The Clinical Clusters Education Model (CCEM) supporting nursing student learning: an implementation case study

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The aim of this presentation is to describe the implementation of the Clinical Clusters Education Model (CCEM) in a Health Service in South East Queensland, Australia. The CCEM is an adaptation of the Dedicated Education Unit (DEU) model for nursing clinical placements. Since the development of the DEU model, evidence supports high levels of student engagement and learning indicating that this approach has value for students, hospitals and universities.1

The impetus for change stemmed from the recognition of the local drift to a facilitator-centric loss of program fidelity,2 in this case student engagement and learning. The process of implementation of clinical education programs based on the successful DEU model often requires adaptation to meet local sociocultural contexts. The risk with adaptation is loss of program fidelity,3 in this case student engagement and learning.

Student feedback indicating increased levels of confidence and satisfaction suggests that the model is feasible and effective, in terms of student learning. Initial student dissatisfaction with the model has since been replaced with model feasibility and effectiveness, and implementation success. Early data during the implementation phase focused on comprehension and translation of the model to the hospital context, and re-negotiation of facilitator-student relationships. The Implementation Phase began in early 2015 and continues today. In February 2017 we entered the Sustainment Phase. In this phase we are focusing on mapping the elements of the DEU model that have been employed in the CCEM, any deviation from the original DEU model and the effectiveness of student engagement and learning.

A key benefit of the phased DAP model for implementation is that this process is continuously iterative, in that ongoing experience can inform continued adaptation as needed.4 For instance changed practices, feedback or outcomes during the implementation phase have highlighted particular aspects of preparation that need to be developed or modified to enhance the capability of facilitator and ward staff to support the CCEM.

Figure 2: Dynamic Adaptation Model applied to the implementation of the Clinical Clusters Education Model – example from each of the phases.

Further research
April 2017
• Facilitator support group with support of academic partners are running Learning circles with students to engage and enhance peer learning

Sustainability
February 2017
• Continue development of resources and build capability of facilitator and ward teams to support students in the workplace. e.g. posters – scope of practice for students per year level aligned to patient role in ward
• Mapping for any deviation from the DEU model e.g. program fidelity, program adaptation, program effectiveness and implementation fidelity

Implementation
January 2015
• Learning circles with facilitator group run by academic partners. Informed implementation phase of feedback, issues and needs to be addressed e.g. students’ orientation to model changes, governance issues – retention of escalation pathways for student practice issues
• Master Class series for facilitators continued
• Resources for wards – posters, newsletters
• Resource sessions for ward staff by facilitation team – Supporting nurses in the workplace

Outcomes to date
During the implementation phase, evaluation data was collected to ascertain model feasibility and effectiveness, and implementation success. Early data suggests that the model is feasible and effective, in terms of student learning. Initial student dissatisfaction with the model has since been replaced with student feedback indicating increased levels of confidence and satisfaction.

An ongoing challenge for sustainment of the CCEM is the continual churn at least a 30% turnover of temporary staff within the facilitator group across the year. Hence a critical factor is the evolution of orientation and development strategies that stay aligned to the direction of the model.

Further research
In April 2017, led by our academic conjoint positions we are implementing a strategy to explore students’ engagement in peer learning. The strategy is coordinated by the facilitator group and utilises learning circles with student groups to explore a clinical situation/topic of their choice.

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The framework for implementation: Dynamic Adaptation Process

The Dynamic Adaptation Process (DAP)3 which includes the phases of Exploration, Preparation, Implementation and Sustainment provides the theoretical framework for the case study of implementation. The DAP has been used for large-scale program implementation in family services. Like family services, clinical education is grounded in multiple networks of relationships and interests, therefore the selection of DAP is considered to be appropriate.

Using the DAP framework the stages of development and evaluation are summarized in Figure 2. After two, separate four week trials at one hospital in the Exploration Phase, the structure of the CCEM started to take shape in October 2014. In this Preparation Phase, the focus of learning shifted from a direct facilitator-student relationship to a student-ward staff focus, where students had greater locus of control over their learning experience, within established boundaries (scope of practice). The preparation phase focused on comprehension and translation of the model to the hospital context, and re-negotiation of facilitator-student relationships.

The Implementation Phase began in early 2015 and continues today. The process of implementation has been challenging as ward staff learn to engage the students into their work, providing experiences that are appropriate to their learning journey.

In February 2017 we entered the Sustainment Phase. In this phase we are focusing on mapping the elements of the DEU model that have been employed in the CCEM, any deviation from the original DEU model and the effectiveness of student engagement and learning.

References