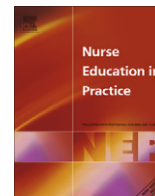




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## Supporting disabled students in practice: A tripartite approach

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### SUMMARY

Universities are required to make reasonable adjustments for disabled students. For providers of professional courses, in this case pre-registration nursing, this requirement is perceived to pose significant challenges. In part this is due to the nature of the course, where practice learning is a central component and therefore clinical hands-on experience of the care of patients/clients is an absolute requirement. Concerns around the ability of disabled students' to meet the programme requirements have been expressed.

This article describes the co-development of a **six-phase** tripartite model that provides a supportive framework for disabled student nurses in the practice environment. A brief overview of the literature will be given and a single case study will be used to demonstrate the model in action. The development of broad partnership working between the Practice Learning Team, The Disability Service and the Student Placement Facilitator, taking a student centric approach, is outlined. Finally, the process by which a critical knowledge base, on which decisions around reasonable adjustment can be made is discussed.

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### Introduction

The number of students with disabilities entering Higher Education, nationally and internationally, is increasing year-on-year (Higher Education Statistics Agency (HESA), 2009) (Fleming, 2005; Ashcroft et al., 2008), with 6.8% of undergraduate students having disclosed a disability (HESA, 2009). It is not surprising, therefore, that there are a number of healthcare students with a range of disabilities accepted onto professional higher educational programmes (Ijiri and Kudzma, 2000; Konur, 2002; Wright and Eathorne, 2003). Within our **faculty**, the disabled student ratio is much higher with 1 in 10 having some form of disability (Buckinghamshire New University, 2007). This poses unique and sometimes complex challenges for the faculty and our practice partners. However, under the Disability Discrimination Act (DDA) (Her Majesty's Stationary Office (HMSO), 1995; HMSO, 2005), the University is required to make reasonable adjustments to meet the needs of disabled students and in such a way that is non-discriminatory (Scullion et al., 2002).

This article outlines a co-developed **six-phase** tripartite model of working and describes how collaborative partnerships between the **practice team**, the **disability service** and practice partners ensured parity between support strategies available within the university and in practice. The model deals with placement modification through an on-going, dynamic step-by-step process that evolves as the student moves into different practice settings. Such an approach allows practice partners to create an enabling environment for disabled students.

### Contextual background

The Faculty of Society and Health at Buckinghamshire New University provides **pre-** and **post-registration** nursing, diploma and degree, and social work programmes for NHS London in North West London. Our annual intake of pre-registration student nurses, for the Adult, Mental Health and Child Health branch, is 420, with two intakes per academic year; September and February. The practice placement circuit is comprised of five NHS Trusts, three NHS Primary Care Trusts and a large number of independent and private sector placements across North West London and South Buckinghamshire. The pre-registration team consists of 27 lecturers with a designated Practice Learning Team, a Portfolio Leader for Practice Learning and a Lead for Practice Learning. A **well-established** link lecturer network exists to support practice areas. The pre-registration team **is** supported by a further 47 **post-registration** lecturers who provide specialist input and support for pre-registration students in practice.

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Over the last 2 years, members of the Pre-registration Team have noted an increase in the number and complexity of declared disabilities (Buckinghamshire New University, 2007). Within the DDA (HMSO, 1995, p. 2), disability is defined as ‘a physical or mental impairment which has a substantial and long-term adverse effect on a person’s ability to carry out normal day-to-day activities’. This definition is strikingly broad and illustrates how easily these disabilities might be present in our study or working environment, albeit hidden. The most common types of disability encountered within our student population are dyslexia, dyspraxia, dyscalculia, anxiety, physical impairments, hearing deficits, progressive and long-term medical conditions and mental health concerns. This growing awareness of the needs of disabled students, particularly in practice, prompted the practice team to explore the available evidence in order to inform the development of a supportive model based on the principles of enablement and partnership working.

Literature review

Much of the literature explores the impact of the various Disability Discrimination Acts on nurse education programmes in the United States, Australia, Canada and the UK (Magilvy and Mitchell, 1995; Konur, 2002; Selekman, 2002; Ryan and Struhs, 2004; Sanderson-Mann and McCandless, 2006; Ashcroft et al., 2008). Strategies to support students, particularly from an academic stance tend to concentrate on learning disabilities, such as dyslexia (Selekman, 2002; Roberts and Mitchell, 2005; Sanderson-Mann and McCandless, 2006; White, 2007). Furthermore, there is limited literature detailing strategies for specific types of disabilities, such as attention hyperactivity disorder (Bradshaw and Salzer, 2003) and visual impairment (Atkinson and Hutchinson, 2005).

