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Evaluating the impact of a coaching pilot on students and staff.

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Abstract

This coaching pilot was developed following the publication of a number of reports that recommended a review into how student nurses are taught in clinical practice. A bespoke version of the Collaborative Learning in Practice( CLiP) (2014) model was developed, which used both coaching and peer learning to encourage students to lead on the delivery of care for a designated group of patients.

A senior student led a team consisting of a further two junior students and they were given the responsibility of directing and coordinating the team in the manner expected of a registered nurse. A qualified nurse was responsible for the supervision of the students and used a coaching approach to teach. Findings revealed that the students benefitted from being able to work autonomously and were able to enhance their leadership and management skills.

Key Phrases and Key Words

Coaching, Student Nurses, Peer Learning, Mentoring

Declaration of Interest

No conflict of interests declared.

Introduction

The 2015 report entitled Shape of Caring (Health Education England) advocated a teaching model that championed coaching and peer learning entitled ‘Collaborative Learning in Practice’ (CLiP) (2014). Current Standards to Support Learning and Assessment in Practice (SLAiP, 2008) state that students are required to be mentored by a registered nurse who has undertaken an NMC approved programme and the nominated mentor must have been available for 40% of the students’ placement time in order to complete a valid assessment.

However, in a climate of an evolving nursing workforce and the introduction of roles such as the nursing associate, it is essential to examine the current mentorship model in order to ensure that clinical placements provide optimal learning opportunities. Increasing numbers of students in placement areas can prove onerous on mentors (Huggins, 2016) and can adversely affect student satisfaction (Vinales, 2015).

Newly released NMC pre-registration education standards (2018) have mandated the absolution of mentors in favour of three new roles: Academic Assessor, Practice Assessor and Practice Supervisor. An NMC approved course will no longer be required in order for registered professionals to supervise students. Furthermore, reform of the way in which students are taught in clinical practice is implicitly recommended in the form of a coaching approach. It is anticipated that both Practice Supervisors and Practice Assessors adopt a coaching approach to teaching and minimise use of direction and instruction. In order to ensure that the future workforce is equipped with the required level of skill to care for an aging population with increasing demands on the role of the registered nurse a review of the existing model of mentorship is required as is cultural change. Whilst the NMC standards (2018) are pertinent across the UK, the Shape of Caring (2015) and other exploration on the subject is England centric.

Background

Experiential learning in clinical placement currently constitutes 50% of pre-registration programmes. Student satisfaction is often linked with having a sense of belonging, being a valued member of the team as well as the availability of quality learning opportunities (Jokelainen et al, 2010). However, limited placement circuits and the proliferation of healthcare staff taking advanced roles such as Assistant Practitioners and the introduction of the Nursing Associate role has impacted upon student satisfaction. The Shape of Caring (2015) review was considerate of this and acknowledged that the principles of the current SLAiP (2008) standards would be difficult to sustain.

As said, the CLiP (2014) coaching model was championed in the Shape of Caring (2015) review. The CLiP model promotes that a registered professional, with experience of the clinical area assumes the role of coach. Typically, the coach will supervise a group of students of mixed experience who would be the directors of care for a designated group of patients. In addition, the coach provides feedback to the students’ allocated mentor in order for them to formulate an assessment of their student’s performance. Mentoring differs from coaching in a number of ways (Table 3). Typically, mentoring is directive and relies on mentors providing instruction to students. Conversely, coaches encourage students to be the main providers of care and to problem solve and practice without full direction but under supervision. The benefit of coaching is that students are able to think critically and are equipped to practice autonomously at the point of qualification.

In order to comply with the new NMC pre-registration nursing standards (2018) and to ensure that the student experience is maximised in the face of anticipated challenges, a derivative of the CLiP (2014) model that was originally developed by the University of East Anglia was utilised for the coaching pilot.

Design

In order to implement change that is sustainable, it is necessary to consider the use of a change management model to provide structure to a change project (NHS Improvement, 2018). Plan-Do-Study-Act (PDSA) cycles are widely used in healthcare (Coury et al*.,* 2017) and are suited to projects that require multiple iterations. Consequently, the design of the coaching pilot was based on a PDSA approach.

Plan

A steering group consisting of university staff, senior nurses within the participating organisation and Clinical Placement Facilitators (CPF’s) was developed following the publication of draft NMC standards (2018) and in light of an upsurge of interest in coaching following the CLiP (2014) project. The steering group was responsible for agreeing the structure of the coaching pilot (see table 1) and concluded that in order for the pilot to succeed, all participating staff would receive coaching training based on the GROW coaching model (Whitmore, 2009) (see table 2). It was also determined that a literal implementation of the CLiP (2014) model was not feasible due to limited resources so a bespoke coaching model that incorporated the key principles of CLiP (2014) was designed.

