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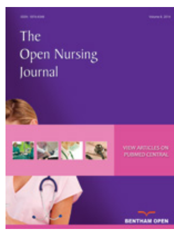

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RESEARCH ARTICLE

Investigating The Implementation of a Collaborative Learning in Practice Model of Nurse Education in a Community Placement Cluster: A Qualitative Study

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Abstract:

Background:

Attracting new graduate nurses to work in the community is problematic, and this has contributed to shortages in this sector in the United Kingdom and internationally. This paper reports the findings of a pilot study to implement Collaborative Learning in Practice in one region of the United Kingdom, which was intended to increase placement capacity, introduce students to this sector, and accelerate their learning and development of key skills and behaviors.

Study Aim:

To investigate the views of student nurses and the staff supporting them on placement about their experiences of implementing Collaborative Learning in Practice.

Methods:

We conducted four focus group interviews between winter 2018 and spring 2019, with 31 staff and students in two English counties in the South West of England. These were transcribed and analysed using the Framework Method; themes were discussed and agreed by the research team.

Results:

Three themes emerged: Peer support, which concerned the benefits of being in placement with other students; Developing and learning, which was about the acquisition of skills including leadership; and Organisation, which related to issues and concerns involved in the preparation and daily management of the collaborative learning in practice experience.

Conclusion:

Some positive aspects were reported, particularly in relation to hospice and General Practice Nursing placements. Most clear was the supportive potential for peer learning fostered by Collaborative Learning in Practice. Less positive aspects were the potential for horizontal violence and some aspects of nursing home experiences. We believe more work needs to be done to make nursing homes an attractive option for students and new graduates, and regarding visual materials for pre-placement preparation.

Keywords: Collaborative Learning in Practice, Community nursing, Focus groups, Thematic analysis, Undergraduate nursing students, Nurse education.

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1. INTRODUCTION

The global nursing workforce faces times of shortage [1]. This mismatch between many societies' needs for skilled community nurses and the divergent perceptions of its potential nursing workforce [2] comes at a time when global demand for community nursing is rising rapidly with an aging population [3]. Nurse education in the United Kingdom (UK) has recently seen a greater focus on nursing patients in out-of-hospital settings and the revised Nursing and Midwifery Council (NMC) standards [4] include out-of-hospital nursing in its definitions and premises concerning the 'future nurse'. Despite this emphasis, it seems that particular nurse staffing problems

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exist in this sector, with an 'image problem' amongst school-leaving potential undergraduate nursing student recruits [5], as well as student nurses, who believed that community nursing offered them few challenges and little interest compared to acute in-hospital nursing [2].

As nursing was added to the UK Shortage Occupation List in 2015 and has remained listed since, the domestic labour market cannot meet the demand to fill vacant posts [3]. The NHS still requires a coherent plan to address nurse staffing shortages across the system [6] and staffing shortages are well-documented in community and district nursing settings [7]. A further consideration in the UK is the extent to which nursing homes may be forced to close where there is a lack of registered nurses [3]. Nurse staffing numbers are in decline in adult social care including registered nurses in the care home sector, where vacancies across the sector stood at 12% [3], which compromises the ability of homes to continue [8]. Although the number of General Practice nurses [GPNs] has risen slightly between 2014 and 2018 [7] an issue with that sector's recruitment has traditionally been low capacity in the sector for hosting students [9]. The impression amongst some students is that such placements offer little in comparison to acute sector areas [2] which, when combined with imminent retirement of many GPNs [9] and pay differentials between GPNs and nurses in the NHS [10], is likely to exacerbate shortages in the future [11]. Some studies indicate, however, that when students are exposed to community and GPN placements, they can gain a great deal from them [9, 11]. Misconceptions are replicated in relation to nursing home placements, which have been discussed as offering limited potential for learning, and are a barrier to recruitment in that sector [12, 13].