The lack of empirical data, particularly in terms of the challenges the disabled students face in practice (Wright, 2000), has led to anecdotal rhetoric as to their suitability to fulfil clinical roles (Wiles, 2001; Watkinson, 2002). However, there is no evidence to substantiate this claim (Sowers and Smith, 2002). The Disability Rights Commission (DRC) in their recent report, Maintaining Standards: Promoting Equality (DRC, 2007) has presented universities, the Nursing & Midwifery Council (NMC) and the National Health Service (NHS) with challenging research findings. The report illustrates the difficulties faced by disabled students seeking to train or work as an NHS professional. Furthermore, the DRC (2007) argues that the healthcare environment is one where individuals are reluctant to disclose a disability. In that they may choose to conceal their disability as there is a discriminatory culture within healthcare upholds the notion that disabled practitioners represent a danger to patient safety (Maheady, 2003; Morris and Turnbull,

- The aims of the model are to:
1. Extend support provided for disabled students to encompass practice.
  2. Design a tripartite proactive working arrangement between the university, practice partners and students.
  3. Establish a working policy for practice that incorporates the identification of appropriate support for disabled students.
  4. Develop a valid and reliable system to plan, implement and evaluate practice support provided for disabled students.

Fig. 2. Aims of the tripartite model of working.

2006). However, the DRC (2007) argue that many of the assumptions and stereotypes that appear to exist in the NHS and the nursing profession about disabled individuals being potentially unsafe in practice are unjustified in reality.

The lack of reliable and relevant evidence to inform policy and practice has meant that universities, disability services and practice partners, are working without clear direction. There is a paucity of data on which to make critical decisions as to the level and type of support required for disabled students in practice. Ultimately the decision as to whether a student is fit to practice has to rest on whether they are able to provide safe, competent, effective and independent practice at the point of registration (NMC, 2004). The dichotomy between regulatory requirements and disability legislation results in practice partners and universities struggling to reconcile the demands of both (Manthorpe and Stanley, 1999; Crawshaw, 2002). However, the Special Educational Needs and Disability Act (SENDA) HMSO, 2001) part IV places a duty upon universities to work in partnership with practice partners to ensure a student centric approach is adopted to lead to a positive practice learning experience (Konur, 2002).

The six-phase tripartite model

To foster a holistic, student-centric approach to supporting disabled students in practice, a six-phase tripartite model of working was developed. The model relies on the engagement of three key groups: the Practice Team, comprising the Portfolio Leader for Practice Learning; the Lead for Practice Learning; and the Disability Service and a representative from the host trust (in this case the Student Placement Facilitator (SPF)). Students have a responsibility to work alongside the University, the Disability Service and the SPF, to ensure the reasonable adjustments continue to meet their needs. The model enables the Practice Team to work in partnership with a broader range of people to gather and collate relevant information, undertake consultation on behalf of and in collaboration

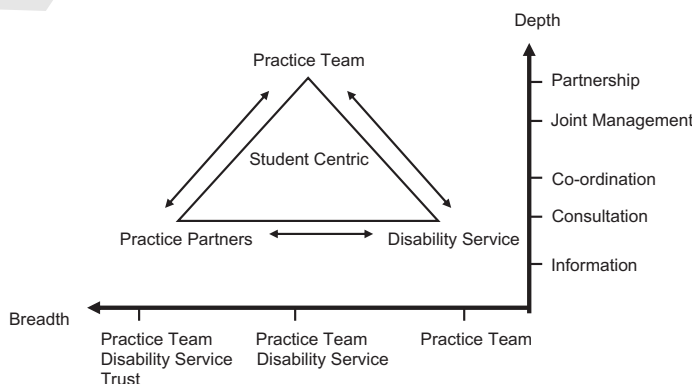


Fig. 1. The tripartite model of working.

158 with the student, co-ordinate reasonable adjustment requirements  
159 within the practice environment and jointly manage the students  
160 practice experience (Fig. 1).

