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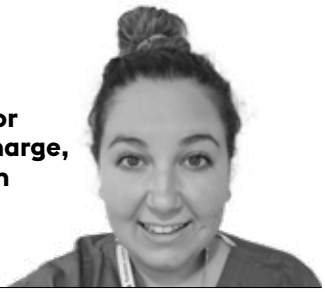

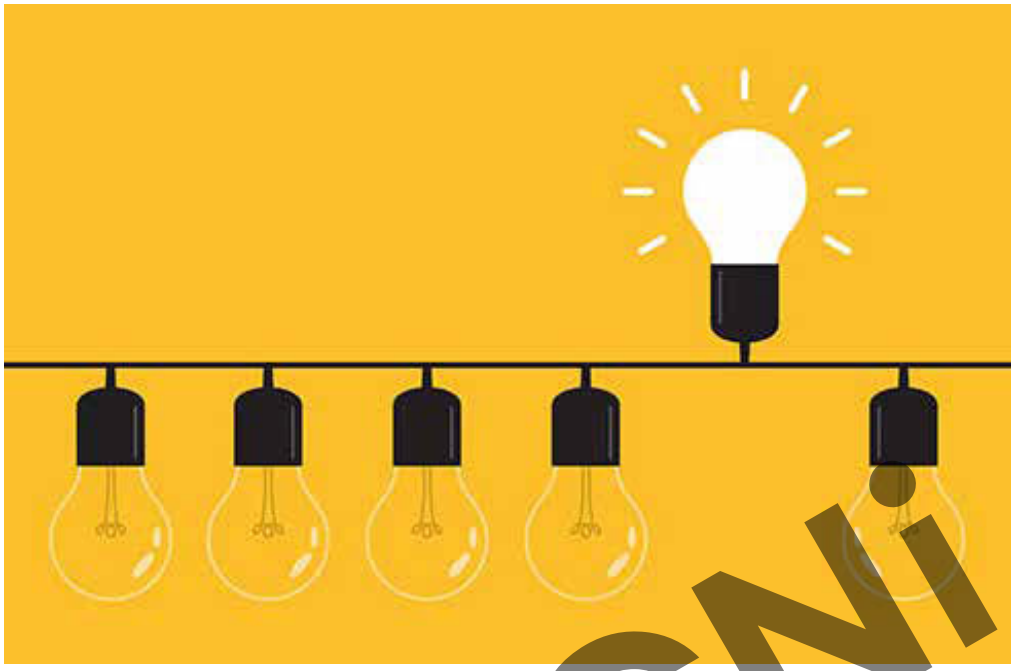

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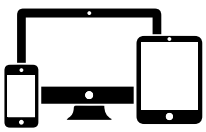

On the web
Everything you need to know about revalidation:
rcni.com/revalidation

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New content themes launched to guide and inspire nurse managers and their teams

The role of digital technology in the delivery of patient care was accelerated by the COVID-19 pandemic when remote triage and consultations became part of everyday practice in healthcare settings. Yet despite growing evidence that a digitally literate nursing workforce can support and enhance patient safety and outcomes, many nurses report a reluctance to engage in the use of digital technology.

By Sophie Blakemore
co-editor of Nursing Management
𝕏@editor_sophie

Lack of confidence in digital skills and a lack of training are some of the barriers cited by nurses in a clinical article in this issue (page 27) and a recent online article: Improving nurses' digital literacy and engagement with digital workflows through a data-driven education model (**rcni.com/data-digital-literacy**).

To help nurse leaders build their own and their teams' confidence and understanding in digital technology in healthcare, we have launched a 'digital nursing' content theme.

Our aim is to encourage nurses who have successfully implemented digital technology in their workplace to write and publish articles with us that share best practice and inspire others.

Another new theme this year is 'mental health' which we hope will support nurse managers and leaders to look after their own well-being, as well as that of their staff.

As healthcare services come under pressure in these demanding and financially challenged times, it is more important than ever to take care of yourself and your teams.

We are now commissioning articles on these new topics, as well as on our pre-existing themes which include leadership, communication, and workforce, and welcome any expressions of interest from potential authors passionate about sharing their work. You can email me at sophie.blakemore@rcni.com or go to Author guidelines (page 42) for publishing articles with RCNi.

I look forward to hearing from, and working with, you in 2024.

'As healthcare services come under pressure, it is important to take care of yourself and your teams'

Our mission

Nursing Management inspires and shares professional excellence in nursing leadership and patient care. Focusing on management and leadership trends as they affect the nursing sector, the journal provides trusted advice for senior managers, nurses in leadership roles and aspiring nurse leaders across all nursing disciplines. It is available in print or digital formats and includes unlimited access to our website.

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sophie.blakemore@rcni.com
jennifer.sprinks@rcni.com

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Twitter
@editor_sophie
@RCNI_Sprinks

Website
nursingmanagement.co.uk

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Why I wanted to be a nurse leader and how I set about achieving it

Three nurses reflect on how the Internationally Educated Nurses and Midwives Online Leadership Programme has affected their UK careers

By Lynne Pearce
health journalist

While many internationally educated nurses work at senior levels in their home countries, their experience and expertise is unlikely to be recognised when they first arrive in the UK.

But the Internationally Educated Nurses and Midwives Online Leadership Programme developed by the Florence Nightingale Foundation (FNF), working with the Burdett Trust for Nursing, aims to change this.

Here, three overseas nurses discuss how the course helped them achieve their leadership goals.

'If you want to progress further, a leadership course is a good place to start'

Johniel Jagonap is a senior staff nurse in anaesthetics at Queen Mary's Hospital, Roehampton

Feeling at a standstill in his career, Johniel Jagonap opted to do the leadership programme in the hope it might help him progress.

'I had been in my post for five years,' he says. 'I felt like I had become very skilled but I was still on band 5. I was promoted after doing the course.'

He credits the course with achieving his first band 6 role as a senior staff nurse in anaesthetics at St George's University Hospitals NHS Foundation Trust. 'I learned how to speak up and be confident in my communication. Even small things from the course have been helpful,' he says.

After qualifying in 2008 in the Philippines, Mr Jagonap worked as a theatre nurse. In 2017 he came to the UK, following in the footsteps of his sister who was already a sister at Frimley Park Hospital in Surrey, where he secured a post working in a urology ward.

But gaining his UK registration was challenging and after failing his objective structured clinical examination (OSCE) twice, he felt despondent. 'All of my dreams were shattered,' he says. He had to wait for six months before starting again from scratch and this time he was successful.

'I can be stubborn when I am under pressure and I didn't want to give up even though it was tough,' he says. But he believes his struggles have been beneficial. 'I'm able to use my resilience now,' he says.

Once he achieved his PIN, he successfully applied for a post at Basingstoke and North Hampshire Hospital, where he was initially a scrub nurse before moving into anaesthetics, where he stayed for the next four years.

'I wanted to see what healthcare in the UK was like and where Mary Seacole had trained. It felt like a calling'
Lelete Holson-Patterson

In August 2023, he started his new post as a senior staff nurse in anaesthetics, based in the surgical treatment centre at Queen Mary's Hospital in Roehampton. 'It is the highlight of my career so far,' says Mr Jagonap.

During the FNF course, he enjoyed discovering his own leadership style and learning how to present himself well, including understanding the importance of body language. 'It helps me to get my message across, and has helped to improve my confidence,' he says.

'I recommend the course, especially to those who feel stuck. If you want to progress further, a leadership course is a good place to start.'

'I reflect on an aspect of the course every single day'

Lelete Holson-Patterson is a clinical sister at Medway Maritime Hospital

Clinical sister Lelete Holson-Patterson has put her leadership course learning into practice, initiating a quality improvement project on her ward to improve discharge for patients.

'It has helped me carry out some strategies in my clinical setting,' says Ms Holson-Patterson, who works at Medway Maritime Hospital, part of Medway NHS Foundation Trust. 'Sometimes there can be challenges when discharging patients,' she adds.

Working with colleagues, Ms Holson-Patterson created a new system to help expedite safe discharge and improve patient flow.

She qualified as a nurse in Jamaica in 1998 and moved to the UK in 2019. She initially worked in care homes in London, Suffolk and the Midlands, achieving her UK nursing registration two months after she arrived.

Seeking a career change inspired her original decision to relocate. 'It felt like the right time,' says Ms Holson-Patterson. 'Most of our nursing education in Jamaica refers to the UK. I wanted to see what healthcare in the UK was like and where Mary Seacole had trained. It felt like a calling.'

She took up her current band 6 role two years ago before seeing the leadership programme advertised in two organisations where she is a member – the Caribbean Nurses and Midwives Association and the Nurses Association of Jamaica (UK). 'Both encouraged its members to explore it, so I applied,' she says. 'I was so happy when I got through. It was an eye-opener.'

She found the first module on personality enlightening. 'It looked at how we share and talk in the workplace and understand each other. It was refreshing and gave me another perspective,' she says.

Other highlights include modules looking at co-consulting (a method of action learning) and personal development. 'This is about how you present yourself, your confidence, how you articulate your concerns and how to gain attention,' she adds.

Ms Holson-Patterson completed the course in May 2023, and feels it will have a long-lasting impact, expanding her professional network and shaping her future career aspirations. 'It has definitely provided a useful road map for me, especially coming from overseas,' she says. 'It has helped me to see the opportunities that are here.'

Looking ahead, she hopes to move into education and research: 'I reflect on some aspect of the course every single day,' she says. 'I have been recommending it to everyone. It helps you to grow, not just professionally but personally too.'

'Life is short not to pursue your dreams'

Paul Jared De Jesus is a clinical educator at University Hospitals Birmingham NHS Foundation Trust

Just weeks after arriving in the UK, Paul Jared De Jesus was promoted to a band 6 role. 'Back then, I didn't understand the band system or appreciate it was a big thing for an internationally educated nurse to achieve this,' he says.

With 16 years' experience as a qualified nurse in the Philippines, Mr Jared De Jesus moved to Birmingham in October 2021, initially taking up a post as a theatre nurse at Solihull Hospital, part of University Hospitals Birmingham NHS Foundation Trust.

'The pandemic made me realise that life is short, and I needed to pursue my dreams of working overseas,' he recalls. 'Like many internationally recruited nurses, you want to provide a good life for your family, but also do something for yourself and explore the world.'

Three months later, he successfully applied for a clinical educator post at the trust, where he supports international nurses to pass their OSCE – a vital component of becoming a registered nurse in the UK.

Professionally, he became active on social media, where he first heard about the FNF leadership programme.

Among several aspects of the course he has found invaluable is taking the Myers-Briggs personality test. 'I'd done it before and it showed me as highly introverted, but now I'm in the middle,' says Mr Jared De Jesus. 'As we grow in our profession, our personality changes and it's important to have that awareness – for yourself and when you're interacting with others.'

Quality improvement

He also found the sessions on quality improvement useful. 'International nurses need to speak up when we want to see change,' he says. 'I have learnt how to approach this now. You need to give reasons and data before you ask to do a quality improvement project.'

'The pandemic made me realise that life is too short, and I needed to look at my goals and pursue my dreams of working overseas'

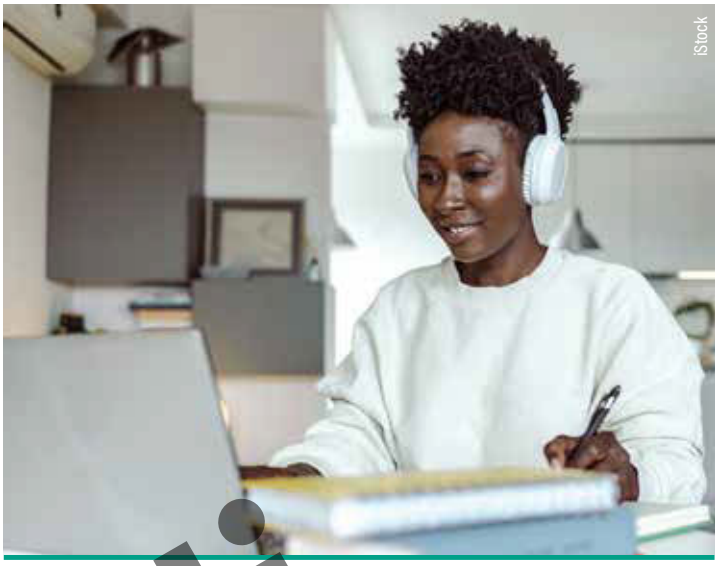
Paul Jared De Jesus

Since completing the course, he has been appointed to a newly created band 7 role as a safer staffing educator, starting this month. 'I'm delighted to get it,' he says. 'The inspiration I took from the course has definitely helped me and I would encourage others to do it. You will not only develop your leadership skills, but how to speak up and present yourself too.'

Now he hopes he can inspire others to fulfil their potential. 'I never shy away from telling my story to international nurses,' he says. 'Feedback has helped me develop my career and I am keen to pay it forward, passing on my knowledge and experience to help others advance.'

Further information

Florence Nightingale Foundation (2022) Internationally Educated Nurses and Midwives Online Leadership Programme. **tinyurl.com/FNF-leadership-programme**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What is the Internationally Educated Nurses and Midwives Online Leadership Programme?

Developed by the Florence Nightingale Foundation (FNF), with the Burdett Trust for Nursing, the Internationally Educated Nurses and Midwives (IENMs) Online Leadership Programme is a free course open to all IENMs practising in the UK, in the NHS, social care or private healthcare.

The eight-month long online course started in 2022, attracting 2,500 applicants for 1,000 places. The course offers IENMs the chance to develop their own authentic leadership style, enhance their skills and improve their career opportunities.

Eligibility requirements

To be eligible, practitioners must have gained their primary nursing or midwifery qualification outside the UK and be UK registered or going through the process and practising here.

The course takes about 30 to 40 hours of studying and there are five modules, which include personality preferences and performance in teams; leading with presence and impact; and using your authority and influencing change.

