The Team Leader Model: an alternative to preceptorship

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KEY WORDS

Students, graduates, supervision

ABSTRACT

Objective
To improve the clinical practice environment for student nurses through an increased understanding of the relationships and of the situations in which that practice occurs.

Setting
Fremantle Hospital and Health Service (FHHS) in partnership with Curtin University of Technology.

Subjects
This project sought to assess a new model of supervision and support based on a team approach, the team being a Registered Nurse, Graduate Nurse and a Student Nurse, that supported students, graduates and staff.

Main outcome measures
To determine if the students clinical placement provided a reality of practice, where the student became the leader of the shift, supervised by the supervisor. To understand the relationships of support between graduate and student nurses, and to determine if the allocation of students via the Team Leader method reduced preceptor burnout.

Results
The Team Leader Model demonstrated that it provided an improved allocation model of student supervisors, students felt a greater sense of reality of practice, and graduates appreciated the support of the Team Leader.

Conclusion
The model has been perceived by staff and students as a practice that can provide for a better clinical practice placement for the student.

INTRODUCTION

The 'Team Leader Model' was introduced at Fremantle Hospital and Health Service (FHHS) in partnership with Curtin University of Technology in February 2006. The initiative for the project was three fold: the ongoing negative feedback from graduate nurses on the support provided by their nurse preceptors, the increasing requests for student placements, and a need to increase graduate (first year registered nurses) positions. This project sought to assess a new model of supervision and support based on a team approach, the team being a registered nurse, graduate nurse and a student nurse, that supported students, graduates and staff. This paper explains the model, describes the changes made as a result of the three year evaluation project which employed the principles of action research and outlines implementation strategies used to support the change process.

BACKGROUND

The preceptor role at FHHS had become limited to a small group of nurses who were permanent staff working full time hours. This led to staff feeling exhausted and dissatisfied with the role, as reported at preceptor training sessions. The ongoing demand on staff to precept was leading to 'stress and burnout' as has been documented within other organisations (Yonge et al 2002, pp. 22). Preceptors found they were often allocated to precept a graduate and student nurse at the same time. This resulted in feelings of abandonment by the graduate nurse as the preceptor's time was spent with the undergraduate, leaving little or no time to assist the graduate. This increased the staff members' dissatisfaction with the preceptor role, which at times led to a negative clinical experience for students and for graduates' dissatisfaction with their program, in particular the level of support offered by preceptors.

This feedback from staff was not unique to Fremantle Hospital. The report 'Clinical Placements of Nurses in WA: A project to assess and improve the quality and scope of clinical education' (Saunders et al 2006, pp. 6) noted that the role of preceptoring undergraduates:

> *was identified as difficult to fill, with no obvious advantages or professional benefits for the clinical nurses who undertook it. The role was perceived as overly burdensome, and was often translated as such to students. A lack of recognition for the role, staffing issues, and limited professional benefits from undertaking this role create (d) ongoing difficulties in filling these positions.*

As a result of this feedback and a need to increase student and graduate numbers, the position of Staff Development Educator for Student Placements and Preceptorship (changed to Undergraduate Coordinator 2008) was introduced in 2003 with the purpose of implementing an intensive education program to promote and support the preceptorship program.

The preceptorship education program commenced in November 2003 and consisted of a six week (one hour per week) course that was conducted in semi-formal ward based sessions. Single study days were also available. A total of 86 sessions and 18 study days were presented over two years. Over 1,000 attendees are recorded for the ward-based sessions. Despite this intensive program and an increase in staff support for preceptorship, the role still struggled to reach its full potential, with graduate feedback in 2004-2005 continuing to highlight the lack of support they felt from preceptors.

A strategy was required to assist staff as student and graduate positions were increased to combat the workforce crisis of declining numbers of nurses. The Team Leader Model was introduced in 2006 to provide an alternative model of undergraduate supervision that also provided support to new and junior staff. The model sought to reduce the workload on nurses currently working as preceptors and to provide a better clinical placement for students that promoted their development.