1.1. Collaborative Learning in Practice

In this context of rising demand [14] and recruitment and retention problems in the South West of England, we piloted a model of placement learning known as Collaborative Learning in Practice [CLIP]. CLIP originated in Amsterdam, and is an initiative in which student nurse capacity is increased in a placement, with an emphasis on peer learning and support that has consistently been shown to be beneficial for student nurses' confidence and competence [15, 16]. Coaching takes place by qualified professionals, as opposed to mentoring [17]. Many benefits are asserted including accelerated leadership and skills acquisition as a result of earlier exposure to patient care responsibilities [17], and enhanced team working [18]. To date, little research has demonstrated systematic benefits: a report from the University of East Anglia [19] indicates that stakeholders believed CLIP to be a step forward in placement learning and a superior method for preparing undergraduates for registrant practice [20]. This is important as it has been argued that many graduates are not yet fully work-ready at point of registration [21, 22]. CLIP may, therefore, influence neophyte graduate nurses' engagement and intention to stay in the profession [23] if it helps new registrants with their transition: as students, they are directly responsible for patient care and engaged in the clinical activity they need to thrive [24] and so may avoid the mismatch between expectations and reality which disillusions many completing students [25]. Even despite the current lack of evidence, Health Education England (HEE, a non-departmental public body which aims to provide an appropriately skilled workforce, to better meet the needs of patients; see https://www.hee.nhs.uk/about) has championed the use of CLIP, supporting its development [26].

1.2. Local Pilot

In partnership with HEE and placement staff, staff from the university responsible for nurse education in the South West Region began processes of preparation, education, and support for students and staff in three nursing homes (one of which was withdrawn from the pilot), two hospices and two GP practices in two counties in summer 2018. The first students were allocated in the autumn of 2018. In total, 152 staff received face-to-face preparation by university staff on how to run CLIP, which had already been successfully implemented elsewhere in the region in hospital settings. Thirty-four students were allocated to these six areas across two English in total counties, when in previous allocations, perhaps three or four might have gone to the hospices and two to a GP surgery.

1.3. Scientific Rationale

In this context of global and regional shortages of community nurses, it was timely to investigate the views of student nurses and their clinical support staff concerning the implementation of this pilot project. We chose qualitative methodology as we believed this to be the most effective means of investigating such a novel and innovative development. Qualitative research is ideally suited to this type of evaluation because it takes a more holistic, person-centered, rich, and in-depth perspective, synthesizing data to understand the opinions and attitudes of participants [27]. Focus groups were chosen as the method of data collection because they allow for interaction among participants, who share, discuss and explore their views and opinions of a given topic, which can highlight the complexity in social situations [28]. They are suitable to access relatively large groups of people with broadly similar experiences, such as staff and students in these CLIP placements. Furthermore, focus groups are ideally suited to descriptive qualitative research such as this, as they allow for group discussion, debate and consensus about emerging issues, as well as voices of disagreement to be heard, when properly moderated [29].

2. MATERIALS AND METHODS

2.1. Aim

To investigate the views of student nurses and the staff supporting them on placement about the similarities and differences in clinical placement experiences in CLIP areas compared to non-CLIP areas.

2.2. Objective

To conduct focus group (FGs) interviews with adult nursing students and their placement support staff to gain an understanding of the impact of CLIP on their clinical placement experiences.

Table 1. Focus group participation

Location	Students attended/invited	Focus group numbers	Staff attended/invited	Focus group numbers
County 1	12/16	1	5/21	1
County 2	10/18	1	9/17	1
Totals	**22/34**	**2**	**9/33**	**2**

Table 2. Schedule of questions in the focus group.

FOCUS GROUP QUESTIONS FOR STUDENTS	FOCUS GROUP QUESTIONS FOR PLACEMENT STAFF
1. Tell us your experiences of working on CLIP ward 2. What are the differences between CLIP and a 'traditional' placement? 3. How did you feel working more closely in groups with other students? 4. What have your challenges been? 5. How could this CLIP experience be improved? 6. Anything you'd like to raise or discuss that hasn't been mentioned so far?	1. Tell us your experiences of facilitating CLIP? 2. What have your challenges been? 3. What are the differences between CLIP and a 'traditional' mentoring? 4. How do you feel that students working more closely in groups with other students develop them? 5. How could this CLIP experience be improved? 6. Anything you'd like to raise or discuss that hasn't been mentioned so far?

