The Collaborative Learning Units © Model of Practice Education for Nursing: A Summary

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*** These Schools of Nursing are all part of the Collaboration for Academic Education in Nursing (CAEN)**

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The Collaborative Learning Unit Model (British Columbia)

The Collaborative Learning Unit (CLU) model of practice education for nursing is a clinical education alternative to Preceptorship. In the CLU model, students practice and learn on a nursing unit, each following an individual set rotation and choosing their learning assignment (and therefore the Registered Nurse with whom they partner), according to their learning plans. Unlike the traditional one-to-one preceptorship-, an emphasis is placed on student responsibility for self-guiding, and for communicating their learning plan with faculty and clinical nurses (e.g., the approaches to learning and the responsibility they are seeking to assume). All nursing staff members on the Collaborative Learning Unit are involved in this model and, therefore, not only do the students gain a wide variety of knowledge but the unit also has the ability to provide practice experiences for a larger number of students.

Specifically, a Collaborative Learning Unit is a nursing unit where all members of the staff, together with students and faculty, work together to create a positive learning environment and provide high quality nursing care. Clinical nurses preparing to adopt the CLU model have described a positive learning environment as one where questions are expected. Students recognize a positive learning environment when they perceive their questions are welcomed, and when they receive thoughtful responses at mutually selected times for students and staff. For faculty (e.g., academic instructors), key questions focus on determining what nursing knowledge is needed to provide high quality nursing care. Thus, in a CLU, where critical questioning is promoted, students can systematically learn to “think like a nurse” and can demonstrate what they know and can do, as undergraduate nurses who are members of a health care team.

While staff and faculty work together to support and advance student learning and promote high quality nursing care, the CLU model enables a level of student independence that helps them move into the work-world. As well, the CLU concept bridges a perceived gap between academic and clinical expectations. In this model, nursing faculty, clinical nurses and students work collaboratively to enhance learning opportunities as well as develop the professional knowledge base of nursing.

The intention behind this summary is to describe the origins and purposes of the CLU, as well as to outline key structures and approaches associated with the origination of the model on Vancouver Island between 2002 and 2005. The material in this summary is based on experiences of University of Victoria, North Island College, and Malaspina University College Schools of Nursing in partnership with Vancouver Island Health Authority. We acknowledge the other sites where CLU has been trialed (i.e., University of Victoria Lower Mainland Campus/ Fraser Health Authority and Selkirk College/Interior Health Authority). We anticipate that this report can provide information about the model as it was conceptualized, as well as help focus future evaluation research across sites where CLUs have been implemented.

Background

In 2001, nurse leaders Dr. Mary Ellen Purkis (Director, University of Victoria School of Nursing) and Anne Cooke (Chief Nursing Officer, Vancouver Island Health Authority), suggested the Collaborative Learning Unit approach as an alternative to

the traditional Preceptorship model of practice education. The Collaborative Learning Unit model was based on the 'Dedicated Education Units' concept developed, successfully implemented, and researched in Australia[1]. In that students are assigned to nursing units, the CLU model may also seem similar to the former model used when nurses were educated in hospital programs. However, in the CLU approach the students are not attached to the units as an 'extra set of hands' to augment the nursing workforce, but are present as learners with a primary interest in gaining entry-level knowledge and competency associated with baccalaureate-prepared nursing practice. As learners in the CLU model, students are supported by experienced clinical nurses, faculty and, ideally, nurse researchers. The contemporary CLUs provide an efficient and optimal clinical learning environment for nursing students by using proven teaching/learning strategies that effectively use and integrate the expertise of all clinical nurses on the units, faculty, and student peer-support strategies.

Purposes and design

Professional valuing of co-learning and lifelong learning underpin the CLU model. Principal purposes are to:

1) Create a positive environment for learning, for all those at the placement location including those from practice and academic institutions.
2) Provide nursing students with quality practice education that promotes both 'practice and job readiness', improving recruitment of new graduates and retention of experienced nurses; and
3) Decrease demands on individual staff nurses and workload associated with the Preceptorship model.