161 The model was co-designed with specific aims (Fig. 2) and to  
162 ensure that appropriate support is provided before, during and  
163 after the clinical placement (~~The Quality Assurance Agency~~  
164 ~~(QAA), 1999~~). It is based on the integration of services that are re-  
165 viewed and modified at all stages of the students programme  
166 (Fig. 3). The underlying principle is that support is comparable  
167 and seamless to that provided whilst in an academic setting as it  
168 was acknowledged that reasonable adjustments made in practice  
169 are often not aligned to that provided by the university (Stanley  
170 et al., 2007). An important component in ensuring that the Practice

171 Team and Disability Service had similar perspectives around the  
172 context of practice involved acquainting the Disability Service  
173 advisors with the world of nursing. It was agreed that to do this  
174 the Disability Service advisors would spend a day in different prac-  
175 tice settings. This allowed the advisors to gain first hand experi-  
176 ence of the complexity and challenges such environments pose,  
177 which in turn informed future discussions around suitable place-  
178 ments and reasonable adjustments.

### Case study – the model in-action

179 In order to describe the concepts and processes of the model, a  
180 single case example is used. Guidance as to whether ethical  
181

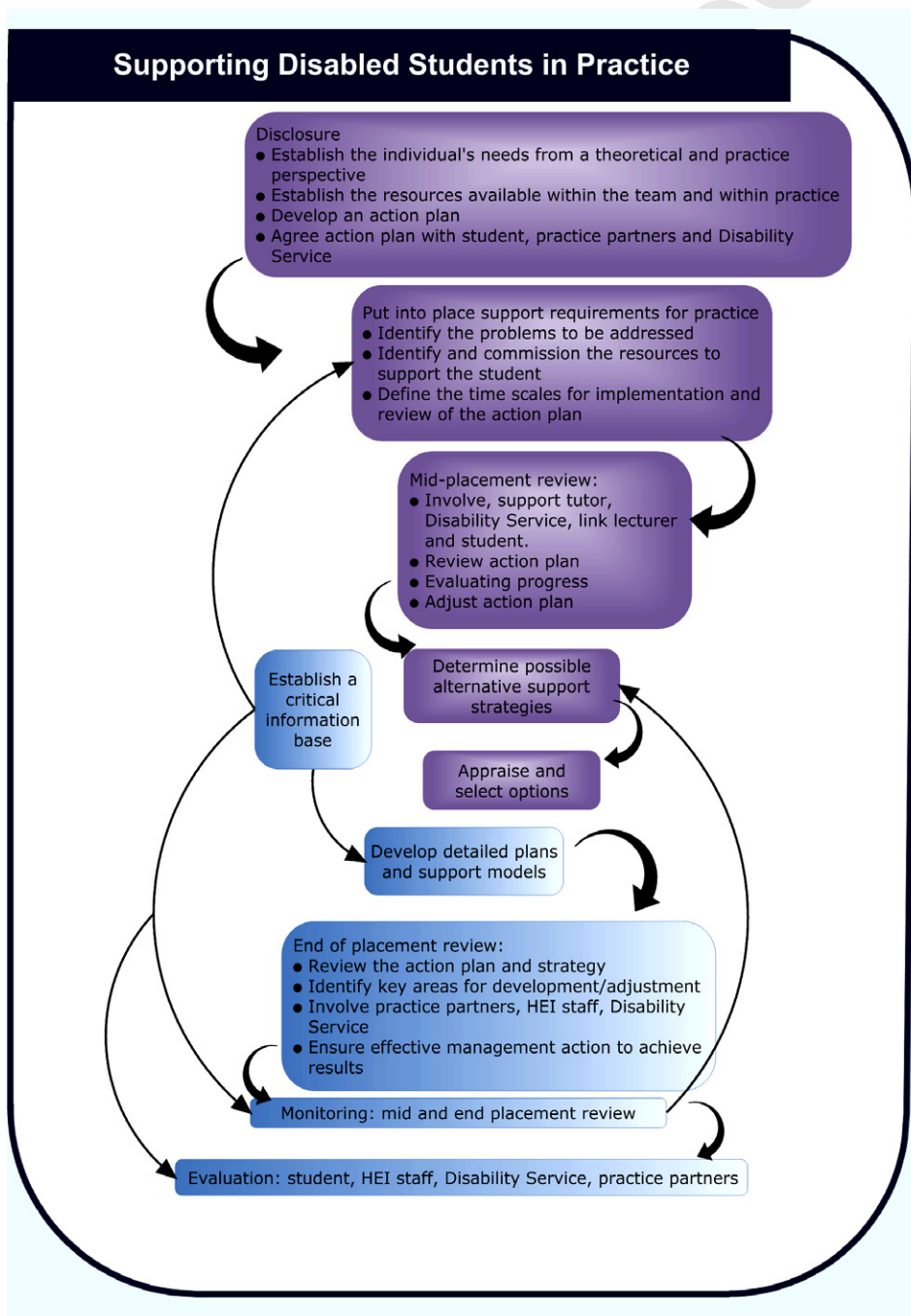


Fig. 3. The tripartite model.

1. Disclosure: identifying and assessing need(s)
2. Establishing support systems and processes in practice
3. Mid-placement review; determine alternative strategies
4. Development of detailed plans and models of support; establish critical information base
5. End of placement review; evaluation
6. Revise support strategy

Fig. 4. The tripartite model at a glance.

1. Provision of coloured paper
2. Provision of coloured overlays
3. Additional skills training
4. Additional support in practice
5. Provision of modified or specific equipment
6. Provision of a quiet room to write up notes
7. Flexible working
8. Provision of frequent breaks
9. Provision of counselling

Fig. 5. Examples of reasonable adjustments.

approval was required was sought from the University Ethics Committee, who advised that consent from the student was sufficient. Consent was gained from the student and her name and some aspects of her disability changed to ensure anonymity and confidentiality (NMC, 2008). Although the model is designed to be applied in an individualistic way, there are key phases within the framework that are applicable to all disabled students (Fig. 4). Using Helen's student pathway, the six-phase tripartite model will be illustrated.

Helen, a 20-year-old disabled student nurse, provides an ideal example to illustrate the key phases of the model in an applied way. Helen attended a university open day and declared her physical disability, Myalgic Encephalopathy (ME). Helen requested advice as to her suitability to pursue a nursing career. During further discussion with the Practice Learning Lead, Helen highlighted that some days were better than others, with bad days resulting in debilitating fatigue, problems with concentration, pain without swelling in small and large joints and headaches. Such days made it difficult for her to perform daily activities.

