

# NET

networking  
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in healthcare

# NET2015

## **26th International Networking for Healthcare Education Conference**

**Tuesday 8–Thursday 10 September 2015**

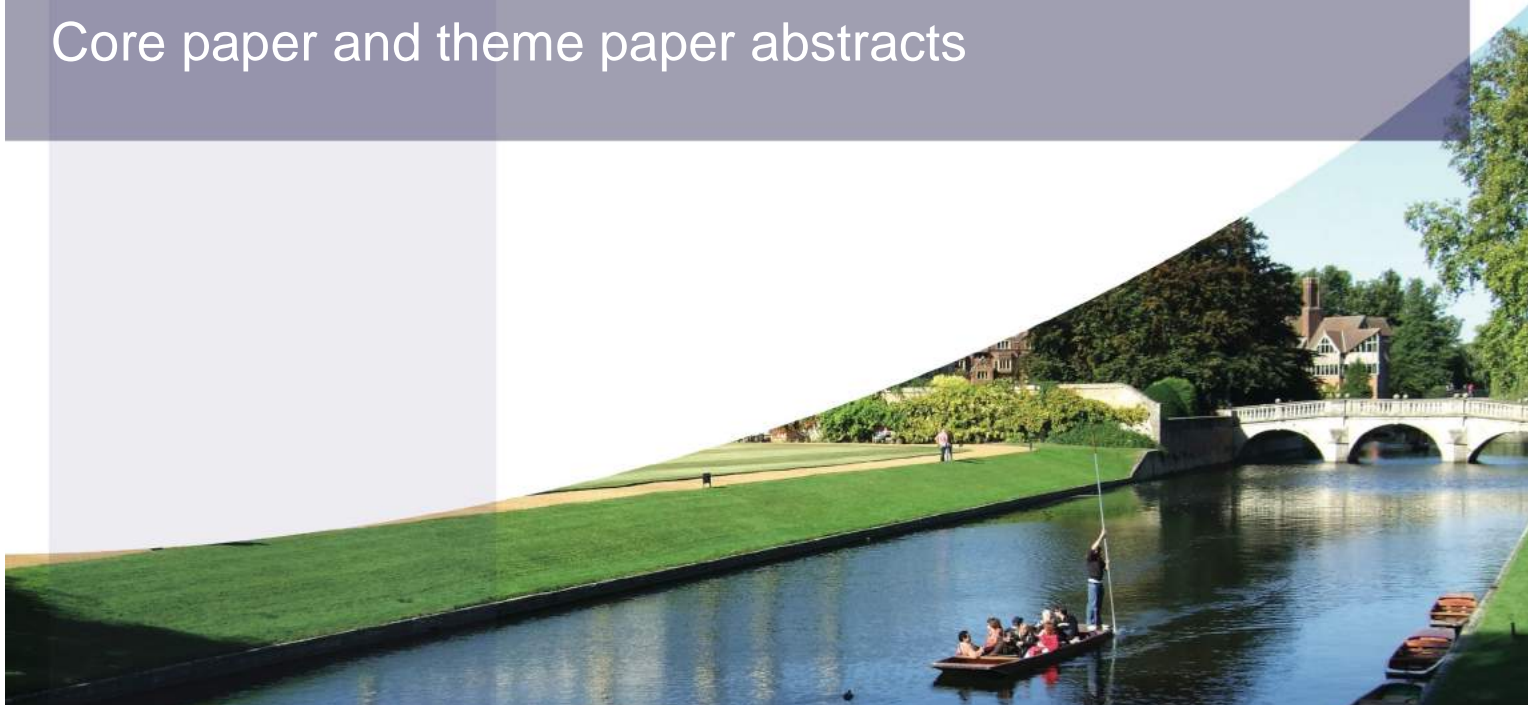
Churchill College, University of Cambridge CB3 0DS, UK

Group 2 of theme sessions

Wednesday 9 September 2015

Educational innovation and enhancement

Core paper and theme paper abstracts



# Group 2 of the theme sessions Wednesday 9 September 2015

## Educational innovation and enhancement (EIE)

### Core paper and theme paper abstracts

**Please note:**

References are as supplied by authors

USA and Australian spelling has been retained as appropriate

Papers included are those being presented at the conference at the time of going to press.

# Core paper

## Biographical details of core presenters

Claire A. Rushton, Lecturer in Nursing and NIHR Research Fellow, Keele University, UK; Sanghamitra Pati, Additional Professor, IIPH Bhubaneswar, Public Health Foundation of India (PHFI), India; Julie Green, Lecturer in Nursing, Keele University, UK; Gabriele Messina, Research Professor of Public Health, Department of Molecular and Developmental Medicine, University of Siena, Italy; Anna Strömberg, Professor in Nursing and Head of Division of Nursing Science, Linköping University, Sweden; Davide Golinelli; Agnese Verzuri, University of Siena, Italy; Simon White, Senior Lecturer in Pharmacy, Keele University, UK; Tiny Jaarsma, Professor in Caring Sciences, Linköping University, Sweden; Pauline Walsh, Head of School; Umesh T. Kadam, Professor in Clinical Epidemiology and Health Services Research, Keele University, UK

**Claire Rushton** is a National Institute for Health Research doctoral research fellow at Keele University in the UK. She is developing a research programme focused on comorbidity and prognosis in cardiovascular populations. Claire has been a cardiovascular nurse and lecturer since 1997, is a European Society Cardiology Heart Failure Nurse Curriculum task force member and has developed undergraduate and post graduate nursing curricula both locally and internationally.

**Sanghamitra Pati**, a physician turned public health professional, is currently working as Additional Professor at the Indian Institute of Public Health, Bhubaneswar, Public Health Foundation of India (PHFI). Prior to this, she had been working as a faculty member in state medical colleges and also adjunct faculty member in nursing, pharmacy and physiotherapy colleges. At PHFI, she is involved in teaching Non-communicable and Chronic Diseases, Health Communication and Promotion, Public Health Nutrition, Primary care quality and equity, Implementation research. Currently her research work focuses on primary care based prevention of multiple chronic diseases (multimorbidity) through capacity building of health care providers and curricular interventions in health professional education

**Julie Green** is a Doctor of Primary care Sciences, Queen's Nurse and nurse lecturer at Keele University in the UK. Julie has a wealth of experience in community and district nursing and is award lead for District Nurse Specialist Practice locally. Julie is developing a research programme on multimorbidity and has a special interest in patient-centred approaches and interventions.

**Gabriele Messina** MD Dr.Ph MSc Epidemiology graduated in 1999 at the University of Siena. In 2002 he obtained the Master in Epidemiology (London School of Hygiene and Tropical Medicine) and in 2003, the Degree of Specialist in Hygiene and Public Health at the University of Siena. From 2005 he has been Research Professor of Hygiene and Public Health in the University of Siena and has published more than 90 scientific full papers.