Drawing on knowledge of current contexts of nursing practice and teaching/learning in nursing, the CLU model is designed to:

- Provide high quality, in-depth clinical experiences, for nursing students.
- Serve as a complementary adjunct to preceptorship, not as a replacement.
- Increase nursing students' opportunities and exposure to clinical situations.
- Maximize students' clinical learning and ensure all students achieve required clinical competencies.
- Improve 'practice readiness' of nursing graduates, building skills for the self-directed learning that is key to enhancing 'job-readiness' in new employees.
- Bridge the gap between academic and clinical expectations.
- Provide increased professional development and socialization among clinical nurses and nursing students, thus improving recruitment of new grads and retention of experienced staff.
- Increase collaboration and professional development between academic nursing colleagues and clinical nurses.
- Increase instructor availability to students and staff on the clinical units and reduce instructor travel time and costs, relative to preceptorship and student numbers on each unit.

Over time, it is anticipated that adopting the CLU model will:

- Provide research opportunities for nursing faculty, clinical nurses and students to collaborate in evidence-based practice/clinical research.
- Improve health system effectiveness through enhanced quality of patient-centred care.

[1] Edgecombe, K., Wotton, K., Gonda, J, and Mason, P. (1999) Dedicated Education Units (DEU): 1 A New Concept for Clinical Teaching and Learning. Contemporary Nurse (8):4 p 166 – 171
Gonda, J., Wotton, K., Edgecombe, K., and Mason, P. (1999) Dedicated Education Units: 2 an Evaluation. Contemporary Nurse (8):4 p. 172-176. .

- Improve access to nursing programs and reduce waiting time for qualified applicants, where lack of other types of practice placement availability may act to limit enrollment.
- Result in local improvement to the nursing shortage (re: improved recruitment and retention).
- Involve other professions in addition to nursing to provide an opportunity for interprofessional education
- Increase the population of Registered Nurses (RNs) and staff experienced in collaborative learning, facilitating increased tolerance for ambiguity, complexity and change.

Key structures

The Collaborative Learning Unit model builds on core learning principles that characterize the current practice education model (i.e., preceptorship). However, opportunities to positively impact the quality of nursing practice are enhanced through establishing different collaborative learning relationships among nursing faculty, undergraduate student nurses, unit staff and unit managers. Change is possible when each participant is cognizant of the new model's goals, the necessity for collaboration, and their own roles and responsibilities within the model.

Key structural features of the model's design include:
1) Background support and commitment for implementation – practice and education institutions
Successful implementation of the CLU model for a health authority and school requires collaboration between education and practice partners, a common vision about practice education, and clarity of purpose. For example, in order for a smooth transition when a School wants to gain access to a particular context for student learning, or when a Health Authority wants to allocate and distribute resources to support learning, mutual benefits must be perceived and an atmosphere of consultation is necessary. Thus, background support required for the in-depth change the CLU model engenders includes the presence of champions at a high level in both the Health Authority and the School of Nursing (e.g., Chief Nursing Officer and Chair/Director).

The need for support translates into both staff time and funding being made available from both organizations, for coordination of the implementation and evaluation (see Appendix A for details on commitments in one example). It is at the administrative level that an implementation/evaluation plan and timeline is developed and reviewed for fiscal planning (i.e., a process for identifying foci of learning, initial and subsequent units, and numbers of students). At the unit level, successful implementation of the CLU model requires the commitment of the instructor, manager, and direct supervisor (if other than manager). For example, the support of these individuals is needed to provide orientation time for - clinical nurses, faculty and students to the model as it will apply on their unit, ongoing representation at working group meetings, and day-to-day problem solving. The change process also requires the willingness of students, faculty and clinical nurses to be open to this new way of working and learning together, and to be patient with what is a complex process.

2) Clarity of roles for key participants:
Articulating summary role statements provides a foundation on which each unit can build their own ways of working together. In a CLU:
- Students are responsible for:

a. Learning - They balance knowledge acquisition with 'being' and 'doing' of professional nursing. They are the experts in their own learning.

b. Communicating - They provide evidence of their knowledge and decision making abilities, their way of being as a nurse, and their ability to give high quality nursing care within the context of their learning.

- Clinical nurses are responsible for:

a. Clinical Expertise - They make decisions that effect high quality nursing care. They are the 'clinical experts'.
b. Communicating - They share their knowledge and expertise. They give feedback to students and faculty about the students' nursing practice, and talk about their own experiences and how they think things through, in order to promote student learning.

- Faculty are responsible for:

a. Guiding learning - They make decisions that effect student learning and guide the learning process in a collaborative manner. They support learning with students and staff.
b. Communicating and Evaluating - They communicate about the students' nursing practice with students and clinical nurses, evaluate student progress and articulate their appraisals.

