



CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

Confounding expectations: reflection on simulation with learning disability service users

Andrew Southgate

Department of Nursing and Applied Clinical Studies, Faculty of Health and Social Care, Canterbury Christ Church University. Email: andrew.southgate@canterbury.ac.uk

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Abstract

Background and context: Recent reports have highlighted deficits in care that some people with a learning disability receive when they are admitted to acute care settings. This may be related to the questionable learning offered to pre-registration adult nursing students in this field of practice, since these may not equip the students with the level of skills and knowledge required to deliver safe and effective care to these people. Simulation has become a core component of pre-registration nursing education. Involving service users in simulated learning could be regarded as logical progression towards enhancing the student experience and the subsequent delivery of care.

Aims and objectives: To reflect on the impact that simulation involving learning disability service users may have on pre-registration adult nursing students and the facilitator, in terms of personal and professional development.

Conclusions: Involving learning disability service users in pre-registration education can provide valuable learning opportunities for the students and the facilitator.

Implications for practice:

- The learning associated with simulation for the facilitator can be unexpected and unintended
- Collaborative working with other health professionals and service users can facilitate personal and professional development
- Reviewing Benner's theory (Benner, 1984) in the light of this learning revealed that I may not recognise the level of expertise I have until the tacit knowledge becomes explicit through reflection

Keywords: Collaboration, lecturers, learning, learning disability, role modelling, simulation

Introduction

My reflective account focuses on the insights I have developed regarding simulated learning when used in collaboration with service users with a learning disability. The reflective process has helped me to appreciate the skills necessary for simulation involving people with learning disabilities in pre-registration adult nurse education and also how to manage personal and professional anxieties related to my inexperience of working with people who have a learning disability. The aims of the reflection are to share what I have learned and to review, critically, the effectiveness of involving learning disability service users in simulated learning within higher education healthcare courses. I used Johns' Model for Structured Reflection (Johns, 2004) as it had the potential to provoke in-depth reflection. It also provided structure for my reflection via a series of cues or questions that are related to Carper's

(1978) patterns of knowing. The Johns model, consists of focusing on and then describing the event, reflection using a series of questions, consideration of alternatives and finally exploration of what is now felt about the experience and the subsequent learning.

Background

Internal factors influencing my reflection

I am a senior lecturer within an adult nursing department. One of my responsibilities is leading the development of the learning disability experience that pre-registration adult nursing students encounter during their educational programme. My clinical background is within the specialities of trauma and orthopaedics, and general surgical nursing. I became a ward manager within general surgery and undertook a secondment as senior nurse for surgical services within the NHS. I then became a practice placement facilitator with responsibility for pre-registration adult nursing students undertaking clinical placements. I have done academic courses leading to successful completion of degree, postgraduate and masters programmes, as well as clinical courses aimed at enhancing the care delivered in the acute setting. However, my development relating to the needs of people with a learning disability has been negligible.

External factors influencing my reflection

Before starting my pre-registration course, I attended a school for children with special needs as part of a sixth form community experience programme. I had no further educational input into this area until I did an online learning disability awareness module as a practice placement facilitator. This enabled me to reflect on my knowledge and skills related to the needs of people with a learning disability. Undertaking this module was an enlightening experience. For example, I was not aware of the inequalities that people with a learning disability encounter when accessing healthcare and that life expectancy for those with a learning disability is lower than the national average. In addition, I learned that coronary heart disease and respiratory disorders are leading causes of death for people with a learning disability. I realised my insight into the healthcare needs and consequent challenges faced by people with a learning disability was inadequate. Accessing key documents such as *Treat me Right* (Mencap, 2004) and *Death by Indifference* (Mencap, 2007) highlighted the gravity of the issues experienced by people with a learning disability. Consequently, I developed insight into the multifaceted nature of ill health among this population (Schrojenstein Lantman-de Valk and Walsh, 2008). I then reviewed my personal and professional values in this respect and considered how I could take this forward in terms of educating and developing others.

I attempted to make sense of the complexities of professional practice in the light of knowledge gained through education (Higgs and Titchen, 2001; Delany and Watkin, 2009). This was challenging since I was in a non-clinical role and not able to influence directly care management and delivery. I had enhanced my knowledge base, yet opportunities to develop my skills and implement my new knowledge appeared limited. However, I took the opportunity to highlight and promote the healthcare needs of people with a learning disability when facilitating placement evaluation sessions for pre-registration adult student nurses. It became clear to me that I had developed an interest in and enthusiasm for advocating for people with a learning disability in the acute setting.