**Anna Strömberg** is Professor in Nursing and Head of division of Nursing Science, Department of Medical and Health Sciences, Linköping University, Sweden. *Tiny Jaarsma* is Professor in Caring Sciences in the Department of Social and Welfare Studies also at Linköping University, Sweden.

**Davide Golinelli** was born in Bologna and completed his M.D. Degree at the University of Bologna. He also now works at the Post-Graduate School of Public Health, University of Siena, Italy.

**Agnese Verzuri** was born in Siena and completed her M.D. Degree at the University of Siena. She now works at the Post-Graduate School of Public Health, University of Siena, Italy.

**Simon White** is a Senior Lecturer in Pharmacy Practice at Keele University in the UK. He completed his PhD at the University of Nottingham on cardiac rehabilitation patients' perspectives on medicines and lifestyle modification. He is Fellow of the Higher Education Academy and a Fellow of the Royal Society for Public Health.

**Pauline Walsh** is head of the School of Nursing and Midwifery at Keele University. She has wide ranging clinical experience and has worked in education since 1991 gaining a wealth of experience in curriculum design and delivery. Pauline is an experienced leader within higher education, is involved in many regional and national groups and has recently been elected as chair of the Royal College Of Nursing Education Forum. Current research interests involve curriculum development approaches, attrition and retention on health care programmes and most recently developing resilience in nursing students to enhance their confidence in dealing with challenging experiences within clinical practice.

**Umesh Kadam** has developed an international multimorbidity research programme within primary care and care interfaces over the last ten years in the UK. He is a Professor of Health Services Research and Clinical Epidemiology at Keele University, general practitioner and Fellow in Public Health.

## Development of an international comorbidity education framework

**Claire A. Rushton, Lecturer in Nursing and NIHR Research Fellow, Keele University, UK; Sanghamitra Pati, Additional Professor, IIPH Bhubaneswar, Public Health Foundation of India (PHFI), India; Julie Green, Lecturer in Nursing, Keele University, UK; Gabriele Messina, Research Professor of Public Health, Department of Molecular and Developmental Medicine, University of Siena, Italy; Anna Strömberg, Professor in Nursing and Head of Division of Nursing Science, Linköping University, Sweden; Davide Golinelli; Agnese Verzuri, University of Siena, Italy; Simon White, Senior Lecturer in Pharmacy, Keele University, UK; Tiny Jaarsma, Professor in Caring Sciences, Linköping University, Sweden; Pauline Walsh, Head of School; Umesh T. Kadam, Professor in Clinical Epidemiology and Health Services Research, Keele University, UK**

### Introduction

Globally populations are living longer, which means people often live with two or more conditions at the same time and this issue has become an international healthcare priority (OECD, 2011). The concept of two or more conditions in healthcare language has been conceptualised into distinct terms of 'multimorbidity' and 'comorbidity' (van den Akker, 2005). The focus of multimorbidity is on the *patient* living with two or more conditions and the related holistic implications to self-management and healthcare delivery. In contrast, the focus of comorbidity is on how *other conditions* might influence the management of an *index condition*. Yet international healthcare systems and delivery is currently based on single condition frameworks (Lugtenberg *et al.*, 2011) and undergraduate and postgraduate training programmes have either been developed for holistic care or the polar opposite in the management of the single conditions or delivery by specialist teams. The clear evidence gap in terms of education and training is how quality and standards of care for each of the single condition frameworks can be integrated to form the optimal chronic disease and *other conditions* management which improves the overall care of the patient. This is a critical education and training gap as patients with comorbidity face poorer outcomes in terms of quality of life, morbidity and mortality (Rushton, 2014; Pati, 2014; Rushton, 2015) and care that ignores comorbidity can be irrelevant or harmful (Tinetti *et al.*, 2004). Comorbidity thus presents a major challenge to health care policy and higher education institutions (HEIs) across the world.

Nursing as a profession has developed along a single disease management trajectory with ever increasing disease targeted specialist roles which can leave nurses less confident to deal with comorbid patients' complex needs. Nurses need to carefully consider comorbidity to avoid specialism being at the expense of patient-centred practice (Chummun, 2006). Nursing has philosophical roots in holism which emphasises the multidimensional components of care and patients' response to illness. Yet, in the same way that specialism has begun to dominate healthcare delivery, the review of individual conditions is most often the focus of nurse education and there is extremely limited comorbidity teaching. A clear example is the segregation of mental and physical health (Blythe and White 2012) or of biological systems. The implications of gaps in comorbidity education and training extend to all other healthcare disciplines with single disease approaches similarly dominating in medical education (Yardley, 2015; Barnett, 2012; OECD, 2011) and in pharmacy, where multimorbidity drives the prescription of several medications meaning that enhanced skills for pharmacologists to tackle complex comorbidity are required (Duerden *et al.*, 2013).

Current approaches to healthcare education have been criticised as out-dated and at risk of 'producing ill-equipped graduates given the challenges to be faced' (OECD, 2011). There is a global push for more inter-professional learning to realign competencies with population priorities (Frenk *et al.*, 2010) and for redesign of current healthcare curricula for the management of people with multiple long term conditions. While there is continuing health education and other opportunities for further training, often what is learned in undergraduate schools shapes how a clinician practices over their life career. A key question is whether health professionals are acquiring the correct skills to meet the changing burden of multiple diseases. There also needs to be emphasis on the development of new public health and multimorbidity prevention approaches in developing and developed countries, the relevance of which will apply across all healthcare disciplines (RCN, 2012; Zodpey *et al.*, 2014). This issue has become an international policy priority and the upcoming challenge will be to redesign the clinical curricula to truly fit the requirements for patient-centred care. Nurses are well placed to extend their holistic principles to develop new frameworks for learning about disease within the broader context of comorbidity and for making this an integral component to education delivery. Given the common gaps in healthcare curricula across health professional disciplines and potentially in the international context, we wanted a framework that could be used within or across disciplines including inter-professional education and different international settings.

### Aims and objectives

We aimed to develop an International Comorbidity Education framework (IECF) that could be used within current healthcare curricula to integrate comorbidity care principles with disease specific teaching and learning.

Our *objectives* were:

- i. to assess the current understanding of comorbidity management in student populations from nursing, medicine and pharmacy, using self-completion questionnaires.
- ii. to develop an international group of HEI representatives (clinicians and academics) across four countries (England, Sweden, Italy and India) to develop the ICEF using the student surveys and current evidence.

## Methods

Using structured questionnaires, we surveyed nurse, medical and pharmacy students to obtain the students' understanding of multimorbidity and comorbidity. Students were presented with three increasingly complex scenarios of a patient with (A) a single index disease (B) A patient with an index condition and an additional comorbidity and (C) a patient with several comorbidities in addition to their index disease. They were asked about whether they felt they had the adequate knowledge, training and confidence to provide care for these patients. These questionnaire surveys were carried out in different student groups from England, Sweden, Italy and India.