Phase 1: disclosure, identifying and assessing need/s

The University encourages an atmosphere of open disclosure at all stages of the students' journey. Following disclosure at the University open day, a physical assessment of Helen's disability, in terms of her fitness to practice, was arranged. Key to the assessment was whether Helen was able to engage in the core activities of nursing. Helen was invited to attend a nursing skills session at the University in order to undertake a task analysis. This would enable early identification of potential areas that would require reasonable adjustment in practice.

The task analysis included bed making, cardio-pulmonary resuscitation and injection technique. Helen was able to perform the skills without any problems and the assessor was confident that Helen had the appropriate dexterity and strength to perform nursing skills. To complete the assessment Helen was referred to the Occupational Health Department and the Disability Service for further advice and assessment. Following the assessment process Helen was offered an unconditional place on the programme which she accepted.

Phase 2: establish support systems and processes in practice

The emphasis of this phase is dependant on the student's disability, their specific needs and willingness to engage as an active participant. Key to the initial stages was that a balanced and educative communication of Helen's specific needs was shared confidentially with key individuals involved in her future education and development. A routine, sensitive and private approach was made to Helen by the Disability Service Advisor to determine whether she wanted support during the programme. Following that initial discussion, the Disability Service initiated a meeting with the Practice Team to discuss Helen's placement needs. The SPF from the host trust was invited to engage in this discussion. This allowed for open discussions around reasonable adjustments in practice to start well in advance of Helen's practice placement.

The Practice Team, Disability Service and SPF adopted an approach that considered Helen's practical needs balanced against the statutory practice requirements of the programme. This ensured that Helen was able to gain a breadth of nursing experience whilst being sensitive to understanding her particular needs. Within the faculty, placements for disabled students are given priority during the planning phase, this enabled obstacles, such as transport and distance, to be removed from the overall decision-making process. A stable learning environment was selected in negotiation with the SPF, where Helen would be supported to develop coping strategies that would enable her to gain confidence in her clinical practice. This allowed Helen to capitalise on her strengths.