Table 3. Themes and sub-themes.

THEME	SUBTHEME
PEER SUPPORT	Learning together & sharing Team dynamics Problem-solving
DEVELOPING AND LEARNING	Mentoring relationships and coaching Patients Skills acquisition
ORGANISATION	Preparation Placement management

2.3. Participants, Recruitment and Ethics Issues

We secured ethical approval from the Faculty staff ethics committee. This was valid for the students and staff in the hospices and nursing homes and in addition, we gained permission to proceed *via* their own governance arrangements. For the GPNs, we secured capability and capacity approval from the UK Health Research Authority (HRA) *via* its Integrated Research Application System (IRAS). Potential attendees were invited to attend focus groups (FGs) in their local areas. There were separate FGs for students and staff. Students in the CLIP placements were invited using their university email accounts, and we accessed staff *via* managers who acted as organisational gatekeepers. All potential participants were sent a consent form and participant information sheet (PIS) which included the usual guarantees of confidentiality, anonymity, right to withdraw, and assurances about secure data handling. All those who attended gave informed consent in writing to proceed with the study. Table **1** shows the numbers invited and the rates of participation. FGs took place in both counties in winter 2018. We ran two student FGs. We offered two FGs with a mixture of hospice and nursing home staff; however, only one county's staff participated in this offer. Delays in securing IRAS meant that we offered an additional two FGs for the GPNs in spring 2019; however, only one practice took up that offer. In total, we offered six FGs in two counties but ran only four FGs, two in each county.

2.4. Data Collection

All the FGs were recorded and transcribed, lasted approximately an hour and took place in rooms made available by the organisations in which students and staff were working. All the FGs were attended by a facilitator (GW in all cases) and a moderator (JB in one group and BM in the other three). Table **2** shows the schedule of questions used in the FGs.

2.5. Data Analysis

The transcripts from all the FGS were considered together for analysis and were analysed independently by five members of the research team, who constructed themes using the Framework Method [30]. This involves five stages of familiarisation (immersion in the raw sources data); identifying a thematic framework by identifying all the key concepts; indexing, in which the thematic framework is applied to all the data by annotating the transcripts with codes; charting to allocate data according to the appropriate part of the thematic framework to which they relate; and lastly mapping and interpretation, in which associations between themes emerge, alongside explanations for the findings [31]. Once this process had been completed, the research team met twice to discuss and agree on the final thematic analysis.

In the following anonymous presentation of our findings, we present quotes suffixed with C1Staff1 to mean County 1 FG Staff participant 1, C2 Student2, meaning County 2 FG Student participant 2, and so on. Table **3** shows the themes and sub-themes.

3. RESULTS

The three themes that emerged were: Peer support, Developing and learning, and Organisation.

3.1. Peer Support

The first theme that came through strongly from staff and students was the extent to which CLIP placements offered the opportunity for peer support. It was clear that the capacity increase meant students were now working with other students in ways that had not been the case previously. A subtheme within this was that of learning and sharing together, which was reported as:

> *'Peer learning has been quite beneficial because the second years taught the third years some stuff as well and you know, just because everyone has different placements so I think that's been really beneficial just learning from each other and different experiences and you know, different ways to change dressings and things'*. C1Student6.
>
> *'I've learnt from the third years. I've learnt an awful lot from the third years not as "this is how you do this" and not communication skills, but management and you just learn from each other don't you'.* C2Student9.

