12 Tips for Establishing a Hospital Based Student-Led Service

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Abstract

This paper presents 12 tips and recommendations for healthcare facilities and health sciences university academics to support the establishment and sustainability of a student-led service (SLS). SLSs enable students to develop their professional and clinical skills in an authentic clinical environment. Key features that underpin a sustainable SLS include a service based on the principles of evidence-based and quality driven patient-centred care; clearly defined student learning outcomes which can be met in a safe and supportive learning environment; clearly defined, evidence-based patient outcomes; an awareness of ethical considerations to ensure that patients and students are not exploited; clearly defined stakeholder outcomes; and opportunities to partner with university expertise to develop innovative models of care for the future. In the current climate of placement shortages, SLSs offer a sustainable work integrated learning model to meet student placement capacity demands and to support unmet health service provision at various healthcare facilities.

Keywords: student-led services, university-hospital partnerships, health science students, supervision

Introduction

This paper presents 12 tips for planning, implementing, evaluating and sustaining a student-led service (SLS). The recommendations provided are translated from current literature and the authors’ experience with implementing an aged care SLS with a physiotherapy (PT) department at one metropolitan Sydney hospital (Nicole et al., 2015). The term SLS is used to encapsulate all terms used in the literature on this topic.

Student-led services are a viable work integrated learning (WIL) placement model for patient care and clinical placements (Schutte et al., 2015), enabling health science students to build on their clinical skills in an authentic
environment. SLSs enable depth of learning in "narrow clinical areas" (Chen, Sheu, O'Sullivan, ten Cate & Teherani, 2014, p. 143) or subspecialty clinics, suggesting that student learning for this placement model is a process of iteration whereby the student has ongoing opportunities to practice a skill to attain competency. A systematic review by Schutte et al. (2015) concluded that SLSs provided an "optimal context-based" (p. 261) clinical experience and are a suitable clinical education model when they are focused on student learning to meet clear learning outcomes and competencies through the service provided. Students report positive clinical learning experiences which consolidate knowledge, skills and build self-efficacy (Smith, Yoon, Johnson, Natarajan, & Beck, 2014) and for universities, SLSs offer sustainable WIL models to meet student placement capacity demands (Nicole et al., 2015). Within the diversity of SLS contexts, functions, locations and student learning outcomes, optimal SLS models also includes patient-centred care, and support unmet health service provision (Bacon, Williams, Grealish, & Jamieson, 2014; Grealish et al., 2013; Nicole et al., 2015).

For the purposes of this paper the author defines a SLS in the context of a clinical placement that is part of the core clinical practicum for health science students. The service delivered by students (i) is supervised by both discipline and non-discipline specific clinical healthcare professionals (ii) fills an identified service gap in primary health care, whereby the (iii) students become the knowledge brokers for the new model of care delivered for the identified service gap. Hence the service provided by the students is developed, delivered and evaluated by the students with support from university academics.

The 12 Tips presented including the key stakeholder responsibilities listed in Table 1, offer an evidenced-based framework for university-healthcare facility partnerships to establish successful and sustainable SLSs. Tips are discussed under the headings of preparation, student supervision, student orientation and sustainability.

### Preparation

#### Tip 1

**Clarity of roles**

University clinical placement research initiatives underpin the innovative clinical placement frameworks and models now being introduced within many healthcare facilities. Clinical placement models are evidence-based, trialed internationally across disciplines and healthcare facilities, and are supported by government grants and funding. The diverse models are adaptable and flexible to individual site need, ensuring that both service users and students have a positive experience in the healthcare setting.

Table 1 outlines the key responsibilities for the healthcare facility and university. It is recommended that these responsibilities be included in formal placement agreements or contracts.
Tip 2

Map service gaps and purpose of the service

A SLS can be identified by mapping the core workload-workflow experiences of all department staff, including allied health assistants (AHA). The mapping exercise should identify low risk (medically stable), high volume (high referral rates or waiting lists) patient groups that could be seen by health science students with regular, daily oversight supervision by the nursing unit manager (NUM) or similar who could support regular same-discipline professional supervision. The purpose of the service should be clearly identified. For example the service might aim to fill an unmet service gap, reduce a defined waiting list, enhance an existing service, and/or provide an educational service for patients and their family/carers.