'Internationally educated nurses start off at band 5, which is a travesty when we're desperate for talented nurses in our health system,' says FNF director of nursing and midwifery leadership development Lucy Brown.

Self-belief and being heard

'We looked at what internationally educated nurses need to progress in their careers and spoke to individuals,' says Ms Brown.

'A lot centres on empowerment, which is about giving nurses a voice and a seat at the table. It's not just about banging on the door, but kicking it open, making sure they are being heard.'

Due to demand, a second course started in autumn 2023. 'We are hoping to run it subsequently, perhaps even twice a year. But we are looking for funding,' says Ms Brown.

Self-belief and finding their voice are the two biggest takeaways from the course, Ms Brown believes. 'Nurses suddenly look inwards and realise how incredible they are. We just hold a mirror up,' she says.

Ellie Grainger
Clinical nurse manager, Guy's and St Thomas' NHS Foundation Trust

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Overhauling the discharge process in day surgery

Nurses at a day treatment centre in London have challenged the standard four-hour wait after surgery

When designing the day surgery unit in our new children's day treatment centre at Evelina London Children's Hospital, families wanted to know why – regardless of the type of procedure – their children had to wait four hours after general anaesthetic before discharge.

Some children undergo short or simple procedures or scans, and keeping them in hospital for four hours post-operation may not be beneficial or necessary.

I am passionate about improving the experience for children in hospital, in particular for those having day surgery. As a clinical nurse manager, I tried to establish why we had a four-hour wait.

Rather than there being any clinical guidance or evidence to say that something happens at four hours post-anaesthesia meaning a child can be discharged, the reason appeared to be more 'because this is what we've always done'.

Due to the somewhat arbitrary nature of our existing discharge process we decided to develop instead a 'criteria-led' discharge process by consulting post-general anaesthesia guidelines. This process would allow children to return home sooner, when appropriate, without additional time spent waiting on the ward.

It is important for children to return to a familiar and comfortable setting, in a less busy and more private environment where they can recover. Hospital environments are generally loud and busy, especially on a short-stay post-operative ward.

Essentially, criteria-led discharge means there is a set of pre-defined criteria that each child must reach before they can be discharged.

These criteria include: observations being consistent with pre-operative baseline observations, the child being alert and having returned to their usual behaviour, pain is controlled, no nausea or vomiting, tolerating fluids, wound site clean and dry (if applicable), cannula removed and post-operative advice given and understood.

In addition there are three supplementary criteria, which are applied on a case-by-case basis by the surgical/medical team:

1. Passing urine (mainly for urology patients or those who have had caudal anaesthesia).
2. A minimum of three hours wait for some (mainly children who have had a tonsillectomy).
3. The child must be reviewed by the medical/surgical team before discharge.

Increased capacity

Once the child has reached the generic criteria and any of the three other additional criteria, they can be discharged. Feedback after implementing the pathway has shown it benefits the family and the hospital. The amount of time children waited on the ward after their operation, particularly for plastic surgery and gastroenterology procedures, has been significantly reduced.

Criteria-led discharge also means that one bed space has the potential to be used multiple times in a day. Therefore, more children can receive the elective surgery or procedure that they have been waiting for. For example, in our new unit we have 13 bed spaces and we now have the capacity to treat up to 16 children a day.

Bringing in a new way of working was not without its challenges. Changing the mindset of the clinical team, who have always kept children for four hours and to make sure they pass urine after general anaesthetic, was the biggest.

'It is nurses who are responsible for signing the child off as fit for discharge, so they needed to feel confident in their decisions and assessments'

Ensuring that nursing staff felt confident enough to discharge patients sooner was crucial. It is nurses who sign the criteria-led discharge document meaning that they are responsible for signing the child off as fit for discharge, so they needed to feel confident in their decisions and assessments.

The change was implemented successfully because the project was collaborative, involving the contribution of nurses, anaesthetists and surgeons. This gave everyone a feeling of ownership, which was important when implementing the changes and making them successful.

Since introducing criteria-led discharge and presenting at various teaching sessions, other wards at Evelina London have been in touch to start adopting it. It has also been presented at a national forum and other wider teaching sessions, and I have been contacted by colleagues in other hospitals who are interested in introducing it to their practice.

How the day treatment centre introduced criteria-led discharge

I was involved in the planning for the new children's day surgery unit ahead of its opening and the team decided that all children and young people should follow the criteria-led discharge pathway. A team made up of the clinical leads for the unit, a service improvement manager, a practice development nurse and the clinical nurse manager set about developing a criteria-led discharge process.

First, we conducted audits on different services and how long children were staying on the ward after their operation before being discharged. I created a teaching session for the ward nurses as well as a competency document to ensure that nurses had the appropriate training to be able to follow the new pathway. I added it to our handover sheet so that people were reminded about it every day.

Designing a survey

The other members of the pilot team presented criteria-led discharge to their own teams and encouraged them to fill out the forms. During the pilot period, we audited the timings again to establish what difference, if any, criteria-led discharge was making to the patient flow and discharge timings.

We designed a survey with the service improvement team to be given to staff and families to gain feedback about the process. This was positive, with all patients who responded to the survey telling us they felt they were sent home at the right time.

I felt broken after a clinical negligence complaint

An accusation about my nursing practice blighted my life. Now I want to help others break this dangerous taboo

Anonymous
The author is an advanced nurse practitioner who worked in general practice until 2022

As a nurse, the idea of anyone imagining you would harm a patient seems to me unthinkable. The thought of hurting someone through your actions is sickening. We go into nursing to do good and make a difference. We want to be there at times when people need us the most and help them through.

Being a nurse is what makes me who I am. But last year my world stopped when a patient complained about the care I gave, and sought to bring a clinical negligence claim against me.

I had recently relocated and was settling into my job at a new practice when it happened. While waiting for my next patient one morning, I received an email from NHS Resolution, forwarded by my previous boss, confirming that a complaint had been made about me and was now being pursued legally by a patient.

I was dumbstruck. My heart began racing. I couldn't see straight.

Statement of response

When I rang the contact number on the email, the basics of the claim were explained to me and I was told I needed to write a statement of response, stating what had happened in the consultation in question, which was two years ago.


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Shaking uncontrollably, I walked out of work, making an excuse to my manager, and drove home in a daze.

I had so many emotions: anger, fear, embarrassment, shame, terror. I needed to figure out who to speak to – did I need to tell the Nursing and Midwifery Council? Did I need to tell my new boss? How could I continue to practise as normal when this was looming over me?

I felt so alone. I cried for days. I was ashamed to tell my husband, my family, my colleagues. When I spoke to my GP, it was even hard to tell her what was happening – I was worried about giving a bad impression to another healthcare professional.

Even though it had not been proved that I had actually done anything wrong, I felt like the existence of the claim threw a shadow of doubt over my clinical integrity.

Union guidance

My union gave me useful guidance to help me to write my statement. I went over the day of the consultation again and again, writing notes, trying to ensure I didn't miss the tiniest detail. Luckily my clinical notes were very good, which helped my case.

When I received the full details of the complaint against my old practice, in which I was the only named person, my solicitor felt we had good grounds to dispute the entire claim. The thought of going to court terrified me, but I still strongly felt I was in the right, so we agreed to dispute.

I didn't feel I could work as a clinical nurse at this time – I had lost trust in my patients and my confidence was gone – so I lined up a job in a non-clinical role as I had to pay the bills. I wasn't required to mention the case to them, so they didn't know about it.

It felt like I was two different people, wearing my 'happy work persona' mask in the office, then coming home and feeling completely broken.

Needing normality

Throughout the process, my mental health was put under immense strain. I had always thought I was good at taking care of myself, but this experience tested me to the extreme. I have had to learn to give myself permission to practise self-care, especially on days when I just wanted to wallow in self-pity.

At other times, I have had to motivate myself to take part in activities and social events that I desperately didn't want to go to because I knew

'How could I continue to practise as normal when this was looming over me?'

'Everyone hopes something like this won't happen, but I am proof that it does. I urge you to be prepared in case it happens to you'

I needed that 'normality' – even if I felt like I was hiding my true self behind a mask of smiles and idle chit-chat.

I didn't want to talk about it even with my husband and parents. I felt ashamed in case I had done something wrong and deserved all this. I have panic attacks now, something that has never happened to me before, and even had moments of feeling suicidal. I have had dark times, but I sought professional help and have been given medication and the psychological support I need to help me manage daily life.

Everyone hopes something like this won't happen, but I am proof that it does. I would urge you, my fellow nurses, to be prepared in case it happens to you, and to work on building up your mental strength, which is something I wish I had done.

Healthcare pressures

In the current financial climate, with such tremendous healthcare pressures and an increasingly litigious culture, it feels like the likelihood of similar legal actions is growing.

When it happened to me, I fell apart. Fourteen years after qualifying, having studied for a master's and a non-medical prescribing qualification to become an advanced nurse practitioner, I left the NHS job that I loved because of the fear that it might happen again. And I cannot see myself ever returning to clinical practice.

If it happens to you, don't be like me and try to deal with it on your own: seek help, talk to people. It may feel like a taboo subject but try not to be ashamed. Your colleagues will support you. And make sure you document everything. My documentation saved me.

My case was ultimately dropped by the patient following a lengthy investigation by NHS Resolution, which fully supported my stance that I had done nothing wrong, but I will never be the same again. I'm now a stronger person, but I'm a broken nurse.

I have spoken to a select few colleagues about my case, many of whom have opened up about similar issues or complaints that they too never speak off. We need to bring these conversations out into the open. It could happen to any of us, so for all our sakes, we need to break this taboo.

The author can be contacted at heartbrokennurse@aol.com

Further information

Better Health and NHS (2023) Get Your Free Mind Plan. **tinyurl.com/BHNHS-mind-plan**

NHS (2024) Practitioner Health. **www.practitionerhealth.nhs.uk**

Laura Hyde Foundation. **www.laurahydefoundation.org**

RCN counselling service. **tinyurl.com/RCN-counselling-service**

Samaritans. **www.samaritans.org**

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Learning disability and autism: best practice tips

Advice for non-specialist nurses on adapting practice for people with a learning disability and autistic people

By Allie Anderson
health journalist

About 2.5% of the population in England has a learning disability, while latest estimates suggest that as many as 1.2 million people are autistic. People with learning disabilities and/or autism face health inequalities throughout their lives and often have complex needs. Nurses in all settings will provide care for people with learning disabilities and/or autism, who will have a range of needs.

New guidance from NHS England aims to support nurses with the day-to-day management of the health of patients with a learning disability and/or autism. We set out points all nurses need to know.

'Many people with profound and multiple learning disabilities also have lots of physical conditions,' says learning disability nurse Gerard Wainwright, who works in West Yorkshire. 'We tend to see things like greater obesity and a higher risk of mental health problems, such as depression and anxiety. This means they might be more likely to be going in and out of hospital.'

Severe mental health problems are 8.4 times more common in people with a learning disability than in people without a learning disability, while 37.5% of people with a learning disability are classified as obese and more than one fifth are estimated to have epilepsy.

Data also suggest that epilepsy and obesity – as well as sleep problems, sensory impairments, allergies and autoimmune conditions – are more prevalent among autistic people than in the general population.

Access to healthcare services

RCN professional lead in learning disabilities Jonathan Beebee says having a learning disability means people tend to delay accessing health services. 'It can be difficult for people with learning disabilities to identify their health needs, and they may not be able to report health problems in the same way,' he says. 'They might not understand pain and discomfort as being a sign that something is wrong and that they need to seek support.'

This leads to poorer health outcomes. The most recent Learning Disability Mortality Review (LeDeR) found that in 2021, 60% of people with a learning disability died before the age of 65, compared with 10% of the general population. And last year the Health Service Journal, citing leaked NHS figures, reported that in a single year autistic people without a learning disability are 51% more likely than the general population to die.

How small changes brought benefits to patients in an emergency department

At the Royal London Hospital emergency department, making small but significant changes has brought benefits for patients.

The children's emergency department has a calming sensory room for children with additional needs.

The department also runs a community emergency medicine service with the London Ambulance Service and London Air Ambulance, allowing patients who find hospital surroundings too challenging to be treated at home where possible. 'Autism champions' support and train other team members to ensure autistic patients get optimum care.

New ways of working

The team's commitment to new ways of working won them a National Autistic Society Autism Inclusion Award, an accolade given to non-specialist services that go the extra mile to support autistic people.

'The biggest thing we can all do is care and stop and listen to our patients about their individual care and choices,' says paediatric department lead nurse Sarah Gamester on winning the accolade. 'We can all make small adjustments that have the potential to make the world of difference for some of our patients, families and carers.'

This is an abridged version of an article at **rcni.com/learning-disability-autism**

Many of these deaths occur needlessly, as in the case of Oliver McGowan. Eighteen-year-old Oliver, who was autistic and had epilepsy, mild cerebral palsy and learning disabilities, died in November 2016 after being given the antipsychotic drug olanzapine, despite repeated warnings that he reacted badly to the medication. An independent review found Oliver's death was 'potentially avoidable'.

Following a campaign spearheaded by Oliver's parents, all health and social care staff must now receive role-appropriate training on how to support autistic people and people with a learning disability. The requirement was enacted into law as part of the Health and Care Act 2022.

The government's recommended training, the Oliver McGowan Mandatory Training on Learning Disability and Autism, is designed to equip health and care staff with the skills and knowledge to provide safe, compassionate and informed care for this patient cohort.

Exactly how the training will be delivered to nurses in different settings is still unclear – the draft code of practice was under consultation until 19 September – but the existence of formalised training is widely welcomed.

Mandatory training will hopefully give nurses more confidence, but many cases require input from learning disability nurses and liaison teams. The majority of, though not all, acute hospitals will have access to specialist nurses, Mr Beebee says, but what exactly that comprises varies across the country.

'Sometimes it's one nurse, sometimes it's a team of five. It's worth finding out what's available in your local area in the acute trusts and in the community, because learning disability nurses have great insight that can help patients to make the best decisions for themselves.'

