Sustaining a good model of practice education in challenging times

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Abstract: The Bacon Report (2001) recommended an increase in the numbers of occupational therapists, physiotherapists, and speech and language therapists in Ireland. As a result four new programmes were introduced in 2003. These new programmes, along with the existing programmes, resulted in a significant increase in placement requirements, against a backdrop of public service reform and a challenging economic environment. A National Steering Group for Practice Education was established to oversee the development and implementation of a national model of practice education. Three key principles underpinned the development and implementation of this model i.e., the use of an organisational development approach, promotion of an interprofessional approach, and innovative models for delivering practice education. First, the use of an organisational development approach involved key stakeholders in all aspects of the process, thus promoting ownership and collaborative problem-solving.Second, the use of an interprofessional approach promoted collaborative working and the achievement of quality outcomes within relatively short time-frames. Third, the exploration of innovative models of placement delivery has been helpful in relation to increasing placement capacity. As well as benefitting students, some of these models have been positive for patients. The learning from these experiences may be useful for other health and social care professions.

Keyword: Practice education; sustainability; organisational development; interprofessional approach; innovative models of placement delivery

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Introduction

The Bacon Report (2001) recommended an increase in training places in occupational therapy, physiotherapy, and speech and language therapy in Ireland and in 2003 four new programmes were introduced. These programmes gave rise to a significant increase in the number of places required to facilitate students to reach their clinical competence. Furthermore, the new programmes placed significant pressure on a system which was already struggling to meet existing demands. Prior to the introduction of the new programmes there was no formal system in place in relation to practice education for the therapy professions.

In this paper we discuss the design and implementation of a national practice placement education model for three therapy professions in Ireland. A National Steering Group for Practice Education (comprised of key stakeholders from health, education, and the professional bodies) was established to provide leadership in the development and implementation of the practice education model for the three therapy professions. This group was initially jointly established by the Department of Health and Children and the Health Services Executive (HSE). It was set up to have representatives from key stakeholders involved in practice placement education e.g., representatives from professional bodies, therapy managers groups, management of the HSE, higher education institutes, and local area management. The initial work of this group coincided with a time of economic growth and prosperity in Ireland, known as the 'Celtic Tiger', where funding was available for investment in public sector developments. During this time a substantial investment was made by the Irish Government, which resulted in the creation of three new types of posts which were specifically designed to support practice educators i.e., therapists in practice who facilitated student placements. These new posts, funded by the Department of Health and Children included: Practice Education Coordinators (located in the higher education institutes) Practice Tutors and Regional Placement Facilitators (located in the health service). At that time, financial incentives were offered by the HSE to therapists who facilitated student placements i.e., an allowance was provided which was to be used for continuing professional development (CPD).

However, in spite of this initial commitment to funding, the subsequent financial crisis and public sector reform have presented significant challenges to the on-going implementation and maintenance of the

practice education model. For example, there has been a moratorium on public sector recruitment, a reduction in public service head count, changes in terms and conditions for employees (such as pay cuts, increase in working hours, reductions in annual leave, and removal of the allowance for CPD), and an overall 14% cut to health budgets. Furthermore, there have been additional demands on the health sector in relation to placement provision because higher education institutes have also been under pressure to generate revenue e.g., by increasing student numbers.

In this paper, we discuss the design of a model of practice education which focused on developing a supportive environment for all key stakeholders involved in the practice education system. We examine three key principles which have been identified as significant contributors to the sustainability of the model, i.e. adopting an organisational development (OD) approach, interprofessional working, and the promotion of change in the delivery of practice placements.

Adopting an organisational development approach (OD)

One of the key features of developing and sustaining the practice education model has been the use of an organisation development (OD) approach. Coghlan and McAuliffe (2003 p.14) state that 'organisation development is an approach to planned organisational change' and highlight that 'OD emphasises employee participation in diagnosing problems and in finding and implementing solutions to those problems and evaluating the results.' The development and implementation of the practice education model was based on the following core assumptions or principles of OD from the work of Richard Beckhard (1969 p114).