While undertaking the mapping exercise, we recommend

- Engaging and collaborating with multidisciplinary staff in the workload-workflow mapping
- Identifying the roles of clinical educators (CEs), oversight supervisors and other support staff
- Identifying the support needs of CEs, oversight supervisors and other support staff

Tip 3

Define your SLS

From the authors’ experience, it is important to define the SLS you will implement, with consideration to the following:
• Frequency/days of service:
  ○ Number of days/week, and/or weekends
  ○ Hours of service: all day, mornings, afternoons or out of hours
  ○ All year round service or for example, a clinic that runs for 2 weeks every 3 months
• Service context:
  ○ Ward, outpatient, community or clinic
  ○ Walk-in or scheduled appointments
• Healthcare disciplines required for service provision: single-discipline v interprofessional SLS (IP-SLS)

Tip 4

Establish strong university-healthcare facility partnerships

Strong university-healthcare facility partnerships build placement capacity and positively support both students and staff (Nicole et al., 2015). Such partnerships involve university academics facilitating CEs, students and support staff on and off-site during placement (refer to Table 1). Although not essential when planning to implement a SLS, academics can support CEs as they move through preparation, implementation and evaluation of a SLS. In addition, academics can offer additional support and/or education.

University-healthcare facility partnerships are strongly recommended if the SLS is expected to be implemented year round, especially to guarantee student allocation quota. The aged care Temporary Stay Unit SLS described in Nicole et al. (2015) operates 48 weeks of the year to address the service gap.

Once arrangements with the university partner are in place, schedule biannual planning days to:

• Present and discuss funding, healthcare model changes or curriculum changes that may impact the SLS
• Review student quotas for sustainable service provision
• Determine evaluation strategies with clearly defined desired evidence-based stakeholder outcomes
• Showcase SLS achievements, milestones and research opportunities

Tip 5

Choose appropriate patient types for ward-based and outpatient clinic SLSs

Once the patient group is determined, choose the SLS context and the students required (discipline and cohort). IP-SLS are recommended whenever clinical placement periods align across disciplines. Create a safe IP learning (IPL) environment, inviting university academics to facilitate with educational opportunities, peer learning, team teaching, mentoring and resources (Dowling, 2001; Guenther, Shadbolt, Roberts, & Clark, 2014; Nisbet, Lincoln & Dunn, 2013, Nisbet, et al., 2015). Outlined below are recommendations for establishing SLSs in the acute, sub-acute/rehabilitation and outpatient or hospital-based community settings.

Acute ward-based SLS

Examples for acute ward settings could include respiratory, general surgery or orthopaedic wards. Due to patient acuity, these patients are frequently high risk, requiring 1:1 student supervision, particularly for medical, nursing, PT
and speech pathology (SP) students. A SLS could be established in these settings by allocating 'student-led beds' within such wards (Meek, Morphet, Hood, Leech, & Sandry, 2013), where patient selection is based on agreed criteria appropriate for students to manage in a SLS context and address learning outcomes.

**Sub-acute or rehabilitation based SLS**

Low risk/high volume aged care and chronic disease patient groups commonly sit in this patient group where student-led beds or wards could be established. Dependent on client need, supervisor needs may be moderate to high for occupational therapy (OT) students, and low to moderate for medical, nursing, PT and SP students.

**Outpatient or Community SLS**

Outpatient SLSs are typically free or offer a reduced fee. Low risk/high volume patient groups are ideal for post-discharge clinics, chronic care, speech and communication, exercise and education groups. Outpatient SLSs are contingent upon self-sustaining and reliable referral systems to maintain year-round service provision. This can be achieved, in part, by having students generate referrals from the ward setting, networking with general practitioners and community health services. Review available patient transport services to enable patients to attend the SLS.