Diagnostic overshadowing

One problem autistic people and people with a learning disability commonly encounter is diagnostic overshadowing. This happens when healthcare professionals assume that a patient's symptoms and behaviours are attributable to their autism or learning disability rather than considering a different physical cause.

The consequences of diagnostic overshadowing can be grave. 'Over 40% of the learning disability population die because of pneumonia and aspiration pneumonia and many of those deaths are avoidable,' says Mr Wainwright.

'I have heard people say, "They've aspirated because they've got a learning disability", but this wouldn't affect the ability to swallow.'

Nurses can take steps to mitigate these risks by exploring other possible causes of a patient's symptoms and behaviours and getting to know the patient. Nurses should check whether an autistic person or a person with a learning disability has a hospital passport – this outlines information relating to the person's health and care needs, including treatment plans, medications and communication preferences.

Although helpful, hospital passports are not a perfect solution as they can get lost or overlooked. They also contain only basic information, thereby omitting what may be small yet significant details that could make hospital a much less frightening place for someone with autism or a learning disability.

Good communication

'Hospital passports are great but it's often better to speak to the person,' says Mr Wainwright. When there are communication barriers, for example, it is essential to talk and listen to the person and their family or carer. 'The patient might take comfort in having certain music on or having a particular item with them, or there might be a fragrance that helps them feel calm,' he says.

Getting to know patients can empower nurses to make reasonable adjustments to their care – a legal requirement under the 2010 Equality Act. NHS England guidance says reasonable adjustments 'aim to remove barriers, do things in a different way, or provide something additional to enable a person to receive the assessment and treatment they need'.

Some changes – such as providing dedicated quiet spaces for people who experience sensory overload – can require greater investment and be more difficult to implement.

Delivering the best care for autistic people and people with a learning disability can be a difficult balancing act. Nurses should assume that patients have capacity in line with the Mental Capacity Act, while also making sure families are involved in conversations and decisions.

'Prioritise working in collaboration with families, unless there is a good reason not to,' says Mr Beebee. 'There might be safeguarding concerns, or the person might want to discuss something private such as sexuality or sexual health. And sometimes people will make unwise decisions, but that's okay.'

'Prioritise working in collaboration with families, unless there is a good reason not to'

Jonathan Beebee, RCN professional lead in learning disabilities

Further information

DisDat (2004) Disability Distress Assessment Tool. **tinyurl.com/DD-disability-distress**

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NHS (2021) Mental Capacity Act. **tinyurl.com/NHS-mental-capacity-act**

NHS England (2022) Action from Learning Report 2021/22. **tinyurl.com/NHSE-leder-report-action**

NHS England (2023) Clinical Guide for Front-Line Staff to Support the Management of Patients with a Learning Disability and Autistic People – Relevant to all Clinical Specialties. **tinyurl.com/MHSE-lds-autism-guide**

Wong-Baker FACES Foundation (1983) Wong-Baker FACES Pain Rating Scale: Instructions for Use. **wongbakerfaces.org/instructions-use**

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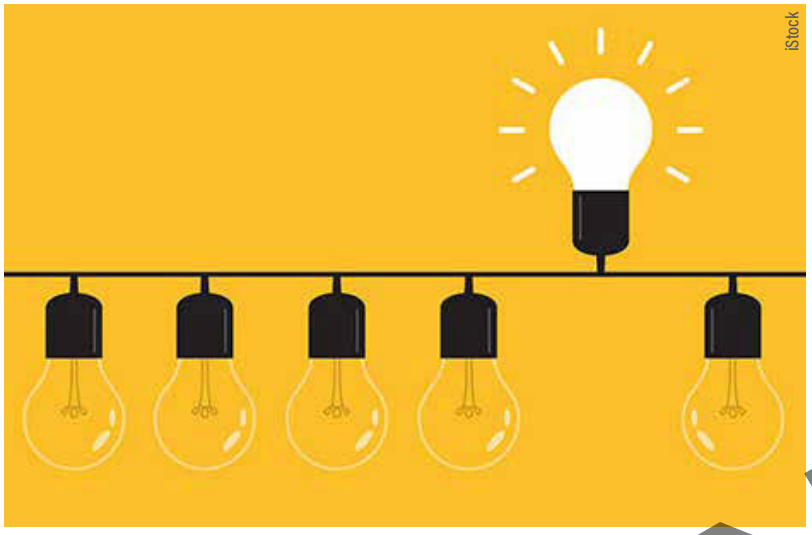


How to make your vision of an innovation happen

We find out from nurses who have turned their innovative ideas into fully fledged businesses and social enterprises

By Yvonne Covell
health journalist

As an advanced nurse practitioner in a general practice in a small Yorkshire community, Helen O'Connell was aware that many people coming to the surgery were not in need of medical treatment.

'Whether they were hungry, lonely or, for example, struggling to cope with their teenager's mental health issues, I would say that for 20% of our patients, the need was more for what we would call social prescribing,' she says.

Ms O'Connell wanted to do something practical to help, so decided to set up a food bank. 'Talking to people who came to use the food bank made me realise people don't know where to go to seek help when something goes wrong in their lives – that's how I formed the idea for social prescribing website Treacle.me.'

Treacle.me is a free and easy to use social prescribing directory that gathers together information about small local groups – as well as national help and support – into one site.

'I spoke to a web designer who lived in the village, who told me it would cost £1,000 to create the kind of website I was after,' says Ms O'Connell, a finalist in the community and general practice nursing category at the 2023 RCN Nursing Awards for creating Treacle.me.

Initial funding

'Some years ago, a patient had left the practice some money in their will, to be spent for the good of the community,' she says. 'At the next practice meeting, I said: "I've got an idea for a website, and could I have £1,000 from the fund for it?". Everyone at the meeting liked the idea, and the fact the work was going to someone in the village, and said yes. It was the spring of 2020, I had the £1,000 and I was off. I spent two to three months working with the web designer to create the site,' adds Ms O'Connell.

'There are so many small enterprises helping people in different ways, but they don't have the money to promote themselves, so they were very happy to be on the website. I wanted it to be super-easy to log on and find help.'

Other nurse-innovators funded initial startups themselves, as well as researching and applying for grants.

Innovators' tips for getting your idea off the ground

- **Start writing things down** 'If you have an idea, draw pictures of it, make notes and gradually add to it,' advises Neomi Bennett, nurse and founder of Neo-Slip
- **Value your skills and experience** 'Nurses think they don't have certain skills, such as sales, but they do,' says Ms Bennett. 'For example, selling your product or idea is like persuading a patient to take their medication or do more exercise – even if they don't want to. Nurses are very adaptable and are good at communication, problem solving and risk assessment.'
- **Be bold** 'If you've spotted a gap, you know the context and you've thought through the pros and cons, don't let go of it,' says Matty Cain, mental health nurse and founder of First Person Project
- **Try not to worry about others stealing your idea** 'You can't steal someone's passion to do that and overcome the obstacles,' says Ms Bennet
- **Attend trade fairs and exhibitions** 'These can be invaluable for meeting people who can help you,' says Ms Bennet. 'One company even invited me to display Neo-Slip on their stand'
- **Surround yourself with people who believe in you** 'I met people who were so positive about Treacle.me that they wanted to come and work with me,' says Helen O'Connell, nurse and founder of social enterprise Treacle.me. 'Having positive voices around you spurs you on'
- **Do some research into what training courses are availabke,** advises Ms O'Connell. The NHS Innovation Accelerator, for example, provides significant support and training to individuals innovating in the healthcare system

RCN Nurse of the Year 2020 Ana Waddington won the award for her work founding YourStance, an initiative in which healthcare professionals teach life-saving skills to young people at risk of serious violence in London.

She says finding funding was the biggest obstacle she had to overcome in the early days. 'For two years, I did everything with my own funding and donated items. I became exhausted by it,' says Ms Waddington.

'I then successfully applied for a grant from Barts Charity, which helped me to build the foundations of the organisation.'

Mental health nurse Matty Caine set up mental health support centre First Person Project in 2019. 'I worked as an independent nurse for a while to raise the money to put into practice my vision for a people-powered mental health centre in Liverpool, which I was later able to set up and fund as a social enterprise,' he says.

'I had lots of ideas, straight from when I was at university, but I was always told things couldn't be done a different way,' says Mr Caine.

'It was only when I'd gained more experience and reached a senior level that I had the confidence to innovate.'

He says tenacity and determination are key, alongside a belief in yourself and your idea.

'Don't stop asking: "Are we as efficient as possible?". You have to have the courage to be disliked, to be misunderstood when you come up with ideas for doing things differently,' he says.

Ms O'Connell agrees: 'Don't let someone tell you it can't be done,' she says.

All the nurse entrepreneurs we spoke to say they used their transferable nursing skills when getting their initiatives off the ground – alongside learning along the way, both on-the-job and through taking courses.

'I had to learn the business administration side of things, often by trial and error,' says Ms O'Connell. 'I worked out we needed to be registered with Companies House as a community interest company with directors. I opened a social enterprise bank account with the bank that seemed the easiest to deal with at the time.

Step-by-step process

'I now employ three people part-time to keep the website up to date,' she says. 'That leaves me to do what I'm good at – going out to talk to people.'

Ms Waddington agrees that it is about knowing what your skills are, and then finding people who have skills to complement yours.

'I am not skilled at grant writing but my co-director is amazing at it and has experience of grant applications. She is focused on applying for funding, and is the reason we are surviving financially.'

For Ms O'Connell, expanding the reach of Treacle.me has been a step-by-step process. 'We are part of a GP super-partnership, who offered to pay me half a day a week to expand Treacle.me to a wider area,' she says.

'As time went on, I spotted some opportunities to advertise, even without a budget, to raise awareness.

'Since getting Treacle.me up and running, it has been a continuing journey of facing new challenges and trying to get the idea taken up at a larger level. I had a significant two-year NHS investment to cover the Bradford District and Craven area, but that is due to run out in April this year, so our future is uncertain.

'The most rewarding thing I've experienced is the positive feedback from so many different types of people – social workers, teachers, job centre staff – all of whom come into contact with people who need help and use the website.

'I also have such positive messages from the public – that's what I live and breathe for.'

Further information

First Person Project. **www.firstpersonprojectcic.co.uk**

Florence Nightingale Foundation. **www.florence-nightingale-foundation.org.uk**

Treacle Me. **www.treacle.me**

YourStance. **www.yourstance.org**

Go for it: my advice to anyone with an idea to develop

Neomi Bennett (pictured) won the innovations category at the 2019 RCN Nursing Awards for inventing Neo-Slip, designed to help people put on compression stockings.

'I came up with the idea when I was a nursing student on placement and saw patients struggling to put on their compression stockings,' says Ms Bennett.

'I knew these stockings were potentially life-saving for them, but they just couldn't manage them. I remember visiting one couple in their home and they were using the stockings as curtain ties because they couldn't get them on.

Do things bit by bit

'I was studying at Kingston University at the time, and my lecturers were really enthusiastic about the idea, which helped.

'I even had business meetings at the university as I was getting the product off the ground.

'It's a myth that you need to have lots of money to get started – it's better to do things bit by bit and use the resources that you have around you.

'I also had some financial support from the Florence Nightingale Foundation.

Getting in to the NHS supply chain

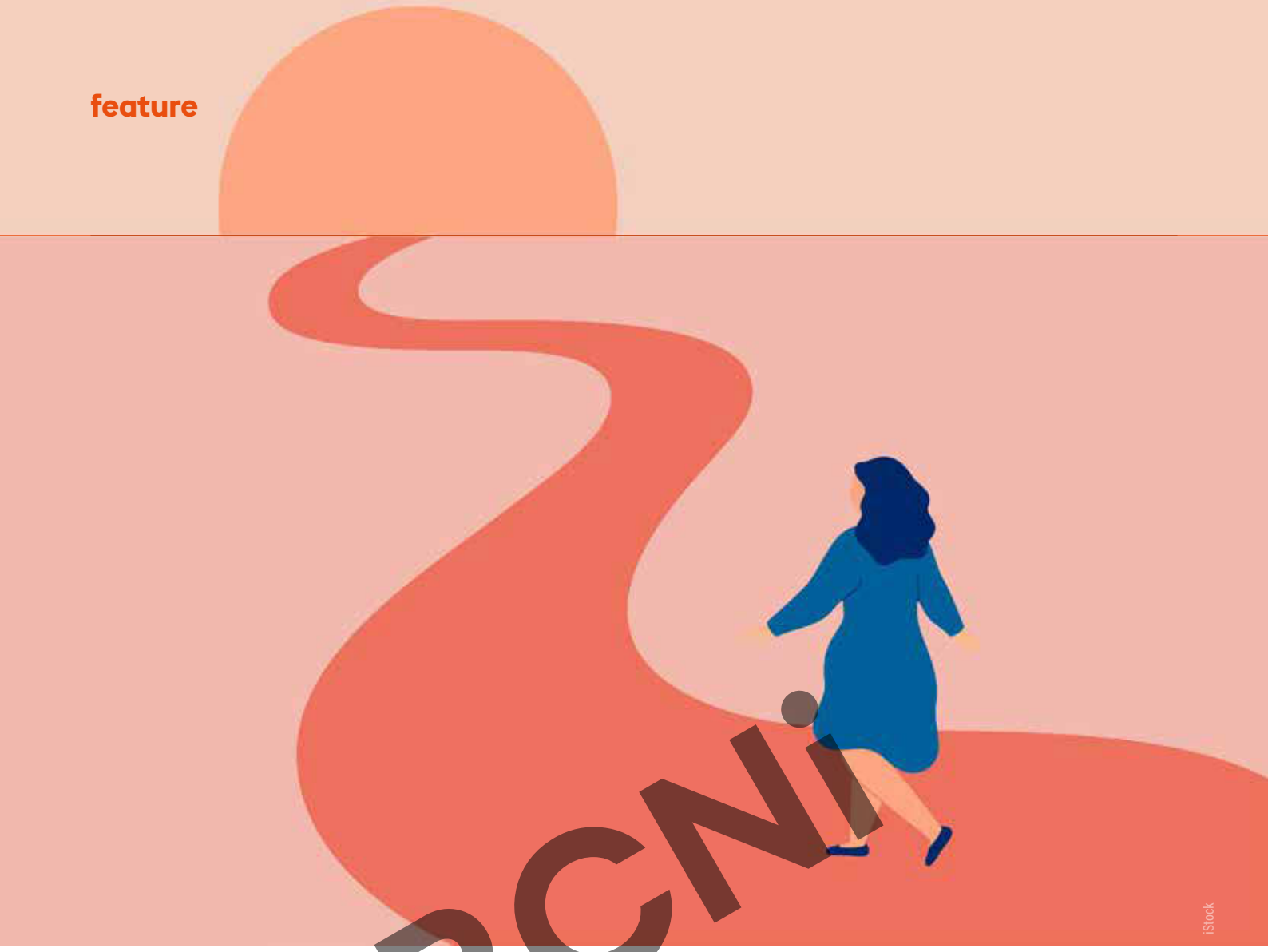
'There were lots of obstacles along the way, and it took a lot of determination to get the product out to patients.