A core international group of HEI representatives was formed including heads of schools, across the three disciplines, to explore current curricula and gaps. We conducted two HEI workshops in the UK and Sweden (Rushton *et al.*, 2014) and had face to face and virtual meetings with Italy and India respectively. Finally we used the students surveys and HEI discussions together with current evidence to develop a 6 stage ICEF that could be used across the health disciplines and applied to different learning and teaching modalities such as lectures, case or problem based learning, reflective portfolios, practice case management and clinical scenarios or e-learning activities. We have currently surveyed English student nurses for feedback on the ICEF and the next steps will include feedback from students from the different disciplines. We plan to increase the number of pharmacy undergraduate students included in the development of the framework and to extend our work to physiotherapy discipline. Finally we aim to test different methods of embedding the framework into current healthcare curricula.

## Results

### *Socio-demographic characteristics*

A total of 894 students participated in the survey which included student nurses (n=522), medical students (n=344) and pharmacy students (n=28). The student samples were drawn from the England (41%), India (49%), Italy (8%) and Sweden (2%) (see Figure 1). The UK sample included more mature student nurses (20% over age 30 years) than the sample from India (6%) or the other European countries (10%). India had the lowest number of male nurse student responders (5%). Medical student responders in India and Italy were all aged below 30 years and roughly half were female (see Table 1). Most pharmacy student responders were female (71%) and aged below 30 years (89%). There were more novice learner nurses in the UK sample (42% in first year) and all other students across the disciplines and countries were in their final year with the exception of Indian students (where most were in their mid to final years).

### *Current knowledge, training and confidence for comorbidity cases*

The overall proportion of the undergraduate student sample who reported that they had sufficient understanding for the management of case A was: knowledge (51%), training (47%) and confidence (54%). However, the overall proportion of the undergraduate student sample who reported that they had sufficient understanding for the management of case C was lower; knowledge (31%), training (30%) and confidence (32%). A similar pattern was shown across all health disciplines and within each country (Table 2 and Figure 2). Overall perception of knowledge, training and confidence was lowest in English student nurses and highest in Indian student nurses. Medical students in India and Italy reported similar levels of understanding but with Italian students perceiving lower training and confidence for the most complex case C. Across disciplines pharmacy students reported the highest levels of understanding in all three dimensions.

### *Current awareness and training*

All students reported wanting more training in comorbidity (range 71-95%). Overall, in the students who responded to the question 'what is comorbidity?' there appeared to be understanding of the multiple nature of comorbidity but there was lack of clarity or consistency in the definitions presented. Students often used the terms multimorbidity and comorbidity interchangeably. Most reported the *number* of coexisting conditions to be the differentiating factor (comorbidity; 2 conditions, multimorbidity; >2 conditions). Medical students from India and Italy referred to the *timing* of disease using 'pre-existing diseases' in their comorbidity definition. Italian nurses included the type of condition (acute, chronic, primary) and English nurses and pharmacists included the *focus* on one condition in their definition. Students reported a range of topics taught in their current programmes that would help them to learn about comorbidity (see Table 1.), but no students reported learning about comorbidity specifically.

### *The framework*

We used current evidence including multimorbidity and comorbidity care delivery frameworks (Department of Health 2014, American Expert Panel 2012) and the student feedback on their current training to develop a 6 stage comorbidity education framework for integrating comorbidity concepts with disease specific teaching and learning. Our main objective was that the framework would be comprehensive enough to include all the main comorbidity principles but simple enough to be

useful at different stages of training and across different health disciplines. We wanted to develop a simple version that could act as an aide-memoire for student learners and teachers in disease specific contexts and a more detailed version that would also provide important links to broader curriculum learning.

The 6 stages included in the framework were (i) conditions, (ii) context, (iii) conflicts, (iv) corroboration, (v) communication and (vi) collaboration (see Figure 3 for the brief version and supplementary file for detailed version). We presented this framework for feedback to 254 English nurse undergraduate students and 89% reported that the framework was easy to understand and 92% felt that the framework would help them to learn about comorbidity. Nurse student comments included the need for better integration of social and healthcare systems to improve the care of people with learning disabilities and physiological or mental health comorbidity. Clearer inclusion of the prioritisation of two competing conditions with conflicting care regimes was raised and the need to balance the health professional's role with patient centred care. Students suggested that links to evidence and resources would be useful as would an electronic resource that could be used to transfer learning to practice. The framework was revised following the student feedback and an initial review by HEI academic members from the four countries.

### Discussion

Comorbidity is an important challenge for healthcare practice but has not yet been included explicitly or consistently within professional health education programmes internationally. Our surveys have shown that a high proportion of students from different healthcare disciplines reported that they lacked sufficient knowledge, training and confidence to care for people with comorbidity even in their final year of training. A comorbidity education framework, developed through a comprehensive process of academic, clinical and student feedback, provides the potential for better integration of comorbidity with current curricula. However, as with any learning and teaching framework, the simple and structured approach does not in itself ensure that learning will take place. This requires the management and integration of such a framework into education programmes. The future challenge will be how the framework can embed into current curricula and fit with a variety of pedagogical approaches, across different disciplines and international settings. This will require a systems approach with integration of the comorbidity concepts with broader curriculum teaching and learning (Jochems *et al.*, 2004), requiring formal curricula mapping.

Comorbidity is a complex phenomenon requiring higher level learning to synthesise skills, knowledge and attitudes for transfer to diverse clinical settings and for the development of competence. This requires students to 'learn to learn', to problem solve, think critically and self-assess, skills which fit best with theoretical approaches to learning such as social constructivism (Duane *et al.*, 2014). The comorbidity education framework provides the content and concepts which are student-centred and evidence-based. Construction and collaboration of learning is best facilitated by social and experiential learning using approaches such as problem or case based learning (Brandon and All, 2010) which will then lead to consolidation of learning and competence through practice based learning (Yardley *et al.*, 2015). This might pose challenges to countries who are in the transitional phase from traditional teaching to problem based learning approaches (Nanda *et al.*, 2013).

### Conclusions

Comorbidity education and training is a current major gap in international health curricula and a more holistic approach to multiple condition management is required to better prepare healthcare undergraduates for 21<sup>st</sup> century care. An international comorbidity education framework (ICEF) that can be easily applied to current curricula, utilised in different teaching and learning modalities and within and across professional groups, provides the potential for the realignment of professional competencies with international healthcare policy priorities.