I built on this when I became the lead for learning disability in the department of adult nursing and applied clinical studies. This role was created in response to evidence that healthcare workers often lacked understanding and education in this area (Clarke and Griffiths, 2008). In addition, the Nursing and Midwifery Council was committed to enhancing the educational preparation of pre-registration adult nursing students in respect of the needs of those with learning disabilities in acute settings (Nursing and Midwifery Council, 2010). Further urgency and impetus has been given to this since the publication of *Death by Indifference: 74 Deaths and Counting* (Mencap, 2012 and Michael, 2008). This lead role involves liaising with lecturers who are registered learning disability nurses to explore, implement and evaluate creative ways to enhance the learning experience and knowledge base of pre-registration adult students.

The current situation

An evaluation of the students' learning disability experience within the university revealed a range of issues (unpublished internal evaluation). These included inconsistencies with the way students completed European Union Directives on awareness of other fields of nursing, and then their struggle to apply what they had learned when caring for learning disability service users in hospital. Further challenges included uncertainty from both the lecturer's and students' perspective about the role of the link lecturer in facilitating and supporting students on clinical placements (Price et al., 2011), and the lack of clear learning objectives for the placements. This led me to ask: are there alternative methods of educating students that would benefit both their learning and the quality of care delivered to those with learning disabilities?

The case for simulation: external drivers

The reduction in the number of learning disability clinical placements for students and the quality of those available is recognised (Department of Health, 2012). A potential solution is to develop simulation opportunities. Using simulation for educating healthcare students has been championed by the Department of Health (2008) and the focus has moved from the potential of simulation towards investigating how it can be used more effectively (Issenberg, 2006). Simulation using service users can better prepare students for clinical activities and can be defined as 'high fidelity' since it accurately replicates the reality of clinical practice (Decker et al., 2008; Cant and Cooper, 2010). The benefits of simulation are recognised by key stakeholders (Nursing and Midwifery Council and Council of Deans for Health, 2007; Lundberg, 2008; Nehring, 2008) and include: students becoming active learners; enhanced ability to apply and transfer learning to clinical settings; providing a non-threatening learning environment; and opportunities for students and facilitators to engage in reflection (Cioffi, 2001; McClimens et al., 2012; Williams and Dousek, 2012). Informal evaluation has been undertaken with some of the people with a learning disability who have participated in the simulations. The feedback suggests it has helped them to appreciate what a hospital setting would be like. It also allowed them to help the students understand that learning disability is a broad term and that a number of them live independently in the community.

Simulation pilot

The simulation project was led by an experienced learning disability senior lecturer, who recognised the potential benefits of involving service users in simulations. Service users from an already established local health group participated in the simulations, which took place in the university skills laboratory. The aim was for students to undertake hospital admission and document relevant information. The students orientated and welcomed service users to the environment, undertook an assessment using a Health Passport (Bell, 2012) and recorded the service users' vital signs. Before the simulation, students attended a seminar to provide them with information, such as the challenges associated with caring for people with learning disabilities in acute settings and communication strategies. The simulation was facilitated and overseen by me and an experienced learning disability practitioner.

Reflection on simulation

I was initially sceptical of engaging service users in simulation due to my lack of knowledge of its benefits, inexperience of facilitating simulation-based education and limited experience of engaging with people with a learning disability. I knew that during the simulation students would encounter difficulties requiring guidance from me so I was anxious before and during the activity. Reference to the literature allowed me to explore my anxiety; evidence suggests that it is not simply contact that helps shape positive attitudes and feelings towards others, but also the context in which the contact takes place (Horner-Johnson et al., 2002; Stachura and Garven, 2007). As my contact to date had been extremely limited, I recognised my anxiety was related to inexperience and lack of contact with people with a learning disability, rather than inadvertent stereotypical labelling (Hein et al., 2011).

The intended outcome of the simulation session was to enhance and develop the students' skills and knowledge. However, an unintended and unexpected outcome was the personal and professional development and learning that occurred for me. During the session, I had two choices: either to observe and take a back seat or actively participate and engage in the session. I decided to engage for two reasons. I felt I needed to role model positive behaviour and attitudes (Bandura, 1997) as students learn from the actions and conversations of practitioners (Perry, 2009). When reflecting on this in more depth, I discovered that role modelling can be identified as a way to help teach less experienced staff how theory links to practice – a concept referred to as craft or practitioner knowledge (Price, 2007). This was one of the overall aims of the simulation and I now appreciate that role modelling during simulation is an important element of the education process for students. Furthermore, I realised that although my experience with people with a learning disability was limited, I was able to use existing skills and knowledge and apply them to a new context.

My second reason for engaging was to develop my skill and confidence in communicating with people with a learning disability. I knew this was required so embraced the opportunity as part of my continuing professional development and ongoing practice development (Nursing and Midwifery Council, 2011). The feelings I had during the session were similar to those identified by students (McCaughey and Traynor, 2010). For example, I enjoyed being 'part of' the activity and the anxiety I felt was balanced by a sense of achievement, heightened insight and greater confidence with my communication skills. I also learned that continuous review of how I communicate with those with a learning disability is required; the term learning disability is broad so levels of communication and understanding from those with a learning disability cannot be assumed (Bradley et al., 2012).