Evidence suggests that dedicated learning areas are successful in enhancing students’ learning (Melillo et al.,2014). Therefore, a section of the participating ward consisting of seven low acuity patients was labelled the ‘learning zone’ (see diagram 1). In order to mitigate risk, it was not deemed appropriate for the students to be the directors of care for acutely unwell patients or those with more demanding needs. Three students, consisting of one senior student and two junior students that were on placement at the same time assumed control of the learning zone under the supervision of the coach that had received GROW model (2009) coaching training. Full supervision from the designated coach was required at all times to ensure patient safety and to minimise risk.

In terms of evaluating the pilot the use of focus groups was deemed appropriate. As the coaching pilot was not intended to be a research project the focus groups were for evaluative purposes only.

The aim of the pilot was to initially address questions that had been raised following examination of reports such as Shape of Caring (2015) such as:

* Can the coaching model be realistically applied to clinical placement given the fact that there were limited resources available in terms of additional staffing to implement the pilot?
* Can the coaching model enhance student learning and maintain student satisfaction?
* Are mentors able to assess students despite not directly working with them?

Diagram 1

Side Room 1

Side Room 2

Bay One

Bed 2

Bed 1

Side Room 3

Bed 4

Bed 3

Do

In order for any change project to be successful and sustained it is essential that all individuals involved understand the aims and objectives (Alvesson and Sveningsson, 2015). In order to achieve this, ward staff that were participating in the pilot as a coach not only received comprehensive coaching training but were also aware of the need to innovate and reform practice. The project was championed by the ward matron and staff, regardless of role and seniority, were informed of the learning zone and the need to be considerate to the fact that students would be directing care.

During the pilot, frequent visits were made by academic staff from the participating university and also the CPF for the clinical area. Logistical issues such as coordinating off duty and ensuring that students still worked a sufficient amount of time with their mentors whilst participating in the pilot proved problematic on occasion. Students were also required to work set shifts in order to ensure that three students were on duty at the same time.

In addition, the students received appropriate preparation via a presentation that stated the rationale and organisation of the pilot. As the students were not expected to coach themselves, it was not deemed necessary for them to receive the coaching training that had been delivered to ward staff.

Study

Two focus groups were held at the conclusion of the pilot in order to evaluate the effectiveness of the coaching pilot. Focus groups are considered to be an effective way of gathering qualitative data (Stewart and Shamdasani, 2015). Although focus groups can provide a rich form of data, there is also a propensity for participants to be led by more assertive members of the group (Kreuger and Casey, 2015). Consequently, it was deemed necessary to have two focus groups: one consisting of ward staff and the alternate group solely comprising students in order to generate honest discussion and dialogue.

Both focus groups were held on the ward that participated in the pilot. Ideally focus groups should be held in a neutral location, which may lend itself to a more open discussion (Tong, Sainsbury & Craig, 2007). However, due to limited resources this was not feasible and both focus groups were carried out in identical conditions on the ward.

Both focus groups were held over the duration of 45 minutes and aimed to ascertain whether the pilot compromised or enhanced the student experience and whether organisational or logistical issues hindered the pilot. Mentor satisfaction and the efficacy of the preparation that ward staff received was also explored.

Act

Findings from both the student and mentor focus group determined that the coaching pilot was successful overall but would require incremental change for future iterations. The introduction of a learning zone was successfully received and staff that participated in the coaching role were able to effectively use the GROW coaching model (2009).

The student experience was positive overall but there was poor compliance in completion of a learning log, as students felt that it was an additional workload that they didn’t deem necessary. Future iterations of the pilot will emphasise the importance of the learning log as a method for students to demonstrate that they have achieved competency and can evidence their learning outcomes.

For future cycles there will also be a need to consider providing extra support to the ward staff that arrange student off duty. Students were concerned about the lack of time working directly with their mentors and balancing this with the need to arrange off duty in a way that structured the coaching pilot proved problematic on occasion.

Change can only be considered if it becomes embedded, sustained and results in a cultural shift (Gage, 2013). Therefore, a second cycle of the coaching model will resume in the same placement area, in addition to a further roll out across two similar wards with the intention that repeating the coaching model for a second time will provide familiarity and an increased chance of sustaining change.

Findings

During the student focus group particular attention was paid to the responses of the third year students as they had the necessary experience to provide comparison between the existing mentorship model and coaching:

‘It made it the best placement I have ever had. I was nervous starting, but I feel so much more confident and have loved working with my team.’

In addition, a first year student responded:

‘It’s been good and I’ve learned a lot. It made me feel more relaxed knowing I could turn to a third year student if I needed support. I’ve been able to do a lot of skills in the learning zone.’

Students were unanimously positive about working in a dedicated learning zone and stated that being coached allowed them to develop their problem solving and leadership skills.

The second focus group consisting of registered nurses involved in the pilot raised minor concerns of the issues that they encountered:

‘There were positives and negatives. The third year students had no knowledge of the specialty so it was difficult for them to lead a team at first. The first year students were also on their first placement and some had no care experience at all.’