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**Table 1: Questionnaire surveys of students**

	England		India		Italy		Sweden
	Nurses (n=341)	Pharmacists (n=28)	Nurses (n=116)	Doctors (n=367)	Nurses (n=45)	Doctors (n=27)	Nurses (n=20)
Age under 30, (%)	80	89	94	100	100	100	90
Female, (%)	88	71	95	53	84	48	75
No prior health work experience, (%)	44	61	66	88	71	59	55
More multimorbidity training wanted, (%)	92	71	91	80	69	85	95
First year of training, (%)	42	0	3	0	0	0	0
Final year of training, (%)	22	57	85	9	100	100	100
<b>Terminology</b>	Comorbidity used interchangeably with multimorbidity. <ul style="list-style-type: none"> <li>• Most described multimorbidity as multiple conditions and comorbidity as two conditions. Pharmacists included multiple drugs in their comorbidity definition.</li> <li>• Medical students from India and Italy referred to the timing of disease using 'pre-existing diseases' in their comorbidity definition</li> <li>• English nurse and pharmacy students included 'a focus' on a condition with other conditions.</li> <li>• Italian nurse students included a mix of acute, chronic or primary diseases in their comorbidity definition</li> </ul>						
<b>Current course content</b>	<p><b>Nursing</b></p> <ul style="list-style-type: none"> <li>• England: Pathophysiology, older persons, case studies, long term conditions, dementia, health implications, clinical practice</li> <li>• India: Internal medicine, psychology, clinical care, pathology, disability, nursing applied to medicine, pharmacology</li> <li>• Italy: Disease and conditions (major to minor), obesity, emergency care, psychology, health promotion, society, community health, diagnostics, illness impact.</li> <li>• Sweden: Polypharmacy, complex diseases, psychiatry and geriatrics</li> </ul> <p><b>Medicine</b></p> <ul style="list-style-type: none"> <li>• India: Internal medicine, psychology, geriatrics, medical pathology, clinical care, pharmacology</li> <li>• Italy: History taking, management guidance, clinical experience, general examination, pharmacology, drug interactions, mentors, screening, epidemiology, social medicine, lifestyle, emergency medicine, seminars, linked diseases, concepts of health, prevention &amp; intervention.</li> </ul> <p><b>Pharmacy</b></p> <ul style="list-style-type: none"> <li>• Therapeutics, case studies, clinical placements, pharmacology, care planning, public health</li> </ul>						

**Table 2: Student survey responses to cases**

Student discipline (N)	CASE A			CASE B			CASE C			More training?
	Knowledge N(%)	Training N(%)	Confidence N(%)	Knowledge N(%)	Training N(%)	Confidence N(%)	Knowledge N(%)	Training N(%)	Confidence N(%)	Yes (%) N(%)
<b>ALL</b>										
Nursing (522)	265 (50.8)	246(47.1)	283 (54.2)	225 (43.1)	191 (36.6)	220 (42.2)	164 (31.4)	152 (29.1)	168 (32.2)	468 (89.7)
Medicine (344)	178 (51.7)	164(47.7)	125 (36.3)	155 (45.1)	123 (35.8)	115 (33.4)	111 (32.3)	95 (27.6)	89 (25.9)	277 (80.5)
Pharmacy (28)	20 (71.4)	16 (57.1)	16 (57.1)	17 (60.7)	14 (50)	13 (46.4)	14 (50)	7 (25)	7 (25)	20 (71.4)
<b>UK</b>										
Nursing (341)	111 (32.6)	109 (32)	138 (40.5)	90 (26.4)	65 (19.1)	80 (23.5)	49 (14.4)	43 (12.6)	49 (14.4)	312 (91.5)
Pharmacy (28)	20 (71.4)	16 (57.1)	16 (57.1)	17 (60.7)	14 (50)	13 (46.4)	14 (50)	7 (25)	7 (25)	20 (71.4)
<b>INDIA</b>										
Nursing (116)	102 (87.9)	94 (81)	94 (81)	94 (81)	91 (78.5)	88 (75.9)	82 (70.7)	79 (68.1)	87 (75)	106 (91.4)
Medicine (317)	163 (51.4)	154 (48.6)	115 (36.3)	142 (44.8)	114 (36)	101 (31.9)	103 (32.5)	93 (29.3)	86 (27.1)	254 (80.2)
<b>ITALY</b>										
Nursing (45)	33 (73.3)	28 (62.2)	33 (73.3)	27 (60)	25 (55.6)	40 (88.9)	20 (44.2)	17 (37.8)	19 (42.2)	31 (68.9)
Medicine (27)	15 (55.6)	10 (37)	10 (37)	13 (48.2)	9 (33.3)	14 (51.9)	8 (29.6)	2 (7.4)	3 (11.1)	23 (85.2)
<b>Sweden</b>										
Nursing (20)	19 (95)	15 (75)	18 (90)	14 (70)	10 (50)	12 (60)	23 (65)	13 (65)	13 (65)	19 (95)

Figure 1: Percentage students by discipline and country origin

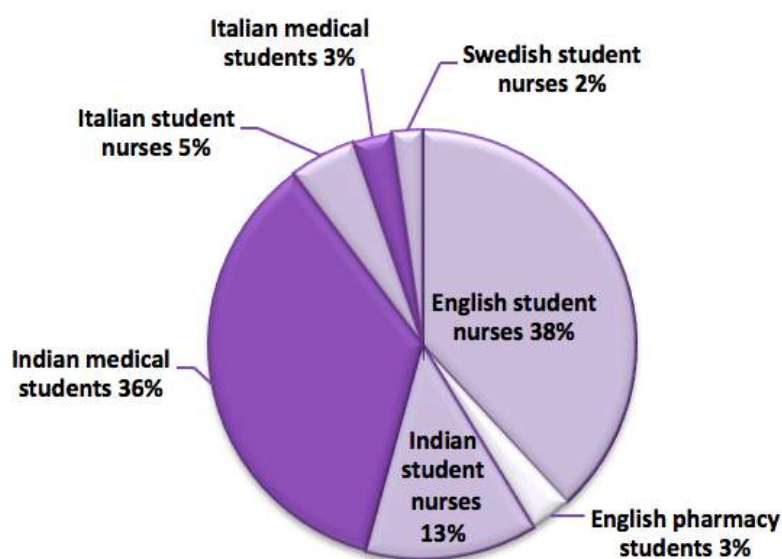


Figure 2: Student reported understanding of comorbidity management

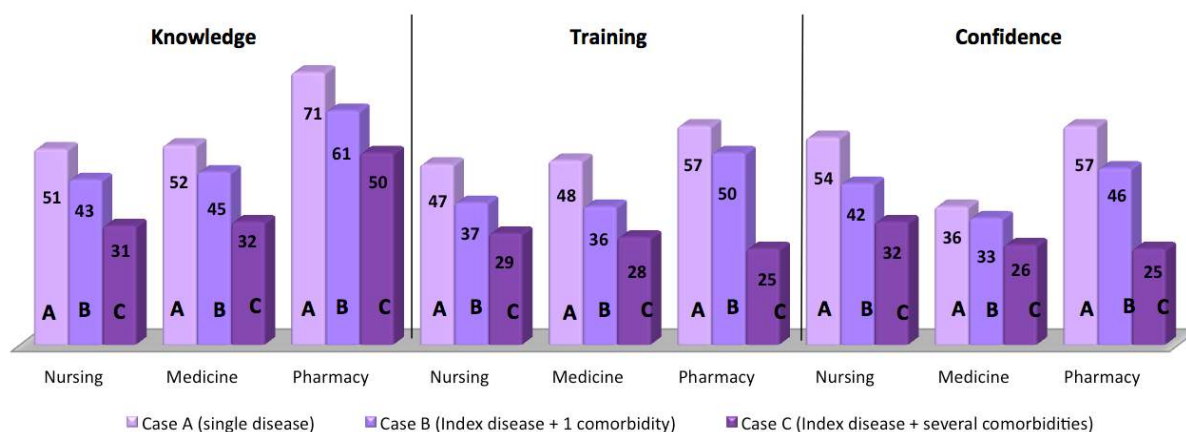


Figure 3: International comorbidity education framework (brief version)

