

Implications for Operationalising the New Education Standards for Nursing

Dr Jacqueline Leigh and Professor Debbie Roberts 5th September 2017

Registrants and Higher Education Institutions (HEI's) are currently being consulted by the Nursing and Midwifery Council (NMC) regarding potential new standards for pre-registration nursing education. The consultation sets out new standards for pre- registration nursing together with an education framework that underpins the associated theory and practice. Whilst this document does not contain the final standards, it does offer a glimpse of what the newly registered nurse should know and be able to do at the point of registration in order to practice safely and effectively and continue to develop their expertise. The draft proficiency standards are referred to in the document as being 'ambitious, setting out the enhanced knowledge and skills that people can expect from nurses in the future' NMC 2017: 5).

It is interesting to look at the document in terms of practice learning, particularly in relation to by whom and how student nurses will be supervised and assessed in clinical practice and what the educational requirement should be. Within this paper we offer some personal perspectives about the potential impact of these new standards in practice.

Background:

The NMC document: Standards to Support Learning and Assessment in Practice: NMC Standards for Mentors, Practice Teachers and Teachers proposed a single developmental framework for the preparation of those individuals supporting student learning in clinical practice (NMC 2006, 2008). Consisting of four stages the framework defines and describes the knowledge and skills that nurses and midwives must possess at each stage to support and assess students on NMC-approved pre- and post-registration programmes. The specific responsibility and accountability of a mentor is clearly delineated in the document, and includes organising and coordinating learning activities in practice and supervising and assessing total performance of the student. The literature concerning the importance of mentors to learning is plentiful. Within the UK, since their inception; mentors have been lauded as being pivotal to student learning in clinical practice.

Despite the general consensus that mentoring is so important; it seems that the preparation of mentors is not proportionate to the importance it plays within nurse education. Preparation of mentors currently consists of a minimum of 10 days, at least 5 of which should be protected learning time over a period of 3 months in both academic and practice settings.

Perhaps it is unsurprising then that mentors often feel unprepared for the enormity of their role, particularly in assessing students. Evidence suggests that there is an underestimated and under recognised emotional aspect to assessing students in clinical practice (Wilson, 2014. Black et al 2014). Black et al (2014) describe the 'personal price' and 'professional responsibility' experienced by mentors. More recently, Hunt et al (2016) describe coercive behaviours used by students in order to manipulate clinical assessment decisions. Behaviours described include those who tried to curry favour through flattery; those who used distracting tactics; such as feigning illness through to making denigrating comments and overt aggression (Hunt et al., 2016).

Nurse mentors are struggling to fulfil the role with minimal formal support from their work environment (Nettleton and Bray 2008). Often mentorship is seen as an aid to career progression rather than as a valued qualification in its own right (Lauder et al 2008). Others have suggested that "Not all nurses and midwives are suited to the mentoring role but many job descriptions/role

profiles state that nurses should have a mentoring qualification to progress, either within their grade or to move to the next. Nurses may be pushed into taking on a mentoring role, either as an aid to career progression, or because the current one to one mentoring model relies on large numbers of mentors to feed and maintain it. Not only is there a need for large numbers of active mentors but the system relies on a regular stream of 'mentors in waiting' to replace those who move onto other roles" (Andrews et al 2010: 253). Furthermore, anecdotally it seems that whilst the NMC recognises that sign-off mentors need protected time for undertaking the role and this is acknowledged as one hour per student per week, in addition to 40% of the student placement time. Without additional funding, employers will be hard pushed to support this, in any meaningful way, and there is unlikely to be robust quality assurance mechanisms by which the competence of sign-off mentors is continually assessed (Andrews, 2007).

Therefore, it is understandable the NMC is looking to review the way in which student nurses are supported in clinical practice.

The new proposals:

In the consultation and draft document, Annexe 2 contains the education and training standards which all approved education institutions (AEIs), practice placement and work based learning providers must meet in order to manage and deliver all NMC approved education programmes.

On reading, a key message and what will not change from the current pre-registration standards is the fundamental requirement for partnerships between AEIs and healthcare organizations to provide the practice based learning for the student nurse.

"Overall responsibility for the day-to-day management of quality lies with AEIs in partnership with practice-placement and work placed learning partners who offer 'hands on' practice experience to students" (NMC Annexe 2:4). The NMC suggests that there should be a partnership approach with shared responsibility for theory and practice learning and assessment (R2.2).

What is new is the introduction of the Five Pillars for education and training:

1. Learning culture
2. Educational governance and quality
3. Student learning and empowerment
4. Educators and assessors
5. Curricula and assessment

Simultaneously, new roles are introduced such as practice supervisor (Pillar 3), educator and assessor (Pillar 4). When reading these documents the difference in roles is not clear. The preparation required by those occupying such roles is not made explicit leaving the reader to make their own assumptions.