Getting into the NHS supply chain is difficult – they do a huge amount of due diligence, so that everyone can have confidence in the products the NHS use.

'Feedback from real patients was invaluable. I remember when we were trailing an early design, one gentleman said: "Neomi, we need to have a handle on the tip – it gets stuck". I went back to the manufacturer and we added a loop at the top of the Neo-Slip.

'Our hope is to scale up in the future. We have just won a large-scale NHS contract and plan to increase our promotional efforts.

'My advice to nurses who are thinking of starting something would definitely be to go for it. There are so many opportunities for innovating.'



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Get your head round retirement with advice from former nurses

Leaving the nursing profession can cause some people to have a sense of lost identity. Find out how you can plan ahead, emotionally and practically, and also work toward a new purpose

By Claire Read
health journalist

Even though Pip Hill opted for a gradual retirement from clinical research nursing, she had not anticipated the extent to which stopping work would hit her.

After a spell working two days a week, she retired fully in March 2023 – yet it was not until six months later that she felt ready to relinquish her registration.

'I just could not bring myself to come off the register,' she says. 'When I did, it felt huge. I just felt, "I'm not a nurse anymore."'

Her experience is far from unique. When a group of retirees aged 55-75 was asked which life milestones had provoked the biggest emotional response, almost one quarter named retirement. It was the third most common answer after having children and getting married.

'I knew in my head that nursing wasn't who I was, but I needed to accept it emotionally as well'

Jane Bates, retired nurse

The research, conducted in 2021 by the Financial Services Compensation Scheme, sums up the extent to which a career coming to an end can have a profound effect beyond the monetary.

Sense of identity

For nurses, the emotions generated by this milestone can be particularly acute. That is because nursing is a profession with a strong sense of identity, generated by practitioners themselves and from a societal view of what it means to be a nurse.

Jane Bates (right) helping out at the weekly coffee morning for her local community

For Ms Hill, that loss of identity was tied up with the loss of aspects of her work that had been particularly important to her. One such loss was patient contact, which had still been central to her pre-retirement role in clinical research.

'I had mainly been dealing with men on the prostate cancer trial, and over the years we'd built up good relationships,' she says. 'I was seeing them every few weeks and going through all sorts of things with them.'

Although she had looked forward to the end of office politics, the extent to which she missed being part of a team also surprised her. And while her siblings and best friends were occupying their time in retirement looking after young grandchildren, her grandson was now in his late teens and so did not need support in the same way.

'I felt a bit useless really. I felt as if I wasn't of use to anyone anymore.'

Emotional gap

It is commonly accepted that retirement will leave a financial gap, and people are rightly reminded to prepare for it. Living comfortably on the state pension alone is challenging and so, as UNISON acting deputy head of health Alan Lofthouse puts it: 'The earlier someone starts planning for their retirement the better.'

Retirement preparation can valuably go beyond considerations of money. It is not enough to think through the financial gap; it is also important to prepare for what Ms Hill experienced – the emotional gap, and the potential sense of lost identity and purpose.

These are areas in which former doctor Jonathan Collie specialises. He is the founder of a social enterprise called the Purpose XChange, which helps people to establish their purpose and find ways of fulfilling it at every stage of their life – including after a career has ended.

Dr Collie stresses that retirement does not have to be a distinct line between working and not working. 'You could continue work, readjust your work,' he says. 'You could look at a startup or innovation: do you want to start a social enterprise, do you want to monetise a hobby?'

And there are other ways of feeling purposeful, he says. 'There's learning and personal development. Do you want to go back to school? Do you find a mentor? Do you start reading [about a topic that interests you]?

'Giving back is a big one too. Do you want to volunteer? Volunteering is working, it's just unpaid. But there's also coaching, mentoring, the transfer of knowledge, helping other people, getting involved in your community, connecting more with others.

'And then there's creative expression. It can be art, it can be writing, it could be music, it could be acting, it could be learning a language. Your "purposeful plan" could dabble with any or all of these things. It's entirely up to you.'

Mid-career disillusionment

Importantly, this is a plan that can be built at any stage of a career – it is not retirement-specific. Dr Collie would like to see nurses and their employers engage in conversations on purpose regularly.

He believes such conversations would help to address the potential for mid-career disillusionment or

Pip Hill, retired research nurse, exploring the Grand Canyon, Nevada, US


Marcus Chung

Courses, training and hobbies can also provide a creative outlet

frustration among nurses. It can be difficult to feel a sense of purpose and identity if, for example, it is starting to feel like administrative work rather than patient care is dominating working hours.

Community support

For Ms Hill, retirement has already been busy. She and her husband travelled to the US for a long touring holiday, and are in the process of doing up their house. She is also doing lots of walking and Pilates.

And she has applied to be a volunteer for Macmillan Buddy, a service of Macmillan Cancer Support that offers weekly support to people with cancer. She says she had thought of becoming a community-based Macmillan nurse at the start of her career, but interesting roles on an oncology ward and then on a chemotherapy unit intervened.

She hopes retirement may provide a different way to meet her original ambition of offering community support to people with cancer. It is a sign, perhaps, that things never truly end – they just change.

'I felt a bit useless – as if I wasn't of use to anyone anymore'

Pip Hill, retired clinical research nurse

Further information

Macmillan Cancer Support (2024) Volunteering as a Macmillan Buddy. **www.macmillan.org.uk/volunteering/macmillan-buddies**

How a stranger's wise words changed Jane Bates's feelings about retirement

When Janes Bates (pictured) retired, the emotional impact was such that she decided to take herself on a retreat. She travelled to the Scottish island of Iona, telling herself she 'had to get her head around' the complex range of emotions she was experiencing.

'It felt as though I was losing my identity and that was hard,' says Ms Bates, who retired in 2019 after a long career working across multiple specialties, most recently in ophthalmology.

'I had been a sister on an eye ward for a while, now I wouldn't be, so who was I? It was a funny feeling because nursing is about identity and I think is more than a job. It's hard to give up.'

While walking on Iona she met 'a lovely, slightly older lady' and the two got chatting. Her new friend asked what had brought her to the island. Ms Bates explained how affected she felt by her retirement and how nursing had been so central to her identity.

'And she said: "It's not who you are. I want you to take this on board. It [nursing] is what you do, not who you are."

'I don't know why, but a stranger saying that made it hit home. It helped me, because I knew in my head that nursing wasn't who I was, but I needed to accept it emotionally as well.'

She says one reason her profession felt so tied to her identity was the number of friends she had made along the way. 'A strong link with other nurses has been one of the backbones of my life – my nurse friends.'

Keeping in touch

So when she retired, she ensured that connection remained. 'I keep in touch with loads of my ex-colleagues. It was fortunate that my retirement came around at a time when a lot of people had left, the personnel were changing. So a lot of my friends retired around that time. That made it easier, because I would have missed them terribly otherwise. We still see each other of course, so that helped ease the passage of retirement.' She also retains her connection to the profession via her regular column for Nursing Standard.

During the lockdowns, she began writing what she describes as her 'nursing life story'. 'I was thinking about how the health service has changed, why it has changed. I've written reams but I don't know what I'll do with it yet.

'Writing is what I would have loved to have done when I left school – studying English and becoming a writer,' she adds. 'But I felt I ought to do something that was for other people, not just for myself. So I got into nursing and it gets into your blood. It's who you become.'

Since her retirement she has found a multitude of ways to continue that sense of serving other people. As well as supporting her daughter and two grandchildren she also helps her local community.

'We have a coffee morning at our local church, which I help with, and it's mainly elderly people who come. I also have a few elderly neighbours who I visit, and who know if they want anything that I'm there.

'And people often come to me and ask me about their eyes,' she adds with a chuckle.

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AUTHOR TESTIMONIAL

The importance of highlighting effective practice

Publishing in journals is an important responsibility of academics, researchers and practitioners. It helps us to share information about innovative and effective nursing practice.

Evidence-based practice is vital to nursing, and health and social care, but research suggests it is less widespread than it should be. One reason may be that front-line practitioners do not always have the support, time and knowledge to search for and review evidence.

Parveen Ali
is a lecturer at the University of Sheffield School of Nursing and Midwifery.
She is a co-author of an article on intimate partner violence: Ali P, McGarry J, Dhingra K (2016) Identifying signs of intimate partner violence. Emergency Nurse. 23, 9, 25-29.

*For a comprehensive range of free author resources go to **rcni.com/publish-article-with-rcni***

Making research accessible

There is a need for the latest evidence to be provided in an accessible format and this is where the role of journals such as those published by RCNi becomes significant.

Articles in RCNi journals tend to be shorter in length and are written in accessible language so that practitioners working in specific clinical fields recognise their relevance to practice immediately. As a result, they can keep themselves updated about current evidence on relevant practices so they can improve care provision.

A glance over recent issues of Emergency Nurse, where I published an article with my colleagues, shows the breadth of topics covered in the journal, from perceptions of the nurse practitioner's role to managing hypopituitarism in emergency departments. These articles provide nurses with an opportunity to reflect on their understanding of such issues, and help them develop their knowledge further.

Another example is our article, which was aimed to help nurses identify signs of intimate partner violence in emergency and urgent care settings. There is evidence to suggest that healthcare professionals, including nurses, are poorly prepared to identify and manage patients experiencing domestic violence. However, there are few resources for them to refer to and articles such as ours provide a much needed accessible resource that helps them review the salient issues.

Sharing work

There are many other sections of the RCNi journals that provide readers with a wealth of information, for example about clinical and policy updates, practitioners' opinions and news.

Publishing in RCNi journals has provided my colleagues, Julie McGarry and Katie Dhingra, and me with a great opportunity to share our work. This will help my colleagues in academic or clinical settings, as well as nursing students, to disseminate the findings of their research and scholarly work to front-line practitioners, thereby increasing the impact of their work more quickly.

Also in this issue

DIGITAL NURSING

Exploring perceptions of digital technology and digital skills among newly registered nurses and clinical managers
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WORKFORCE

Facilitating international students' learning during placements: the experiences of practice assessors and practice supervisors
p35

Why you should read this article:

- To understand how small group teaching sessions can assist participants to learn new knowledge and skills
- To learn how to plan a small group teaching session by setting aims and learning outcomes
- To appreciate the importance of assessing participants' learning and addressing gaps in their understanding throughout the delivery of small group teaching sessions

How to design and deliver a small group teaching session

Jacqueline Harley

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Correspondence
j.harley@health.gov.je
𝕏@harleyjacq

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Rationale and key points

Small group teaching sessions are commonly used in healthcare to deliver education, provide practice updates and support continuing professional development. Such sessions can provide opportunities for participants to acquire new knowledge, foster peer relationships, consolidate learning and develop skills. This article provides a step-by-step guide for nurses and other healthcare professionals on designing and delivering a small group teaching session.

- A small group teaching session requires considered, detailed and methodical preparation.
- When designing a small group teaching session, it is important to determine its aims, learning outcomes, group characteristics, location and timeframe.
- A well-planned small teaching session includes learning activities that are constructively aligned to the aims and intended learning outcomes.
- Assessing participant learning and addressing gaps in their understanding is essential during the delivery of small group teaching.

Reflective activity

'How to' articles can help to update your practice and ensure it remains evidence based. Apply this article to your practice. Reflect on and write a short account of:

- How this article could improve your practice when designing and delivering a small group teaching session.
- How you could use this information to educate your colleagues on small group teaching methods.

Author details

Jacqueline Harley, programme manager, Higher Education Department, Government of Jersey Health and Community Services, St Helier, Jersey

Keywords

continuing professional development, education, educational methods, learning outcomes, peer support, professional, professional issues, training, universities

SMALL GROUP teaching is a focused and interactive educational approach in which a limited number of participants engage in discussions, problem-solving and skill-building activities under the guidance of a facilitator. In healthcare, small group teaching is used to disseminate information, develop clinical skills and share practice updates among practitioners. By promoting a collaborative and targeted learning environment, small group teaching can equip practitioners with the knowledge and skills required to deliver high-quality, evidence-based healthcare (van Diggele et al 2020).

This article is intended for nurses and other healthcare professionals who are responsible for delivering small group teaching. It offers a step-by-step guide explaining how to prepare and deliver a small group teaching session, together with a discussion of the evidence

base underpinning this activity. The steps and principles outlined in this article can be applied to both face-to-face and online small group teaching sessions.