"1. The basic units of change are groups, not individuals.
2. An always relevant change goal is the reduction of inappropriate competition between parts of the organization and the development of a more collaborative condition.
3. Decision making in a healthy organization is located where the information sources are, rather than in a particular role or level of hierarchy.

4. Organizations, subunits of organizations, and individuals continuously manage their affairs against goals.
5. One goal of a healthy organization is to develop generally open communication, mutual trust, and confidence between and across levels.
6. People support what they help create. People affected by a change must be allowed active participation and a sense of ownership in the planning and conduct of the change."

The National Steering Group for Practice Education engaged the services of an internal OD Consultant to facilitate the group to apply these principles to the development and implementation of the practice education model. For example, for each piece of work involved in the design and implementation of the model a conscious decision was made to ensure that each stakeholder's perspectives were represented i.e., the perspectives of the higher education institutes, professional bodies, therapy managers groups, management of the HSE, students, and local area management. In practice this meant that when new sub-groups were formed to address a particular issue (e.g., the steering group to oversee the therapy project officers and designing large-scale workshops to clarify roles and responsibilities), careful consideration was given to the composition of the group. This multi-stakeholder involvement represented a microcosm of the overall system and facilitated a sense of ownership, collaborative problem-solving and decision making. Using this OD approach provided stakeholders with time and space to reflect on and generate solutions to problems, which may not have been possible under the usual bureaucratic organisation structures.

Furthermore, in tandem with the above, the principles of the Kolb and Frohman Cycle of Planned Change model were used to guide all aspects of the work. The basic elements of the cycle are: entry and contracting, diagnosis, planning and negotiating interventions, taking action, evaluation and depending on the outcome of evaluation, either mainstreaming or termination (See Figure 1 overleaf).

Each piece of work started with in-depth data collection and diagnostic phases, with the aim of understanding the multiple perspectives to inform the design of effective interventions. One of the key learning points has been the importance of using this Cycle of Planned Change and in particular allocating time to the diagnostic and planning

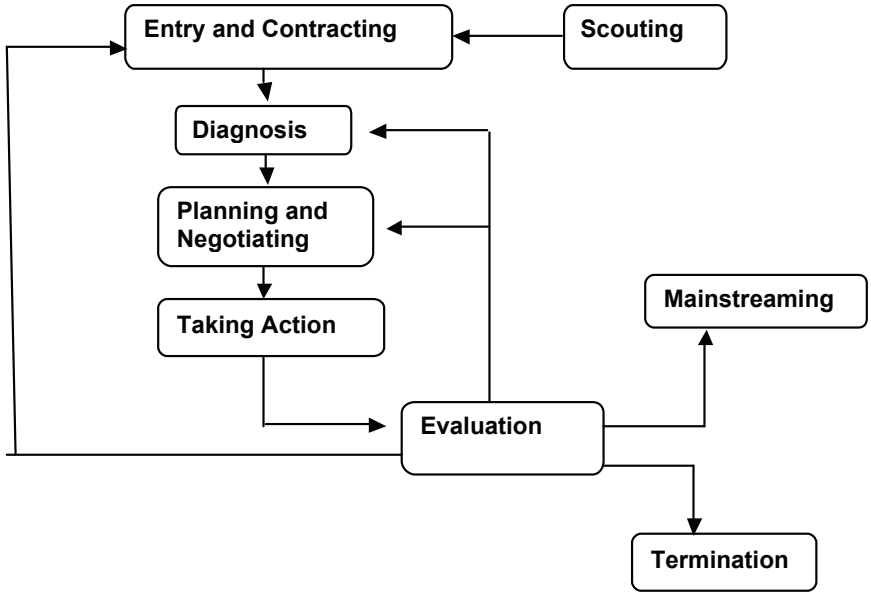

Figure 1: The Cycle of Planned Change in Organisation Development.
Kolb and Froham 1970, Newmann (adapted) 1989

phases, despite pressures to act quickly and skip steps. As a result of this methodology, stakeholders have been facilitated to collaboratively create workable solutions.

