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Implementation of a structured programme of preceptorship for Newly Qualified Practitioners (Midwives) in one North West England Maternity Unit --Manuscript Draft--

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Abstract:	This article discusses the application of a structured, approach to the development and implementation of a programme of preceptorship with an evidence based content, to strengthen the experience for Newly Qualified Practitioners (NQP's) and support competence and confidence in clinical practice.
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Implementation of a structured programme of preceptorship for Newly Qualified Practitioners (Midwives) in one North West England Maternity Unit

Abstract

This article discusses the application of a structured, approach to the development and implementation of preceptorship programmes with an evidence based content, to strengthen the experience for Newly Qualified Practitioners (NQP's) and support confidence and competence in clinical practice. The development and implementation of a programme of preceptorship for NQPs in midwifery is explored and recommendations made for current practice.

At a recent conference at the University of Chester (2015) it was stated that Health Education North West England (HENWE) allocates £550 for each NQP to facilitate a programme of support to be implemented at local level. It is therefore timely that all NHS Trusts consider how programmes of preceptorship can be developed and implemented with a clear, robust audit trail to identify how the allocated funding is utilised.

Introduction

During the authors' early nursing and midwifery education and progression in the 1980s, several colleagues suggested they had experienced a range of emotions related to their support and development as newly qualified practitioners (NQPs). Personal experiences also highlighted the value of support and development and ignited a passion to improve the experience of the NQP. The opportunity to re-introduce and further develop a programme of preceptorship in a NW maternity unit came when the author secured a lecturer practitioner position.

A structured, evidence approach was utilised to facilitate the planning and implementation of the programme. The process was relatively uncomplicated due to prior recognition of the benefits of a package of support and education by the senior team on the maternity unit, and close links with academic staff at the University who offered support and advice. The work was supported by the practice development midwife as joint programme lead

Main Text

The definition of preceptorship was explored to support the planning process. The Department of Health (DH) (2010:11) have, since the study was conducted, defined preceptorship as a “period of structured transition for the newly qualified practitioner”. It is also a time when confidence is developed for the NQP to become an autonomous professional and refine skills, values and behaviours and this enables the practitioner to continue on their journey of life-long learning. The DH also states that preceptorship is not a way to meet any shortfall in pre-registration education. However early discussions when planning the programme highlighted that NHS Trust policies relating to both nursing and midwifery student practice may delay development of the NQP with some skills, for example venepuncture, peripheral cannulation and suturing. A review of the pre-registration midwifery curriculum content highlighted further specific skills midwives need to develop to care for women effectively which may not be achieved during midwifery education due to lack of opportunity, for example episiotomy, perineal suturing and fetal scalp electrode attachment. The programme would therefore need to be developed to meet a shortfall in pre- registration education to support future practitioners to bridge the novice - practitioner gap. In 2009 the Nursing and Midwifery Council (NMC) highlighted that this development would be required to achieve competence after initial registration (NMC 2009:19).

Informal discussions were held with relevant stakeholders to identify key elements which should be included in a programme of preceptorship for midwives. This included 6 NQPs who would be commencing on the programme. Current level 6 students who would soon become NQPs also contributed ideas and fears! 4 midwifery clinical managers, 6 potential preceptors, medical staff and the University link lecturer also participated in the planning stage. There were visits to 3 other local maternity units to share ideas. Complaints and critical incidents which had involved NQPs were considered and service needs were also acknowledged.

Several common concerns were raised: for example, how the NQPs would acquire specific knowledge such as caring for a woman with diabetes in labour. Skills acquisition was also a source of some anxiety particularly cannulation, the application of a fetal scalp electrode, episiotomy and perineal suturing. Trust

guidelines were revisited in line with National guidelines, including the National Institute of Clinical Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) Greentop Guidelines. A literature search was also undertaken using CINAHL to inform the development of formal study sessions.

Consideration was also given as to how the NQPs would be supported during preceptorship as the NQPs had expressed concerns as to whether their preceptors would have the time to support them in their development. Observations in the field suggested that for effective learning and development there was a need to ensure the preceptorship programme facilitated a supportive working environment. This was later supported by Hobbs (2011) in a qualitative, ethnographic study into the professional and cultural experiences of newly qualified midwives. The need for a supportive programme was further echoed in a longitudinal study of this programme (Mason and Davies, 2013) and by Feltham (2014). Support for the NQPs was available from the 2 programme leads, Supervisors of Midwives and clinical managers. HE NCEL (2014) states that “group reflection and discussion should be included” in preceptorship programmes. The NQPs were allocated time to attend regular study and meetings which included the opportunity to share experiences. The importance of the peer group in the process of learning was also considered in the development of the programme (Rogers 2010). Supportive groups have since been said to help to buffer the “reality shock” and address emotional issues surrounding the transition from student to qualified status (Ferguson and Day 2007). The group under consideration were small and had just completed a three year programme of midwifery education at the same University, so were comfortable with each other. Large numbers of NQPs undergoing preceptorship may not have this relationship; however they could be allocated to small groups for reflection and discussion to facilitate peer support.

