



Dr Brenda Rush

Role: Associate Professor in the School of Nursing, Midwifery and Physiotherapy

Teaching Responsibilities: Mental Health Nursing

Personal Profile: Brenda is a programme leader for the Diploma/BSc in Nursing (mental health). She chairs the Pre-registration Mental Health Curricula Advisory Group and the Service User and Carer Advisory Group. Her research interests focus on user and carer involvement in nurse education and she is currently leading the videoconferencing project, which is supported by the Visual Learning Lab.

Bringing learning to life, and life into learning in the School of Nursing

Connecting staff and students in clinical settings over distance

What was the teaching and learning issue that you sought to address?

We were inspired by the Teaching and Learning Observatory (iTLO) developed by Professor Do Coyle and colleagues in the School of Education. We wanted to see if we could implement it in a healthcare clinical practice setting because of our need to help students to link theory to practice.

What did you actually do?

We talked to colleagues from the iTLO project in the School of Education to get some background about the practicalities of the system. I then asked what people here in the Division of Nursing thought about the possibility of student nurses being able to watch live practice in a clinical area. Although there was concern about consent, colleagues could see the potential.

I made contact with Nikki Walsh, a lecturer at the Boston centre, who had connections with a diabetes clinic in Lincolnshire. She knew the specialist diabetes nurse, who helped us get the permissions we needed. I then wrote an information sheet for the patients and together we wrote a letter inviting patients to a group education session to prepare them for taking insulin for the first time.

The idea was for the students to have a lecture on the biological basis of diabetes and then to link

At a glance:

The Interactive Teaching and Learning Observatory (iTLO):

The iTLO connects learners, teachers, student teachers, teacher trainers and researchers in different sites in different countries via videoconferencing facilities for a range of purposes. Its uses range from supporting new student teachers by offering them 'live' observations of lessons (as a means to illustrate and exemplify practice) to collaborative action-research projects jointly led by researchers, teachers and learners.

Initially part-funded by the DfES Training Schools Initiative, the iTLO is a regional, national and international network. It uses and integrates a range of additional interactive technologies to support the development of learning communities.

Videoconferencing

with the clinic via the videoconferencing system. There were immediate and obvious advantages to this. Firstly, not all of our students could get into the small clinic, whereas on the first occasion using the videoconferencing equipment we had four patients, one carer and the diabetes specialist nurse in the clinic, with 16 students in the classroom, all of whom could observe.

During the clinic the nurse showed the patients the 'pens' that are used for injecting insulin. The students had the same equipment in the classroom and were going through the same procedures. They could do it at the same time. At the end, the students could ask questions of the patients, the carer and the nurse. The evaluation was really good. The students felt it was 'a respectful and ethical way of learning with patients', and 'a fantastic real-life experience'. Our School covers 3,000 square miles and includes centres at Boston, Derby, Lincoln, Mansfield and Nottingham. As you can



imagine, being able to link students in these locations with clinical practice settings across the region is an invaluable addition to their learning experience.

What are your future plans?

I have been talking to all sorts of groups in the Division of Nursing. There is a huge amount of enthusiasm and an increased appreciation for the potential uses of the system. I have talked to staff specialising in Learning Disabilities, for example, who are hoping to start a similar system. They have agreed to videoconference client-centred assessments, with the multi-disciplinary team present: client and carer, nurses, physiotherapists, occupational therapists and doctors. This kind of experience would not be possible without the videoconferencing technology.

The potential applications in clinical practice training are immeasurable. Nurses



who teach breastfeeding to students in practice are enthusiastic about it. In Mental Health, colleagues are interested in using the system to demonstrate to students in a classroom how to assess someone. Lecturers on 'Return to Nursing' courses can see the application too. There are many opportunities for using videoconferencing in this way. However, we do need to ensure the technology works: it needs to operate effectively at the remote site, and there are, quite rightly, restrictions in the Health Service on how much access can be given to outside agencies. So there is a lot of exciting work yet to do.

What are the learning and teaching benefits of the system?

I think an important factor is that, in contrast to watching a video, this is not about just observing situations, it is about interacting with them. We are not simply 'gazing' at the patient - it is a two-way encounter. The students can ask questions that they couldn't ask in practice, and the

Videoconferencing

service users can give their perspective on a particular matter that is important to them. In this way the students are learning from the patients' experiences and knowledge.

How do you envisage embedding use of the technology in teaching practice in your School?

It will be possible, but it will take time. People are still getting used to the idea, but there are so many applications in terms of module outcomes. Most modules need a patient perspective, for example, and this is an educationally sound way of providing this. The videoconferencing technology helps to link the theory to the practice. Most sessions in Nursing have a practical element, so this gives them more clinical exposure. The diabetes clinic, for example, is an example of good practice in group education. Not many students would be able to see this first hand, so the videoconferencing session increases capacity, and it also means that the students can ask questions immediately. Everything is live and interactive.

How do you measure the success of it?

What I am most pleased about is how willing patients are to take part in these developments. One of the students at the diabetes clinic asked the patients 'How did you feel about the fact that we were looking in?' Both patients and carers said that 'We forgot you were there'. And the patients are really pleased to answer questions. They say that they feel



“There is a huge amount of enthusiasm and increased appreciation for the potential uses of the system”

they are giving something back to the health service which has been helping them. The fact that the students recognise and

value this 'real-life' access is in itself the best measure of success. Student comments: 'A really good way of learning - will enjoy doing this again - real life'; 'a respectful and ethical way of observed learning'; 'A valuable educational experience of real life', are all proof of the impact this is having on bringing learning to life. I now want to go on to conduct a larger evaluation study to determine the mechanisms that contribute to successful outcomes for a teaching and learning observatory in clinical practice.