Staff had similar perceptions:

> '[CLIP placement] *helped massively* [agreement] *because if you look at the fun they had together, because they supported each other'*. C2Staff2.
>
> *'I think their own confidence, there's a lot of trust and respect. One of the girls did actually put on her summative* [assessment feedback], *she said it was a fantastic placement, which I thought was lovely. But she obviously put that she had a lot of support from peers'*. C1Staff3.

A second subtheme relating to peer support and linked to learning and sharing was that of the importance of team dynamics. This was clearly a factor in students' enjoyment and learning in each placement but did need some managing by staff:

> *'They really did work together and they came up with ideas and it worked so well in that regard but the minute you talk to someone "you're the third year, you need to be supervising" it was a completely different ball game and it very much became a power trip'*. C1Staff5.
>
> *'…there were a couple of instances where the students, the power of numbers, they become quite intimidating amongst themselves – they were quite forceful, it made them quite forceful characters… we've had a couple of instances where we've had to address that and challenge that and I don't think that would've happened in a traditional mentor-student model'*. C1Staff5.

Students did not report this issue of conflict between themselves; instead, they noted team dynamics as having a different meaning, concerning collaboration, workload, and expectations of them in their student roles:

> *'My 'positive' is the fact that there were other students there so I didn't feel like a loner, the 'newbie' going in just because it is quite daunting sometimes when you go into a busy ward so to have a familiar face each time. I like having other students around for support'*. C2Student8
>
> *'I think that's been the highlight for us* [laughs]*… I think just, in general, we've been learning together more. Which we might not have done if it was just single* [student alone]'. C1Student2

One aspect frequently mentioned regarding students' roles was the extent to which they identified and wanted to move beyond the role of healthcare assistant (HCA). This comment is typical of students' views and illustrates a conflict between their own expectations and the expectations of staff:

> *'We kept getting told that they'd had students previously and they stopped having them for a while because they were "too posh to wash" and so… we felt we had to prove ourselves as HCAs (which is not what we're there for) and we were worried to complain because obviously, you don't want to be seen as reluctant to do the basics. But that's all very well but we were like "come on you've got to start giving us more to do, more learning"* [to progress towards registration]. C1Student5.
>
> *'That was about being more assertive, about saying to the HCAs "actually no I'm not going to get that bell, you go and get that bell I'm doing this". Because that's what was happening, I was having people going "do you want to go get that bell?" and I'm thinking actually no because I'm doing Crosscare* [clinical management software for Hospices, ©Advanced] *for my patient. But it was about "step up, if you're going to be a Band 5* [UK NHS grade of graduate registered nurse] *you've got to act like one". That's what I got told wasn't it, that's what had come over, I'm not a Band 4 anymore, I've got to be a Band 5*

> *and I've got to be more assertive and say "I'm looking after those patients can you actually get that bell"'*. C2Student6

A third subtheme concerned the extent to which students engaged in problem-solving in the placements:

> *'They really did work together and they came up with ideas and it worked so well in that regard'*. CIStaff5.
>
> *'They are collaborating with each other'*. C2Staff3
>
> *'It's the way forward'*. C2Staff2
>
> *'How much this will benefit student training as it goes forward'*. C2Staff3
>
> '[Three speakers agree about CLIP offering more] *hands on* [experience] *and confidence.'*

Students clearly reported that collaboration took place amongst themselves, and although they did not identify this as a beneficial source of learning, they were, in fact, acquiring new skills in this area and finding solutions to problems for themselves:

> *'We're lucky having a group of students that are also willing to actually get on and find a way that it works'*. C1Student4.
>
> '*At the beginning, we would have liked to have someone telling us where to go but now we're quite grateful that we can organise it ourselves'*. C1Student2.

3.2. Developing and Learning

The first aspect of this theme was the issue of mentoring relationships and coaching. Although CLIP pre-dates the implementation of the revised NMC standards [32], students identified that their relationship with their mentor had altered in their CLIP placements. These views were typical in relation to mentoring; some students mentioned the concept of coaching but this was not well-developed:

> *'They've already got 20 nursing residents so we're already on top of each other and I know it's meant to be that you're working together but you do need some time with your mentor'*. C1Student9.
>
> *'I think personally I miss having that time with my mentor in a hospital setting. To think that you work so closely together and you're always learning new skills, new information. I have really enjoyed the CLIP process but I don't feel like* [coaching has] *really benefitted us on this particular placement'*. C2Student8.