It was recognised that a supportive relationship during preceptorship could be of mutual benefit for the preceptors as well as the NQPs. Kirkham (2007) considers that such relationships can be a sustaining factor in the workplace impacting on retention of staff. Informal support for the preceptors was also available on an ad hoc basis from the programme and clinical leads and also via midwifery supervision. It could be argued that there is a general lack of support and recognition for preceptors in Nursing and Midwifery highlighted by the fact that there is no specific requirement for

additional formal qualification or review of preceptors (NMC, 2007). The HE NCEL (2014) Preceptorship standards now clearly state that their preceptors must undergo training and education that is distinct from mentorship preparation Jones, Warren and Davies (2015, p 22) also suggest that preceptors must have the appropriate skills and knowledge to preceptor in order to “support individuals to flourish” however there is no evidence of this being implemented nationally.

As far back as 1992 it was highlighted that there is a need to develop aims, objectives and content so that students know what is expected of them (Ramsden, 1992). The aim of this preceptorship programme was to consolidate and develop existing and new knowledge, skills and experience to ensure the NQP would be confident and competent to deliver high quality, and woman centred care in all birthing environments. This was stated in the documentation given to the NQPs at the start of the programme. Salkie (2003) highlighted the importance of defining the knowledge and understanding to be developed and this discussion took place at an induction to the programme. The level of learning was also considered as the NQPs had all successfully completed a degree and achieved a level of competence required by the NMC (Steinaker and Bell 1979, Benner 1984). Specific objectives were developed in line with evidence from Trust and National guidelines and the literature search; to enable the NQP’s to evidence progression through the programme. NHS professionals are required to meet specific objectives and it could be argued that they are expected to “mould to the organisations identity by complying with its requirements (Barkley 2011). The programme considered the needs of the organisation and competencies were mapped to link to the Knowledge and Skills Framework as in midwifery progression to band 6 is dependent on completion of preceptorship. Evidence of specific induction and mandatory training requirements were also provided.

The following outcomes were developed to reflect the knowledge and understanding required to achieve the programme outcomes.

At the end of the preceptorship programme you should be able to:

- Utilise woman centred, evidence based care to implement realistic care plans.

- Be able to demonstrate progress in the development of confidence and competence in interpersonal and practice skills which are identified in the programme and additional skills as required.
- Develop proficiency in time management and prioritisation of workload
- Engage in the wider organisation
- Understand and fulfil all aspects of the professional role
- Utilise appropriate mechanisms to cope with stressful circumstances and events at work

The Darzi Report (DH, 2008) stated that “the confidence of midwives to practice competently on qualification will need to be built up during a foundation year.” This programme was designed to be completed over 12 – 18 months to facilitate individual development needs. Some of the NQPs had opted to work part time and it was recognised that they may need a longer programme to achieve the required experience and competencies.

Progression through preceptorship was demonstrated by the submission of a practice portfolio containing simulated and “real” assessment of specified clinical and interpersonal skills. The NQPs were also expected to provide simple reflections which demonstrated development in inter personal skills, specified clinical skills and ward management. In addition their preceptors would submit reflective statements discussing individual strengths and any areas for development. This is a familiar process as reflection is integral to Nursing and Midwifery practice. Documentation was designed in collaboration with all stakeholders to be a succinct and user friendly as possible as there was some apprehension about the perceived overwhelming mountain of documentation which would need to be completed to evidence progress through preceptorship.

NQPs will have different strengths, skills and abilities on initial registration therefore a personalised, rather than standardised programme was planned. The programme was designed to be flexible both in the time NQPs worked and developed in each clinical area and in the teaching strategies utilised to support the achievement of specific competencies. This practice has since been supported by a large qualitative

study “Sink or Swim” (N:62) of newly-qualified midwives’ experiences (Hughes and Fraser 2011). The NCEL (2014) also state that preceptorship should be “tailored” to meet the needs of individuals.

It has been suggested that practice based education and support facilitates the development of decision making expertise more effectively than traditional teaching (Kitson Reynolds 2009). Structured, evidence based study and skills sessions were developed to meet the learning needs highlighted in the initial discussions. The content was reviewed by members of the senior midwifery team. The study sessions were designed to create an environment conducive to learning with knowledge and application of learning theory and learning styles. A variety of teaching strategies were therefore utilised to support various individual needs however planning for teaching in future programmes should also consider the recent Mind the Gap report (Jones, Warren and Davies, 2015, p 22.). This explored the needs of early career nurses and midwives in the workplace in Birmingham and Solihull and highlighted generational differences within healthcare professions, suggesting that this is an essential consideration for future educational programmes. Future programmes will also need to support the development of a high degree of technological literacy in the current workforce (HEE, 2014).