The OD consultant took on different roles depending on what was needed, sometimes consulting to the process and sometimes facilitating workshops or meetings so those involved in leading the process could take up their stakeholder role fully. Having this informed, but at the same time outside, perspective meant that the OD consultant could sometimes surface or speak to issues, or make observations that would be difficult or unhelpful for those in role to do. The OD input was also crucial in designing workshops and engagement events in order to maximise engagement and in creating a safe environment where issues could be raised and worked through. Having the expertise of an OD Consultant also provided assurance and confidence to the group that the workshops would be designed to be solution-focused addressing particular issues and would not be side-tracked by other issues. Without exception, the initial investment of time in data collection, diagnosis and planning resulted in events which worked well and interventions that harnessed positive energy and practical

outputs. The most recent intervention, a large scale problem-solving workshop (with 80 participants), took place in the context of the financial crisis in Ireland, with significant budget issues, a moratorium on recruitment, pay cuts, and on-going health service reform, all of which impacted on the provision of practice placements. In the context of this backdrop there was considerable potential for negativity and despair. However, with a solid base of OD expertise and methodology the event was positive and provided opportunities to value and support those involved, nurture the champions of practice education, harness positive energy, create practical solutions, and re-energise the system. Furthermore, events like these keep practice education firmly on the agenda at local and national levels.

Another aspect of the Cycle of Planned Change which has been valuable in terms of sustainability has been the use of an iterative approach. There are on-going challenges to the maintenance of the model in the context of the economic environment and public services reform. Therefore, it has been necessary for the group to address these challenges in a systematic way to ensure that the model continues to adapt to changing needs.

Interprofessional working

A second key principle underpinning the development and sustainability of the practice education model has been the promotion of interprofessional working. In the early stages of the development of the model, the term multidisciplinary was more commonly used in practice and indeed this term was used in some of the earlier documents published in relation to practice education (e.g., Guidelines for Good Practice, 2008). However, on reflection it was considered that the term 'interprofessional' more accurately reflected the ethos and practice inherent in the development of this model. 'Interprofessional education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care' (CAIPE, 2002). As outlined above, the group created opportunities for all of the professions to work together. Despite cultural and practice differences in the professions, it was recognised at an early stage that there were also many commonalities, particularly in relation to practice education.

One of the first tasks of the Steering group was to design new posts to support practice education across the professions. This was approached on an interprofessional basis and resulted in the creation of a common job description for each post which met the needs of each of the three professions. In addition, therapy project officers were appointed to carry out a programme of work identified at national level to support practice placements. One of the key outcomes of this process was the publication of a suite of documents to support practice education. One of these documents is the Guidelines for Good Practice in Practice Education (2008). These guidelines were jointly developed across the three therapy professions and they outline common processes at each stage of the placement process including roles and responsibilities in relation to preparation for placement, during placement, and post-placement. A second document, entitled Practice Educator Competencies (2008), set out a common set of competencies for a practice educator in the following areas: education, supervision, assessment/evaluation, professional practice and management/administration. These documents were widely distributed through the stakeholder networks and are accessible online. These documents are still in use and were reviewed in 2011 as part of an overall evaluation of the practice education system (Report on the Review of Practice Education System, 2011). The benefits of working collaboratively and pooling resources resulted in high quality outcomes in a relatively short period of time.

The benefits of an interprofessional approach are also reflected in the recent establishment of the Practice Education Co-ordinator Network (PECNET). The Practice Education Co-ordinator (PEC) is university-based and has a key role in sourcing and co-ordinating clinical placements. This role is particularly challenging in view of the issues outlined above. Therefore, it is important that the PECs are supported in their role thus strengthening the sustainability of the process. The members of this newly formed network have highlighted the value of sharing experiences and resources, as well as supporting and learning from each other. To this end, the newly formed PECNET group plans to put in place mechanisms to support practice educators to further enhance interprofessional learning e.g., joint workshops to promote best practice nation-wide. In summary, there has been a culture shift whereby interprofessional working is now bedded into the practice education model.