Staff views were similar regarding mentorship, but a degree of contrast with students' views was in evidence regarding coaching:

> *'For me, I think it's still early days. I think* [coaching] *needs to be introduced much earlier, because they're literally going in blind and suddenly being put in this position* [of change]. *It's not a gradual process at all'*. C1Staff3.
>
> *'We've had a couple of instances where we've had to address* [student conflicts] *and I don't think that would've happened in a traditional mentor-student model. I think they've "got a bit big for their boots"'*. C1Staff4.
>
> *'So the students had the opportunity to see patients on an individual basis and experience what it's like to be an autonomous practitioner. With someone supervising from afar who was able to step in at a moment's notice'*. C2Staff1
>
> Interviewer: *'so that's really a coaching model as opposed to mentoring model'* [agreement].
>
> *'And I think that works well in general practice, the coaching model'*. C2Staff1.

A second element here concerned the students' relationship with patients, which was described by some staff as problematic due to the greater number of students in their placement area, to the extent of being 'overwhelming' (C1Staff2) where many students were trying to access patients in a ward or bay setting. However, there was the recognition that a patient focus was central to all students' activity, and because students were able to take their own clinics in one GP practice, the staff there found that students were spending more time with patients in CLIP than previously. Staff reported that patients valued this:

> *'The patients really enjoyed the students because you see that you are extra time* [agreement] *so they can talk about their problems'*. C2Staff2.
>
> *'They* [patients] *also felt they were helping* [students]'. C2Staff3.

In terms of patient contact and clinical skills acquisition, students in GP practice had required training in venepuncture as an essential skill prior to starting the placement, and this was valued as something that added to their patient care. In other settings, students were not so clear that they had developed many new clinical skills. This was reported as because the nursing home placements were too 'slow', and multiple students trying to access patients meant that potential for skills acquisition was spread too thin:

> *'I feel I've lost a bit of skill, well not lost skill but I've not gained any* [clinical] *skill and not what I'd expect for a third year close to my sign off'*. C1Student6.

However, for some students, their placements had helped with other skills related to their forthcoming registrant role. For example:

> *'A hospice is an excellent place as a third-year because the decisions you have to make are so complex and you have…there's so much to think about and it's all about pain management and symptom management and you had to keep on top of it otherwise, your patients won't benefit'*. C2Student5.

3.3. Organisation

Despite an exhaustive strategy by university staff to prepare placement staff for CLIP, the availability of on-line resources, and sessions for students in the university setting, students and staff both reported not feeling prepared for CLIP. Although some acknowledged that they had received information, there was a belief that more could be done:

> *'We had about a half an hour lecture about it, like a quick rush through "this is what CLIP is, you'll be doing this, everyone's doing it" and we were like "ok"'*. C2Student9.
>
> *'They said our mentors will know about it and when we went there they were like "don't know what this is"'*. C2Student10.
>
> *'I asked questions in that half-hour lecture about what it's going to be like in a nursing home and they just didn't know and they couldn't answer my questions so we had no preparation'*. C2Student8.
>
> *'We get that this is a pilot and why we're doing it but the fact that the nurses where we were didn't have any information about it'*. C2Student10.
>
> *'When we arrived they said, "I hope you know more than I do because I haven't got a clue"'*. C2Student3.

In part, this perceived lack of preparation stemmed from this being the first time these areas had run CLIP. This was typical from the staff:

> *'The students actually didn't feel as prepared as I expected…they didn't know what they were coming into. They had the idea of it, but not any more than that'*. C1Staff2.
>
> *'We had it explained to us how it would work and I'm sure the students had it explained to them, how it would work, but then they came in blind as did we so we got told it but no one had experienced it so that made it quite difficult to gain traction'*. C1Staff1.

