bradley, 2003) in a way that uni-professional teaching and learning strategies cannot do. Additionally, students are thought to have the opportunity to work together closely and communicate frequently, develop trust and mutual respect (Devonshire and Wozniak, 2006; Hall and Weaver, 2001). In this context, the multidisciplinary team can be viewed as a community of practice (Wenger, 2006; 1998).

However, in the clinical context, the multidisciplinary team concept requires deeper analysis. The team has an identity defined by their shared sphere of interest, namely the provision of healthcare to a patient. Membership of the team requires and presumes a commitment to the team process (e.g. collaborative activities and discussions, support, and information-sharing) and therefore a sharing of discipline-specific knowledge and competence. While members of the multidisciplinary team will thus build relationships that enable them to learn from and with each other, this presupposes time and sustained interaction (Wenger, 2006). There is limited research on how nurse educators reconcile the intentions or aspirations of interprofessional education and the realities of clinical practice and tertiary education delivery. This paper aims to address this lacuna.

Simulated virtual learning environments: a setting for interprofessional education and practice
Simulated learning environments are learning spaces that provide learning, teaching and professional socialization opportunities. These environments can be viewed as what Donavan, Hutchison and Kelly (2003) describe as a controlled learning environment. This type of learning environment is viewed as the means by which students can develop clinical and professional communication skills in a realistic and safe environment (Ker *et al.*, 2003; Hilton and Pollard, 2004). Simulated learning environments closely replicate the actual clinical environment and contribute to authentic learning experiences (Clapper, 2010; Herrington, 2006). As (Clouder *et al.*, 2011) explain, simulated learning environments as a general concept provide a 'powerful interface' to draw together students from diverse professional backgrounds to engage in rich dialogue and learning, develop empathy for each other, and is an ideal medium for promoting interprofessional learning and practice (Bradley and Postlethwaite, 2003; Craddock *et al.*, 2006). The use of simulated learning environments is well established in a number of disciplines including health. Simulated virtual learning environments are web based teaching and learning environments that use a metaphor of physical space and place (Grenfell and Warren, 2010, p.25) to provide teaching and learning opportunities for students. Both real time and virtual simulated environments have been used in the ACT previously but not to facilitate interprofessional engagement and learning between students.

In an effort to investigate what this type of learning environment might offer to health students, the project involved a simulated virtual learning environment with the intention being to provide an opportunity for students to use new technologies and to access new ways of learning (Metcalfe *et al.*, 2009), and to promote collaboration, communication and team work. The project team was nevertheless aware of distinct differences in the virtual and real-time environments; for instance, unlike real-time simulated environments, there is not the same competition for physical and human resources, such as space and large numbers of staff. However the need for appropriately preparing staff to design, implement and evaluate such endeavours and the need to gain the support of educators and other key stakeholders has been identified as crucial or the success of such ventures (Greenstock *et al.*, 2011; Health Workforce Australia, 2010).

Overview of context
The Collaborative Simulated Learning Environment Package (CSLEP) is a collaborative venture between two educational and health service providers in the Australian Capital Territory (the University of Canberra and the Canberra Institute of Technology), funded by the Australian Capital Territory Government and Health Workforce Australia. This project commenced in 2010 and finished in July 2012. The aim of this project was to provide access to simulated learning environments for tertiary educational and health service providers in the Australian Capital Territory. Using the virtual platform *Second Life,* students from nursing and allied health disciplines collaborated in the assessment and collaborative care planning for a virtual client. A number of processes were established to oversee the development of this project:

- constitution of the steering committee
- teaching and learning strategies
- working party
- Wiki development
- use of *Second Life*.

Constitution of a steering committee
In October 2011, a steering committee was established by and for representatives from Canberra Institute of Technology and University of Canberra. This group comprised thirteen members and had oversight of the project. The steering committee was also responsible for establishing an appropriate pedagogical framework for the development of the teaching and learning strategies and designing the evaluation of the pilot project. The committee met every second month between October 2011 and June 2012. A working party was also created, and was responsible for developing the teaching and learning strategies developed by the steering committee (see below).

Teaching and learning strategies
The steering committee agreed to develop two specific teaching and learning strategies in the virtual environment. The strategy discussed in this paper was a clinical scenario; it involved admission of a fictional older person to an acute hospital setting, for whom a multidisciplinary team of students (enrolled nurse, community

worker, nurse, pharmacist and dietician) needed to work collaboratively to provide an assessment and develop a comprehensive, multidisciplinary care plan.[1]

Working party
The working party (a subset of the steering committee) constituted academic representatives from CIT and UC. Staff represented the disciplines of nursing, enrolled nursing, community work, dietetics, aged care and pharmacy. The role of the working party was to develop the clinical scenario, script the characters and health journey of the fictional patient, and describe the learning outcomes for students from each discipline group. The working party was also required to review the *Second Life* environment and work with educational designers to modify the CIT Hospital environment to meet the needs of the activity.

Wiki development
A Wiki was established to facilitate communication between the steering committee and working party members. The Wiki held relevant project documentation and allowed members to collaborate by editing documents as works-in-progress. The intention of the Wiki was to facilitate communication between the steering committee and the working party in relation to the oversight, development and implementation of the project.

The Wiki was also used as part of the student experience in this activity. Students would be able to ask questions of the patient in the clinical scenario, and the correct questions elicited additional information which would help them continue to work through the scenario.