My decision to participate was influenced internally by my desire to learn, and to provide a supportive learning environment. Mentoring by lecturers can decrease stress and anxiety in clinical learning environments (Moscaritolo, 2009). While this research was not specific about the location of a clinical learning environment, simulation with service users in a skills laboratory setting constitutes a clinical learning environment to me. I initially did not perceive my role as that of a mentor, since the Nursing and Midwifery Council (2008) definition of a mentor is associated with supporting and assessing a student in the practice setting. However, Jokelainen et al. (2011) describe some of the principles of mentoring as the facilitation of learning and the creation of an environment conducive to learning. I consider these principles were put into practice and achieved during the simulation; this was backed up by the students' evaluations. Therefore, I now believe that my position as a lecturer includes a mentoring element.

There were two significant external factors that influenced my decisions to support and become involved in the simulation. First, the insight I gained from the learning disability awareness module made a deep impression on me with regard to the lack of equality of care received by those with a learning disability. My philosophy of nursing and education is based on humanistic principles and reflects the cultural change in healthcare as nursing develops from focusing on behavioural outcomes towards holistic outcomes (Boychuck Duchscher, 2000). Therefore, I considered involvement in the simulation to be an ideal opportunity to explore how I could facilitate and role model holistic care to students, with the ultimate aim of improving the care experience for those with a learning disability. In addition, a philosophy of collaborative working underpins Canterbury Christ Church University's Interprofessional Learning Programme. Involvement in this enterprise would provide the opportunity for me to work with and learn from professionals from other departments within the university, who are experienced learning disability practitioners, service users, carers and professionals external to the NHS (Health Sciences and Practice Subject Centre, 2011). I now have greater appreciation of the complexities of the future needs of people with a learning disability (Emerson and Hatton, 2011) such as their need for time and space to become more comfortable within a hospital environment. I am also better placed to impart this knowledge to students in the future.

This is the first time I have engaged with service users in an educational context. The experience was a positive one for me since I recognised that I was not the 'expert' in the field. The involvement of service users potentially places them in a position of power, which can be threatening for lecturers (Felton and Stickley, 2004). However, their enthusiasm to support the initiative created a non-threatening environment for me and is consistent with research (Priestly et al., 2010) demonstrating that learning disability service users actively engage in activities that will have a positive impact on the lives of other disabled people. Service user involvement is regarded as a core component of nurse education (Terry, 2011) although barriers to this have been identified (Smith et al., 2009). The participation of service users in simulation has clearly demonstrated to me that these can be overcome by engagement and partnership working.

I could have declined to support or engage in the simulation. However, the consequences for others include stifling creativity in the delivery of education, alienating service users who were keen and willing to engage in collaborative working, denying students an opportunity to learn in a supportive environment and hindering the improvement of care for those with a learning disability. On a personal level, I would not have recognised the advantages of simulation and the benefits of involving service users in education. Furthermore, I would not have gained new insights, some of which are discussed in this paper. This new knowledge will positively influence how I respond to simulation using service users in the future. For example, I will have less anxiety about my own ability to interact and facilitate simulated learning.

However, there are those who may be reluctant to involve service users in such a way. There is no clear evidence that simulation actually improves outcomes (Eppich et al., 2011) and cynics may use this as rationale not to embrace future initiatives. In spite of this, I feel confident of my ability to explore with dissenters the benefits of simulation using service users. There are other issues that need to be addressed such as those related to consent, payment and professional accountability if clinical observations appear abnormal. Additional challenges such as ensuring equity for all students and not appearing to take advantage of the service users also need to be explored and are potential factors that may negatively impact on the development of the initiative.

Conclusion

Reflecting on the involvement of learning disability service users in simulation has provided the opportunity for me to explore what I learned from the situation. This has enabled personal and professional growth: I have greater insight (Finlay, 2008) into aspects of my role as a lecturer, such as mentoring; more confidence in my ability to facilitate simulated learning; and an appreciation of the willingness and motivation of service users to collaborate and engage with pre-registration nursing education programmes. I consider my knowledge base relating to simulation, involvement of service users and working with people with a learning disability to be at the level of advanced beginner (Benner, 1984) as I am able to adapt principles based on past experiences to guide my actions. My personal reflection within this paper has been related to the literature. By continued reflection and more experience related to simulation, involvement of service users and working with those with a learning disability, I aim to be able to adopt a more critical and insightful view. Therefore, the next step in my developmental journey will focus on a more critical analysis of the literature and my own learning.

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Andrew Southgate (RN, BSC Hons, MSc Nursing, ENB 219, ENB 998, PCG Cert Healthcare Management), Senior Lecturer Adult Nursing, Department of Nursing and Applied Clinical Studies, Faculty of Health and Social Care, Canterbury Christ Church University, Canterbury, UK.

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