The last sub-theme relates to placement management, meaning how things were organised on a daily basis, shift patterns, rostering and students working together as part of the CLIP concepts of peer support and horizontal integration of different year groups. The major challenge for the staff concerned rosters for a larger number of students than had previously been in placement areas; this exchange between staff in different areas represents:

> *'It works because we've made it work but that's been with a phenomenal amount of effort that's gone into that to make it work'*. C1Staff 4.
>
> *'Lots of adapting and changing, and regrouping and re-working rotas...to go from the four to having the two together and you know, it's just constant. And to revisit and review what we're doing for them to experience the organisation, and well the clinical area I suppose'*. C1Staff 3.
>
> *'We've had to re-shift the rota, change them around so they're not on the same shift as it's just overwhelming. One lot go off and you don't know what the other lot are doing'*. C1Staff 2.

For students, shift patterns were also an issue, but this was about accessing mentors; similar to the comments about preparation, students also believed that information exchange could have been improved during placements:

> *'We found it very stressful, we feel as a third-year, you added a lot of extra pressure on us because we had two essays on the go and another which we've been researching. It was constant emails'*. C2Student1.
>
> *'I found the organisation a bit confusing'*. C2Student3.

4. DISCUSSION

This study was successful in addressing its primary aim, which was to investigate issues related to the implementation of CLIP in the community sector, specifically nursing homes, hospices, and GP practice settings. This is an important study internationally because it relates to the exposure of student nurses to community nursing, including increases in placement capacity, which may go some way to ameliorate nursing shortages in that sector. We note that staff and students'

perceptions of CLIP concepts differed according to the area in which they were working. Students and staff working in the nursing home sector were generally more negative in their perceptions, with students struggling to connect their nursing care activities with potential registrant practice, and staff reporting conflicts and difficulties. Students in the GP and hospice placements had more of a focus on the clinical skills they developed, the opportunities for complex care (with sick patients in the hospices, and including social prescribing [33] in the GP practices) and activities such as seeing patients in clinics independently (in GP practice, with supervision available but at a distance) and venepuncture. The GP setting's supervision most clearly resembled a coaching model in this respect.

Students in this study clearly identified positive views on the extent to which CLIP offered peer support, friendship, and opportunities for peer learning. The importance of peers has been widely reported as beneficial on many levels for student nurses including reducing depressive symptoms [34], making friends and remaining on programs [35], engagement and belonging in a placement to enhance placement learning [16, 36]. Accordingly, we argue that this study demonstrates that peer support is a successful feature of CLIP, even in its infancy, which is commensurate with what little literature exists on CLIP as a strategy for placement learning [17, 18, 20, 26]. This must be tempered by the observations from some staff that there were issues with students appearing to become 'overbearing' to their more junior colleagues; students did not report this but might be expected not to do so in a public forum such as a focus group. This may be an artefact related to conflicting personalities possible in any workplace, but it is also consistent with the theory of horizontal violence in nursing, in which those perceived as having greater hierarchical status 'bully' those lower down the pyramid. This can take the form of small and large deprecations, allocation of unpleasant or lesser status tasks and aggression [37]. This phenomenon has been articulated at a macro level from the feminist perspective of nurses' subversion to patriarchal cultures, but our study also illustrates that Farrell's [38] meso- and micro-level analyses (regarding respectively workplace practices and interpersonal conflicts) were also relevant. Arguably this says less about CLIP and more about previous unpleasant placement experiences (which are common, [39]) where students have been exposed to this culture of horizontal violence. However, CLIP sets up another potential hierarchy when there are first, second and third-year students together. We appreciate that it is impossible to judge how personalities might interact or to plan accordingly in advance, but it is possible that it may need more active management in CLIP than in other forms of placement organisation. It is also possible that some element of horizontal violence was in evidence in the reports from students that they had to repeatedly prove themselves as able to provide fundamental nursing care. This was mentioned as 'being used as HCA'; students also reported working out ways to deal with this, and thus it would appear that almost unknown, students were developing assertiveness and delegation skills, which are essential elements for the graduate registered nurse and have been reported in a systematic review of the literature as otherwise lacking in new registrants [40]. We speculate that if there are simply more students in practice, supporting each other more effectively than if a single student was on her own, such a strategy could have benefits in ameliorating horizontal violence between permanent staff and students, and may help change the organisational culture [41], even if it increases the potential for between-student horizontal violence. It is also possible that the issues between students might reduce as they become more used to working in CLIP models with other students.