Second Life
The CIT Hospital on *Second Life* was viewed as a suitable virtual environment for the location of the scenario. Developed in 2003 by LindenLabs in San Francisco*, Second Life* was seen to support the aim of collaborative learning opportunities by providing students with a *virtual* community of practice (Lave and Wenger, 1991) in which to practise and develop requisite skills in multidisciplinary team work (Grenfell, 2008). *Second Life* avatars were customised to suit the different roles of the care team and patient.

The intended learning outcomes for students from this activity were:
- to apply their discipline-specific (relevant) assessment and care planning process to the health journey of Eunice Bennett
- to practice communication within the context of a multidisciplinary team
- to attend a 'virtual multidisciplinary team meeting' in *Second Life*, to discuss and develop a collegiate plan for Eunice, with the other members of the health team.

This activity took place over two weeks during winter term at the University of Canberra and semester break at the Canberra Institute of Technology. This period of time included one orientation session to the *Second Life* environment and Wiki, specific times for each student to meet and assess the virtual client and a designated time for the multidisciplinary team meeting.

Reflecting on the journey: key challenges

1. Project communication
The project involved a large team from a variety of disciplines in two different organisations. As such, establishing effective organisational and communication processes was challenging. While the Wiki was particularly effective as a communication tool between team members, members nonetheless had competing demands on their time; all carried full time teaching loads, held various administrative portfolios and were involved in other research activities. This meant that, at times, communication was sporadic. Someone needed to take on the role of coordinating the working party members others to prevent a lag in project momentum. In order to ensure project momentum, the working party needed coordination in a timely manner; however this was not considered nor put in place at the outset of the project. As a result, two members (one from each institution) assumed *'de facto'* coordinator roles of the working party's activity, and took responsibility for the final look of the Wiki and *Second Life* environment.

2. Understanding and utilising the virtual environment
The steering committee and working party had membership from staff with a variety of experiences and knowledge of virtual environments. This added to the existing complexity of the design task in that designing the virtual learning environment required additional thought and planning than mere pedagogical considerations. In fact, the members had to address pedagogical questions such as 'What are the most effective teaching and learning strategies for this particular environment'? 'How do we meaningfully replicate our practice in a virtual environment?' On the one hand, the team sought to use terminology that was familiar to students (irrespective of discipline). Yet on the other hand the team was conscious of maintaining the integrity of students' disciplinary understandings. Furthermore, while the steering committee and working party believed that the teaching and learning strategy they chose would meet the intended learning outcomes, they were aware that the exercise had to have efficacy and practicality for students. That is, the student experience had to be one that was meaningful,

[1] The second project not reported in this paper was the development of a scenario that provided nurse and enrolled nurse students with the opportunity to develop their skills in administering intravenous therapy.

actively engage them, accommodate their other study and work commitments, and leave them wanting to know and learn more (Clapper, 2010).

3. Promoting multidisciplinary collaboration and participation
Another concern of the steering committee and working party was to develop teaching and learning strategies that met certain criteria in the student experience. These criteria were to:
1. Facilitate multidisciplinary collaboration
2. Ensure meaningful participation of each group member
3. Adequately acknowledge the scope of practice of each disciplinary area
4. Provide students with equal opportunity to demonstrate their knowledge and skill within their identified scope of practice.

Therefore, the development of the 'task' itself was a critical component of the teaching and learning strategy, in order for students to experience the activity as authentic and credible (Herrington, 2006) at the same time as expand their understanding and awareness of other disciplinary concerns and approaches.

4. Interprofessional education as an 'ideal' type
While the provision of an interprofessional educational experience was the objective of this project, it might be more appropriately considered an 'ideal' type. Neither the students nor the working party had the opportunity to build the depth of relationship required to effectively work together in their respective teams. This feature of interprofessional education is largely absent in the literature. The working party needed to be cognisant that not all students would have a clear idea of their own professional role and identity, an understanding of what effective teamwork involved, communication skills (e.g. negotiation and conflict resolution skills), or the ability to recognise the role, scope of practice, and professional boundaries of other health disciplines. Moreover, the students who undertook this project came from a variety of undergraduate and graduate entry programs. While this is to be expected in the modern tertiary environment, it was nevertheless implausible to expect the students to have the same level of understanding and experience as each other. This, too, appears to be an overlooked aspect in the literature. In fact, what appeared to be missing was some kind of 'precursor' or preliminary work (aside from an orientation to the activity, *Second Life* environment and Wiki); to the type of learning environment they could expect in the activity. Example skills include being able to comfortably enter into a community of diverse practitioners, enact their discipline-specific understandings and role, connect confidently with other disciplines, and to share their beliefs, values and knowledge about their practice (Gherardi, 2006; Lee, 2009).

Lessons learned
Coming together in any collaborative venture is an opportunity to learn new knowledge, skills and importantly to reflect on the processes that took place during the course of the collaboration. It is important to reflect on these challenges in terms of the learning that took place since these challenges offer insight into what opportunities exist for improving projects like this in future.

The successful outcome of any collaboration requires team leadership and coordination. While there were designated project coordinators from both institutions leadership at the working party level was less clearly defined.