The research was coordinated by the Staff Development Educators (SDE) Undergraduate Coordinator Mrs Ann Hobson, Graduate Program Coordinator Ms Kylie Russell (mid program

transferred into Undergraduate Coordinator role job share), and Professor Robin Watts, Curtin University of Technology.

Model

The key elements of the model include:

- moving the responsibility for the supervision of undergraduate students from one staff member, the preceptor, to the ward staff together managing their placement and experience;
- teams of three: a registered nurse as 'Team Leader' and supervisor, an undergraduate student and the third being a staff member who would benefit from additional support e.g. graduate nurse;
- reality of practice - allocation of a patient load to the undergraduate student for the shift;
- inclusion of undergraduate students on continuous practice as ward 'staff' e.g. on roster;
- the support role of ward 'Student Liaison Nurses'; and
- culture change - importance of ongoing staff education.

The following section provides further detail on a number of these key elements.

Students on continuous practice are placed on the ward roster. The manager allocates shifts according to the ward's staff mix. This allows students to experience being part of a roster. They are able to change shifts as required in discussion with the manager, as for any staff member. This promotes a professional accountability in maintaining and negotiating a roster. It accepts that students cannot always follow the same roster as a preceptor due to their own family and work commitments.

On shift the student is allocated a patient load. The student's name is placed on the allocation board/ book. This is designed to encourage the student to be the 'doer' rather then the 'follower' in patient care. It encourages the development of time management skills and problem solving. The student is encouraged to take responsibility for planning and implementing patient care for the full shift.

A registered nurse (RN) is allocated as a 'Team Leader' for the shift. Their role is to provide direct and indirect clinical supervision to the student. They sign off as appropriate in the student's workbook for skills and competencies achieved in the shift. Team Leaders wear a badge for the shift so that others know they are in the role. This is to encourage the nurses to identify themselves as being in a different position thereby assisting them to focus on providing supervision rather than the hands-on care. It also reminds other staff to approach the student about their patients directly to encourage the student to develop and gain confidence in their communication skills.

The Team Leader Model is designed to share the workload of student supervision. No one staff member works every shift with a student. The Team Leader concept allows the workload to be shared amongst all staff including part timers and casuals. This reduces stress and workload demands on staff who would normally be allocated as the 'preceptor' for the student's entire practical placement.

A third member of the team can be included in the group. This can be a graduate nurse, junior nurse, orientee, agency nurse, or another student. If the third member of the team is an employee of the hospital or agency the Team Leader provides support for them. If it is another student the Team Leader provides direct and indirect supervision. When the team consists of two students their patient load must be such that the Team Leader is able to effectively provide the level of supervision required.

To support the students in their placement each ward area has two to three Student Liaison Nurses. The role of these nurses is to:

- act as a resource to students when on shift;
- socialise the student into the work group/ environment;
- promote the role of students in the ward environment; and
- work as a team leader.

The role of the Student Liaison Nurse is primarily that of a student socialisation agent. This includes

welcoming students, introducing them to the team, ensuring they are included in social functions, enquiring after them to ensure that all is well, a person to ask questions of and a shoulder to lean on after a challenging day. They do not assume the role of the university clinical instructor; they are not to performance manage. Student Liaison Nurses promote students in the workplace, and ensure that the Team Leader is there to support the student. The role also provides feedback to the hospital's Undergraduate Coordinator at the regularly planned meetings. This provides ongoing feedback as a part of the quality management/action research feedback cycle.

A positive attitude towards students is vital to the success of the model. Ward staff, managers and staff development nurses must view students as an asset to the organisation. If students are not viewed in a positive manner staff will be unwilling to allow them to take on an active role and not trust them to undertake the learning opportunities available to them in the clinical placement.

EVALUATION OF THE MODEL

The aim of the evaluation study was to assess how well the Team Leader Model met the needs for which it was designed and to identify the factors that facilitate its effective implementation in the context of a tertiary level hospital. In a more general sense the aim was to improve practice through an increased understanding of the relationships and of the situation in which that practice occurs.

A brief outline of the research process has been included.