The implementation of new NMC standards for UK nurse education relating to supervision and assessment in practice [32] has added impetus to a central feature of CLIP, which is a coaching model, as opposed to a mentoring model. Although the concept of mentorship seems ill-defined in the international literature [34], in the UK, mentoring student nurses has until 2019 been a role encompassing professional behaviour monitoring, skills development, personal support and formal assessment of practice, vested in one individual who also carries a patient caseload. This diverse range of activities have been noted as problematic [42], placing an emphasis on students to conform, build relationship and undertake emotional labour to convince mentors that they were 'good students' [43], creating dependency on the mentor [44]. There have been concerns that over-cautious mentors inhibit rather than facilitate students' learning, so that students observe rather than participate in patient care, stunting the development of clinical and leadership skills, meaning that they may not be ready for registrant practice [45]. Furthermore, it is alleged that students can manipulate mentors to gain unwarranted pass decisions from them [46]. Although these concepts are not explored by the NMC in their standards, the separation of assessor and supervisor in revalidated UK programs since September 2019 means that the perception of supporting students as burdensome, carrying a high workload, without sufficient time [47] will change. CLIP facilitates a coaching style, which is believed to be beneficial to clinical skills development, as well as critical thinking and leadership capacity, and reduces the burden of mentorship for the clinical coach [18]. In our study, despite preparation, including coaching workshops, staff did not seem to have a well-developed concept of themselves as coaches rather than mentors, and students articulated these role differences. Indeed, an influx of additional students, more than they were used to, contributed to some staff perceptions of 'overwhelm', and of not knowing what the students were doing. We contend that this is unsurprising in a very new placement learning model like CLIP, and that in later iterations, this will change.

Some commentary from participants relates to the preparation of staff and students to undertake CLIP. Those strategies encompassed a great deal of work by university staff, but it appears that for some people adjusting to CLIP remained problematic. It is likely that this is for three reasons: because this was the first time this model had been operationalised in these placement areas; because some of the placement areas were having substantial increases in student capacity; and because all participants were adjusting to placement learning based on coaching as opposed to mentoring. It is clear that change is difficult and often stressful for clinical staff and

organisations, particularly when they perceive themselves and their workload already to be a full capacity [48]. We believe, and have some anecdotal evidence to support the view, that with greater familiarity with CLIP, this feeling of overwhelm would be reduced. We have also reduced the numbers of students going into placement areas that identified numbers as a particular problem. Lastly, the extent to which students believed they gained from their placements was dependent on where they were placed. Whilst there were some gains in terms of clinical skills, leadership and decision making, mostly reported by those in GP practice and hospices, students in nursing homes believed they got little from their placement. This is similar to the position reported in the literature in relation to students preferring acute sector placements to community ones [49], scoring nursing home placements poorly in regard to the extent of potential innovation in learning, with limited opportunities for furthering their knowledge [50, 51]. Many student nurses may already have worked as care assistants in nursing homes, want to move on from this and see the acute sector as a means to do that. At a time when staffing community care in the UK and internationally is problematic [6, 7], it is clear from our study that more work needs to be done to make nursing home placements attractive to students and as a career destination for new graduates.