Preparation

- When preparing a small group teaching session, identify a rationale for why it is needed and the intended benefits that it will bring.
- Establish the aims of the session and its intended learning outcomes.
- Consider the characteristics of the group members including their professional roles, level of experience and the expected group size.
- Construct a session plan that details how the aims and intended learning outcomes will be met, including modes of delivery, teaching and learning activities, resources, timeframe, assessment and evaluation methods.
- Determine how you are going to enable different styles of learning. Consider using a blend of visual, auditory and participatory activities such as group discussion, flip charts and PowerPoint presentations to deliver key learning points.
- Keep the information balanced, bearing in mind that what matters is how well the group understands the content, not how much information is provided to them.
- Identify any prerequisites that the group members need to meet before participating, such as completing a pre-session questionnaire. Inform the group members of these in advance, providing sufficient time for them to prepare.
- Establish where you will deliver the session, ensuring that the chosen location has the appropriate facilities to support delivery such as adequate room size, seating and breakout space for group work. If you intend to use social media platforms, make sure you have access to pertinent, compatible software and equipment that are unrestricted by barriers such as firewalls, which might impede teaching and learning activities.
- Identify the measures you will use to assess the participants' understanding and learning.
- Plan how you are going to evaluate the session's content and design, for example you could ask participants to complete end-of-session questionnaires.
- Consider how you will evaluate your performance. For example, you may want to complete a reflective account or invite a peer to observe the session and provide feedback on your delivery.

Procedure

1. At the beginning of the teaching session introduce yourself, set the scene and ask the group what they hope to learn from attending. The group's learning requirements will guide any alterations you need to make to the session.
2. Provide a session overview, including its aims, intended learning outcomes, structure, format and timing. At this point, give the participants a chance to clarify anything they do not understand.
3. Once the session has been introduced, use your session plan as a guide to ensure coherence, optimal flow and appropriate timing.
4. Be prepared to make minor modifications in response to issues such as timing or managing group engagement, should these arise.
5. During group breakout activities be prepared to move around the room and 'tap into' these discussions to check the participants' understanding and learning. Monitor the time taken by such activities, since these can often run over if not carefully managed.
6. Record notes on the session plan about those parts of the session that require further development, such as aspects of group work that did not work so well.
7. Use questions frequently throughout the session to facilitate critical thinking and assess participants' learning.
8. As the session concludes, summarise the key learning points and identify the 'take home' messages.
9. Invite group feedback about the session's content and design, including what worked well and what did not, as well as feedback on what they have learned from the session.

Evidence base

Providing peer group education is an integral part of the professional role of many healthcare professionals, including nurses. Nurse specialists, clinical educators and practice education facilitators are among those responsible for delivering continuing professional development (CPD) education to front-line staff. According to Zhang et al's (2022) systematic review and meta-analysis, peer teaching is a favourable teaching and learning strategy that is positively associated with the development of theoretical knowledge and procedural skills among healthcare professionals.

CPD education can have many benefits for healthcare professionals, such as the

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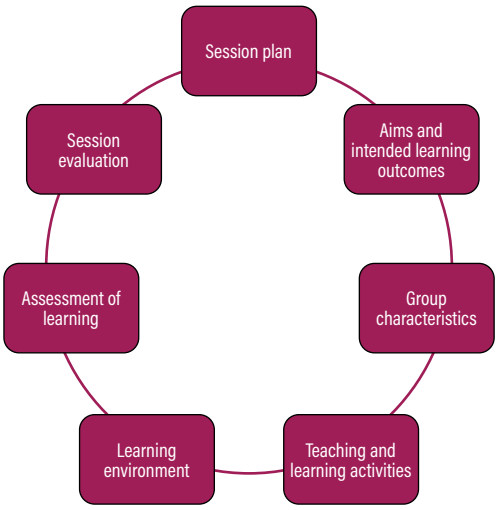
development of their knowledge, skills and professional attributes, increased confidence and enhanced career development (Allen et al 2019). It can take place in a variety of environments, including hospital, clinical and community settings, and can be delivered using formal approaches such as lectures, small group teaching sessions and simulation exercises. Although there are advantages and disadvantages to each of these approaches (Burgess et al 2014, Sørensen et al 2017), small group teaching is increasingly becoming the preferred approach in healthcare professionals' education (van Diggele et al 2020). Small group teaching is associated with enriching the learning experience and enabling learners to develop their understanding in conjunction with their peers (Xue et al 2021). It has also been found to support the development of teamwork and problem-solving abilities (Dirks 2019).

Figure 1 shows the main components that need to be considered when designing and delivering a small group teaching session. Collectively, these dynamic components underpin, support and facilitate teaching and learning in the session.

Session plan

Planning is central to delivering a teaching session effectively (Yonkaitis 2020). Session plans provide a blueprint for delivering teaching by detailing the dynamic components required to meet the aims and intended learning outcomes. Moore-Cox (2017) emphasised the value of planning for nurse educators, suggesting that it enables them to plan and record activities intended to encourage active classroom learning. Table 1 shows an example of information required for a session plan.

Figure 1. Main components of a small group teaching session



Aims and intended learning outcomes

Underpinning the small group teaching session are its aims and intended learning outcomes. The aims are the overall expectations for a session, while intended learning outcomes specifically identify the different steps that the group members need to undertake to meet the session aims and demonstrate their learning (Butcher et al 2020). Learning outcomes should be constructively aligned with the session aims and should reflect the intended learning, while being mindful that learning cannot always be guaranteed (Biggs and Tang 2011). In this way, the group members can identify the level of learning and understanding that is expected of them.

Group characteristics

Effective teaching requires an understanding of the group's characteristics, since this can enable the facilitator to tailor the content, pace, level and teaching methods required to meet the group's needs and preferences (Kelm and Niven 2019). By recognising group dynamics and individual communication styles, engagement may be improved, effective interaction can be encouraged and the overall learning experience of participants can be maximised (Merlin et al 2020).

Teaching and learning activities

Hughes and Quinn (2013) proposed that educational content should be made available through a variety of activities to address different learning styles. The facilitator should be aware that individuals may have a mixture of preferred learning styles and activities, such as those outlined by Honey and Mumford (1992) (Table 2). These preferences can inform the choice of resources that group members access, as well as their level of contribution in group teaching sessions (Kurt et al 2022). Offering a variety of teaching and learning activities can play to the group's strengths and promote engagement, thus enabling a higher level of understanding (Clynes et al 2020).

Learning environment

Learning in the classroom can be optimised by the physical environment and classroom design (Han et al 2018). Important environmental conditions include space, lighting, noise and ventilation. Additionally, the spatial layout and functionality of furnishings such as tables and chairs have been shown to be conducive to

promoting dialogue and interaction (Han et al 2018). Auditory and visual systems are also important, since collectively these systems can promote an engaging and effective learning environment (Han et al 2018). Auditory systems include items such as audio speakers and microphones that improve audibility and clarity of sound, while visual systems include multimedia screens and whiteboards.

Assessment of learning

One of the main factors that can influence learning is formative assessment. Bennett (2011) suggested that formative assessment is a prevailing enhancement to learning that is useful in determining the level of knowledge and understanding attained by participants. It can also identify gaps in knowledge. Learning can be formatively assessed by using measures such as learning checks, assessment tasks and the use of low-order and high-order questions (Lipnevich and Panadero 2021). Low-order questions focus on recalling and describing facts, for example 'Describe the stages of Tuckman's team formation theory', whereas high-order questions require analysis and synthesis of the information, for example 'Critically appraise Tuckman's team formation theory'.

Session evaluation

Session evaluation is important for ensuring and enhancing the quality of teaching and learning, and it can assist in determining the usefulness and relevance of a small group teaching session (Biggs and Tang 2011). Feedback can be gathered from the group through evaluative measures such as questionnaires, which review the session content, course materials such as supplementary reading materials and modes of delivery such as group-led activities. The application of a structured measure for feedback provides opportunities for participants and the facilitator to identify the strengths of the session and areas for improvement.

Requesting input from colleagues and personal reflection can be beneficial for developmental purposes, supporting the facilitator's professional development and improvements to the teaching session. Peer observation – which entails fellow educators observing and learning from each other's practice and providing constructive feedback (O'Leary 2020) – can encourage a critical and reflective conversation about teaching and assessment practices. This practice can enhance the facilitator's self-awareness, confidence and facilitation skills.

Table 1. Example of information required for a session plan

Session title:			
Date and time:			
Duration:			
Expected number of participants:		Actual number of participants:	
Aim(s) of the session:			
Intended learning outcomes: By the end of the session, participants will be able to:			
Time (minutes):	Facilitator activities:	Participant activities:	Resources:
	Example: » Welcome » Introductions	Example: » Questions and answers	Example: » Presentation » Trust policies
Additional observations:			
Facilitator's name:			

Table 2. Preferred learning styles and activities

Type of learner	Preferred style	Preferred activities
Activist	» Learns by doing » Engages in new experiences wholeheartedly and impartially » Relishes the present moment » Thinks deeply because they prefer work that is challenging and requires concentration	» Brainstorming » Problem-solving » Group discussion » Puzzles » Competitions
Pragmatist	» Tests out concepts, theories and methods to discover how well they function in the real world » Looks for novel concepts and seizes opportunities to try out new applications	» Case studies » Problem-solving » Group discussion
Reflector	» Enjoys taking a step back to think about their own and other people's experiences » Gathers first-hand information, then considers and evaluates it from different angles before reaching a firm decision	» Paired discussion » Personality tests » Self-analysis questions » Feedback » Time apart » Coaching » Observing others
Theorist	» Places the highest value on logic and reason » Prefers to determine the theory that underpins each activity » Enjoys synthesising and analysing data » Combines and transforms contradictory data and observations into comprehensible theories	» Using theories » Models » Statistical data » Anecdotes » Quotes

(Adapted from Honey and Mumford 1992)

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Why you should read this article:

- To gain insight into the views and perceptions of nurses regarding digital technology and digital skills
- To recognise that using digital technology is likely to have both advantages and drawbacks for patient care
- To acknowledge the need for nurses to receive appropriate and accessible digital literacy training

Exploring perceptions of digital technology and digital skills among newly registered nurses and clinical managers

Emma Caton, Julia Philippou, Edward Baker et al

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Correspondence
edwardbaker@nhs.net
@edbaker_ed

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Abstract

Background Digital technology has an increasing role in healthcare, but staff lack opportunities to develop their digital skills and there is a lack of research on education and training in digital technology for staff.

Aim To explore nurses' perceptions of the use of digital technology in their practice and to identify the digital skills required by newly registered nurses to work in a digitally enabled environment.

Method Individual semi-structured interviews were conducted on an online communication platform with nine participants – four newly registered nurses and five senior nurses working in clinical and/or management roles. Inductive thematic analysis was used to analyse the data.

Findings Several barriers and facilitators to the use of digital technology were identified, including around infrastructure, time, skills, training, support, leadership, familiarity and confidence. The use of digital technology may enhance care consistency and increase patient autonomy, but it may also erode nurse-patient relationships.

Conclusion Digital technology can enhance patient care but organisational barriers, notably in relation to digital literacy training, need to be addressed for nurses to fully adopt it.

Author details

Emma Caton, research assistant, King's College London, London, England; Julia Philippou, senior lecturer, adult nursing, King's College London, London, England; Edward Baker, nurse consultant in emergency care, King's College Hospital NHS Foundation Trust, London, England; Geraldine Lee, reader in advanced clinical practice, King's College London, London, England

Keywords

communication, education, information technology, management, nurse-patient relations, professional, professional issues, technology

Background

Digital technology has an increasingly central role in patient care – a trend that was accelerated by the coronavirus disease 2019 (COVID-19) pandemic with the rise of digital technology to facilitate remote triage, consultations and monitoring in primary and secondary care (Hutchings 2020). In its consultation on the digital future of nursing, the Royal College of Nursing (2018) found that more than half of the 896 nurses and midwives who had taken part (n=522, 58%) had reported using digital technology or data 'all the time' in everyday practice.

Nurses have expressed concerns about using digital technology and have identified a lack of professional development opportunities to increase their digital skills (Brown et al 2020). Further barriers to the use of digital technology in clinical practice include

functional and technical issues (Burkoski et al 2019), suboptimal software performance (Vollmer et al 2014) and a lack of adequate infrastructure (Asah 2013). These barriers likely affect nurses' willingness to use digital technology (Gürdaş Topkaya and Kaya 2015).

Using digital technology requires a certain level of digital literacy, which has been defined by Health Education England (HEE) (2016) as 'the capabilities which fit someone for living, learning, working, participating and thriving in a digital society'. Higher levels of digital literacy have been associated with more positive attitudes towards the use of digital technology in healthcare (Gürdaş Topkaya and Kaya 2015) and with enhanced patient care (Klieb and Nagle 2018, Burkoski et al 2019). Crucial factors in digital literacy include education – with higher qualifications associated with greater digital literacy (Gürdaş Topkaya and Kaya 2015, Klieb and Nagle 2018, HEE 2019, Brown et al 2020) – and training and support from employers (Brown et al 2020).

The Topol Review was commissioned by the Department of Health and Social Care to explore how to prepare the healthcare workforce to 'deliver the digital future' (HEE 2019). It identified that, to improve digital literacy among healthcare professionals and support a digitally enabled healthcare system, the NHS must cultivate a 'culture of learning' (HEE 2019). The Phillips Ives review was set up in 2022 to specifically prepare the nursing and midwifery workforce to 'deliver the digital future' (HEE 2023). It will identify what is required to meet the two aims of NHS England's chief nursing information officer for nurses and midwives, which are to ensure that:

- Nurses and midwives are empowered to practise and lead in a digitally enabled health and social care system.
- Nursing and midwifery practice is fully supported in the use of digital technology and data science.

Despite the rapidly increasing use of digital technology in healthcare, there is a lack of education and training opportunities to support the development of staff's digital skills (HEE 2023). There is also a lack of research on education and training in digital technology for health and social care staff (Anderson et al 2021, Rice-Jones 2021).

Aim

To explore nurses' perceptions of the use of digital technology in their practice and to identify the digital skills required by newly registered nurses to work in a digitally enabled environment.

Method

Design and recruitment

This qualitative study was designed following the Standards for Reporting Qualitative Research (SRQR) (O'Brien et al 2014). Convenience sampling was used to recruit newly registered nurses and clinical managers working in hospital or in the community in one acute teaching hospital trust and one community trust in central London.