It is essential that all members involved in such projects have similar levels of pedagogical and technological competence on the part of the task-design team. The resources required to bring interdisciplinary team members *up to speed* with aspects such as the design and use of the various technologies is significant. An alternative strategy that is recommended is that members of this project team could develop a series of virtual scenarios that tertiary institutions around Australia could access along with a guide for the group of educators whose students would be undertaking the activity.

The experience of designing teaching and learning activities such as this highlight the need for continuing to develop activities that acknowledge and build a multidisciplinary ethos but which do so in way that build the skills and knowledge students require to take part in this type of learning activity, skills that are assumed in the literature. More specific thought and planning needs to be given the type and length preparation, orientation and induction student have prior to embarking on such activities.

Conclusion
At the time of writing this paper, the *Second Life* scenario is ready for testing and evaluation by student and staff participants. Ethical clearance has been gained from both institutions and the evaluation will comprise both qualitative and quantitative data. The results of this evaluation will be used to plan how this activity will be further developed and integrated as a core interprofessional learning activity between Canberra Institute of Technology and the University of Canberra. This paper has identified additional lessons that should shape any future iteration of this learning tool in an effort to make it more practicable and meaningful for both students and educator-academics.

Acknowledgements
The author acknowledges the project funding support provided by the Australian Capital Territory Government and Health Workforce Australia; the combined efforts of a number of committed academics from the University of Canberra and Canberra Institute of Technology who made this project work (in particular Ms Lynette Jackson and

Ms Kathy Korsch (CIT) and Professor Deborah Davis from the University of Canberra). The author is also deeply indebted to her writing mentor Dr Anna Hutchens for her comments and editing of earlier drafts of this paper.

References

Australian Health Ministers (2009) *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009–2014.* Australian Commonwealth Government.

Belanger, E., Rodriguez, C. (2008) More than the sum of its parts? A qualitative research synthesis on multi-disciplinary primary health care teams. *Journal of Interprofessional Care,* 22: 587-597.

Bradley, P., Postlethwaite, K. (2003) Setting up a clinical skills learning facility. *Medical Education,* 37: 6-13.

Clapper, T.C. (2010) Beyond Knowles: what those conducting simulation need to know about adult learning theory. *Clinical Simulation in Nursing,* 6: e7-e14.

Clouder, D.L., Goodman, S., Bluteau, P., Jackson, A., Davies, B., Merriman, L. (2011) An investigation of "agreement" in the context of interprofessional discussion online: A "netiquette" of interprofessional learning? *Journal of Interprofessional Care,* 25: 112-118.

Craddock, D., O'Halloran, C., Borthwick, A., McPherson, K. (2006) Interprofessional education in health and social care: fashion or informed practice? *Learning in Health and Social Care,* 5: 220-242.

Dennis, S. (2006) The tip of the iceberg. In: C. Gamble, G. Brennan (eds) *Working with Serious Mental Illness. A manual for clinical practice* (2nd edn). Edinburgh: Elsevier.

Devonshire, L., Wozniak, H. (2006) Working together: developing eLearning activities to promote interprofessional learning. *Synergy*. Available from: http://www.itl.usyd.edu.au/synergy/pdfs/2325.pdf (accessed on 7 October 2012).

Donovan, T., Hutchison, T., Kelly, A. (2003) Using simulated patients in a multiprofessional communications skills programme: reflections from the programme facilitators. *European Journal of Cancer Care,* 12. Available from: http://ezproxy.canberra.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=9885627&site=ehost-live

Gherardi, S. (2006) *Organizational Knowledge. The texture of workplace learning.* Malden: Blackwell Publishing.

Greenstock, L., Brooks, P., Bingham, A. (2011) *Interprofessional Learning (IPL) Opportunities in Simulation.* Report prepared by the Australian Health Workforce Institute. Version 2.

Grenfell, J. (2008) *A Postcard from Second Life. Deakin Arts Education Centre in Second Life. A report on the implementation of the Arts Education STALGS Grant 2007.* Melbourne: Deakin University.

Hall, P., Weaver, L. (2001) Interdisciplinary education and teamwork: a long and winding road. *Medical Education,* 35: 867-875.

Health Workforce Australia (2010) *Use of Simulated Learning Environments (SLE) in Professional Entry Level Curricula of selected professions in Australia.*

Hercelinskyj, J., McEwan, B. (2011) The Charles Darwin University Hospital: Creating an authentic virtual learning environment for undergraduate nursing students. In: M. Keppell (ed.) *Physical and Virtual Learning Spaces in Higher Education*. IGI Global.

Herrington, J. (2006) *Authentic E-learning in Higher Education: Design principles for authentic learning environments and tasks.* Chesapeake, Vancouver: World Conference on E-Learning in Corporate, Government, Healthcare, and Higher Education.

Hilton, P., Pollard, C. (2004) Supporting clinical skills developments. *Nursing Standard,* 18. Available from: http://ezproxy.canberra.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=13128722&site=ehost-live

Ker, J., Mole, L., Bradley, P. (2003) Early introduction to interprofessional learning: a simulated ward environment. *Medical Education,* 37: 248-255.

Lave, J., Wenger, E. (1991) *Situated Learning: Legitimate peripheral participation.* Cambridge: Cambridge University Press.