4.1. Limitations

This study encompassed students from one university in one English region accessing placements, and as such we do not make claims that their experiences would necessarily be replicated or generalised to elsewhere; however, we argue that lessons learned here can be valuable to others seeking to implement CLIP, and so our findings have a degree of transferability.

4.2. Rigour and Reflexivity

In common with other qualitative researchers, we argue that our work is rigorous, because we have used appropriate processes of data collection (FGs), analysis [30], and discussed, agreed and constructed a narrative as a cooperative event as opposed to relying on the interpretations of a lone researcher. We have taken care to be transparent in our thematic analysis by providing appropriate quotes to illustrate the themes, acknowledged our position in relation to the research, and so believe our work has a high degree of reflexivity and transparency [52].

CONCLUSION

This paper has reported on a pilot project to implement a method of placement learning known as CLIP for student nurses in community settings. We evaluated the pilot using FGs with staff and students, and data were subjected to thematic analysis by the research team. The key themes that emerged were Peer support, Developing and learning, and Organisation, and while there were some positive aspects and gains reported terms of peer support, clinical and leadership skills, these were mostly features of hospice and GPN placements. Less positive aspects were the potential for horizontal violence, the perception of ineffective preparation (despite extensive processes undertaken by university staff), and issues with daily organisation including rostering and the logistics of accommodating more students than previously.

RECOMMENDATIONS

We recommend, therefore, firstly, that more work needs to be done to prepare students and staff for CLIP. Similar to others [53], we believe that generational change has implications for educating the millennial learner, and so there is a need for high quality, visual materials, available to be streamed over the internet, to which students and staff can refer whenever they need. Such materials have been shown to be acceptable to learners [54], should be developed professionally, evaluated for authenticity and validity [55], and be context-specific.

Secondly, we recommend that a greater focus be given in undergraduate nursing curricula to positive aspects, career benefits, and skills available to nurses in the nursing home sector. We note that the UK Queen's Nursing Institute (QNI) offers resources on the transition to community and nursing home nursing, and funding for projects and innovations (see https://www.qni.org.uk/explore-qni/nurse-led-projects/more-information/). Studies have found that community supervisors of undergraduate nurses sometimes scored low on the potential for innovation and learning [49 - 51], so we recommend that universities seeking to develop nursing home placements work with providers to develop cultures of innovation and learning within their organisations. This should make them more interesting and attractive to students and improve recruitment and retention of new graduates to the sector.

LIST OF ABBREVIATIONS

CLIP = Collaborative Learning in Practice
FG = Focus group
GPN = General Practice Nurse
HEE = Higher Education England
NHS = National Health Service
NMC = Nursing and Midwifery Council
PVI = Private Voluntary and Independent sector care provision
QNI = Queen's Nursing Institute
STP = Service Sustainability and Transformation Plan
UK = United Kingdom

AUTHORS' CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria [recommended by the ICMJE (http://www.icmje.org/recommendations/)]:

• Substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;

drafting the article or revising it critically for important intellectual content.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

The study has been approved by the University of Plymouth, UK with approval No. 17/18-935.

HUMAN AND ANIMAL RIGHTS

No animals were used in this research. All human research procedures were followed in accordance with the ethical standards of the committee responsible for human experimentation (institutional and national), and with the Helsinki Declaration of 1975, as revised in 2013.

CONSENT FOR PUBLICATION

Informed consent was obtained from all participants.

AVAILABILITY OF DATA AND MATERIAL

Not applicable.

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CONFLICTS OF INTEREST

None. The authors wish to make clear that all, to a greater or lesser extent, have been involved in the implementation of CLIP in the South West Region of England. AK is Associate Head of School for Placement Learning at the regional nurse education provider, The University of Plymouth School of Nursing and Midwifery, and is HEE Fellow for Placement Learning. JB is HEE Quality Manager and involved in CLIP as the project manager. GW, CJ, BM, DC all had some involvement in CLIP implementation in the organisations with which they link the School of Nursing and Midwifery.

GW is Editor-in-Chief of the Open Nursing Journal.

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