Innovative models of placement provision

There are multiple barriers in relation to meeting placement requirements which are reported in the literature, all of which are relevant in the Irish context e.g., managers and therapists reporting that they do not have time or resources to take students, and student education may not be viewed as core business for health service practitioners. There are also increased pressures in the work-place e.g., more clients with complex needs, changing structures in the health services, economic crisis, new workplace policies, inadequate staffing levels and infrastructure, increasingly part-time workforce, and recruitment freezes (Rose, 2005; McAllister, 2005; Kathard, 2005; Kersner & Parker, 2001; Kersner and Parker, 2004; Parker and Kersner, 2001). Given these ongoing challenges in relation to meeting placement requirements, a third key principle underpinning the development of the practice education model has been the need to develop innovative models of placement.

The group took a leadership role in promoting alternative models of placement to facilitate students to develop their clinical competence. There was a need to enhance the practice educator experience (i.e., the therapist in clinical practice who facilitates the placement) and the student experience in order to improve the quality of placements (Rose, 2005; Kersner & Parker, 2001; Kersner and Parker, 2004; Parker and Kersner, 2001). The universities designed and delivered high quality interprofessional learning events for practice educators which focused on promoting confidence and willingness to provide placements, as well as preparing and supporting practice educators in relation to working with students (e.g., the influential work of Ann Parker, Consultant in Higher and Professional Education, in NUI Galway in the earlier stages). These courses included face to face sessions in universities and the development of the Online Practice Educator course (led by School of Occupational Therapy, Trinity College Dublin). Every effort was made to ensure that these courses were accessible to busy practice educators. A key strength of these courses is that they are transferable to other professions and have been accessed by practice educators in other health and social care professions.

A further aim of these courses was to facilitate practice educators to conceptualise practice education in a different way, viewing students as a valuable resource rather than a chore (Lyons et al., 2009; Henderson,

Heel & Twentyman, 2007). Furthermore, in the literature there have been examples of non-traditional and innovative models of placement. For example, Overton et al. (2009) provide an overview of innovative placement models in occupational therapy. They define non-traditional placements as those which do not involve one-to-one supervision in a typical clinical setting. Examples may include placements in settings where students receive supervision from a professional different from that of the student, role-emerging placements, project placements. Others have written about use of non-traditional sites in speech and language pathology placements (Jones et al., 2011). Some examples of non-traditional placements which have been implemented in Ireland include 2:1 and 4:1 practice educator/tutor to student models, interagency placements, and emerging area placements where the student is supervised on-site by a member of staff from another discipline with professional supervision provided by university staff (see the Report on the Practice Education System, 2011 for further information). These innovative models of placement have not only benefitted students but have also resulted in benefits for patients e.g., reduction in waiting times for patients; some services have maximised the opportunity to provide intensive rehabilitation; and some universities have developed on-site clinics. Student participation has also resulted in the implementation of new initiatives such as conversation partner programmes for people with aphasia and new stuttering clinics (for further information see the Report on the Practice Education System, 2011). There has been a culture change in that practice education has become embedded, to some extent, in practice.

Conclusion

In conclusion, the model of practice education in Ireland is still relatively new and continues to evolve, requiring on-going support and nurturing. In the earlier stages of the development of the model, it had been envisaged that the practice education model would become embedded in practice and that the work of the National Steering Group for Practice Education would become redundant. However, it has become clear that the work of this group has been essential in keeping practice education firmly on the agenda in the health sector, particularly in the context

of ongoing challenges. The key principles which have brought the group this far include: the use of an organisational development approach, interprofessional working, and innovative models of delivering practice placements. The practice placement model has evolved from an individual profession-focused approach to one that is collaborative and interprofessional. Current priorities for the group include exploring untapped placement capacity to off-set potential burn-out from existing practice educators, ensuring that we hold onto what we have in the context of budget cuts, and continuing to promote communication and problem-solving at local and national level. It is important to keep placements firmly on the agenda at local and national level, particularly in the context of competing priorities.

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