Reasonable adjustments in practice were considered. Examples are provided at Fig. 5. Minimal guidance as to what constitutes a reasonable adjustment is given, noting that the overriding concern is that the adjustment(s) should support a student to provide safe and effective practice. However, in practice the decisions are more common sense and practical than might be anticipated. In Helen's case, the following reasonable adjustments were made: regular breaks were to be taken and Helen was advised not to work long days or more than three shifts in a row.

Finally, to ensure appropriate support was provided by her mentor, Helen declared her disability with the support of the Practice Team. Therefore, the relevant link lecturer and mentor for each of her clinical placements were made aware of Helen's disability and the reasonable adjustments required. The mentor received appropriate preparation, including an advice sheet prepared by the Disability Service, and support to enable Helen to fully engage with the learning environment.

Phase 3: mid-placement review; determine alternative strategies

The mid-placement review involved the Practice Team, Disability Service and the SPF. A review of Helen's progress against the action plan was undertaken. Helen's mid-placement review was very positive and her overall progress encouraging. A review of the reasonable adjustments agreed at the beginning of the placement indicated that Helen could gradually introduce greater flexibility into her work patterns. In this particular case, no additional reasonable adjustments were needed.

Phase 4: development of detailed plans and models of support; establish critical information base

The aim of this phase is to develop a body of critical information based on the group's experiential learning of utilising an array of participatory support models for disabled students in practice. To do this, a student pathway analysis is undertaken by the group, which follows the student journey from pre-enrolment through to graduation. This enables analysis of key points in the student journey that leads to the formulation of detailed action plans and processes that could be developed and applied to different student situations. This exercise enables the formulation of evolving models of practice to aid critical judgements that can be made around reasonable adjustments.

285 Phase 5: end of placement review; evaluation

286 The end review was undertaken by the group and designed to  
287 ensure effective management of the support framework in terms  
288 of achieving optimum student support in practice. Helen's path-  
289 way was discussed and analysed to identify which aspects of the  
290 support worked well and those which did not.

291 Helen's end of placement review was very positive, with favour-  
292 able comments on her performance, progress and professional atti-  
293 tude offered by her mentor and link lecturer. Helen was asked to  
294 evaluate the support provided for them. She found her practice less  
295 arduous than anticipated and was confident that she could com-  
296 plete the programme as long as she continued to work on those  
297 coping strategies that had been developed for and by her.

298 Phase 6: review support strategy

299 Evaluation of the enabling model allowed for critical discussion  
300 between all members of the group and ensured that the support  
301 provided for Helen was sufficiently flexible to continue to meet  
302 her changing needs during the programme. The support strategy  
303 was reviewed by the group and Helen was invited to participate.  
304 As she progressed through the programme small alterations were  
305 made to the working time arrangements, with Helen taking an ac-  
306 tive stance in this process as her confidence and coping strategies  
307 developed. She therefore became proactive in the practice setting  
308 and less dependant on external means for support.

309 Supporting change: moving forward

310 The modern healthcare arena means that nurses are working  
311 under the stress of continuous service change, with the focus  
312 being on the achievement of targets and managing, with often  
313 less than optimal staff resources, to deliver complex patient care  
314 and treatment regimes. Against this backdrop mentoring dis-  
315 abled students may be seen as yet another initiative that must  
316 be incorporated into their busy schedule. There may be a great  
317 deal of resistance to this, resulting in negative attitudes being  
318 voiced by staff, "why should someone do nursing if they have poor  
319 memory recall or have difficulty reading and need more time to  
320 understand instructions?", with the overall perception being that  
321 the student is backward, lazy or slow (Riddick, 2000). There is  
322 a risk that disabled students who disclose a disability will be-  
323 come stigmatised, causing them to become isolated and to lose  
324 confidence. Anecdotal evidence suggests that practice staff have  
325 limited awareness of specific learning needs of disabled students  
326 and the workplace adjustments required to support them in  
327 practice.

328 It is argued that a combination of information, education and  
329 supported contact with a disabled person can result in positive  
330 attitudes towards disability (Happell, 2000; Chan and Cheng,  
331 2001). In order to raise disability awareness within the University,  
332 a number of mediums have been used (Fig. 6) and the mentorship  
333 preparation and update programmes have been developed to  
334 incorporate information around supporting disabled students. A  
335 scenario-based approach is taken which allows mentors to discuss  
336 their concerns and the issues around supporting disabled students  
337 in practice. This forum allows exploration and discussion around

1. Annual mentor upd-ate
2. University led disability awareness workshops
3. Mentor Matters magazine
4. Disability information for mentors on virtual learning environment
5. Specific advice sheets from the University Disability Service

Fig. 6. Disability awareness activities.

the requirements of special educational needs, the DDA and how  
it applies in practice.