The NMC state:

“Our education framework and the new requirements for learning and assessment provide flexibility for approved education institutions, practice placement and work placed learning providers in developing innovative approaches to education for nurses and midwives while being accountable for the local delivery and management of NMC approved programmes in line with our standards” (NMC 2017:5).

This statement could be interpreted in different ways, for example permission by the NMC for entrepreneurialism. Alternatively this statement could be perceived as the NMC being vague with no real ideas of their own.

Pillar 3 states that students are supervised and supported in practice learning by practice supervisors who are suitably prepared registered health and social care professionals with current knowledge and experience. This is a departure from the current profession centric approach to mentorship (Andrews et al 2010). The Department of Health have long since recognised that supervising students is a key part of every professional practitioner’s role (Department of Health 2000:25). Inter-professional mentoring, specifically, has a number of potential benefits. Through interactions with a variety of providers, students learn about the roles of other disciplines and how to collaborate in a team. These interactions are suggested to be relatively easy to introduce without the need for radical changes to the structure of the placements or the curricula (Lait et al 2011). Lait et al (2011) go on to argue that although providers from disciplines other than the student’s may not be able to teach clinical skills because of professional regulations and differing skills sets, they can still mentor students (Lait et al 2011). Furthermore, most of the competencies identified as essential for the placement educator role in medicine, occupational therapy, nursing, and social work are not profession specific, including generic skills such as enabling learning, knowledge of learning theory, ability to manage learning environment, and modelling professional responsibility (Emerson 2004).

A future NMC approach that is flexible seems more akin to other health professional such as medics and physios whose professional bodies are less prescriptive around the preparation for the practice based teachers and assessors. For example, The Health and Care Professions Council (HCPC) favour the term ‘placement educator’ and have no specific requirements or expectations for their role development and instead require that education provider ensure that placement educators are suitably qualified and prepared for the role. They do not set specific requirements for the length or content of this training and instead leave the level of detail to be decided by individual education providers. Placements are also often cited as being ‘overcrowded’ with students; with some suggesting that these conditions severely compromise the value that practice experience offers students (Hutchings et al., 2005). Therefore, it will important for the professions to have some sustained dialogue in order to agree how this inter professional supervision of students in practice will take place. Without this dialogue there is the danger that practice supervisors could be indeed be mentors but by another name.

There is no detail within the draft standards regarding the preparation to become a practice assessor; perhaps those undertaking the current role of the sign-off mentor will undertake this new role? Whether there will be enough individuals to make this role sustainable and offer enough assessment opportunities to the large numbers of student nurses remains unclear.

What seems to be absent from this new consultation and draft document are the prescriptive elements for the education and on-going continuing professional development needs of educators and assessors of student nurses in practice. The current requirements for mentorship (NMC 2008) have led to the proliferation of credit and non- credit bearing programmes that prepare the qualified nurse for the role of mentor. Prescriptive annual updates are also required in order to comply with maintaining ‘live’ mentorship recognition.

Accompanying the draft educational framework is a document outlining the minimum standards of proficiency with outcome statements that are suggested to apply to all four fields of nursing practice; although it is noted that the technical annexes are still under development. The notion of standards of proficiency indicate that these will be assessed as a pass/fail element of the pre-registration programme; despite calls for innovative assessment schemes that allow for the grading of clinical practice (Roberts 2011). The standards are grouped under seven areas of proficiency:

1. Be an accountable professional
2. Public and population health
3. Assessing needs and planning care
4. Providing and evaluating care
5. Leading nursing care and working in teams
6. Improving safety and quality of care
7. Coordinating care.

Outcome 5.8 suggests that at the point of registration individuals will 'supervise students assessing the quality of their delivery of nursing care, documenting performance, promoting reflection and providing constructive feedback'. Therefore the skills associated with learning and teaching in clinical practice will be acquired as part of the new pre-registration programme; with no requirement for an additional post-qualifying course in order to support students. In what seems like an already over-crowded curriculum; the time devoted to this invaluable aspect of being a registrant may be minimal. Therefore, the questions raised by Andrews (2007) and Andrews et al (2010) about how on-going competency of to practice within the new role will be achieved and assured may continue to be unanswered. Whether the newly qualified nurse is fully equipped to deliver the high quality supervision of practice to take the profession forwards will require robust evaluation.

Summary and recommendations:

Taking a position that the NMC are offering some flexibility regarding practice based learning, now is the time for AEs and healthcare organizations to work collaboratively and to set the benchmark for quality teaching and learning in clinical practice. Reconsidering models of student support is imperative. This includes the use of coaching as opposed to mentoring and to redefine the practice roles required. Be creative and entrepreneurial adopting service improvement and transformation tools and techniques.

