Collaborative coaching and learning in midwifery clinical placements: an evaluation

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Abstract

The model of coaching and collaborative learning is based on the nursing model of collaborative learning in practice developed at University of East Anglia and support by Health Education, East of England.

The model was adapted to fit the midwifery antenatal and postnatal ward where it was trialled between September 2016 and August 2017. During the implementation students, coaches, mentors and other staff on the ward areas were supported by the practice development midwife.

Evaluation data was collected in the normal module evaluations and showed overall satisfaction with the model and the opportunities for sharing learning.

The model is now being rolled out to other placement areas. Keys to success include good preparation of the clinical placement areas and supported from a practice educator.

Key Points

1. NMC standards for supervision of students suggests that the mentorship model needs to change
2. Coaching models have been piloted in nursing
3. Coaching in midwifery education provides opportunities for peer support and shared learning experiences which evaluated well.

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Introduction

The UK Nursing and Midwifery Council education framework contains standards for student supervision (NMC 2018) which intends to change the way student nurses and midwives are supported and assessed in learning environments. The NMC places responsibility on the partnership between universities and placement providers for the quality of the learning. It also requires the clinical placement areas to be fully immersive clinical learning environments in which all staff become involved in supporting the education of future nurses and midwives . Thus, the mentorship model (NMC 2008) which currently exists requires significant overhaul to meet the new standards which incorporate separate roles for supervision and assessment of students in placement areas.

Midwifery students currently are supported in clinical practice by a mentor to whom they have access for at least 40 percent of their placement (NMC 2009). Mentors have until now been prepared to a standard set by NMC (2008) and retain the qualification through annual updates and triennial review, to ensure quality of placement education (Fisher et al, 2017). The mentor supervises the learning and conducts the assessment of practice in the placement area. The assessment is supported in many areas by a university academic midwife resulting in a tripartite process between student, mentor and academic. Whilst the process of grading practice is controversial Fisher and colleagues found in a survey of midwifery educators that the supportive collaborative relationship between clinicians and academics is generally viewed as robust (Fisher et al, 2017).

Student learning in placement is brought into sharp focus when we consider the importance of safe patient care. Criticism of nursing and midwifery practice in the reports from Francis (2013) and Kirkup (2015) has drawn attention to the quality of training environments in hospital settings and has encouraged closer working between universities and placement learning environments to ensure quality of care is at the heart of the learning process. The duty to report concerns is now made clear to students and to nursing and midwifery staff supporting learning in clinical placement areas. The Willis report (2015) on nursing education recommended that one to one models of mentorship should be reviewed, citing collaborative learning in practice as a possible way forward for supporting clinical learning.

The Collaborative Learning in Practice (CliP) Model (Lobo et al, 2014) was introduced in University of East Anglia (UEA) supported by Health Education England based on a real life learning ward system used in Amsterdam. The system has been evaluated (Hill et al, 2017) and shown to have a number of benefits, but is not without issues (see table 1). It requires training of the coaches, preparation of the placement environment staff as well as student preparation. The key to successful implementation lies in the preparation and support of the placement areas by dedicated practice education staff. Huggins (2016) explains the process of coaching in terms of the skills of questioning employed to support student learning. This requires coaches to develop a form of 'conversational questioning' enabling the student to problem solve on issues of prioritising and providing patient care. In this way coaches stand back from care giving and enable students to develop nursing skills.

Experienced mentors in midwifery already embrace a model of gradually more distant supervision over time. In the University of East Anglia midwifery curriculum students move from *observer participant* in care through *supervised participant* to *supervised practitioner* and reach the level of *competent practitioner* in the final year of the midwifery programme.

The preparedness for role as a registered practitioner has been visited a number of times in the literature (Monaghan, 2015) and the way in which students are supported to develop independence is key to this. Coaching models such as CLiP appear to prepare students to take more responsibility within the learning role thus preparing them better for their role as practitioners at the end of their programme (Hill et al, 2017).