Lee, M.J.W. (2009) How can 3d virtual worlds be used to support collaborative learning? *Journal of e-learning and Knowledge Society,* 5. Available from: http://je-lks.maieutiche.economia.unitn.it/index.php/Je-LKS_EN/article/viewFile/300/282 (accessed on 10 June2012).

Macdonald, C.J., Stodel, E.J., Chambers, L.W. (2008) An online interprofessional learning resource for physicians, pharmacists, nurse practitioners, and nurses in long-term care: benefits, barriers, and lessons learned. *Informatics for Health and Social Care,* 33: 21-38.

Metcalfe, S.J., Clarke, J., Dede, C. (2009) *Virtual Worlds for Education.* River Ciry and EcoMUVE. MiT6 International Conference.

National Health and Hospitals Reform Commission (2009) *A Healthier Future for all Australians:* Final report of the National Health and Hospitals Reform Commission.

Priest, H.M., Roberts, P., Dent, H., Blincoe, C., Lawton, D., Armstrong, C. (2008) Interprofessional education and working in mental health: in search of the evidence base. *Journal of Nursing Management,* 16: 474-485.

Wenger, E. (1998) *Communities of Practice,* Cambridge: Cambridge University Press.

Wenger, E. (2006) *Communities of Practice.* Available from: http://www.ewenger.com/theory/ (accessed on 7 June 2012).

Key words

- multidisciplinary teams
- simulated learning environment
- health education
- interprofessional education
- *Second Life.*

Theme papers

T92

An exploration of student nurses development of the therapeutic relationship

Ann Marie Rice, Lecturer, University of Glasgow; Effie Maclellan, Emeritus Professor, Strathclyde University, Glasgow, UK

Rationale
The therapeutic relationship is integral to the provision of good nursing care and communication is fundamental to this relationship (Moore, 2005). Poor communication and perceived lack of compassion is a common cause of complaint by patients (Audit Scotland, 2008). Literature related to the therapeutic relationship is predominately found in the field of psychology and within nursing, psychiatry and oncology/palliative care (Shatell *et al*., 2005). There is less evidence related to how student nurses develop this relationship. The common themes that emerge from both bodies of literature are empathy, self-awareness and respect. Exploring development in these areas formed the main focus of the study.

Study design
A qualitative case study approach was chosen as the research design. Undergraduate students were studied over 3 years of nurse education, including a new communication skills course which addressed the identified themes.

Sample
A convenience sample of 23 students agreed to participate in the study with 17 students completing.

Data collection tools
- Self-administered vignette (1) scenarios designed to identify empathy and respect (2) four questions to detect self-awareness, completed at the beginning of year one and repeated at the end of each year. Vignettes use brief scenarios, to elicit a range of responses / reactions to a situation and, insight into perceptions, beliefs, judgements and knowledge (Polit and Beck, 2008).
- Johari window to explore self-awareness – repeated each year.
- Focus groups - beginning year 2 and mid point year 3, to explore the impact of the theory, practice learning and other factors.

Results
Vignettes: evidence of development of respect and empathy in all students. Over time, use of more sophisticated language and evidence that empathy and respect embedded in practice. Evidence of development of self-awareness, supported by the Johari window – development in the fourth quadrant (unknown) in all students.

Focus groups: identified a shift from a conscious effort to develop the relationship to a more integrated approach to engagement and communication with patients.

Key themes included:
- role modelling
- trust and openness
- impact on patient outcomes
- reflective practice
- theory – early stages of training
- barriers – staff attitudes, preconceived beliefs about the patient, ward culture, time
- facilitators – reflection, mentor feedback, respect
- nurse attributes – professionalism, patience, openness, trustworthy, confident, knowledgeable, respectful, empathetic.

Conclusion
Students demonstrated development in all three areas and an increased understanding off the therapeutic relationship, its role in nursing and patient outcomes *'it's the most important thing'.* Students understood the facilitators and barriers and were influenced by role models *'my mentor was brilliant with patients; I want to be just like her when I'm qualified'.* Embedding the 3 common themes in the communication skills course facilitated understanding and development of the therapeutic relationship.

References
Audit Scotland (2008) Edinburgh: Scottish Executive Health Department.

Moore, C. (2005) Communication issues and advance care planning. *Seminars in Oncology Nursing*, 21: 1, 11-19.

Polit, D.F, Beck, C.T. (2008) *Nursing Research Principles and Methods* (8th edn). Philadelphia: Lippincott Williams and Wilkins.

Shattell, M.M., Starr, S.S., Thomas, S.P. (2007) Take my hand, help me out: mental health service recipients' experience of the therapeutic relationship. *International Journal of Mental Health Nursing,* 16: 274-285.

Key words:
- curriculum enhancement
- learning
- theory
- practice.

How this contributes to knowledge development within this theme:
- perceptions of the benefits of the therapeutic relationship
- what influences development
- how students recognise a therapeutic relationship.

T93

Are we virtually there yet?

Jenny Bailey, Midwife Teacher, University of Nottingham, UK

Lord Dearing (1997) stated that flexibility in delivering education should include the use of information technology. He further commented about the 'under exploitation' of available technology, mainly due to staff resistance and limited computer aided learning (CAL) resources in the nursing/midwifery educational institutions. However recently there has been a plethora of e-learning tools and multimedia developments which allow a more dynamic approach to education.

One such technology is that of virtual reality where students can learn by being immersed in a clinical situation and learn through role play as the 'story' unfolds.