Method

Action research was selected as the most appropriate methodology for the study. The purpose of action research is "to inform and change practice and develop understanding of the particular context in which it takes place" (Reed 2005, pp. 595). For these reasons Daniel et al (2002) suggested that action research is appropriate for developing and evaluating educational initiatives for university nursing programs, noting that as this type of research is collaborative it can also provide the incentive to reach conclusions that "are comprehensively grounded in the perceptions of those working in a particular social context" (pp. 90). Its purpose is to produce 'practical knowledge' that is useful to those using it every day (Reason and Bradbury 2001, pp.2).

Action research in the clinical education setting involves the identification of an area of educational practice that requires change, the generation of ideas to improve current practice and the evaluation of these ideas in practice. Koch et al (2004) state that this should begin with the question 'How can I improve my practice?' with the process then being cyclical in nature: plan, implement, and reflect. Employing an action research design for this study ensured the workability of the model for the practitioners and facilitated their ownership of the outcomes through their ongoing involvement and contribution (Avison et al 1999, pp. 95).

A participatory action research method was utilised. This method involves the participants within the research process. They identify the problem, and decide ways to change. Researchers play a facilitator role (Reason and Bradbury 2001).

Process

A number of phases for the project occurred:

Phase One Implementation of new model - pilot group, May 2006

Phase Two Data collection and analysis (feedback) -site visits, observation, CNM, ward meeting

Phase Three Review of model, discussions with staff and CNM, slight modifications

Phase Four Implementation of reviewed model, August 2006

Phase Five Data collection and analysis (feedback) - forms, focus groups, reflection, site visit, observation, CNM

Phase Six Review of the model, discussions with staff and manager - no recommended changes

Phase Seven Ongoing review of the model, discussions with staff, manager, and clinical supervisors - no additional recommended changes to date.

Sample

The piloting of the Team Leader Model commenced in March 2006. Two wards were used for the collection of data. Both were surgical wards with two different models of care; primary nursing and team nursing. Staffing on the first ward was very good whilst the latter had a severe shortage of staff. These two wards were utilised throughout the four year evaluation.

Students: Six participants - 7th semester Curtin University registered nurse students (ten week placement).

Graduate Nurses: Six participants (to match student number) on their first rotation.

Team Leaders: staff fulfilling the role were identified by the ward manager on the roster with the initial 'TL'. All staff consented to undertaking the role, with allocations organised by the manager when rostering.

Informing participants

All participants received detailed information on the study via tailored information sessions and handouts by the SDE for undergraduate placements and graduate program. Information sheets and consent forms were given at this time to all study participants and collected prior to commencement.

Data Collection

In line with Avison et al (1999) and Nieswiadomy's (1998) recommendations in respect to action research, a number of data sources were included to ensure a valid explanation of the practice being evaluated. The methods of data collection over the four year period included both written and verbal feedback and observation.

- **Feedback Forms (2nd evaluation cycle only)**

A feedback box was provided in each ward into which participants were asked to place a comment after each rostered shift. Feedback boxes were emptied each week by the SDE's. The information obtained was transcribed into table format to provide a weekly report. This also ensured that any feedback indicating the need for an immediate response could be actioned.

- **Site Feedback**

The Graduate Program Coordinator visited the ward weekly for feedback from the staff, in particular from the graduate nurses. The Undergraduate Coordinator and the Clinical Liaison Academic Support Person gathered comments relevant to the study from students and team leaders in their usual daily interactions. In all cases this feedback was recorded in note form.

- **Group Feedback (2nd evaluation cycle only)**

A session for the students was held in the week prior to the mid placement break of one week (week five). It was designed as a debrief session for the students and as an opportunity to gain an understanding of how they were feeling at this stage in the placement. The session was coordinated by the two SDEs. The discussion was taped and transcribed.

- **Observations**

During the ward visits the research staff also noted any observations relevant to the study including interactions between team members. Given the importance of context in action research, relevant contextual information was also sought and noted.

- **Reflection (2nd evaluation cycle only)**

In order to obtain the students', graduates' and team leaders' reflections on the placement and the model, focus group were held at the completion of the ten week project. These consisted of small groups of five to ten participants. All participants were invited to attend. The session was facilitated by the SDEs. Each session involved a number of semi-structured questions based on the study objectives. These guided the discussion while allowing for more detailed exploration of points raised. Sessions were recorded on audiotape and later transcribed verbatim. This was checked by both SDE's to ensure accuracy.