The rationale for interviewing participants from these two distinct staff groups was to:

- Gather data from newly registered nurses, who deliver most patient care, about their perceptions of digital technology use.
- Gather data from clinical managers about staff's education and training in digital technology and about gaps in staff's digital skills.

To be eligible, participants had to be employed either as a newly registered nurse or as a senior nurse working in a clinical and/or management role. Data were collected and analysed in 2022.

Data collection

Individual semi-structured interviews were conducted and recorded remotely on an online communication platform by the first author (EC), who is experienced in qualitative research. The interviews lasted between 25 and 40 minutes. Separate interview schedules had been developed for the interviews with newly registered nurses (Box 1) and with clinical managers (Box 2). The interview schedules had been developed following a literature review conducted by the third and fourth authors (EB and GL), who are academics involved in preregistration and post-registration nursing education and have backgrounds in working clinically with digital technology.

Data analysis

The interview transcripts were analysed using inductive thematic analysis (Braun and Clarke 2006). First, the transcripts were read and re-read to ensure familiarity with the data. All interview transcripts were coded by EC. The interview transcripts were also coded independently by another researcher – the second author (JP) for the interviews with newly registered nurses and the third author (EB) for the interviews with clinical managers. Due to the significant overlap in concepts that had emerged from the two sets of interviews, the codes from the two sets were collated and reviewed collectively. The codes were discussed within the research team and organised into themes and subthemes. Finally, the transcripts were revisited to ensure that the themes were representative of the data.

Ethical considerations

The study had been approved by the psychiatry, nursing and midwifery research ethics subcommittee at King's College London (Ref: MRA-21/22-28372). Informed consent had been obtained from participants before the interviews.

Findings

Nine nurses were interviewed: four newly registered nurses and five clinical managers. Participants were aged between 28 years and 49 years (mean=38.5, standard deviation=6.8) and 67% (*n*=6) of them were female. Most participants (*n*=8, 89%) held a master's degree level of qualification. Participants' time in their role ranged from less than one month to 48 months (median=12, interquartile range=46.5). Participant characteristics are shown in Table 1.

The analysis of data generated three main themes:

- Digital technology use in the workplace.
- Effects of digital technology on patient care.
- Developing digital skills.

Digital technology use in the workplace

Participants used a variety of software programs and electronic systems to perform different tasks. All participating newly registered nurses mentioned using electronic systems and solutions – for example MedChart, Profile Information Management System (PIMS), e-noting and more generally the electronic patient record (EPR) systems used in the NHS – primarily for note-taking and information retrieval.

'We use e-noting for medical notes. We use something called MedChart which is for prescriptions and giving medications… PIMS which is for admitting and discharging patients or transferring them from different wards… EPR where we can order blood specimens, view previous clinical letters… So there's quite a few.' (Participant 4, newly registered nurse)

Participants described how the use of digital technology had rapidly increased during the COVID-19 pandemic, when face-to-face services had had to be reduced. Participants acknowledged that the use of digital technology is likely to become commonplace in healthcare.

'In general practice, since COVID we rapidly moved to telehealth right at the beginning of the pandemic… We completely switched over to telephone and video consultations.' (Participant 8, clinical manager)

Newly registered nurses described digital technology in their workplace as easy to use and easy to understand when it was working correctly, but mentioned that it did sometimes fail. Appropriate connectivity and bandwidth (the amount of information that can be sent between computers at one time) are needed for digital technology to be used effectively. Some participating clinical managers expressed concerns that some software programs were not fit for purpose – for example, not capturing all relevant information or incorrectly transferring data – and were too rigid in their design, making it difficult to adapt them when needed.

'It's [digital technology] very easy to understand and use… It's very simple to use.' (Participant 2, newly registered nurse)

'The system is very simplistic and does not capture the information… It only picks up limited fields… but I need much more than that if I need to run audits on compliance with NICE guidelines and WHO guidelines.' (Participant 6, clinical manager)

Participants used a large variety of electronic systems and explained that they often had to switch between systems to perform different tasks. This created challenges, notably because of the many different log-in details to remember. Participants suggested that combining certain functions to reduce the number of systems they needed to access would be helpful.

'Having multiple packages can be quite confusing, you have to have multiple log-ins… It's difficult to keep track, especially when they're asking you to change your password every 3 months… It can be overwhelming.' (Participant 1, newly registered nurse)

Newly registered nurses did not always have the time to fully engage with digital technology, especially when there were technical barriers to its use or when the department was short staffed. Clinical managers noted that staff did not always fill in all information fields in a program or system due to time constraints, resulting in incomplete records.

Implications for practice

- Healthcare organisations need to provide nurses with more opportunities to develop their digital literacy
- It could be useful to formally assess nurses' digital skills in the workplace
- The positive effects of digital technology, which include enhanced consistency of care and increased patient autonomy, need to be publicised
- When using digital technology, nurses must be careful to maintain optimal relationships with patients
- Involving nurses in the development of software programs for clinical practice would help make these fit for purpose

Box 1. Newly registered nurses' interview schedule

- Tell me about any digital technology you use in the workplace in your practice
  - Prompt: To record patient data? For remote monitoring? How do you feel about using it? Is there anything you particularly like or dislike?
- What kind of training have you had on using digital technologies?
  - Prompt: Study sessions? Demonstrations from reps? Was it formal or informal training? What was your experience of the training?
- What do you think is the impact of digital technology on person-centred care?
- Do you think that digital technologies have a place in remote health monitoring (in the community) for chronic disease management?
- What digital skills do you think you need?
- Do you think that digital technologies have a place in developing your leadership skills?
- What do you think are the skills that you said you have, or need, that would be important in progressing your career?
- Do you have any other comments you would like to make?

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'Nurses on the wards with [staff shortages], they would tend to fill in only the minimum as necessary… They have less time to fill in the details on the computer.' (Participant 6, clinical manager)

Clinical managers acknowledged the important role of nurse leaders in encouraging staff to embrace digital technology in the workplace. Nurse leaders needed to ensure that new practices using digital technology were clearly communicated to staff and appropriately implemented.

'Leadership plays a very important role, especially ward managers or ward sisters… If we have low compliance with what we request from nurses, it means leadership is not actually reinforcing the parts.' (Participant 6, clinical manager)

Participants noted that the use of digital technology to provide care was not always suitable, for example for patients who did not have a recent smartphone or optimal connectivity, or for patients – particularly older ones – who were not familiar with digital technology. Asked whether they thought digital technology could be used for patient self-management, one participant said:

'It depends on the individual… My ward is for 65 years of age and above, so for some people, that would be appropriate if they know how to use more modern technology, but for other people that might not.' (Participant 5, clinical manager)

Some participants noted, in relation to themselves or to other staff, a tendency to avoid using digital technology when there was a lack of skills, a lack of confidence or technical issues. People would either delegate the task to a more competent member of the team or revert to paper-based methods.

'I found that when people found it [digital technology] difficult to use, they would shun away from it, they would really not be interested in it because it was difficult or it wasn't working.' (Participant 8, clinical manager)

'It's a faff for me because it's not within my daily [practice]… I leave it to the other nurse who is always there to do [it], and I do other bits.' (Participant 7, clinical manager)

Box 2. Clinical managers' interview schedule

- What is currently happening within the clinical environment in regard to digital technology?
  - Prompt: What apps/software do you use? Do you have any implementation plans?
- What education/training does your trust offer to nurses around digital technologies?
  - Prompt: What does the training involve?
- Are there any challenges to engaging with the training?
- What other barriers are there to prevent nurses using digital technologies in your trust?
- Do you think that digital technologies have a place in patient self-care in the context of chronic disease management?
- When recruiting a band 5 nurse, can you tell me what importance you would put on their existing digital skills?
- Do you think that digital technologies have a place in developing leadership skills?
- Do you have any other comments you would like to make?

Table 1. Participant characteristics

Number	Role	Band*	Gender	Age	Time in role
1	Newly registered nurse	5	Female	47 years	1 month
2	Newly registered nurse	5	Female	35 years	2 months
3	Newly registered nurse	5	Female	39 years	12 months
4	Newly registered nurse	5	Female	28 years	24 months
5	Clinical manager	6	Female	33 years	8 months
6	Clinical manager	7	Male	40 years	<1 month
7	Clinical manager	7	Female	49 years	48 months
8	Clinical manager	8	Male	34 years	48 months
9	Clinical manager	8	Male	42 years	48 months

*Band 5 = newly registered nurse (entry-level); band 6 = nurse with direct clinical responsibility; bands 7 and 8 = senior nurse, nurse manager or clinical nurse specialist

Effects of digital technology on patient care

Digital technology enabled participants to access patients' medical records and treatment plans, retrieve and update patient information quickly, and track disease progression. These benefits of digital technology could enhance the consistency of care for patients with long-term conditions. One participant mentioned that digital technology enabled them to take and record clinical pictures during assessments, for example of a patient's wound. Having these images would allow more comprehensive and objective assessments than having descriptive notes alone. Recording patient information digitally could also prevent potential misinterpretations of handwritten notes.

'If all nurses or the clinicians have good knowledge of digital [technology] it will be more helpful to update information for the patients, their diagnosis, their treatment plan… If we want to access that information, it's readily available.' (Participant 3, newly registered nurse)

'Our system allows us to take a picture and upload that into the patient's notes, that [is] quite helpful with wounds for example to give a bit of continuity of care… It's good to see how it's progressing, the healing and all that.' (Participant 9, clinical manager)

Some participants expressed concerns about reduced interactions with patients resulting

from the use of digital technology. Newly registered nurses felt that using a computer while being with a patient might make the encounter feel impersonal or distant. They felt that potential safeguarding issues might be missed if their attention was focused on the digital tool rather than on the patient.

'It's quite difficult isn't it because you want that face-to-face interaction but then you're having to face the screen… Sometimes you can lose that actual contact with the patient, or if there's a safeguarding issue, you might actually not spot that because you're not reading the patient's body language.' (Participant 4, newly registered nurse)

The use of digital technology to conduct consultations remotely was identified as being beneficial in terms of managing the demand for services. By using digital technology to monitor some patients, in-person services could be allocated to patients with greater needs. Furthermore, digital technology could provide an overview of the workload within the department, enabling staff to spot and prioritise outstanding tasks more easily.

'[Remote technology] will probably reduce the workload to an extent, we could get more staff going into those who need one-to-one visits… So if digital technology can come in it will help because we can't see everyone.' (Participant 7, clinical manager)

'[Newly qualified nurses] can see on the screen how the area is at the moment in terms of how busy it is… It offers a really good platform for structuring the work and how to go about progressing through the priorities of things that need doing.' (Participant 9, clinical manager)

Participants thought the use of digital applications (apps) and remote monitoring devices could increase patients' autonomy in managing their health. Apps, for example weight management apps, can be accessed at any time so patients can use them when and where it suits them. Remote monitoring devices, for example for monitoring blood glucose levels, can support patients to self-manage a condition such as diabetes mellitus. Furthermore, digital technology was also deemed to be useful for educating patients about their health and well-being.

'You don't have to have that face-to-face, you don't have to have an office space where people can come in and discuss this, it [remote weight monitoring services] can all be done from home, people can do it in their own time.' (Participant 8, clinical manager)

'[Remote technologies] help to teach patients to self-manage for themselves, they could use the blood glucose monitoring system where they can take their own readings over time… They could send it off to the GP systems or whoever is monitoring them.' (Participant 7, clinical manager)

Developing digital skills

Participants identified fundamental digital skills – such as navigating the internet, typing on a keyboard or keypad, printing documents and using common software programs – as essential in the workplace. Participants mentioned that having general knowledge of information technology (IT) and of digital devices for personal use supported them to use digital technology in the workplace. Clinical managers emphasised the importance of staff recording data clearly and accurately and having an adequate understanding of General Data Protection Regulation (GDPR) – implemented in the UK through the Data Protection Act 2018.

'[You need] basic knowledge of IT… How to use your different functions on your keypads.' (Participant 4, newly registered nurse)

'[You need to know] how to use a standard computer, mobile technology… Knowing how to use different applications, it will make the transition easy in terms of being able to use the digital technology that [is] in use in the workplace.' (Participant 7, clinical manager)

Clinical managers explained that the digital skills of newly registered nurses were not extensively assessed during the recruitment process and that it would be useful if applicants had some knowledge of the electronic systems commonly used in healthcare and/or previous experience of using them. Newly registered nurses recognised that having digital skills could be beneficial for their career progression, but not as much as other skills such as communication skills and clinical skills. This was echoed by clinical managers, who, when recruiting, placed more emphasis on clinical skills and caring qualities than on digital skills.

'As a nurse, we need more interpersonal skills and technical skills like nursing procedures, like IV cannulation… If we are good at computers that will also help, otherwise I think we need more personal skills.' (Participant 2, newly registered nurse)

'It was mainly just to know that they're willing to learn, and willing to try new things… That was the extent of my finding out how well their digital literacy around this would be.' (Participant 8, clinical manager)

Mandatory training on the electronic systems used in the workplace would be provided

to new staff by the trust during induction. That training was primarily in the form of online self-directed training, but participants expressed a preference for more active training methods involving demonstrations and practice. Participants indicated that they would like to have more training on fundamental IT skills, for example on keyboard shortcuts. In some departments, mandatory training would be supplemented by departmental inductions or teaching meetings. Support from senior staff or practice development nurses would be available to staff if they experienced challenges using digital technology.

'I had online training, they would give you fake patients and you would have to follow the instructions online of how to use the platforms.' (Participant 4, newly registered nurse)

'[Newly qualified nurses] have regular teaching meetings and we tailor to topics on that teaching programme according to what needs doing.' (Participant 9, clinical manager)

Many participants explained that their confidence in using digital technology had been gained from previous personal experience and/or through exposure in the workplace, either through formal training or regular use in practice.