Taught sessions were designed to be short and interactive so that the NQPs could engage with the content and maintain concentration. Topics included issues that were agreed in the discussion stage and relevant to current practice: for example, breaking bad news, clinical decision making and the care of pregnant and labouring women with diabetes. Biggs (2003, p.101) suggests that practically the only advantage of the lecturing format is exposing students to “the most recent developments in the field”. However as clinical practice is constantly reviewed in the light of current evidence it could be argued that there is value in utilising taught sessions. To encourage interaction, scenario discussions were planned with the opportunity for individuals to share experiences with reflection to support the learning. Errington and Church (2005) suggest that learning from experience can improve outcomes in clinical practice. “Linking previous experience with theory and practice against a backdrop of interaction with others” also “fosters an atmosphere that is conducive to deep learning through active learner participation” (Gibbs et al 1990).

HE NCEL (2014) suggests that relevant skills training should be available to meet the needs of individuals. Skills drills and simulation are the accepted format by which health care professionals gain and maintain the skills to manage a range of obstetric emergencies. The potential of this as a mechanism for learning was acknowledged and simulation was utilised to develop specific skills for example cannulation, suturing and episiotomy. This was difficult in the case of developing the confidence to perform an episiotomy as manikins were not available for use in the NHS Trust. The development stage involved a local sports firm, a swimming cap pulled over a small football, inserting fingers between and the cap and the ball and simulating a cutting action. The manager made brief enquiries and then rapidly retreated. It was anticipated that rehearsing and refining skills using theatrical simulation would allay fears by introducing a fun element in a safe environment. The learning developed during pre –registration education would be reinforced thus reducing the gap between practice and theory as highlighted later by Darra (2006). Mapp and Hudson (2005) later suggested that simulation “de humanises” training and puts little focus on the viewpoint of the patient. This issue had been considered in the development of the sessions and simple strategies incorporated. For example during suturing practice the NQPs were asked to discuss the impact of the experience on the woman and her birth partner.

Teaching support was enlisted from the MDT. The obstetricians, anaesthetists and paediatricians were eager to support skills development possibly fuelled by the knowledge that if the NQPs could perform specific skills there would be less calls to the wards and departments for the junior doctors to answer. Elements of the learning would be undertaken with other members of the multi -disciplinary team during mandatory training sessions. As far back as 1998 the Confidential Enquiry, “Why Mothers Die” (Department of Health 1998) reported the need for interprofessional learning to improve multidisciplinary working and outcomes for women and babies. These findings have been echoed in subsequent Confidential Enquiry reports and reinforced in the recent Kirkup report (2015).

Potential organisational constraints were identified during the planning stage. It would be logical for NQPs in midwifery to gain experience in order of the experience of the women, i.e. Ante natal, labour and postnatal care. Placement capacity could not support this. Therefore allocations were organised with regard to service needs

and capacity. There was to be a supernumerary week in each of the clinical areas to facilitate orientation and induction to the area. However it was anticipated that this would not always be possible due to service issues, for example sickness and absence. The participants would consolidate practice for several months in one clinical area but it was anticipated there would be an occasional requirement to cover other wards or departments due to service pressures.

The programme was initially implemented in 2003 and monitored and evaluated at local level as is now recommended in more recent preceptorship guidelines published by Health Education, North, Central and East London (HE NCEL, 2014). These guidelines include recommendations from the Francis report (2013) and build on previously published preceptorship guidance.

Informal evaluations were completed by the NQPs following study sessions and clinical experiences. A longitudinal qualitative evaluation was undertaken commencing June 2009 x 18 months (Mason and Davies, 2013). Three overarching themes were identified as: developing competence and confidence, the value of support and the impact of organizational constraints and requirements. The data and ongoing review of evidence were used to further develop the programme. Overall the NQMs felt they had developed personal coping strategies in addition to acquiring clinical skills and consolidating prior learning. These findings were previously supported by Hobbs and Green (2003) and more recently by Feltham (2014).

Conclusion

The implementation of a structured, approach to the development and implementation of preceptorship programmes with evidence based content requires the support of key stakeholders and robust planning to ensure content and delivery is evidence based. It could be argued that the available qualitative studies do not demonstrate effectiveness in terms of cost, quality of care or making recommendations concerning best practice (Currie and Watts 2012) and there are a lack of robust, formalised systems for development, implementation and audit (DoH 2010). However there is strong qualitative evidence consistently demonstrating the value of preceptorship in terms of support and professional development. HEE (2015) suggest that a review is needed to analyse whether the current purpose and provision of preceptorship is adequate to meet the demands of NQP's therefore

Universities, employers, regulators, professional bodies and commissioners need to collaborate to further develop and embed the existing preceptorship standards. Echoing previous reports (DoH, 2008, 2010) a year-long preceptorship programme for newly qualified registrants which also meets the requirements for revalidation is suggested by HEE. However, as Robinson and Griffiths (2009) suggested, “While we wait for the implementation of a national structured programme of preceptorship for NQPs, delivery of such programmes must remain a local responsibility” and structured, auditable programmes which promote evidence based care are required to assure quality of preceptorship for NQPs.

Recommendations for practice

- Preceptorship is vital and structured local programmes should be developed in line with current recommendations and evidence for practice, using the allocated funding
- Programmes should be personalised and flexible to consider and meet individual needs
- Robust, formalised systems for development, implementation, audit, evaluation and review of such programmes are required

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