<b>Conditions</b>	What are the 3 most common conditions (physiological or mental) that might coexist with the index condition?
<b>Context</b>	How might the additional conditions influence the pathophysiology, presentation and progression of the index condition?
<b>Conflicts</b>	Are there any conflicts between the pharmacological and non-pharmacological therapies required for the index condition and the additional conditions?  What are the potential challenges for patient adherence and self-care maintenance and management?
<b>Corroboration</b>	What evidence or guidance exists for the index condition?  Are there any conflicts with the guidance for the additional conditions?
<b>Communication</b>	How might the additional conditions influence the education and information that the patient requires in order to manage their index condition effectively?
<b>Collaboration</b>	Who within the multidisciplinary healthcare team may be required to optimise the delivery of care to the patient with the multiple conditions?

## International Comorbidity Education Framework (ICEF)

Domain	Session checklist	Curriculum links
<b>Conditions</b>	<p><b>What are the 3 most common conditions (physiological or mental) that might coexist with the index condition?</b></p> <p>i. What is the prevalence of these comorbidities in patients with the index disease?</p> <p>ii. Who with the index disease is most likely to have these additional comorbidities?</p>	<ul style="list-style-type: none"> <li>• Epidemiology, prevalence and incidence</li> <li>• Disease clusters and killer combinations</li> <li>• Public health and prevention, inequalities and social deprivation</li> <li>• Ageing</li> <li>• Interlinks between physical and mental health conditions</li> <li>• Shared risk factors, aetiology, pathophysiology of commonly co-occurring conditions</li> <li>• Health promotion, primary and secondary prevention</li> </ul>
<b>Context</b>	<p><b>How might the additional conditions influence the pathophysiology, presentation and progression of the index condition?</b></p> <p>i. How might any additional conditions alter the diagnosis or patient presentation of the index condition?</p> <p>ii. How might the patient's symptoms be influenced by the additional conditions and what symptoms might be common across these conditions?</p> <p>iii. How might the patient's prognosis change in the context of their additional conditions?</p> <p>iv. Are there any available tools to help estimate prognosis? Do they apply to the patient's individual context of multiple health problems?</p>	<ul style="list-style-type: none"> <li>• Pathophysiology of physical illness, diseases</li> <li>• Pathophysiological, psychological, and environmental factors underlying mental health</li> <li>• Shared risk factors, aetiology, pathophysiology of commonly co-occurring conditions</li> <li>• Prognosis frameworks</li> <li>• Autonomy and medical ethics</li> <li>• End-of-life legal and ethical frameworks</li> <li>• Confidentiality</li> <li>• Communication</li> <li>• Breaking bad news</li> </ul>
<b>Conflicts</b>	<p><b>Are there any conflicts between the pharmacological and non-pharmacological therapies required for the index condition and the additional conditions and what are the potential challenges for patient adherence and self-care maintenance and management?</b></p> <p>i. Are there any contraindications across multiple pharmacological therapies?</p> <p>ii. Are there any potential interactions that might occur between different drugs and if so, does the prescription need revising?</p> <p>iii. What are the potential adverse effects of multiple pharmacological therapies?</p> <p>v. Are there any conflicts in self-care maintenance and management plans across the different conditions?</p> <p>v. What are the potential benefits and harms of the multiple potential pharmacological and non-pharmacological therapies?</p> <p>vi. Are there any conflicts or potential challenges for patient adherence to therapy and self-care maintenance and management of the index condition given the additional conditions?</p>	<ul style="list-style-type: none"> <li>• Assessment of patient's preferences for social, psychological, physical and spiritual well-being.</li> <li>• Assessing patient's priorities for care</li> <li>• Polypharmacy</li> <li>• Assessment of potential conflicts between the patient's current or potential therapies and their individual preferences and health goals</li> <li>• Decision making</li> <li>• Mental capacity and advocacy</li> <li>• Patient centred approaches</li> <li>• Problem solving</li> </ul>

<b>Corroboration</b>	<b>What evidence or guidance exists for the care of the patient with the index condition and for the comorbidities?</b>	<ul style="list-style-type: none"> <li>• Literature review</li> <li>• Evidence synthesis</li> <li>• Critical appraisal of different levels of qualitative and quantitative evidence to include interpretation of quantitative data and generalisability.</li> <li>• Interpretation of statistics including relative and absolute risks</li> </ul>
	<ul style="list-style-type: none"> <li>i Does the guidance for the index condition include guidance about the additional conditions?</li> <li>ii What is the quality of the evidence on the index condition within the context of their additional conditions?</li> <li>iii Is there any common or conflicting evidence across the different conditions?</li> </ul>	
<b>Communication</b>	<b>How might the additional conditions influence the education and information that the patient requires in order to manage their index condition?</b>	<ul style="list-style-type: none"> <li>• Patient education and information giving</li> <li>• Principles of self-care in chronic disease</li> <li>• Self-care continuum from maintenance to management</li> <li>• The role of carers and carer fatigue, education and self-care skills</li> <li>• Patient empowerment.</li> <li>• Assessment of a patient's aptitude for self-care maintenance and management given their multiple health problems.</li> <li>• Assessment of care complexity</li> </ul>
	<ul style="list-style-type: none"> <li>i What self-care interventions, telehealth developments or user/carer support groups are available for the index or additional conditions?</li> <li>ii Where there is complexity due to co-existence of multiple conditions, how could consultations be inclusive to ensure that care can be delivered in a seamless manner?</li> </ul>	
<b>Collaboration</b>	<b>Who within the multidisciplinary healthcare team may be required to optimise the delivery of care to the patient with the multiple conditions?</b>	<ul style="list-style-type: none"> <li>• Communication</li> <li>• Professional autonomy</li> <li>• Care coordination</li> <li>• Shared documentation &amp; referral pathways.</li> </ul>
	<ul style="list-style-type: none"> <li>i Are there care pathways and methods of sharing of information, especially across care interfaces that would enhance multidisciplinary team collaboration?</li> </ul>	

# Theme papers

## Brave leadership: Enabling educational innovation in the context of historical constraints

**Wendy Horne, Executive Dean; Sue Gasquoine, Head of Department – Nursing, Unitec Institute of Technology, Auckland, New Zealand**

In 2013 the leadership team of the Faculty of Social and Health Sciences at Unitec Institute of Technology took the decision to implement a 'common semester' for students beginning bachelor degree programmes in 2014. The rationale was based on New Zealand research (Boyd and Horne, 2008; Weller *et al.*, 2011; Ingamells *et al.*, 2013) that builds on international research (Pollard *et al.*, 2006) supporting the education of health and social service professionals in interprofessional environments to better prepare them for the context of practice. Students of social work, nursing, medical imaging, early childhood education, sport, youth development, health promotion, natural sciences and osteopathy enrolled in the common semester for the first time beginning 2014.