'Communicating' is a key element of each participant's role. As the relationships evolve and in the course of day-to-day practice, students, clinical nurses, and faculty speak with each other about the practice of nursing and the learning that is occurring. While dialogue is the preferred and most common mode, sometimes a written form of communication is indicated, and can be initiated by any of the participants. (Developing a 'Feedback' form that fits the educational approach and is suitable for each units' culture and congruent can be part of the initial implementation - see Appendix C).

The role statements provide a point of reference for examining on-the-unit implementation issues that arise during the transition from Preceptorship to Collaborative Learning. For example, in the preceptorship model, it is common for RN preceptors to actively plan and direct learning activities for their student. When carried over into the CLU model, this practice on the part of nurses can interrupt the student's opportunities for self-directed learning and challenge an instructor's ability to gather accurate information for evaluation purposes. Or, if students do not take the initiative to communicate in a way that supports RN-level decision-making and efficiency, then clinical judgments can be impacted. Similarly, if an instructor begins to direct nursing practice rather than to support learning, the clinical practice role is undermined with ensuing confusion. In these situations a review of the roles can foster learning and reinforce positive relationships.

3) Shift schedules for students

On Collaborative Learning Units, rather than partnering with a preceptor nurse in the nurses' schedule of shifts, student groups have their own pre-planned, standard rotations. This means students partner with a variety of nursing staff members over the course of shifts throughout the week. The rotations and shift patterns are designed to address the context of students' learning (e.g., relative familiarity with unit personnel and culture, layout, policies, protocols, equipment and technologies, resources, patterns of communication and documentation). The shift patterns represented in the rotations may reflect a cohort's progress towards program completion (e.g., early on schedules providing repeat opportunities, and shift patterns that more closely represent everyday work closer to graduation).

The rotation can be planned to account for the time required to study and reflect (e.g., shifts *not* scheduled, or shifts where off-unit activities are scheduled) and can be adapted to address individual students' personal situations (e.g., health, child care) to facilitate learning. From the unit perspective, the rotations address the unit

context by bringing only the number of students that the unit can accommodate into the practice setting at any one time (e.g., two, third or fourth year students at a time when instructor-led students from other years or schools are also present). Once the unit is established and familiar with the model, this can permit greater total numbers of CLU students for a term (e.g., six to ten, in eight or twelve hour shifts) thus consolidating the instructor's workload. The number of 'lines' in a rotation (e.g., students) depend on the size of the unit and other student placements on the unit.

4) Students' personalized learning plan
In conjunction with their instructor, students design a personalized learning plan and select their learning opportunities based on this plan (e.g., how to spend their scheduled time on the unit or their study time). The plan is reviewed regularly and revised at the midterm point in discussion with the instructor. The learning plan serves to focus students' decisions about learning activities in practice, and provides students with a basis for daily communication with RN partners on the unit. Those involved with each CLU develop their own way in which students contextualize and communicate their overall learning plans (e.g., a poster with pictures and summary statements, a binder where students introduce themselves, a coffee party).

5) Selecting the "assignment" for learning
Based on their personal learning plan (as ratified with the instructor), on a daily basis students identify their own "assignment" (e.g., with specific patient/resident/client(s)) or "learning activities" (e.g., research and practice focused on some aspect of nursing care). In the beginning of the term, the faculty person facilitates the client selection process by assigning the student to a specific area (e.g., to a patient room) until they learn enough about the unit to make an informed choice - one that will meet their learning needs.

6) Students work with variety of nurses and other staff
Students work with the staff who are involved with their "assignment", whether the staff members are regular or casual employees, new to nursing or the unit, or with thirty years of experience. This provides students and staff alike with an opportunity to look at multiple ways of knowing, being and doing nursing care. Identifying a clinical nurse representative and a student representative on the unit helps to facilitate communication and support the two groups getting to know and trust one another. From the unit's perspective, it can be advantageous to review the present way of identifying who is involved in client's care (e.g., how assignments are made visible from day to day and shift to shift), particularly where there are multiple learners and multiple levels of learner groups on the unit simultaneously.

7) Faculty-staff relationships
The instructor remains with the unit over a period of time to maximize the usefulness of work each person undertakes in building relationships. Initially, the intensity of the instructor presence on the unit is greater in order to establish relationships and understanding of the model and the roles within the unit's culture and context. By the second or third term in this model, although student cohorts are moving through every 6, 12 or 18 weeks, clinical nurses and faculty continue to strengthen relationships and clarify roles. For example, over a term, faculty are perceived and perceive themselves to be a part of the unit's team, something that is not often identified in the Preceptorship model.