Implementing the model

This transformational change was brought about by both the need to provide increasing numbers of students in line with the demands envisaged in the NHS England Five Year Forward View (2014) and the need to create learning environments in clinical areas that could include collective responsibility and collaboration in supporting student midwives. The work prior to implementation of the coaching model included discussions between the UEA and the James Paget University NHS Foundation Trust which included the Head of Midwifery, Lead Midwife for Education, the link lecturer from the university, midwives and clinical educators from both nursing and midwifery. Whilst many universities and placement areas will already have collaborative relationships the role of the clinical educator has been perceived to be key to the successful delivery of the model (Hill et 2017). In this case the clinical educator (JY) was instrumental in initiating and sustaining the coaching model.

The implementation of this initiative was carefully considered and required the placement areas and university to work in partnership to ensure that timing and preparation were co-

ordinated for commencement of the change. The implementation of such a model in practice involves both behavioural and organisational change. Effective and educationally sound practice based learning and the desire to create forward thinking, professionally responsible and resilient health care practitioners with the ability to provide safe, effective care, remained the focus when the plans for implementation were discussed with all relevant parties and stakeholders. Those involved in the planning utilised various dimensions of leadership behaviours (NHS Leadership Academy, 2013) to 'engage the team' and 'share the vision' of implementing the coaching model, whilst 'evaluating information' from the evaluation of the nursing pilot of coaching. The time line for the change is shown in figure 1. The implementation happened over a sustained period of time and still continues to evolve as the model further embeds itself in practice.

Description of process of training and preparation

The coaching model emphasizes the student focused approach to learning and encourages students to identify their own learning needs and objectives and work with their coaches and peers to accomplish these. The care of women and babies is delivered by students who are being supported by coaches. Hope et al (2010) suggest that students learn best when submersed in "doing", through active engagement and experiential learning in the practice environment, this is reflective of the model adopted in collaborative coaching. The evidence to date suggests that both students and staff have found coaching to be a positive experience. The students report feeling more empowered and confident in their knowledge and skills. Furthermore where it is used in nursing, there has been a marked reduction in the anxiety related to the transition from student to qualified practitioner (Huggins 2016, Willis 2012).

Identification of wards or areas in which to introduce coaching is very important. There are certain criteria that need to be considered, with possibly the most important being the department team leaders enthusiasm and commitment to the new concept of student learning

in practice coupled with an effective and positive relationship between department leads, clinical educator and link lecturer. Once areas were identified there were workshops set up to train the staff, the main aim of these was to ensure that the staff were aware of the similarities and differences between mentoring and coaching. This includes identifying the skills and attributes needed to be an effective coach, these include the ability to "stand back" and allow the students to deliver the care whilst providing a supportive and understanding environment for the students (see table 2). As with mentoring, coaches are seen as the role models, providing advice and constructive criticism to enable the students to envisage their full potential. There are also barriers to effective coaching that are considered during this training period, for example how best to deal with the feelings of being the "expert" in a given situation and how to control the potential to dominate or control situations thus hindering the provision of meaningful learning for the students. Coaching also involves the techniques needed to explore how best to identify student's levels of ability and support them in appropriate identification of learning objectives through effective conversational questioning and listening. The need to develop trust between coaches and student is paramount to the success of the model. Careful consideration should be paid to the importance of developing working relationships, and how coaches can enable students to develop a solution focused response to difficult situations (Huggins, 2016). Coaches are also trained in the importance of the completion of daily learning logs.