The four courses in the common semester provided early preparation for a career working with people and included courses in anatomy and physiology, human growth and development, people in populations and the development of human cognition.

The courses were designed and delivered using a contemporary blended and flipped learning approach that supported the development of digital capability, self-managed and self-directed learning, problem solving, and scenario based interdisciplinary group work. That is, the teaching and learning model proposed to emulate the skills and capabilities required of graduates in the workplace.

Analysis of the extensive feedback received on the experience of the first delivery of the common semester resulted in changes which included:

- providing new students with information about how the courses will be delivered as soon as possible after programme admission
- early and intensive workshops with students to enable them to engage effectively with the technology
- increasing students opportunities for face-to-face engagement with academic staff, both mandatory and optional
- focus for staff development on engaging with students online and programme redevelopment
- increasing the relevance of course content and activities by ensuring discipline specific scenarios
- closer liaison between 'destination programmes' and the common semester teaching team.

This presentation offers the lessons learned in the implementation of a major change to the traditional way academic health professional programmes are delivered and ponders the future of these changes as the global healthcare workforce attempts to meet challenges as diverse as the aging population in the developed world and the burden of epidemics such as Ebola in the developing world.

Innovative leadership making brave and at times contentious decisions is required in the education of health and care professionals to enable the visioning of a health and social care workforce that is 'unshackled' from the constraints of the historical expectations of academics, regulatory authorities, employers, professional bodies and the funders of programmes.

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### Key words:

- digital capabilities
- blended learning

- flipped learning
- interprofessional education
- practice context.

**How this contributes to knowledge development within this theme:**

- learning and teaching that supports the development of interprofessional capabilities
- promoting and supporting innovation in healthcare education
- responding to 'real time' learner feedback.

## G2ECP-T2

### **An innovative approach to developing career pathways: The transition from support role to nurse**

**Julie Moody, Senior Lecturer Adult Nursing (Practice); Marion Taylor, Associate Professor and Senior Teaching Fellow, Middlesex University, UK**

#### **Introduction**

Since 2011 Middlesex University has facilitated a programme for staff in support and Band 4 roles to enhance and support their practice and development. This programme provides structured learning and an academic award: a Diploma in Higher Education – Assistant Practitioner (DIP HE AP). We are about to commence our fifth cohort of this programme which has had a high pass rate and minimal attrition. There is also a Transition route, which allows students who have completed the DIP HE AP programme to apply for a 'Transition to Nursing and Graduate Study' module – the focus of this paper. Our first cohort commenced the Transition Module in March 2014, and they complete Year 3 of Nursing September 2015.

#### **Context/background/history/stakeholder view**

This process complies with the Nursing and Midwifery Council (NMC) standard that a maximum of 50% of a 3 year pre-registration programme can be achieved via Accreditation of Prior Learning (APL) (NMC, 2010a), as the Transition Module and Year 3 total 18 months. Students are funded in terms of fees and salary support by the LETB, but become full-time students at commencement of the Transition Module.

#### **Facilitating the transition**

This *innovative* module provides academic and clinical experiences necessary for transition. It captures the learning outcomes and syllabus not addressed in the AP Diploma modules, but which are covered in pre-registration nursing modules. Specifically it addresses the ability to apply the Code, analyse key legal and ethical frameworks (NMC, 2008), the role of the nurse, and principles of medicines management/pharmacology principles (NMC, 2010b). There is also a heavy emphasis on *reflection*, record keeping and evidence-based practice (NMC, 2012).

The module includes two practice placements providing both field and out-of-field experiences planned outside the previous area employment area, in other trusts. Along with practice placements completed during the Diploma, this ensures they meet the NMC requirement of 2,300 practice hours. A Practice Assessment Document is provided to document the placement assessments, including NMC Progression Point 2.

*Shared* learning within the group is an integral module component and brings an increased depth of knowledge to the classroom.

#### **Student experiences**

Students report having good support and enjoying good communication before, during and after the module and that, largely, they have good placement experiences.

When undertaking placements in areas outside of their own field of practice, some students experienced anxiety arising from their own perceptions and expectations, and the long day shift working patterns took some students a while to adjust. Additionally, students evaluated that their status as transition students should be clearly identified for staff in clinical areas prior to placements commencing, and we have an ongoing rolling programme of link lecturer and partnership working to embed the pathway into practice.

#### **Where are we now?**

There is growing excitement, *stakeholder* interest, and recruitment potential in our pathway.

Post-feedback developments have included more medicine management content and a summative assessment adjustment to include online drug calculation testing. Current Year 3 students have settled well and are showing great potential.

### Next steps

The transition process therefore is a successful one, and does allow entrance to nursing for some staff that would otherwise not be eligible. It is not a 'back-door' into nursing, but a planned and rigorous pathway that is appropriate for a small number of students. We have been successful in its delivery, support of the students, local reputation, and LETB funding, so we very much hope it continues.

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Nursing and Midwifery Council (2012) *Record Keeping: Guidance for Nurses and Midwives*. London: NMC.

Nursing and Midwifery Council (2010) *Standards for pre-registration nursing education*. London: NMC.

Nursing and Midwifery Council (2010) *Standards for medicine management*. London: NMC.

### Key words:

- transition
- innovative
- reflection
- shared
- stakeholder.

### How this contributes to knowledge development within this theme:

- offers stakeholders an enhancement to their strategies for developing staff and enhancing knowledge
- offers employees an innovative staff development pathway using APL
- provides an educational forum for shared interprofessional learning and development.

## G2ECP-T3

### The lecture-based module: Foolhardy, pragmatic or inspirational?

Linda Orr, Senior Lecturer; M. Campbell, Lecturer, University of Dundee, UK

#### Background

The lecture remains the predominant form of teaching in higher education institutions (Cashin, 2010). The greatest advantage of lectures is, perhaps, the opportunity to share factual information with large numbers of students. The major disadvantage of lectures is the potentially passive nature of this information transmission. Faced with the ongoing challenges of fiscal restraint, we set out to deliver an undergraduate module that, despite being essentially lecture-based, would actively engage students. This paper reports on these developments.