A positive cultural change in terms of attitudes towards dis-  
abled students in practice will be a gradual process and is more  
likely to happen when there are positive case studies that illustrate  
their ability to function as an effective and valued member of the  
team. It is important that mentors recognise that a disability  
should not be used as a label to define the person. Having an iden-  
tified disability should be treated no differently to any other chal-  
lenge within the workplace. The student is likely to have strengths  
in other areas of practice and therefore has much to contribute to  
the team. In addition, mentors need to feel that they are not shoul-  
dering the perceived burden; they need to be supported effectively  
by both university and practice staff. Effective mentoring in prac-  
tice is central to the success of this model.

The team acknowledge that a student's decision to disclose  
their disability is complex, and often results in a trade off between  
the perceived risks and benefits (Mental Health Foundation, 2002;  
Goode, 2007). However, unlike students undertaking a conven-  
tional Higher Education programme, pre-registration nursing stu-  
dents will have to disclose to multiple placements in a range of  
settings (Sapey et al., 2004; Furness and Gilligan, 2004; Morris  
and Turnbull, 2007). Thus, disclosure for these students is not seen  
as a finite event, but as a series of decisions and steps that have to  
be taken throughout the programme, each of which has to be man-  
aged (Stanley et al., 2007). The recurring nature of disclosure can  
be a significant challenge for disabled students.

In the last 2 years, we have witnessed a positive shift in the  
climate and atmosphere surrounding disclosure; key to this is  
the move to a positive organisational culture towards disabilities  
(Stanley et al., 2007). Many factors have influenced this change.  
In particular, the collaborative approach by the Practice Team,  
the Disability Service and the SPF has had a significant impact  
on practice support for disabled students. Primarily, this came  
out of the understanding that neither party can see the complete  
picture in isolation. To fully support the student, a collective ap-  
proach was required; this led to earlier awareness and action.  
For example, the Faculty has adopted early identification meth-  
ods, such as questionnaires that screen for dyslexia. Personal tu-  
tors are encouraged to proactively observe for, discuss and  
evaluate the likely presence of disabilities and refer students  
for assessment faster than might otherwise occur. The intention  
is to identify a student with additional needs as early as possi-  
ble, to discuss their wishes and to facilitate an assessment that  
identifies the type of support required from an academic and  
practice perspective.

Another key factor is the on-going education of faculty staff; to  
ensure we are able to improve the education provision for disabled  
students. Disability awareness training is provided by the univer-  
sity and all staff are actively encouraged to attend the training.  
Such training includes legal and professional requirements, univer-  
sity policies, systems and processes to identify, accommodate and  
evaluate reasonable adjustments and learning strategies to support  
students in the academic and practice setting.

Conclusion

A process of reflective learning through the use of student path-  
way analysis has enabled the group to continue to co-develop the  
framework. It is vital that the adjustment is tailored to the stu-  
dent's needs, rather than adopting a one model fits all approach,  
or making an assumption that a diagnosis will present in the same  
way (Stanley et al., 2007). A participatory approach was adopted in  
the case study as Helen was in the best position to describe and  
anticipate the type of support she required. There is rarely a right  
answer to a complex situation. However, if a systematic model is

followed, a professional and structured approach can be taken and a course of action selected based on best evidence.

In order that a prepared and planned approach to practice can be achieved, a proactive and anticipatory stance should be taken to support disabled students in practice. The over-arching tenet is that disabled students are enabled, as far as possible, to achieve their full potential in the practice setting, through a collaborate partnership. It is axiomatic that the principles of co-construction, development and evaluation through reflexive discourse are used to ensure that the tripartite model of working remains dynamic and responsive to the changing demands of the student and practice.

Disabled students must work positively alongside university and practice staff to ensure the support framework addresses their needs appropriately. Specific preparation of mentors and link lecturers prior to the disabled student entering the clinical environment is vital. On-going disability awareness training and education for university and practice staff is also key to bringing about a positive change in culture. Opportunities for shared learning with other universities and healthcare providers, on a national and international basis, to enable the dissemination of good practice to inform the development of robust supportive models will greatly benefit disabled students.

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