Immersive learning in the virtual arena can enable students to have a 'being there' presence despite physical separation (McKerlich *et al.,* 2011) from the clinical arena. Virtual worlds provide an excellent opportunity for students to exploit connectivist learning pedagogies, where rich interactions amongst the participants can be achieved.

At the University of Nottingham a virtual maternity unit has been developed on their island in Second Life. Second life is a virtual world which simulates real life, and many universities in the UK have a presence there. Avatars have been developed to provide simulation and role play of communication and management of clinical birthing scenarios. The students log in as midwives who are represented by a variety of avatars (black, white, Asian and male), whilst the teacher can adopt the pregnant avatar Gaia. The midwife teacher can direct the role play and has a control panel where basic observations of labour can be changed as progress is simulated. The midwife teacher can alter the basic observations at any time; this includes vital signs, progression in labour and neonatal observations . Interaction is by text chat which appears on the screen, however there is also the facility to use voice controls.

Second life has a virtual 4 hour day and so the light naturally fades and illuminates as the day progresses … this can be overridden where necessary, and the midwife teacher can literally change time as labour progresses. This would allow a whole birthing scenario to be role played within 20-30 minutes rather than a real life time of 18-20 hours or so. Pre-made avatars are important as the whole essence of the project is to help students learn about and practice communication and management of labour. It is not about how to use second life, having said that it does help students become familiar with IT.

This has been a challenging project with regard to time restraints, funding and maintenance of the area; however it is ready for use. Students have helped with the development by using it and helping find any glitches. A second life club has been started which students can attend. Currently the students have not attended in great numbers and perhaps the experience needs to be incorporated into the curriculum to ensure its use. This will be reviewed.

For the future, once normality as a feature has been is established and practiced by students the scenarios can be adapted to include abnormality and pathology, and there is the possibility of the external examiner being present virtually as an avatar for OSCE type assessments where the external can be one of the avatars and watch the scene from her PC. It could also be used by student nurses and medical students in preparation prior to their midwifery placements.

Globalisation of teaching is very important, I strongly believe we have a moral obligation to provide learning resources and share with other institutions from around the world. Where there is IT access this development could also be used as a learning resource.

References
Dearing, R. (1997) *The National Committee of Inquiry into Higher Education*.

McKerlich, M., Rils, M., Anderson, T., Eastman, B. (2011) Student perceptions of teaching presence, social presence and cognitive presence in a virtual world. *MERLOT Journal of Online Learning and Teaching*, 7: 3.

Key words:
- immersive learning
- virtual reality
- simulation
- role play
- communication.

How this contributes to knowledge development within this theme:
- immersive learning enables students to have a feeling of 'being there' presence
- roe play will allow students to develop communication skills and management of care issues
- immersive learning could be used for OSCE type assessment.

T94

UChoose. Broadening the virtual patient paradigm: case examples and evaluation

Simon Messer, Principal Lecturer; Matthew Cownie, Learning and Technology Unit Manager; Fiona Bastow, Senior Lecturer; Rachel Williams, Senior Lecturer; Sheena Payne, Senior Lecturer; Aniko Varadi, Reader, University of the West of England, UK

The importance of simulation in health and social care education has been highlighted in the NHS's recent Technology Enhanced Learning Framework (Department of Health, 2011). Virtual Patients (VPs) are 'interactive computer simulations of real-life clinical scenarios for the purpose of medical training, education, or assessment' (Ellaway *et al*., 2006). Written as either narrative or problem solving branched systems, Virtual Patients utilise a wide set of patient-related data, with which the learner interacts with online and attempts to make a correct diagnosis and proposal for treatment. The data can be presented in multi-media formats which enhance the learning experience (Prensky, 2001).

Virtual Patients are recognised as effective tools that offer the learner the opportunity to practice clinical decision making and test their knowledge in a situated but risk free environment where mistakes are allowed, and even encouraged, to aid the learning process (Zary *et al*., 2006). They also provide a viable alternative for student-patient contact in a workplace where budget constraints are affecting the opportunities for clinical placement (Balasubramaniam and Poulton, 2009). Virtual Patients are learner centred and whilst often associated with problem-based learning (PBL), they can also be considered as examples of case-based learning (CBL). Pedagogically, Virtual Patients promote higher thinking skills such as analysis, synthesis and decision making. This is particularly so of branched systems, where the learner's decisions affect the management of the patient, and hence the pathway taken through the case, resulting in a number of different possible outcomes. Further, they have been shown to be an effective curricula intervention for small group collaborative working (Poulton *et al.,* 2011).

In this paper, we present UChoose, a player for interactive case based learning developed at the University of the West of England with its own content management system for easy case authoring. Primarily developed as a Virtual Patients player, the software conforms to the international Medbiquitous standard for virtual patients, allowing for exchange of cases across systems and institutions (Medbiquitous, 2010). However, the applications for this learning tool extend beyond those of a traditional virtual patient and we present an overview of number of example cases that demonstrate the versatility of this learning tool, including:

- A virtual drug round for level one undergraduate nursing students.
- A simulation of a GP consultation, developed in partnership with Avon, Somerset and Wiltshire Cancer Services for GP case-based learning.
- A virtual nursing student for clinical mentor training.
- Postgraduate midwifery witness skills training interprofessional collaboration with the law school.
- Simulations for biomedical sciences.
- The use of UChoose for formative and summative assessment.