'I've been used to computers from a very young age… I've always had a computer when I was younger, in university we used computers. I've done all my training for various packages.' (Participant 1, newly registered nurse)

Clinical managers acknowledged that adequate training and support, including with troubleshooting, needed to be available to ensure staff felt confident about using digital technology. They identified several barriers to staff accessing training and support, including lack of time (especially given the unpredictability of workloads in some departments), training being scheduled at inconvenient times or support required when it was not available. Formal training in fundamental digital skills was often not available or not funded. Clinical managers acknowledged that it was important to accommodate for different experiences and learning styles among staff, which could require training being tailored to individual needs.

'*We can come in in the morning full of good intentions… Then emergency department takes over… We do have a very dedicated practice development nurse [PDN] but obviously it's one person, not here 24/7, and sometimes it's a situation where the one person needs some help is working on a day when the PDN isn't.'* (Participant 9, clinical manager)

Discussion

The findings of this study suggest that digital technology is widely used in healthcare, with a large variety of programs and systems used in daily nursing practice. Several barriers and facilitators to the use of digital technology were identified, including around infrastructure, time, skills, training, support, leadership, familiarity and confidence. Staggers et al (2018) suggested that usability issues can be overcome by involving nurses in the development of software programs to ensure that they are fit for purpose.

The present study identified a tendency among participants to avoid using digital technology when they lacked confidence or encountered technical issues. Previous studies have shown a reluctance among nurses to adopt digital tools, even when their adoption was encouraged by management (Staggers et al 2012, 2018). Alasmary et al (2014) identified a positive correlation between computer literacy and user satisfaction with digital tools, suggesting that improving digital literacy among nurses could generate more positive attitudes towards digital technology and potentially prevent staff from reverting to paper-based methods.

The ways in which digital technology could affect patient care was a recurrent theme in the present study. Participants recognised that the use of digital technology could generate positive changes, including helping them manage demand for services, enhancing the consistency of patient care and giving patients more autonomy. However, participants also expressed concerns that the use of digital technology could reduce interactions with patients and therefore erode nurse-patient relationships. Previous studies have found that the use of digital technology can make patient care too impersonal – see for example De Leeuw et al (2020). It is important that training emphasises the need for nurses to maintain optimal therapeutic relationships with patients and to fulfil their safeguarding responsibilities.

Participants stressed the importance of possessing fundamental digital skills such as navigating the internet and using common software programs. However, the training provided to newly registered nurses tended to be specific to the programs and systems used by their new employer, rather than cover general computer literacy skills. Brown et al (2020) identified a lack of professional development opportunities for nurses to increase their digital skills. The present study confirms that there is a need for more appropriate training

to support newly registered nurses to acquire fundamental digital skills.

Participants in the present study expressed the view that other skills, notably communication skills and clinical skills, were more important than digital skills. In the eyes of participating clinical managers, when recruiting newly registered nurses, a willingness to learn was considered the most important quality in relation to digital skills.

Having a digital capabilities framework can be useful for healthcare professionals to evaluate their digital literacy, competencies and learning needs. However, healthcare professionals may not be aware of the existence of such frameworks. Qualitative studies by Lee et al (2023a, 2023b) identified that senior clinicians were mostly unaware of the profession-specific digital capabilities frameworks developed by HEE for pharmacists and allied health professionals (https://digital-transformation.hee.nhs.uk/building-a-digital-workforce/digital-literacy/digital-capabilities-frameworks).

Limitations

One limitation of the study was its small sample size. Several approaches were tried over a two-month period to increase the number of participants, but these attempts were unsuccessful. The authors speculate that this was due to heavy workloads. All participants worked in one geographical area, which limits the generalisability of the findings since digital systems are not implemented or used consistently across the NHS.

Conclusion

Digital technology is increasingly used in nursing practice, but there is a lack of research on education and training in digital technology for nursing staff. This qualitative study explored the perceptions of newly registered nurses and nurse managers regarding the use of digital technology and the digital skills needed to work in a digitally enabled environment.

On the whole, participants found that digital technology was easy to use but that technical issues could make its use challenging. Participants thought that digital technology could enhance care consistency, help them manage demand for services and increase patient autonomy. However, digital technology was also seen as potentially eroding nurse-patient relationships.

Nurses need to receive appropriate and accessible training in fundamental digital skills and be formally assessed for their digital skills in the workplace. Nurses also need to maintain optimal therapeutic relationships with patients even when patient care involves the use of digital tools.

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Why you should read this article:

- To read about the experiences of practice assessors and practice supervisors of supporting foreign students
- To increase your understanding of the benefits and challenges of working with international nursing students
- To consider ways of enhancing the learning experiences of international students during placements

Facilitating international students' learning during placements: the experiences of practice assessors and practice supervisors

Kay Norman, Sarah Weaver and Laura Perry

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Correspondence
k.norman@worc.ac.uk
@DrKayNorman

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Abstract

Background There are increasing numbers of international students applying for preregistration nursing courses in the UK. Encouraging overseas students to study nursing in the UK has potential benefits for the profession, but practice assessors and practice supervisors may face challenges when supporting international students during placements.

Aim To explore the experiences of practice assessors and practice supervisors in facilitating international preregistration nursing students' learning during placements.

Method A qualitative interpretive research method was used. Data from ten semi-structured interviews undertaken in one hospital in an acute NHS trust were analysed using reflexive thematic analysis and interpretive approaches.

Findings Three overarching themes emerged: communication, support and collaboration. Participants identified barriers related to language and culture and expressed a desire for additional information about students' background before the start of placements. Solutions included drawing from the expertise of colleagues with similar backgrounds to those of students, using buddying and creating peer support groups.

Conclusion Effective collaboration between universities and practice placement providers is needed to develop interventions that can support practice assessors and practice supervisors to enhance international students' learning experiences.

Author details

Kay Norman, principal lecturer adult nursing, head of teaching excellence, Three Counties School of Nursing and Midwifery, University of Worcester, Worcester, England; Sarah Weaver, senior lecturer adult nursing, Three Counties School of Nursing and Midwifery, University of Worcester, Worcester, England; Laura Perry, lecturer adult nursing, Three Counties School of Nursing and Midwifery, University of Worcester, Worcester, England

Keywords

career pathways, clinical placements, culture, diversity, education, mentors, practice learning, pre-registration education, professional, students, universities

Background

Applications from internatio-nal students for healthcare-related university courses including nursing have increased in the UK in the past few years (Stevens 2022, Higher Education Statistics Agency 2023). Encouraging international students to undertake a preregistration nursing course in the UK can benefit the nursing profession, notably by increasing diversity and disseminating new ideas within the workforce (Stevens 2022).

All nursing students must be able to demonstrate, on registration, the professional standards of practice and behaviour laid down by the Nursing and Midwifery Council (NMC) (2018). During practice placements,

practice assessors and practice supervisors support students to achieve these standards (NMC 2023a). International students require additional support to adapt not only to a new country but also to the culture in UK health services. Ensuring that practice assessors and practice supervisors feel prepared and confident to facilitate international students' learning during placements requires effective collaboration between higher education institutions and practice placement providers.

In recent years, a university and an acute NHS trust providing placements in the West Midlands have worked together to support a cohort of first-year preregistration nursing students from overseas whose first language was not English, through a range of initiatives including additional English language sessions for students, scheduled discussions with academic staff and practice facilitators as part of students' preparation for placements, and language advice sheets for practice placement providers. The university has also recruited a lecturer tasked with international student coordination.

During regular meetings between staff at the university and practice placement providers, the trust's practice facilitator team shared feedback from practice assessors and practice supervisors about their experiences of supporting international students. The feedback showed that practice assessors and practice supervisors had some concerns. In response to those concerns it was agreed that a team of academic staff at the university – the authors of this article – would undertake a study to gain insight into the experiences of practice assessors and practice supervisors in supporting international students, with a view to enhancing their experience and that of students.

Aim

The aim was to explore the experiences of practice assessors and practice supervisors in facilitating international preregistration nursing students' learning during placements. The objectives were to:

- Identify areas of good practice.
- Identify challenges and consider solutions.
- Identify examples of effective collaborative working.
- Use the findings to develop strategies for future learning and development.

Method

Design

The study used a qualitative interpretive approach drawing on social phenomenology (Schutz 1967, van Manen 2017). Qualitative research incorporates participants' perceptions and can lead to a better understanding of the phenomena being explored (Streubert and Carpenter 2010). It is highly suitable when studying phenomena relating to nursing experiences (Parahoo 2014).

Setting and participants

The study took place at one hospital in an acute NHS trust in the West Midlands in 2022. Participant information sheets were emailed to a purposive sample of 70 practice assessors and practice supervisors who had recently supported international students in their first year of a preregistration nursing course. Purposive sampling was used since participants were required to have a specific role (either practice assessor or practice supervisor) in a specific setting (Gerrish and Lathlean 2015). The study was also promoted by the trust's practice facilitator team and through the trust's communication briefings. Six of the 70 practice assessors and practice supervisors who had initially been contacted were no longer employed by the trust. Of the remaining 64, ten agreed to participate.

Data collection

A flexible interview schedule was developed by the authors to address the study aim and objectives, allowing for prompts to explore participants' experiences further as appropriate. Individual semi-structured interviews were undertaken by two of the authors (KN, SW) either in person or through video conferencing. Interviews lasted between 30 and 45 minutes and took place in February and March 2022.

Data analysis

Interviews were audio recorded and transcribed verbatim. Drawing on Braun and Clarke's (2006) reflexive thematic analysis approach and the interpretive approach advocated by Alexiadou (2001), participants' responses were coded then themed by two of the authors individually (SW, LP). The themes were then compared and discussed by all three authors to generate superordinate themes.

Ethical considerations

The study had been agreed with the trust's lead for education and workforce and ethical approval had been granted by the university. To maintain confidentiality, each participant was allocated a unique number and transcriptions of the recordings were identified by numbers only. Participants completed

a consent form and returned it to the researchers. Participants were advised, through the participant information sheet and consent form, that anonymised data could be used for publication purposes and this was reiterated before each interview.

Findings

Three superordinate themes emerged from the analysis of the data: communication, support and collaboration. Findings are reported according to those three themes, with participant quotes to illustrate some of the points made.

Communication

All ten participants identified communication as an area that required improvement. Although the international students would have fulfilled the required International English Language Testing System (IELTS) criteria and had attended additional English language sessions provided by the university, participants felt that many students would probably benefit from continuing to improve their language skills and that this would enable them to engage in effective and meaningful dialogue with their colleagues and patients.

Participants reflected on their own communication style and appreciated the need to consider alternative ways of explaining instructions to ensure they would be understood:

'They [international students] hadn't… said, "Where do you keep this? What do I need?" That became quite a big thing, even when we were asking [them] to help position a patient in bed or walk a patient to the bathroom, they were saying "Yes" then standing there…. We had to take time to ensure they understood…' (Participant 8)

Participants identified that common English expressions such as 'a different kettle of fish' or 'to spend a penny' were often misunderstood or misinterpreted by students. People who have learned English outside the UK may have been taught by someone whose first language is not English, so colloquialisms may be confusing for them. Participant 10, who identified as an international nurse, stressed that international students, who have often learned English from an early age, need to become more confident in asking people to speak more slowly and repeat instructions:

'They [international students] need to be encouraged to say they have passed the basic exam of English and they know English; they have learned English all through their life in school. They just need to continue speaking English and ask the other person to repeat slowly.' (Participant 10)

Most participants felt that international students tend not to ask questions to clarify what people mean, possibly because they lack confidence. For participants, this meant that they needed to consider ways of checking whether students had understood what they were being told:

'When people talk to you a lot, if you don't fully understand what other people are saying straightaway you don't want to be the one to say, "I don't really know what you mean." So then we [practice assessors or practice supervisors] would say, "Do you want to go off and just have a look… and then tell us a bit more about it when you come back, so that we know you understand it?" I do think you have to check understanding… You need to be reassured of understanding, not just a yes or a nod.' (Participant 5)

Participants commented that they needed additional time to explain care procedures and instructions to international students because of English language barriers, which could negatively affect the facilitation of learning, particularly during busy periods. Participants recognised that they had to be patient, encourage students and reflect on their own communication style to ensure students would understand what was being explained to or asked of them:

'Communication was difficult due to understanding of the English language, and perhaps we have accents…. and some of us do talk fast. Sometimes there's difficulty because we wear masks, so that's another issue… It might be two times, or three times, I may have to explain. Sometimes I couldn't understand what they were saying, because they may use different words for other things. So it was just a case of being patient.' (Participant 7)

Participants thought it was challenging for international students to understand care procedures in a different healthcare system and culture from those of their home country. Although students attend lectures on nursing care at university, participants acknowledged that international students may not understand the theory taught at university in the same way as UK students:

'You take it for granted when English is the student's first language and [they are] used to our culture. You take it for granted they know how to talk to patients and what to talk about. It is quite different having an international student who may have different values and different approaches to communication with people. They [international students] said they found it difficult that our population was quite needy. In their country, when someone came

Implications for practice

- Practice assessors and practice supervisors could create peer support groups to discuss concerns and share expertise about international students
- International nurses and senior international students could take on a buddying role to offer additional support to international students
- Trusts could consider appointing an international students' lead or coordinator
- The preparation of practice assessors and practice supervisors could cover cultural awareness and competence
- Universities and practice placement providers could jointly organise cultural learning events

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into the healthcare system they were much more self-caring. Patients' expectations were lower.' (Participant 3)

Many participants identified cultural differences as a factor that affected communication. Participants who had themselves come from other countries were more aware than their colleagues of how cultural differences could affect international students' learning experiences and their integration into the nursing team:

'I am an international nurse. When I came over I struggled a lot because it is a different country, the culture is different, expectations are different, the way we work is different and the weather is different, everything is different in the beginning, but I already had a… sound background of nursing. Initially they [international students] are shy and they need that confidence and backup from us, but they get there.' (Participant 10)

Some participants said they did not understand international students' cultural backgrounds and therefore felt unprepared in terms of appreciating different communication styles and supporting students' professional socialisation:

'Yes, I think cultural differences come into it […] We had a student… who used terminology such as "seniors" and "my elder", which the practice supervisor did not appreciate. We got a practice facilitator's help to assess that situation. She said it's not an elder in the sense that we understand, she probably used the wrong word, she probably meant "peer" or "superior", I don't know… because that is her culture to respect her elders. But it could also be misconstrued as rude.' (Participant 9)

Participants emphasised that despite communication challenges, international students would progress throughout their placement, their communication skills would improve and they would start to feel more confident about having conversations with colleagues and patients.