- **Manager feedback (CNM)**

The CNM's were asked for feedback throughout the project and on completion. This was logged, mainly through email. The information sought related primarily to the role of the CNM in the model and

their view and that of their staff on its workability and impact on the ward.

- **Ward meetings/Inservice**

Both SDEs regularly visited the ward meetings and provided ongoing inservice education which provided an opportunity to discuss the model and seek further feedback. This also ensured new staff working in the area were informed of the project.

Data Analysis

A simple content analysis of the qualitative data obtained was undertaken to identify themes and patterns, positive, neutral, and negative, in the summaries of the written feedback, transcripts of the focus groups and the researchers' field notes. Analysis of the data involved examining "words, descriptions and processes" (Borbasi et al 2004, pp. 148) as the documents were read and reread a number of times. This process is called "data immersion… (which) lets the researcher get in touch with not only the content but also the feeling, tone and emphasis being communicated (Borbasi et al 2004, pp. 148).

The rigour of the study was ensured by several strategies. Participants were provided with the opportunity to review the draft findings e.g. the three staff who documented field notes verified the contents of their summary to ensure a valid interpretation. In addition the data collection and analysis processes were documented in detail allowing an audit trail to be established.

FINDINGS

The pilot group in May 2006 received positive feedback from the managers, staff and students. It was agreed to continue with the model. Modifications were made with the second rotation in August 2006: individual student rosters and Student Liaison Nurses. The model continues to date as presented in this paper.

The outcomes of the four year evaluation have supported the model. All the participants were positive about their experience and the evaluation confirmed the key elements of the model, with some additions and improvements that could be made in its implementation.

From the students' perspective

- Encouraging the student to take responsibility for a patient load provided the opportunity for students to learn the essence of nursing, time management skills, interpersonal communication skills, critical thinking and to develop self confidence. Student feedback highlighted that they were of the view that they had achieved more in their first two weeks of this placement than they had in their entire program.
- Working with different staff highlighted the different approaches to the tasks and patient assessment. This highlighted that, whilst nursing policy and procedures must be adhered to, nurses may still apply subtle differences in how they approach these.
- Frustrations existed when allocated a nurse who would not facilitate learning opportunities. However students appreciated that they all rotated through the different staff, thereby sharing supportive and non-supportive RN's as teachers.
- Working in a team environment with the graduate nurse allowed students to see where they would need to be in their development on the completion of their degree and what to expect as a graduate. It also provided graduate nurses with the opportunity to reflect on their own development and growth. Both being new to the environment and novices in their practice, this relationship provided a familiarity and the opportunity to discuss feelings, concerns, and achievements with each other.
- Individual rosters allowed flexibility of shifts. Students were able to easily negotiate changes with the ward manager. This allowed for greater flexibility with family and work commitments.

Graduates' feedback

- Graduate Nurses benefited from team membership by the ready availability of a more experienced RN. Rather then walking the corridor looking for

someone to ask, particularly when first starting on the ward and orientating to the environment, the Team Leader provided a primary link to the resources available. The role of the Team Leader in this context was to support through answering queries, directing to other resources, and helping with procedures and patient care when time permitted.