A summary of supporting evaluative data from learners is also presented. Overall, learner evaluation is shown to be very positive with the benefits of interactivity, situated learning and flexible access being highlighted, and we conclude that the UChoose tool provides an accessible and cost effective solution for the presentation of online interactive problem-based learning and case-based learning scenarios.

References
Balasubramaniam, C., Poulton, T. (2009) *The Repurposing Existing Virtual Patients Project (REViP).* Final Report. Available from: http://www.jisc.ac.uk/media/documents/programmes/elearningcapital/revipfinalreport.pdf (accessed on 20 January 2012).

Department of Health (2011) *A framework for technology enhanced learning*. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130924 (accessed on 20 January 2012).

Ellaway, R., Candler, C., Greene, P., Smothers, V. (2006) *An Architectural Model for MedBiquitous Virtual Patients.* Technical report. Baltimore: MedBiquitous.

Medbiquitous (2010) ANSI/MEDBIQ VP.10.1-2010 *Medbiquitous Virtual Patient Specifications and Description Document*. Available from: http://www.medbiq.org/working_groups/virtual_patient/VirtualPatientDataSpecification.pdf (accessed on 21 January 2012).

Poulton, T., Balasubramaniam, C., Jivram, T. (2011) *Building a Virtual Patient Curriculum.* Workshop in Medbiquitous Annual Conference, Baltimore, MA. (May 9-11).

Prensky, M. (2001) Digital natives, digital immigrants. *On the Horizon*, *NCB: University Press*, 9: 5.

Zary, N., Johnson, G., Boberg, J., Fors, U. (2006) *Development, Implementation and Pilot Evaluation of a Web-based Virtual Patient Case Simulation Environment – Web-SP*. Available from: http://www.biomedcentral.com/1472-6920/6/10/ (accessed on 20 January 2012).

Key words:
- virtual patient
- simulation
- e-learning
- assessment.

How this contributes to knowledge development within this theme:
- is focussed on e-learning
- is an innovative approach to both formative and summative assessment
- virtual patients offer a learning and teaching strategy for case-based learning.

T95

Enhancing nursing curriculum: synthesizing standards, concepts, and outcomes

Mario R. Ortiz, Associate Professor and Chair of Nursing, Duneland Health Council Faculty Scholar, Purdue University North Central, Westville, Indiana, USA

The purpose of this core paper is to outline a nursing curriculum and program enhancement process that synthesizes nursing core quality standards, educational and practice competencies, and outcomes with the values and beliefs of nursing faculty. This will be done by discussing how the purposes and outcomes of nursing education programs are met. It is important to evaluate micro- and macro-levels within nursing curriculum through a fluid circular process from specific courses and levels through to the curriculum and program outcomes.

Enhancing nursing curriculum happens through assessment and evaluation processes that must be viewed as ongoing and systematic to meet accreditation standards and expectations of all stakeholders (Suhayda and Miller, 2006). The micro-level or specific course level process involves assessing student progress in individual and outcomes for an assignment or individual nursing course. Curriculum evaluation is an ongoing process that serves to ensure the delivery of quality education (Giddens and Morton, 2010). Quality in nursing education is often evaluated according to the ways in which a nursing curriculum prepares graduates according to standards that are deemed central to quality nursing education and necessary for entry-level safe nursing practice. For example, in the United Kingdom, the Nursing and Midwifery Council (2004) outlines *Standards of Proficiency for Pre-Registration Nursing Education*; and in the United States, the accreditation standards developed by the National League for Nursing Accreditation Commission (2008) and the Commission on Collegiate Nursing Education (2009) serve as guidelines for the evaluation of program effectiveness, along with *Quality and Safety Competencies* as outlined by Quality and Safety Education for Nurses (2011). It is important to determine whether nursing curricula incorporate the necessary skills and knowledge to prepare graduates for the current healthcare environment (Leibbrandt, Brown and White, 2005). Nurse and health educators must be knowledgeable about practice and education standards, so that they may facilitate and assess student progress toward their attainment.

The processes of enhancing nursing curriculum must be integrated into the nursing program and its committee structure. This means that the educational committees would have a direct or indirect role in program evaluation. For example, the university assessment committee, which is the governing evaluation committee, assists in

steering the evaluation plan. Then, the nursing enrolment and progression committee examines relationships between student enrollment characteristics and student program success. The curriculum committee examines relationships between the curriculum, teaching-learning practices, and performance indicators. The facilities and resources committee examines utilization and satisfaction indicators as they pertain to learning resources and practice environments. And finally, the evaluation committee examines aggregated data from each nursing educational level within the program and compares it with the systematic evaluation plan, program outcome data, and determines when action and/or change is needed.

This Core paper will outline the nursing program's standards, concepts, and outcomes.

References

Commission on Collegiate Nursing Education (2009) *Standards for accreditation of baccalaureate and graduate degree nursing programs.* Available from: http://www.aacn.nche.edu/ccne-accreditation/standards09.pdf (accessed 14 December 2011).

Giddens, J.F., Morton, N. (2010) Report card: an evaluation of a concept-based curriculum. *Nursing Education Perspectives, 31*: 6, 372-377.