Flexible should not mean reduced quality. Indeed, Health Education England whose wider remit for ensuring that there are high quality learning environments for all healthcare learners in England makes clear their expectations of what constitutes a quality clinical learning environment.

Whichever model of supporting clinical learning is adopted; unless a culture that establishes the value of teaching and learning in practice is recognised and fostered by senior managers, new ventures are likely to fail (Henderson and Eaton 2013). Realising the worth of clinical learning at the bedside requires a major shift in terms of buy-in from senior managers and staff; indeed perhaps it is time to acknowledge the need for those who are responsible for the clinical learning to be supernumerary?

Why not invite key NMC stakeholders to AEs and healthcare organizations and work collaboratively to critically explore the draft standards? The event could be used as a starting point for conversations around the flexible arrangements for the education and development of those responsible for assessing and supervising our future nursing workforce. Be creative and ambitious and explore what future education roles could look like. Take the great from our current systems

and learn from the past and use expertise and leadership to look to the future. Clear is the need for academic leadership (Leigh et al. 2017) to deliver on any new models of education and to create the culture shift required.

Andrews, M., 2007. Contemporary Issues in Mentoring Practice. In: West, S., Clark, T., Jasper, M. (Eds.), *Enabling Learning in Nursing and Midwifery Practice*. John Wiley & Sons Ltd., Chichester (Chapter 1)

Andrews, M., Brewer, M., Buchan, T., Denne, A., Hammond, J., Hardy, G., Jacobs, L., McKenzie, L., and West, S. (2010). Implementation and sustainability of the nursing and midwifery standards for mentoring in the UK. *Nurse Education in Practice* 10 (2010) 251–255

Black, S., Curzio, J., and Terry, L. 2014. Failing a student nurse: A new horizon of moral courage. *Nursing Ethics*. 2(2): 224-238.

Emerson, T., 2004. Preparing placement supervisors for primary care: an interprofessional perspective from the UK. *Journal of Interprofessional Care* 18 (2), 165-182.

Health and Care Professions Council (HCPC) (2014) *Standards of Education and Training*, London: <http://www.hpc-uk.org/aboutregistration/standards/sets/>

Henderson A., and Eaton E. 2013. Assisting nurses to facilitate student and new graduate learning in practice settings: What 'support' do nurses at the bedside need? *Nurse Education in Practice*. 13: 197-201

Hunt L A, McGee P, Gutteridge R, Hughes M. (2016) Manipulating mentors' assessment decisions: Do underperforming student nurses use coercive strategies to influence mentors' practical assessment decisions? *Nurse Education in Practice*. Doi: 10.1016/j.nepr.2016.08.007.

Hutchings, A., Williamson, G., Humphreys, A., 2005. Supporting learners in clinical practice. Capacity issues. *Journal of Clinical Nursing* 14 (8), 945–955.

Lait, J., Suter, E., Arthur, N., and Deutschlander, S. 2011. Interprofessional mentoring: Enhancing students' clinical learning. *Nurse Education in Practice*. 11 (3): 211-215. Accessed on 1.9.17 via: <https://doi.org/10.1016/j.nepr.2010.10.005>

Lauder, W., Roxburgh, M., Holland, et al., 2008. *The Report of the Evaluation of Fitness to Practice Pre-Registration Nursing and Midwifery Curricula Project*. Commissioned by NHS Education for Scotland.

Leigh J A., Williamson T., Rutherford J., (2017) Stakeholder Perspectives of an Approach to Healthcare Leadership Development through Use of a Multidimensional Leadership Development Conceptual Model, *The International Journal of Practice-based Learning in Health & Social Care*, 5 (1), 77-97

Nettleton, P. and Bray, L. 2008. Current mentorship schemes might be doing our students a disservice. *Nurse Education in Practice*. 8, 205-212.

Nursing and Midwifery Council (2006) *Standards to Support Learning and Assessment in Practice: NMC Standards for Mentors, Practice Teachers and Teachers*. NMC, London. <http://tinyurl.com/5tj5jcj> (accessed 29.9.16)

Nursing and Midwifery Council (2008) Standards to Support Learning and Assessment in Practice: NMC Standards for Mentors, Practice Teachers and Teachers. NMC, London.
<http://tinyurl.com/6hld2nd> (accessed 29.9.16)

Roberts D. 2011. Grading the Performance of clinical skills: Lessons to be learned from the performing arts. *Nurse Education Today*, 31 (6): 607-610.

Wilson AME. 2014. Mentoring student nurses and the educational use of self: A hermeneutic phenomenological study. *Nurse Education Today* 34 (2014) 313–318.

<https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-to-supportlearning-assessment.pdf>