Support

Many participants felt that working with international students required additional time and support from them and their colleagues, which would be particularly challenging in busy periods. Some participants felt that international students required additional support and supervision to avoid potential safety issues occurring as a result of misunderstanding or misinterpretation of instructions or explanations:

'I made everybody aware that they [international students] would need a lot of support, because safety is always going to be an issue. A student needs to be supported otherwise they could become unsafe [to practise]. So it wasn't just the person they were working with that shift, I would make sure that everybody else was aware that they needed to be, not watched, but you know, really well supported. I made the point to my manager as well.' (Participant 2)

However, participants also felt that supporting international students encouraged them to review their own assessment and supervision methods to ensure these would be culturally sensitive.

Participants drew on the support of colleagues who had themselves come from abroad, which made it easier for them to understand and establish a rapport with international students:

'They feel someone who is from their background understands… because I'm sure every five questions they want to ask, they only ask one because they don't know whether they should ask this or not. It is always good to have someone in the team who has lived the journey.' (Participant 10)

Participants identified the trust's practice facilitator team as an important source of support; for example, the team would reassure participants that other practice assessors and practice supervisors experienced similar challenges and would suggest strategies that had enhanced international students' learning in other placement areas. Examples of such strategies included allowing more time to explain care procedures to students and tasking colleagues originally from outside the UK or senior international students to act as buddies for students.

With regard to supporting each other, some participants commented that organising a meeting with the whole team in a ward or service was difficult. However, Participant 3 explained that staff in their clinical area supported each other through a closed WhatsApp group, which they used to identify issues and discuss solutions without delay rather than waiting for a scheduled meeting. Peer support groups were identified as an opportunity for practice assessors and practice supervisors to share their experiences, discuss areas of good practice and support each other to identify solutions to issues.

Peer support for international students was regarded by participants as valuable, with many describing how senior students would support first-year students. However, participants also noted that international students tended to stay together, which they thought limited students' opportunities for practice learning and English language

development. Some participants perceived this tendency as inhibiting independence and preventing students from being proactive in their learning:

'When we had a chat… and said "Look, you are not going to be able to go through this course with you just following each other and not asking" we put an action plan in place and, it sounds mean, but we did split them up so they were on different shifts to encourage them to come out of their shell and to show us they can do this. One really came out of her shell. Their communication improved and they became much more confident.' (Participant 8)

A recurring theme in the interviews with participants was a desire for more preparation to clarify what was expected of them in terms of supporting international students. Participants also wanted more information about students' personal backgrounds, culture and previous experience of nursing before the start of the placement, in the hope that this would help them determine how best to facilitate students' learning.

Participants were asked how they supported international students to demonstrate the NMC's (2018) professional standards and whether they had experienced specific challenges or successes in that respect. Challenges encountered by participants related to communication, language and culture. These challenges initially affected students' ability to understand and demonstrate the NMC's (2018) professional standards, but with additional support they were able to do so by the end of their placement. Participant 8 said acting as a role model would increase students' understanding of professionalism.

'To start, the care and compassion seemed to be lacking. They would hand [patients] a bowl and say, "There you go…" then walk off. But as the placement went on, they did start to draw the curtains and ask, "Do you need any help? I'll leave you a few minutes and then I'll come back and just see." Just checking in with the patients and doing that bit more of the care, realising expectations.' (Participant 8)

'It seems almost unfair putting them into their first placements and expecting them to be achieving quite hard things. The English that is required is not basic English, you're asking them to step into a professional role using professional language. That's not basic English, that's advanced English.' (Participant 3)

Collaboration

Participants collaborated with colleagues and the trust's practice facilitator team when supporting international students and when seeking support for themselves. Some participants said that having support from colleagues with a similar cultural experience to that of international students was extremely helpful:

'I think, definitely, having someone from the student's own culture if possible, so they are able to say, "Help" in their own language, to say "I don't understand." Someone that is on their level just for them.' (Participant 8)

'If a member of staff is from a similar area, you could buddy them up… not necessarily their assessor, but a supervisor. So they [the student] have a contact they might have something in common with.' (Participant 5)

'It is always good to have, in your team, someone who has lived this journey. That will give them [international students] so much more confidence.' (Participant 10)

Participants suggested that buddying could help international students feel more supported during placements and that receiving information about students' country of origin, lifestyle and expectations before they started their placement was central to effective buddying. Accessing such information would involve collaboration between the university and the trust.

Participant 10, who identified as an international nurse, offered to be a resource for clinical staff and students, saying they would be happy to participate in cultural learning events designed to increase their colleagues' knowledge and understanding of international students' customs, cultural practices, traditions and languages:

'I will be more than happy to get involved in those [cultural events]. If they are all international students… I can get international nurses and myself and others [to get involved]… Call us in.' (Participant 10)

Participants thought that collaboration with the trust's practice facilitator team, which they identified as their main source of support, could be extended to international students. Participant 4 thought it would be useful for students to meet a practice facilitator before starting their placement so that they would know someone they could contact if they required additional support. However, this is not always feasible due to limited resources within the practice facilitator team.

Collaborative working with the university appeared to be mostly indirect, via the trust's practice facilitator team – which regularly meets academic staff. Some participants said they were able to get in touch with the academic assessor at the university to discuss students. Participants were not always aware

of the support available to students at the university but said they would ask the practice facilitator team for information.

Participants identified the need for more information from the trust on how they could facilitate international students' learning in preparation for their role of practice assessor or practice supervisor. Since students complete their placements in several organisations, using a case study approach in education sessions could help increase the knowledge of practice assessors and practice supervisors.

Participants wanted to be advocates for students but were unsure what information or resources were available at the trust to help them achieve that. Although participants acknowledged that the human resources department, for example, could help them identify or access additional information or resources for students, they felt they lacked the time to seek additional information or resources and suggested that these could be provided by an international students' lead or coordinator. Many healthcare organisations have a lead who assists in recruiting international nurses and who could become involved with supporting international students as well:

'We need a supervisor or practice assessor group in the trust, so we can link in with each other from other areas. Maybe a lead for international students in the trust to coordinate.' (Participant 7)

'Is there somewhere [within the trust], a support network for them, especially for international students and international nurses, where they can find some resources?' (Participant 10)

Overall, participants felt that collaborating with colleagues, particularly those originally from overseas themselves, helped them better understand their role in supporting international students to improve their practice. Many participants felt that supporting international students benefited both parties:

'For me personally, it's been really interesting working with people from all over the world and from different cultures. It has been really interesting talking to them.' (Participant 3)

'It was a positive experience because I saw her progress so much from start to finish and we formed a lovely relationship. I got a lot from it in terms of having a big challenge, meeting it and seeing them become so much more confident.' (Participant 2)

Discussion

The findings of this qualitative study showed that participating practice assessors and practice supervisors experienced challenges when supporting international students during placements, including language barriers, lack of time to develop effective learning relationships, gaps in their own knowledge and understanding, and uncertainty about where to find support. However, participants also identified potential solutions to these challenges as well as benefits of working with international students. Working with international students increased participants' cultural awareness and prompted them to reflect on the way they communicate with others. Participants also found it interesting and rewarding.

Participants wanted to better understand students' background and culture to facilitate more meaningful and enjoyable learning experiences. This is supported by Strøm et al (2022), who explored Indian nurses' (n=8) experiences of supervising Norwegian students during a short placement in India. Participants in Strøm et al (2022) emphasised the importance of knowing about students' background – for example their health, emotional and social needs, dietary requirements and communication skills – so that they were well prepared and could make students feel welcome. Participants felt protective towards students, anticipated that students would require an in-depth explanation of nursing in the Indian healthcare system, and regarded improving students' cultural awareness as part of their role (Strøm et al 2022).

Luukkonen et al (2023), who explored clinical practice mentors' (n=270) cultural competence in relation to mentoring culturally and linguistically diverse nursing students, suggested that a positive learning environment reduced language barriers and increased opportunities for mentors to develop cultural awareness. Arieli (2013) noted that despite experiencing some challenges and requiring time to adjust to a different culture, international nursing students can have rewarding clinical experiences if their cultural values are not compromised – that is, if staff acknowledge, understand and accept cultural values that may be different from theirs.

A systematic review of the experiences of culturally and linguistically diverse healthcare students of learning in a clinical environment concluded that additional education in culture and language, for students and for clinical staff, was essential to improve experiences and outcomes (Mikkonen et al 2016). The review also acknowledged that cultural and linguistic aspects of healthcare education are under-researched (Mikkonen et al 2016).

Participants in the present study suggested that students could share personal background information with their practice assessor and practice supervisor before starting their placement, since this would help staff to support students. This is an interesting idea that could be further explored. If students were asked to provide personal information, the placement provider would have to clearly explain what the information would be used for, elicit informed consent from students and highlight to them their right not to provide personal information.

The findings of the present study suggest it is important that the different teams involved in organising placements work together to enhance international students' learning experiences. Participants suggested appointing an international students' lead or coordinator as a further source of guidance and information. This is supported by Eden et al (2021) who, in a literature review of the learning experiences of international nursing and midwifery students, suggested that specialist support staff can assist students with integration and socialisation, which are central aspects of professional growth and achievement. Participants in the present study also suggested using a buddying approach, which could be one way of drawing on staff with relevant experience to assist students with professional socialisation.

Participants in the present study regarded the trust's practice facilitator team as their main source of support, but the study findings also suggest that practice assessors and practice supervisors do not always know where to find additional support for international students. Practice assessor and practice supervisor support groups were suggested as a possible strategy for them to learn from their colleagues' experiences. To promote a better understanding of all aspects of international students' learning, such groups could include academic staff. Furthermore, as suggested in this study, it could be useful to review how clinical staff are prepared for their role of practice assessors or practice supervisors in relation to international students.

Limitations

This was a small qualitative study so the findings are not generalisable, but they may still be transferable to other healthcare organisations and may inform further research.

Conclusion

This study explored the experiences of ten practice assessors and practice supervisors in facilitating learning for international preregistration nursing students during placements. Participants identified a number of challenges, including language and culture barriers; lack of information about students' background before the start of placements; and uncertainty about where to find additional support. They also identified potential solutions to these challenges, such as drawing from the expertise of colleagues with similar backgrounds to students, using buddying and creating peer support groups. Furthermore, participants also found working with international students interesting and rewarding. It increased their cultural awareness and prompted them to reflect on their communication style. Central to supporting practice assessors and practice supervisors to enhance the learning experiences of international students is effective collaboration between universities and practice placement providers as well as between practice facilitators, clinical staff and university staff.

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CONTACT

Sophie Blakemore
Jennifer Sprinks
Joint editors / Nursing Management

sophie.blakemore@rcni.com
RCNi_Sprinks@rcni.com

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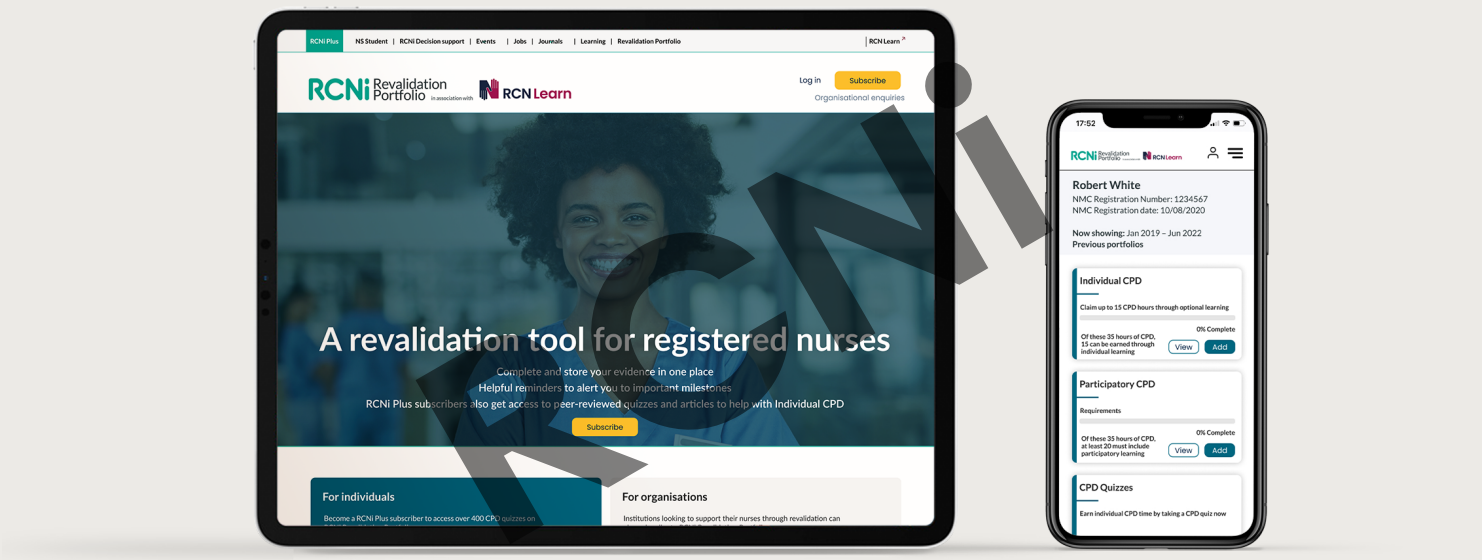

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