Team leaders' views

- Reduced workload of student supervision as not allocated to this role for every shift over the student's placement.
- The responsibilities of the Team Leader were over-emphasised by the participants, with most staff feeling they needed to provide more support than what was outlined for the graduate nurse. Staff were reminded that prior to the Team Leader Model this resource was not available, and the role was not intended to be that of a supervisor of the graduates.
- Team Leaders who felt they had provided adequate supervision or support to the student and graduate reported a positive shift in terms of the patient care delivered, organisation of the shift and feelings of a good day at work. The main facilitator of this perception was the allocation of an appropriate patient load. As a result students felt they had been given the opportunity to practice within their scope with the security of a Team Leader. This provided more opportunities for learning the essence of nursing and provided a sense of achievement.
- Concerns related to the model included the allocation of workload. There is often the perception that with a student and team leader allocated to an area the number or complexity of patients can be increased; this fails to allow the student to work within an appropriate workload and sets the student up for failure.
- Feedback from the team leaders indicated that with an appropriate patient load they were able to provide beneficial levels of supervision. Students were encouraged to manage the workload allowing the team leader time to observe and advise on appropriate nursing care. As the students' confidence and abilities continued to increase during their placement, team leaders often found themselves offering support to all members of staff.
- Staff felt more supported when a student was not demonstrating competence as other staff working with the student could support this assessment and feedback.
- Graduates were not always allocated to work in the team. This depended on the team leader and the graduate on shift. It was felt that the students were the priority of the team leader and that graduates had other support networks in place (in 2008 additional supernumerary resources were provided for graduates).

Clinical Instructors

- At times it was more time consuming obtaining feedback as multiple staff had worked with the student. However this provided a better overall picture of the student's progress as information could be corroborated.
- If a student was struggling it was sometimes necessary to allocate one staff member to provide continuity. However this was generally not a problem as a staff member usually offered to undertake this role.
- Students needing to change shifts or with special requirements were easily managed as this was a simple roster change.

Observations re culture change

Placing students in busy hospital wards, units and departments has always been met with some anxiety. The perception of the increase in workload and students' lack of skills resulted in many staff declining students or insisting on their numbers being reduced. It has been through the intense staff education program and support by the Undergraduate Coordinators in their ward visits that this culture has started to change. Both of the hospital's Undergraduate Coordinators involved in the project from its conception reported witnessing

a change in staff perception of the value of students. Comments made in focus groups and on visits to the wards highlighted the sentiments of staff and managers. These comments indicated that some staff still hold negative opinions and find it difficult to accept that students can be of benefit in the workplace. This same group were observed to be those finding it difficult to allow the student to take ownership of the allocated patients' care.

A number of strategies have been adopted to support the ongoing implementation of the model:

- Facilitating culture change. In the continuing staff development program staff are upskilled to work with students and first year nurses. Topics include communication skills, leadership skills, theory to practice, and the principles of adult learning. Students and graduates are promoted as an essential component of the workforce.
- Introduction of Student Liaison Nurses (introduced after pilot study).
- The need for this role became evident in the findings of the initial evaluation of the model. Expressions of interest were called for and within a month 72 nurses volunteered for the role. Second monthly meetings are held to provide the group with appropriate education and a forum to discuss placements.
- Staff Education and Support. In addition to the more generic content of the staff development program outlined above, orientation and inservice sessions continue to be provided for staff new to the model. Guidance sheets and posters are displayed in the wards.
- Staff are also encouraged to attend the modular sessions of 'Fundamentals of Supervision', 'The Principles of Adult Learning', and 'Introduction to Teaching Clinical Skills and Providing Feedback'.
- Student Orientation. The Undergraduate Coordinator meets with the students on their orientation/first day in the hospital. The model and how it will impact on their placement is explained.

CONCLUSION

It was anticipated that the Team Leader Model of Clinical Supervision would demonstrate the following benefits:

- improve the management and the quality of the clinical experience of the student on continuous practice for their final placement;
- facilitate an improved clinical placement experience that would translate into a graduate better orientated to the hospital and able to transition into the new graduate role;
- better support ward staff in their clinical supervision and teaching of students and graduates;
- allow part time and casual staff to participate in the supervision of students; and
- by sharing the role of student supervision, reduce staff burnout.

The evaluation study demonstrated that the model met the aim and objectives that it set out to achieve. Staff and student feedback on the project indicated that the Team Leaders not only enjoyed working with the students but also appreciated the assistance they had given the ward staff in managing patient care.

The model has been perceived by staff as a practice that can provide for a better clinical practice rotation for the student. This improves the readiness of the student for their imminent role as a Graduate Nurse. For ward staff the model reduces the stress of supporting students and new graduates in the workplace. The Team Leader Model can be introduced to any hospital area as a strategy to help reduce staff burnout whilst promoting the value of undergraduate students.

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