#### Learning outcomes:

- to discuss how active learning methods can be employed within a lecture-based module
- to share how students and academic staff responded to such an approach
- to highlight the benefits of having a shared, underpinning philosophical approach.

#### Setting

Community-focused module for third-year undergraduate nursing students within one HEI.

#### Design

We started by engaging health and social care professionals, along with third sector organisations, in discussions about content and delivery of the module via a World Café event (Schieffer *et al.*, 2004). Having established that intended content was up-to-date, relevant and informed by realities of clinical practice, we moved on to explore and articulate our underpinning philosophy for the module. Finally, we made a conscious effort to be creative and to explore how active learning methods could be employed within an essentially lecture-based module. The innovations employed included: 'The Grab' of a policy-based drama event as the first session, weekly formal debates, scenario-based discussions, technology-assisted quizzes, flipped 'classrooms', 'Question Time' event, 'pop-up' 'Before I die' walls, RSS feeds and a film-based revisit to 'The Grab' on the last day of the module (Higher Education Academy, 2014). The end of module evaluations were very favourable; students and academic staff believed that effective lecturing had been achieved and were able to identify innovations that they had found particularly enjoyable, interesting and useful.



## Conclusion

By utilising a broad range of active learning methods, albeit within a lecture theatre, it is possible to effectively engage students and academic staff, as well as other key stakeholders, in lecture-based modules.

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Schieffer, A., Isaacs, D., Gyllenpalm, B. (2004) The World Café: Part one. *Transformation*, 18: 8, 1-9.

## Key words:

- lectures
- active learning methods
- assets-based approaches.

## How this contributes to knowledge development within this theme:

- discuss how active learning methods can be employed within a lecture-based module
- share how students and academic staff responded to such an approach
- highlight the benefits of having a shared, underpinning philosophical approach.

## G2ECP-T4

### Sustaining connections during practice placements: Supporting first year nursing students using Skype

**Hywel Thomas, Senior Lecturer; Tessa Watts, Associate Dean; Lauren Piercey, Nursing Student, Department Nursing, College of Human and Health Sciences; Elen Davies, Librarian, Library and Information Services; Craig Thomas, IT Technician, College of Human and Health Sciences/Library and Information Services, Swansea University, UK**

#### Background

In promoting integration and engagement and enhancing retention, completion and success, the need for effective student support has never been greater. Support is an imperative for nursing students who face additional challenges associated with simultaneously learning and 'working'. These challenges are primarily associated with the leap into an unknown world: that of work based clinical placements and the 'reality shock' many experience (Kevern and Webb, 2004). Students may find that they have to adapt rapidly to the world of work, the peripatetic lifestyle, whilst at the same time contend with the intensity, complexity, unpredictability and emotional dimensions of professional practice. Whilst most cope, some find placements extremely challenging (Walsh, 2007). Coupled with academic and other demands, these challenges can have an overwhelming cumulative effect. For some pressures become intolerable, early enthusiasm wanes, priorities are reassessed and they fall by the wayside. Indeed issues linked with clinical placements contribute to students' decisions to leave (Watts, 2011).

While mentorship support should be provided locally, students may be isolated from their treasured support networks: their peers and personal tutors. Placements which are geographically distal to the University compound students' relative isolation. For academics, supporting students in clinical areas is fraught with challenges. Yet there are opportunities to capitalise on the potential offered by the advancing digital, mobile technologies that so many undergraduates are familiar with. Indeed, advances in digital mobile technologies are having a transformative impact on pedagogical approaches. However, while the value of social media as an engagement tool in education is recognised (George and Dellasega, 2011), its integration and use in initial nursing education is in its infancy (Schmitt *et al.*, 2012).

Given the diversity of the nursing student population, the nature and structure of the professional programme conjoined with accessibility and convergence of smart mobile devices, the internet and new software applications, creatively used social media can be an effective pedagogical tool. It can be used to enhance the learning experience for information can be disseminated in real time and interaction and feedback may be instantaneous. Moreover social media use promotes active learning whilst also offering flexibility. It may be used to foster integration and create online learning communities of support. Whilst not a substitute for face-to-face contact, social media can be a useful means of sustaining communication and support during students' placements.

This paper reports findings from the investigation of the use of the Skype© social media platform as an additional means of communicating with and supporting first year nursing students during their clinical placements. The findings will be of

interest to academics engaged in programmes with work-based components and also for those with international learning opportunities. Moreover, whilst recognising potential implications in terms of costs and technological requirements, the findings could pave the way for exploration of further mobile technology enhanced learning.

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#### Key words:

- social media
- digital mobile technologies
- student support
- personal tutoring.

#### How this contributes to knowledge development within this theme:

- Skype® social media platform as an additional means of communicating with and supporting first year nursing students during their clinical placements
- illuminates individuals' experiences of using Skype® social media in rural and urban Wales
- identifies and explores the facilitators of and barriers to using Skype® social media platform as a medium for personal tutor support and communication.

## G2ECP-T5

### Neophyte notions of nursing: Enhancing the development of professional nursing identity through teaching about the foundations of nursing

Jacqueline Whelan, Assistant Professor; Thelma Begley, Assistant Professor; Fiona Timmins, Associate Professor, Trinity College, Dublin, Ireland

#### Background

Nursing is a value-based profession viewed as fundamentally caring for and about and helping others (Alfred *et al.*, 2013). However, there is a growing awareness that modern society is more individualistic and less altruistic (Johnson *et al.*, 2007), and concern is that values such as dignity and compassion in nursing are on the decline (Francis, 2013). Therefore, the embodiment of core nursing values, including moral and ethical responsibilities is an essential component of nursing students' education. Essential nursing professional values are conveyed from working within the culture of nursing also in addition from within the classroom setting. However, there is limited evidence about the impact of such teaching or of students' a priori views on the topic.

#### Aim

This paper reports on first year nursing students' initial views on nursing and the process of teaching nursing students professional values. During the Foundations of Nursing module the students are introduced to the nature of nursing and the role of the nurse by exploring the concepts underlying the practice of nursing, legal principles and to the legal and professional framework that governs nursing practice. The 20 hour module is presented in three units of study, as follows:

Unit 1: The Nature of Nursing (6 hours)

Unit 2: Nursing knowledge and practice (8 hours)

Unit 3: Legal perspectives in nursing (6 hours)

## Methods

First year nursing students (n=230) were asked at the outset of the module to outline the following using an open ended question approach during the class:

- What is nursing?

Following lectures, students were asked once again, using the open ended question, for their views on nursing.

## Findings

Qualitative analysis of the initial student responses (n=230) revealed that most nursing students identified nursing as being closely associated with caring and doing for others. Many saw the role as physically caring for those who were sick. These views remained consistent. Lecturers' personal reflections revealed the content to be deemed relevant to both curricular requirements (ABA, 2006) and student needs.