The daily learning logs are an essential tool in the process of this method of learning in practice. They are completed daily by both the student and the coaches. These reflective learning logs formulate the ongoing record of achievement for each student, as required by the NMC standards (NMC 2008). Moreover they encourage students to develop reflective learning skills and can contribute to ongoing reflective practice once qualified, contributing to the three yearly revalidation process (NMC 2015). The reflective learning logs also help coaches to support students to identify and attain learning outcomes as well as allowing the student to set goals and identify learning opportunities linked to their assessment of practice

requirements. This is further developed to share this learning through the provision of presentations of key topics learned during the placement. This enhances the student's confidence, presentation skills, promotes value and satisfaction and shares the learning achieved with peers and staff members. These feedback loop enables coaches and other staff to see the effectiveness of the clinical learning environment. The shared learning contributes to the overall quality of care.

Description of a day

The coaching model is underpinned by a philosophy that students take on a greater responsibility for their own learning. A typical day on the maternity ward would start at handover with the midwifery students becoming actively involved and identifying a woman or small number of women that they wish to care for. The midwifery students are expected to set a learning objective specifically related to the woman/women they plan to care for that day ensuring that this meets with pre-determined learning outcomes in the practice assessment documents.

Students are allocated a 'learning hour' in each shift as part of the coaching model at JPUH and is pivotal to enhancing the students' knowledge and bridging any potential theory-practice gap. During this hour students can access learning materials on line or through the library that enables them to make sense of the learning outcome in relation to the practical care being provided. The coach or clinical educator discusses the learning outcome and the evidence that the midwifery student produces within the hour. The learning is collated and can be presented as part of the student's personal portfolio. This learning hour reinforces the philosophy of the clinical area as a learning environment and ensures that the supernumerary status of student remains a feature of their education.

In addition to the learning objectives the midwifery students take the lead in the care of the woman/women selected, depending on stage of development. They work alongside their peers, who would collectively be supported by a coach. Literature supports that students can

benefit from gaining experience with a range of different people as opposed to a one to one mentoring model (Hill et al, 2017). The coach is usually a registered midwife but may also be a midwifery support worker or nursery nurse. The coach is allocated to the care of those women the students are working with to enable them to appropriately supervise the midwifery students and enable the students to take on increased responsibilities whilst enhancing their practice experience. This forms their clinical responsibility for the shift and ensures safe care and clear lines of student supervision and reporting. The coaches are reposnsbile for providing written and verbal feedback on student performance in relation to the particular learning outcome for the day and reporting any issues to the supervising mentor. The evidence from coaches is collated by the student so that a range of practice contributes to the assessment process undertaken by the mentor. Students have access to their mentor for a minimum of 405 of their time on placement. They have the opportunity to discuss their learning outcomes and progress at the mid point progress review meeting at with the mentor and the link (academic midwifery) lecturer.

Midwifery students are a key member of the team caring for a woman and any other members of the multi-professional team are encouraged to liaise with the student who will in-turn feedback to the coach. Thus the importance of preparing the whole team for the change to a coaching model to support students.

The coaching model encourages students to work closely with their peers which subsequently has enabled students themselves to develop coaching skills amongst one another. This skill is increasingly being recognised as integral to the role of any practitioner working any kind of students or learners in the practice areas (Narayanasamy and Penney, 2014) and being able to develop these skills during their pre-registration training is an additional benefit of this model.

The advantages of the students working closely together and learning from each other was soon identified, particularly in feedback from students themselves. Students were facilitated in practice by the midwifery clinical educator to formally share an aspect of their learning that had been enhanced by being coached. This takes place once a module, generally in the form of a presentation. Clinical managers and link lecturers as well as student peers are invited, actively attend and there is always shared learning. It is an excellent opportunity which has proven its worth in questioning current practice and generating interprofessional discussion. This has empowered students and created a sense of confidence in their valid contribution to team.

The coaching model is currently imbedded on the antenatal and postnatal ward with further plans to expand the model throughout all placement areas.

Student and coach evaluations

The first cohort of students who have experienced the coaching model in their training at the JPUH provided feedback during module evaluations. The feedback from students and clinical staff is positive.