Leibbrandt, L., Brown, D., White, J. (2005) National comparative curriculum evaluation of baccalaureate nursing degrees: a framework for the practice based professions. *Nurse Education Today, 25:* 418–429.

National League for Nursing Accreditation Commission (2008) *Standards and criteria*. Available from: http://nlnac.org/manuals/SC2008_BACCALAUREATE.htm (accessed 14 December 2011).

Nursing and Midwifery Council (2004) *Standards of proficiency for pre-registration nursing education*. Available from: http://www.nmc-uk.org/Documents/Standards/nmcStandardsofProficiencyForPre_RegistrationNursingEducation.pdf (accessed 14 December 2011).

Quality and Safety Education for Nurses (2011) *Quality and safety competencies*. Available at: http://www.qsen.org/competencies.php (accessed 14 December 2011).

Suhayda, R., Miller, J.M. (2006) Optimising evaluation of nursing education programs. *Nurse Educator, 31*: 5, 200–206.

Key words:
- nursing education
- curriculum evaluation
- program evaluation
- professional practice standards.

How this contributes to knowledge development within this theme:
- utilize curriculum enhancement as a meaningful learning experience
- outline congruencies between national competencies with program and course outcomes
- facilitate enhanced student learning outcomes.

T96

Examining the educational values and experiences of assessors (lecturers and practitioners) in relation to viva voce (oral) examinations

Tina Moore, Senior Lecturer; Marion Hinds, Senior Lecturer, Middlesex University, London, UK

Historically, the viva voce or oral examination has been used as one of the many ways in which to assess the learner's knowledge and understanding, both formatively and summatively of the subject material. Whilst this process has proven to be useful as a method of assessment, it has also created a number of challenges. It is viewed as a method which permits the learner to demonstrate a deeper level of understanding; alternatively it is perceived as being time consuming with the possibility of assessor bias. Unless assessors are carefully selected, trained and monitored, assessments may become haphazard.

The use of the viva voce as an assessment tool can facilitate and examine the higher order skills of clinical analysis, synthesis and evaluation. But for it to be reliable, valid, and acceptable, consistent approaches in assessment is vital.

For a number of years Middlesex University have used this method to assess Year 3 learners undertaking the Diploma Advanced and Degree Nursing programmes. As this process has evolved, a number of changes, resulting from student evaluations have been implemented and evaluated. In order to further refine this process and enhance quality, validity and reliability, assessor values and experiences were investigated.

This presentation will put forward the findings of an exploratory study. The results revealed that this mode of assessment provides the opportunity to test the application of the student's knowledge and understanding into the 'real world' of nursing practice and in doing so, enable the discrimination between superficial and real/deep knowledge. This allows the assessor to differentiate the higher order cognitive skills and probe the student's knowledge, understanding and application of complex and abstract concepts for clinical decision making and problem solving. In addition, it can test communication, interpersonal skills and qualities of professionalism.

The final conclusion reached is that the assessor's experiences of clinical practice, practice related knowledge together with effective questioning of the student is closely related to the quality and validity of the assessment process. As a result, several recommendations were made to enhance the quality of assessment and the learner experience.

Key words:
- oral assessment,
- nursing practice.

How this contributes to knowledge development within this theme:
- This study highlighted the reasons for inconsistencies in this mode of assessment
- Implementation of the recommendations from this research will improve reliability and validity of this assessment method
- The recommendations also ensure equity and fairness In assessing all students.

T97

Rejecting reflection: how reflective practice hinders rather than enhances professionalism in healthcare

Mark Cole, Head of Learning and Development, Camden and Islington NHS Foundation Trust, UK

Donald Schön, the leading theorist of reflective practice, argued in 1987 that *'In the varied topography of professional practice, there is a high, hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solution through the application of research-based theory and technique. In the swampy lowland, messy, confusing problems defy technical solution.'* (Schön, 1987, p.3) He argued that it was reflection – particularly the sort of the reflection undertaken as a means of learning from experience – that enabled the professional to engage with the complexity of day-to-day practice, a complexity for which basic professional education failed to prepare the practitioner.

Since Schön's arguments about reflection in professional practice first appeared, Reflective Practice has become the sine qua non for the competent healthcare professional. However, as early as 1993, Atkins and Murphy were compelled to note the lack of a common understanding of what reflection was in practice which made it difficult to evaluate the effectiveness of reflection. (Atkins and Murphy, 1993). To an extent, this marks a beginning in the literature around reflection of recognition that the practice lacks a convincing evidence base that demonstrates its efficacy and usefulness in healthcare.

Underscoring this observation, Greenwood noted that: *'There is also no evidence from the education sector that the use of reflection as a learning tool or strategy equips nurses to be better or more competent practitioners.'* (Mackinosh, 1998, p. 556) This finding was echoed over a decade later, where a systematic review of reflection and reflective practice in health professions education undertaken by Mann *et al.* (2009) led them to state that: *'We found no studies which measured change in clinical practice as a result of, or associated with, reflection.'* (Mann, Gordon and MacLeod, 2009, p.613) They went on to assert: *'Does reflection improve patient care? We found no evidence in this regard. This is not surprising; after all, we do not yet have evidence of differences in quality of care provided by reflective and non-reflective practitioners. However, awareness of uncertainty and validation of assumptions are part of reflective practice and might theoretically have the potential to improve patient care.'* (Mann, Gordon and MacLeod, 2009, pp.613-4)

Despite an evidence base that is based largely on individual case studies and anecdotal accounts, there is now a clear expectation that all healthcare professionals should be reflecting: within higher education, discussion ranges around how reflective activity among students might best be assessed; in practice, reflection is seen to be integral to continuing professional development (CPD), either as an activity in itself or as a means of maximising the benefit from a formal learning event; and practitioners whose performance is adjudged to require remediation are oftentimes required to reflect as part of that process – and to show evidence of having undertaken this.