## Discussion

Despite changes in society, women's roles and the professional identity of nurses, there is still substantive evidence to suggest that nursing is a value-based profession (Johnson *et al.*, 2007). As these appear to be lessening over time (Johnson *et al.*, 2007), and given the immense changes to nurse education over the past 25 years, it is of interest to explore and discuss best practice in terms of teaching and transmitting professional values. In particular, teaching methods need to be considered as the large lecture format may negate against developing a dialogical approach with the students which is fundamental to developing and confirming the required values.

The discussion about professional values is of particular relevance in the Irish context, as most Irish nursing students are self-selecting and have no prior screening for professional values that has become mandatory in many parts of the UK. Therefore, dialogue in respect of teaching professional values is valued.

## Conclusion

Teaching methods and ways of conveying professional values need to be discussed. It is of interest to explore, in this context, how professional values are instilled in nursing students and whether or not approaches could be strengthened.

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### Key words:

- nursing
- student
- identity.

### How this contributes to knowledge development within this theme:

- highlighting the need to explore contemporary approaches to teaching professional values to nurses
- drawing attention to contemporary debates on the topic
- highlighting areas for future research and development within the topic.

## G2ECP-T6

### Understanding the patient experience through the power of film

**Sherri Ogston-Tuck, Senior Lecturer; Kath Baume, Senior Lecturer; Chris Clarke, Senior Lecturer, Institute of Health and Society, University of Worcester, UK; Simon Heng, Service User**

For well over 100 years cinema has proved itself to be a powerful form of communication. Whether produced as entertainment, art or documentary, films have the capacity to both inform us, with what they tell and show, and move us with how they show and tell it. The cinema is a window on human life – its ups and downs – and it is a very valuable tool for studying those situations that are most transcendental for the human being, such as: pain, disease and death (Alacron and

Aguirre, 2007). It is very good at reflecting the materialisation, circumstances and individual and social context in which things happen and has proved to be a suitable medium for describing disease as an individual experience (Dobson, 2006).

Film is a highly attractive teaching instrument, used in the study of different terminal diseases, as well as exploring bioethics (Beauchamp and Childress, 2009) and is a preferred medium over traditional lectures (Edmunds, 2013) to provide realistic examples for adult learners. It can tap into ethical issues; facilitate decision-making; and examine underlying issues such as euthanasia, assisted suicide and professional responsibility. Contrast this with standard means of teaching, such as scenarios. Although a useful pedagogic tool, these are limited because students must imagine the clinical scenario. Film can therefore fill that imaginative gap (Volandes, 2007) and can be utilised as an active teaching strategy for a variety of topics in nursing (Edmunds, 2013) and provide a unique way to promote active learning in nursing education (Herrman, 2006).

The aim of this research project is to investigate learning enhancement through film in nursing education. This medium provides a unique way to promote active learning, provoke emotional responses, generate discussion and enhance clinical decision-making. In addition, as part of the student nurse experience and professional development this affords the opportunity to develop knowledge and skills and understanding of the patient experience, through the power of film.

The objectives of the study are three-fold:

1. To determine how this helps students to engage with their role as health care professionals.
2. To determine how they view the personal experience of illness/disease/disability/death as depicted in films
3. To determine how this may impact upon their provision of patient care.

A mixed methodology approach delivered in 3 tiers will provide a range of data for thematic analysis: 1) Film screening followed by an audio recorded '5 minute reaction' discussion and post screening questionnaire; 2) Contemplative exercises for reflection and blog site for discussion; 3) Focus groups (for a longitudinal data set). Ethical approval has been given from the Institute of Health and Society Ethics Committee.

Preliminary results will be collated from a compilation of data collection, coded questionnaires and transcriptions of the audio recordings cross-matched for thematic analysis with the contemplative exercises and any discussion from the participants. This will provide the preliminary findings for presentation at this conference.

The third tier of the data collection will be extracted from participants invited back for focus groups, which will be constructed in June 2015. Qualitative data gathered from these will be cross-matched with the thematic analysis from tier one and two.

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## Key words:

- film
- teaching
- nursing education
- reflection
- bioethics in healthcare.

## How this contributes to knowledge development within this theme:

- this project meets identified aims from the UK Professional Standards Framework by fostering creative and innovative approaches to teaching and learning
- this project facilitates and supports the design and delivery of continuing education development programmes and activities
- this project enhances student nurse education and their professional development and serves as an impetus for life-long learning.

## Student-centred learning: Giving students the choice of assessment methods

Joanne Garside, Senior Lecturer Adult Nursing, University of Huddersfield, UK

Assessment is a key feature of all academic courses undertaken for award in the UK and has long been recognised as the most influential factor in shaping what students learn. The nature of the strategies used to assess learning varies significantly but more recently has seen the shift from the traditional to more student-centred innovative approaches. A re-approval event by the Higher Education Academy (HEA) has provided an opportunity to re-appraise existing learning approaches of an established NMC and HEA approved MSc Health Studies Health Professional Education programme providing the opportunity to revisit and evaluate in detail the course structure and assessment approaches.

One such assessment approach requires these post-registration health professional education students to meet the learning outcomes in negotiation with the module leader. In summary, students have a 'choice' of assessment task. Through this approach to assessment, students are encouraged to reflect on their individual learning style and understand how to apply assessment tasks to meet module learning outcomes, both of which are essential skills for all educators within the health professions. This style of assessment provides students with the opportunity to choose an assessment type that they are more comfortable with and suits their learning style. Choice also adds some flexibility in the assessment/s that they can produce, in that they may choose more than one assessment type, such as a short presentation and a supportive essay. In addition the student may wish to produce something that may benefit their teaching/assessment practice such as an informative poster or assessment package; alternatively they may want to challenge or develop their presentation skills. These are only suggestions, the student may be as creative as they wish with this assessment type.

In recognising that students have individual strengths, weaknesses, learning styles and preferences concerning mode of assessment, offering choice of assessment was a strategy for inculcating the values of student-centeredness and responsibility for learning. Although recommended in the literature (Race and Brown, 2001; Cowan, 2006) no empirical evidence of benefit in support of this initiative was identified. This themed paper will present an account of the journey taken from original idea (Garside *et al.*, 2009) to the now established approach to assessment within this post-registration programme. The approach will be explored against the contemporary evidence. The ongoing evaluative findings will be presented in themes which include: reaction and decision making, learning styles, autonomy as an educator, stress, achievement and validity.

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### Key words:

- assessment
- choice
- learning styles.

### How this contributes to knowledge development within this theme:

- presents an alternative and innovative approach to assessment in Health Professional Education
- provides detailed local evaluation data in comparison with theoretical positions
- offers practical recommendations when considering offering students implementation of choice of assessment approach.





NET2015

**26th International  
Networking  
for Healthcare  
Education  
Conference**

Tuesday 8–Thursday 10  
September 2015

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Professor Philip Keeley, University of Huddersfield, UK  
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Professor Fiona Timmins, Trinity College Dublin, Republic of Ireland

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