AB Student Midwife

"…I felt I had gained confidence in my abilities much quicker by being able to complete the care package or the woman myself, but felt well supported by my coach and the other students, knowing that if I was unsure about anything I had someone right there to ask…"

"My advice to those of you who are considering a coaching model as a learning platform, is it works, it makes us more confident in our abilities to complete our role whilst still students. Once qualified I am confident we will feel ready to step over the threshold from student midwife with confidence and competence."

CD- Student Midwife

"I feel that using [the coaching model] during my training is developed my confidence from being an observer-participant on the way to becoming a competent practitioner. Through [the coaching model] I am learning it is essential to be organised, have good time management, be a good communicator and work as part of a team…and also gives us the independence to identify our learning needs and build upon our clinical skills whilst having the support of a coach and our fellow students…already I feel my knowledge base is benefitting from this style of learning."

DE- Student Midwife

"[the coaching model] gave me protected time to research and develop knowledge that related directly to women in my care. Also, the coaching model provided me with the opportunity to develop time/workload management skills, which have provided me with the confidence that I will be able to prioritise my workload and deliver excellent holistic care to women once I start my new role as a qualified midwife."

XY- Midwife coach

"I have found that [the coaching model] has allowed students to develop their clinical and communication skills by working alongside their peers and overall found the students have become more confident in their practice. The model encourages the students to share their knowledge to support others' learning in planning and providing individualised care."

Discussion

The model used by the maternity antenatal and postnatal ward is a modified version of that used in the CLiP Pilot project in nursing reported by Hill et al (2017). The ward did not accommodate large numbers of students and most of the students on the ward at any given

time were in the same year group. So this evaluation essentially explored the coaching method. This model did not alter the current practice assessment processes which includes mentoring and tripartite assessment processes involving student, placement mentor and university link lecturer. Mentors were able to review written evidence of learning which contained comments from the coaches who had supervised the students on each shift. This element enables greater objectivity for mentors in assessing performance against learning outcomes, increasing the assessment validity and was welcomed. The findings in relation to student preparedness for qualified role mirrors the nursing evaluation.

The role of coaches in questioning students encourages them to critically examine practice and enables them to reflect on and in action. The presentation in a multiprofessional forum and sharing of knowledge enhances learning and bridges the theory Practice gap. In questioning practice they are able to consider macro management and influence change in a real way. The opportunity to share their learning contributes to service innovation and multiprofessional awareness.

Conclusion

The model is being rolled out across other partner clinical environments with a new placement circuit enabling students from different year groups routinely to be placed together in learning environments. This peer support alongside coaching should enable students to develop confidence in sharing learning and supporting others. The model which allows for separate roles of supervisors and assessors and involvement of an academic in assessment process should meet the requirements of the NMC. The keys to success in implementing any new model are management support for change, support from the

multiprofessional team in each learning environment, consistency of approach and support from a practice educator in the early stages to enable clinical teams to adapt to the new way of working.

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Tables and Figures

Table 1 Summary of Evaluation in Nursing of CLiP(Hill et al 2017)

Students and coaches/ mentors CLiP positively evaluated preparedness of students for qualification
Coaching as a principle is accepted as a strength, but adequate preparation of all stakeholders is important
Balance of staff, patients and mix of students(i.e. proportion of senior and junior students) on any given shift can positively or negatively impact the working of the model
The mentor, student, coach relationship is perceived to be complex and this may impact on overall assessment of student performance by a more distant mentor.
The perceived rigidity of the model made it appear to be more difficult to implemented in some areas. Potential adaptability of the model was not always appreciated.

Table 2 Differences between coaching and mentoring

coaching	**mentoring**
Increased student participation	Student observing practice
Student led	Mentor allocates tasks
Focussed on learning outcomes	Focussed on workload
Enhancing student confidence	May foster student dependence on mentor
empowerment	Learning through being told and shown
Enables coaching of peers and junior students	
Appreciation of other roles in clinical teams	
Enquiry based questioning	

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Figure 1.Timeline for Implementing Coaching model to Maternity