Cole (2006) has made the case – using a Foucauldian approach – that reflection in healthcare is a discursive formation that relates strongly to notions such as the 'confessional' and wider issues of governmentality. This paper will pursue this analysis in order to distinguish between 'reflection' – an assemblage of activities that

distinguish professional from non-professional practice – and reflective practice, which is an apparatus that meshes discourse, institutions, practices and expectations from the perspective of governmentality.

Having freed the notion of 'reflection' from reflective practice, the paper will critically interrogate this concept with the express aim of disarticulating the range of attitudes, aptitudes and behaviours that are subsumed within this general notion. In so doing, it will release these from the restraints that have grown up around them and make an argument as to how the possession and development of these might be encouraged among professionals.

References

Atkins, S., Murphy, K. (1993) Reflection: a review of the literature. *Journal of Advanced Nursing,* 18: 1188-1192.

Cole, M. (2006) The Role of Confession in Reflective Practice: Monitored continuing professional development (CPD) in healthcare and the paradox of professional autonomy. In: D. Lyon, *Theorizing Surveillance: The panopticon and beyond.* (pp.206-229). Cullompton: Willan Publishing.

Mackinosh, C. (1998) Reflection: a flawed strategy for nursing. *Nurse Education Today,* 18: 553-557.

Mann, K., Gordon, J., MacLeod, A. (2009) Reflection and reflective practice in health professions education: systematic review. *Advances in Health Sciences Education,* 14*:* 595-621.

Schön, D. (1987) *Educating the Professional Practitioner: Towards a new design for teaching and learning in the professions.* San Francisco: Jossey-Bass.

Key words:

- reflection
- professional
- foucault
- governmentality
- learning.

How this contributes to knowledge development within this theme:

- critically explores the status of reflection in healthcare and the lack of a robust evidential base to demonstrate its effectiveness
- outlines a theory of reflective practice as an element of governmentality, particularly in respect to its action as a surveillant technology
- disarticulates the practice of reflection (as a key – and embedded – element of professional practice in healthcare) from the discourse of reflective practice in order to refocus on professionalism.

Conference committee

Dr Elisabeth Clark, The Open University, UK
Professor Lorraine Ellis, University of Derby, UK
Professor Philip Keeley, University of Manchester, UK
Professor Gary Rolfe, Swansea University, UK
Professor Fiona Timmins, Trinity College Dublin, Republic of Ireland

Scientific panel

Professor Collette Clifford, University of Birmingham, UK
Mrs Jacky Conduit, University of Birmingham, UK
Dr Kay Currie, Glasgow Caledonian University, UK
Dr Anitta Juntunen, Kajaani University of Applied Sciences, Finland
Dr Amanda Kenny, La Trobe University, Australia
Dr Andrew Mckie, The Robert Gordon University, UK
Professor Sara Owen, University of Lincoln, UK
Ms Patricia Proudford, Amity Group Pty Ltd, Australia
Professor Elizabeth Rosser, Bournemouth University, UK

Conference Convenors

Internationally known convenors have been invited to facilitate the theme groups:

Julia Ball, University of South Carolina Aiken, USA
Abbie Barnes, Keele University, UK
Elisabeth Clark, The Open University, UK
Kay Currie, Glasgow Caledonian University, UK
Karen Egenes, Loyola University, Chicago, USA
Lorraine Ellis, University of Derby, UK
Benny Goodman, University of Plymouth, UK
Carol Haigh, Manchester Metropolitan University, UK
Karen Holland, University of Salford, UK
Alex Hopkins, University of Wolverhampton, UK
Anitta Juntunen, Kajaani University of Applied Sciences, Finland
Philip Keeley, The University of Manchester, UK
Mandy Kenny, La Trobe University, Australia
Una Kyriacos, University of Cape Town, South Africa
Tom Laws, University of South Australia, Australia
Sian Maslin-Prothero, Edith Cowan University, Australia
Elizabeth Mason-Whitehead, University of Chester, UK
Milika Matiti, University of Nottingham UK
Pat Mayers, University of Cape Town, South Africa
Craig Phillips, University of South Australia, Australia
Gary Rolfe, Swansea University, UK
Elizabeth Rosser, Bournemouth University, UK
Fiona Timmins, Trinity College, Dublin, Ireland
Brian Webster, The Robert Gordon University, UK

NET
networking for education in healthcare

NET2012 Conference
Tuesday 4 – Thursday 6 September 2012

Conference organisers:

Jill Rogers Associates
6 The Maltings
Millfield
Cottenham
Cambridge CB24 8RE
United Kingdom

Tel: + 44 (0)1954 252020
Fax: + 44 (0)1954 252027
jra@jillrogersassociates.co.uk
www.jillrogersassociates.co.uk

#NET12Conf