**Tip 6**

**Determine student numbers**

Consider having students work in pairs and implement peer learning tasks to facilitate learning. In parallel, identify the clinical context including (i) number of patient beds or clinic list numbers, and (ii) number of healthcare professionals (HCP) and AHAs usually required. Review available student resources such as lockers, amenities, tutorial rooms, IT/internet provisions and library access. Following this, inform the university partner of student numbers and possible changes to adapt to workflow demands during the year.

**Student Supervision**

**Tip 7**

**Get the supervision mix right**

Choosing a suitable supervision model is dependent upon a matrix of (i) patient acuity or risk; (ii) student skills and competency; (iii) ward/clinic staff mix and supervision experience; and (iv) discipline specific requirements for supervision and competency. Seek advice and clarification from university partners on (ii) and (iv), especially before establishing an IP-SLS. The student orientation period is an ideal time for CEs to assess students’ capacity to work with minimal supervision, detect where support is required and notify the oversight supervisor. Scheduled intervals of 1:1 CE-student supervision are recommended to monitor and assess learning outcomes, competencies and to extend the more advanced student.

Single-discipline low risk SLSs operate effectively with a mix of (i) CEs who may service another clinical area, but avail themselves for students by phone/pager; (ii) an oversight supervisor (ward/clinic NUM), and (iii) a HCP within the SLS (for example, medical, OT) offering IPL opportunities. Key to supervision is integrating students within the
whole SLS healthcare team.

For an IP-SLS, share the oversight supervision role across the HCP team. Implement team teaching to increase student learning opportunities either directly via patient care, or indirectly via case-based tutorials and ward team meetings. Establish SLS expectations with students regarding teamwork, communication, reporting, handovers and referrals, to build professional rapport and respect for each HCP role (Nisbet et al., 2015). Engage with the university partner to facilitate an IPL-SLS.

**Tip 8**

**For the SLS Appoint an ‘oversight supervisor’**

Kennedy and colleagues (2007) define supervision as the intensity of supervisor involvement required for safe patient care. The authors distinguish two main oversight functions: (i) ‘routine’, where the oversight supervisor provides general support for activities that students are deemed safe and competent to complete with minimal supervision; and (ii) ‘responsive’, where the oversight supervisor would immediately notify the CE regarding the students’ performance concerns.

The oversight supervisor(s) facilitate and monitor generic student clinical skills such as handovers, referrals, manual handling, patient safety, communication, professional attributes and teamwork skills. They would be aware of the key duties, roles, patient assessment parameters and discharge goals for the students’ discipline.

Key recommendations for the on-ward oversight supervisor role are:

- Clearly defined role responsibilities, reporting channels and student learning outcomes
- Effective open communication with the students’ CEs to ensure patients are receiving quality care in an ethical, professional and safe manner
- Ensuring that students experience supported learning
- Ensuring that staff are not out of their depth with the oversight supervisory role.

**Tip 9**

**Identify supervision alternatives**

There are variable levels of supervision requirements for health science students across disciplines, facilities, states and countries. Moving from traditional 1:1 supervision, innovative SLSs successfully implement 4:1 and 6:1 student to supervisor ratios (Nicole et al., 2015). For the majority of SLSs, the discipline specific supervisor will be on-site and available by pager/phone. However, Nagarajan et al., (2015) comprehensively describe how tele-supervision and tele-support via Skype has been implemented in Australia and Canada to support and supervise health students remotely.