8) Peer-support strategies designed for students
At this point, three formal structures have been developed to bring students together for mutual support. The first is regularly scheduled (e.g., biweekly), two-hour seminars, the topics of which are identified by students and/or faculty.

Seminars can be held in the facility and may involve, for example, members of the unit's multidisciplinary team or student-led presentations. The second peer-support strategy is shift schedules and rotations that have two students on the unit at any one time. Another peer support strategy used in one school is a web-based chat line for students and the instructor to discuss practice experiences.

9) Preparation for the model – students, staff, faculty
Each term, the new student group attends a school Workshop to introduce them to the course expectations and models of practice education. Students refine their understanding of the Collaborative Learning Unit model in small group and individual meetings with the instructor.

When a unit and its staff take up the Collaborative Learning Unit model, a multi-stage approach is used to introduce key information, support understanding of the change from preceptorship, and identify strategies to support learning (see Appendix B).

Faculty new to the Collaborative Learning Unit model take part in a faculty development workshop, prior to participating with staff and students as above. The University/College teaching team and practice course coordinator assist these faculty to refine their understanding of the model and its teaching/learning strategies, prior to and throughout the term. Providing similar workshop opportunities for other educators who interface with the CLU (e.g., faculty for preceptorship, teacher-supervised practice groups, and Practical Nursing faculty) enhances learning.

10) Student Orientation to the Unit
During the first week of the term, faculty and nurses facilitate unit-specific learning activities. These learning activities are designed to allow students to begin to familiarize themselves with the learning opportunities available to them, and thus expand their learning plan. Advance planning is indicated. Orientation is conceptualized as occurring over the first three weeks (or so) of the term, or until the student is comfortable with the context and able to begin to make well-informed decisions in practice. On some units it has been found useful to include allied health team members in the student orientation sessions and for students to spend time with a unit clerk and LPN to become more familiar with their roles.

11) Working Group Support
The Working Group (could be site or geographically based) provides support for the implementation and ongoing evaluation of the collaborative learning unit model. Regular meetings provide a forum for developing a shared understanding of the collaborative learning unit concept and its implications for evolving the practice of nursing. Membership might ideally include the following:

- a clinical nurse (CLU representative) from each unit where the CLU model is or will soon be implemented
- a student from each unit
- faculty from each unit
- representative of managers of CLUs
- representative of supervisors of clinical nurses (e.g., clinical nurse leader, team leader) on CLUs
- union representative, e.g., district educational coordinator
- professional practice office representative
- evaluation leader (as indicated)
- coordinator and working group chair (preferably from academic institution with paid time to do this work)

It is useful for the manager, supervisor, and a clinical nurse representative from units who are anticipating that they will introduce the CLU model to attend at least one Working Group meeting prior to this introduction.

The Working Group meets two or three times over a 12 to 18 week practice experience. This group and its action-oriented approach is key to ongoing evaluation of the model and how the model is implemented on each unit. It provides a forum for mutual discussion which initially focuses on what is working well and also informs decision making about fine-tuning changes to improve implementation of the model. Later, once the CLUs are in a maintenance mode on the units, this group can provide a means to develop and share creative new ideas for how the CLU model can develop further (e.g., drawing on the expertise available within the CLU, the Health Authority and/or the School of Nursing to address issues in practice; move to an interprofessional focus for the CLU).

12)Evaluation
Evaluation is a critical element and is embedded in the model. Designing an evaluation component that reflects best practices and informs strategies for improving the model is an integral part of the innovative collaboration between organizations characterizing the CLU initiative (see Appendix A). Evaluation to date, on Vancouver Island, has looked at the experience of students, instructors, and clinical nurses; further evaluative efforts are ongoing.

Moving ahead with Collaborative Learning Units: lesson learned

The establishment and operation of CLUs brings together people with different perspectives (particularly between academia and clinical practice). Tensions between the two interests are inevitable. Fulfilling the goal of creating a positive learning environment for all requires each person to challenge some assumptions, beliefs, and values, to give up some ways of knowing, being and doing and to take on other new ones. Making changes of the magnitude required in moving from Preceptorship to Collaborative Learning requires that individuals be constantly attentive to patterns of communication, in the moment and over time, and that they explore the tensions as they are encountered.