Regarding the logistics and organisation of the coaching pilot, the ward lead concluded:

‘It increased my workload at times as the students didn’t like working set shifts and wanted to swap their duty. We had to refuse their requests to swap or the project would not have worked.’

Despite this it was concluded that none of the aforementioned issues were insurmountable and more diligence and support of the ward lead for the coaching model would remedy the organisational issues. Furthermore, it was also concluded that a period of acclimatisation before starting the coaching model would ease student anxieties and allow them to become accustomed to the routine of the ward.

However, all staff that participated in the coaching role concluded that the students’ development was evident and that they were able to assess the students’ competence more clearly:

‘The students had more responsibility it was nice to see their confidence and leadership skills develop. I could clearly see how well they were performing and it helped me to assess them better.’

Discussion

Having evaluated the coaching pilot several themes have emerged. Coaching as opposed to mentoring is a preferred teaching method amongst senior students, whilst junior students preferred a blended approach of both mentoring and coaching. Senior students perceived that coaching allowed them autonomy and they were able to develop leadership skills as a result. Whilst the junior students enjoyed participating in the pilot, they shared the opinion that a more personal and directive approach combined with the coaching would have been beneficial. The junior students had very limited care experience prior to commencing the pilot and believed that direct learning from their nominated mentor would have been of benefit, in addition to the coaching model. Smith (2017) stated that whilst coaching is beneficial and allows individuals to achieve their learning outcomes, a blended approach of both coaching and mentoring can enhance learning further.

In terms of addressing the aims of the coaching pilot, it was concluded that it is feasible to apply the coaching model to placement areas. Although the CLiP (2014) model was specifically advocated in the Shape of Caring review (2015) not all NHS placement providers have the resources to apply the model in its most literal form. However, CLiP (2014) derivatives that still use the core principles of peer learning and coaching, can be applied to any placement area on the provision that there are students of mixed levels of experience. Although the coaching pilot encountered minor difficulties in ensuring that students fulfilled the current SLAiP (2008) standard assessment criteria and also participated in a model designed to complement future NMC pre-registration standards (2018), it is anticipated that these difficulties will be overcome with the introduction of the new NMC standards (2018).

Following evaluation of the coaching pilot, it was also deemed appropriate to allow students a period of induction, with the rationale that their experience would benefit from having time to adjust to the ward culture and routine before commencing the coaching model. A blended approach can improve student satisfaction and also allows mentors the opportunity to work directly with their students thus helping them to assess students clearly. However, following evaluation of the pilot, the registered nurses that acted as the coach concluded that it was more obvious how competent the students were as they were expected to direct and deliver care and lead a team, all skills expected of newly qualified nurses. Failing to fail students remains an issue (Hughes, Mitchell & Johnston , 2016)in practice, however, by using a coaching model it is more straightforward to assess a student’s competency, which may reduce the number of students that qualify but are not sufficiently skilled.

By ensuring that students work in small teams of no more than three, placement areas can ensure that there is not a saturation of students on each shift. The removal of the 40% SLAiP (2008) stipulation, that mentors must be available to students for that amount of time will also allow for more flexibility. Furthermore by creating a designated ‘learning zone’ in each ward area, any individual with learning needs can participate in the coaching method. It is anticipated that Nursing Associates and preceptees that may require additional support can also participate in the coaching model, which will improve confidence, leadership and teamwork. The appeal of the coaching pilot is that students’ learning is enhanced by working in a dedicated learning zone where their learning and development is a priority. However, further exploration is required to ascertain whether a blended approach of mentoring and coaching is more effective and also whether the coaching model can eradicate ‘failure to fail’.

Recommendations

Coaching and peer learning can undoubtedly enhance the student experience on placement (Narayanasamy and Penney, 2014). However, the current form of mentoring student nurses is embedded in ward culture and it will take time and repetition to achieve sustained change. Students must also develop an awareness of coaching and peer learning, which can be achieved by Higher Education Institutions (HEI’s) placing an emphasis on this throughout the duration of pre-registration training. Coaching, peer learning and teamwork should have equal emphasis to clinical skills during simulation sessions and any future curriculum development should acknowledge coaching and the benefits of it on clinical placement.

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| Table 1 |
| A section of the ward would acquire ‘learning zone’ status |
| Three students (one third year and two first year) would work together to lead patient care |
| A registered nurse would supervise the students and take on the role of ‘coach’ |
| Student would complete a daily learning log to evidence their learning and achievement of skills |

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| Table 2 GROW Model (Whitmore, 2009) |
| G- Goal- What would you like to achieve |
| R- Reality- What is the situation? |
| O- Options- What do you need to help you achieve your goals |
| W- Will-What will you do to achieve your goal? |

Table 3

|  |  |
| --- | --- |
| **Mentor** | **Coach** |
| Directive | Non Directive |
| Directs the student’s learning | Allows students to identify their learning needs |
| Answers questions | Asks questions |
| Allocates tasks to students | Encourages students to solve problems |
| Encourages students to learn by observing their practice | Promotes autonomy and independent thinking |

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