Direct supervision alternatives such as informal team teaching or IPL activities are recommended, as they offer opportunities where, for example, the PT student shadows another AHP such as the OT or SP to consolidate their knowledge of HCP roles and referral systems. This opens opportunities for students to manage patients interprofessionally with other healthcare students, enhancing the clinical learning experience.
Student Orientation

Tip 10

Develop a student orientation procedure

A successful SLS offers a welcoming, comprehensive and supportive orientation program (Robinson et al., 2008). Student orientation should reflect a new staff orientation procedure, including a package that:

- Introduces students to all CEs, oversight supervisors, and supporting HCPs in the SLS and their roles in relation to supervision. Include their pager/contact numbers
- Work Health and Safety training, patient safety and risk management procedures
- IT/eMR access and training
- SLS environment and resources (equipment, amenities, site map)
- Patient services, referral options and specialty information
- Placement schedule outlining time allocated to direct patient care, learning activities, tutorials, case presentations, IPL and simulation opportunities.
- Involve former students in the orientation to enhance student service ownership and reduce the resource gathering workload of CEs (Stuhlmiller & Tolchard, 2015).
- Collaborate with academics to prepare pre-placement resources such as student manuals, worksheets, case studies and patient screening/assessment guidelines.

Tip 11

Ensure patient safety, risk management and ethical obligations are met

SLS student activities can be structured and supervised to reduce risks to patients. A four year retrospective Australian study (Gaida, Maloney, Lo, & Morgan, 2015) reported that incidents involving PT students during placement usually occurred at 1100hrs or 1500hrs. Orientation procedures including placement schedules (Tip 10) function to minimise risks to patients and students.

University-healthcare facility partnerships share the responsibility of ensuring that both patient and student needs are not exploited and safety is maintained. CEs and oversight supervisors should inform patients that students will provide their care and gain patient consent. Patients should be offered the choice to be seen by registered HCPs (Buchanan & Witlen, 2006). Reciprocally, students require suitable learning opportunities and working conditions.

Recommendations to minimise risk include:

- Ensure CE is available for high risk patient activities
- Plan for indirect patient activities during high risk periods
- Provide students with safe opportunities to learn from errors and develop strategies to reduce risk.
- Implement robust quality improvement (QI) initiatives with outcome measures centered on patient safety
- Monitor students during orientation for unsafe student behaviours (Killam, Luhanga, & Bakker, 2011).
Sustainability

**Tip 12**

**Ensure quality, research opportunities and sustainability**

QI is now well integrated within medical student-run free clinics and provides a valuable learning opportunity for students (Butala, Chang, Horwitz, Bartlett, & Ellis, 2013; Ryskina, Meah, & Thomas, 2009). Structured stakeholder QI and evaluation processes are essential for SLS sustainability.

QI outcomes can be investigated further through more formal research, informing future SLS model delivery or sustainability, student learning outcomes, patient outcomes, capacity development and productivity. Once a SLS is established, it could offer a viable research platform for randomized controlled clinical trials to drive new models of care for future healthcare delivery. Additional recommendations include:

- Review healthcare facility accreditation guidelines and match SLSs with QI projects to support initiatives.
- Involve university partners to mentor and/or supervise CEs through research opportunities (Scott, Caldwell, & Schuwirth, 2015).
- Schedule regular meetings to ‘debrief-evaluate-review’ the SLS with all stakeholders.

Finally, along with QI and research, sustainability is dependent upon an ongoing commitment between the hospital and university. University-healthcare facility agreements or contracts are strongly recommended to clearly define roles, responsibilities, objectives, outcomes, timeframes, deliverables and evaluation processes required by all stakeholders for the SLS.

**Conclusion**

SLSs offer a rich clinical learning experience for healthcare students. The 12 tips presented in this paper outline recommendations for university-healthcare facility partnerships to establish, evaluate and sustain SLS to meet patient service provision needs, student placement requirements and to provide an authentic clinical learning environment to meet student learning outcomes and competency. A focus on patient-centered care, a supportive student learning environment and clearly defined evidence-based stakeholder outcomes enable a successful SLS framework.

**Take Home Messages**

**12 Tips for establishing sustainable mutually enhancing SLS**
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**Appendices**

**Declaration of Interest**

*The author has declared that there are no conflicts of interest.*