For more information please see the CAEN website at http://caen.ca/

Appendix A

Commitments from Vancouver Island Health Authority (VIHA) and University of Victoria School of Nursing (UVic) for Collaborative Learning Units

Item	UVic	VIHA
Coordination of introduction and implementation of model	Freeing up some time of one instructor to work with others at UVic and VIHA to chair working group, plan meetings, provide facilitation at introductory workshops; develop and update materials to be used at introductory workshops; consults with Provincial Group	One person (HA rep.) for intermittent work with coordinator and others in VIHA to identify new units, meet with leaders on unit, co-write communication materials, attend working group meetings, involve others in health authority as appropriate; consults with Provincial Group
Planning/ Working group	Coordinator, faculty and student reps to attend 2 or 3 Working Group meetings each term	CLU RN reps from each unit with time and wage funding to attend 4 to 6 meetings a year (2 teaching terms); also HA rep and BCNU rep, and managers attend these meetings
Student rotations/ schedules	Coordinator develops schedules utilizing knowledge of student learning needs, context of learning, and information from unit leader; arranges a process through which students choose which line they will take	Manager/CNL/coordinator on unit meets with coordinator to identify capacity for students on unit (e.g., how many can be on a day shift) and discuss any changes on unit expected during student placements
Introductory workshop for CLU reps (clinical RNs)	Coordinators facilitate these workshops, ideally with the CLU instructor	Time and funding for wages for one 4 hour workshop at the beginning of the term for each CLU (useful to have both new and experienced CLU reps. attend)
CLU model introductory workshops for faculty	Coordinator facilitates these	
CLU model introductory workshops for students	Coordinator facilitates these	
CLU model introductory workshops for RNs on unit; may include LPNs as well depending on unit culture and preference	Coordinator and instructor for unit to co-present multiple 4 hour workshops for nursing staff	Replacement of nursing staff to attend one of the 4 hour workshops (important to have critical mass go through this experience) Funding for the RNs/LPNs for these 4 hours; unit leaders are encouraged to attend

CLU model introductory workshops for other staff on unit	Coordinator presents several 20 minute sessions on the CLUs just after the students start their placement	Free up time for other staff to attend one of these sessions (e.g., unit clerks, LPNs (if not involved in 4 hour workshops), social workers, physicians)
Orientation of instructor to unit	Instructor meetings with unit leaders	Unit leaders meet with instructor and work with him/her to plan and implement an orientation to the unit prior to the student placements
Orientation of students to unit	Instructor present and assists	Unit leaders plan orientation with instructor prior to student placements and provide facilitator for actual orientation (will look different on different units –e.g., facilitator may be educator on unit, CLU rep or another clinical nurse on unit; may be one full day for all students or two half days – one at beginning of placements and one after 2 weeks and may include 'buddy shift(s)' (built in to student work schedules).
Evaluation	UVic provides researcher expertise and leads evaluation design; works with suggestions from working group and advises on research aspects of CLU based nursing initiatives that arise over time; carries out data collection, analysis and report writing; consults with Provincial Group	Staff, managers and those on planning and working groups take part in providing feedback for evaluation – in various forms Working group gives ongoing suggestions for evaluation planning and responses to evaluation results

Appendix B

Examples of Initiating the CLU Model on a Unit

Option 1
One example of an implementation approach that has proven effective is as follows

1. Initially several nurses are identified by the manager as potential champions for the CLU model (e.g., clinical nurse educator, clinical nurse leader, and 2 or 3 clinical nurses).
2. Prior to implementing the model they meet with the University instructor, the unit manager, a Professional Practice Office representative, and the practice course coordinator from the University. The purpose of this meeting is to begin building relationships, as well as to facilitate learning about the nursing program philosophy, provide guidelines for teaching and learning and learn about the CLU model. As well, roles and responsibilities, course expectations, and strategies to support a positive learning environment are explored.
3. The unit personnel plan an approach to inform other staff of key points. For example, they distribute posters and fact sheets (see Appendix D), and use these as talking points.
4. In the first week of the term, the instructor provides short (20 minute) information sessions for all staff who are able to attend, including unit clerks, physicians, and other interdisciplinary team members.
5. Midway through the term, once there has been some experience with the model, each clinical nurse attends a workshop to explore a mutual understanding of the roles and responsibilities on the CLU, and to refine their understanding of the vision and possibilities inherent in the model.

Option 2
Another example of an implementation approach shown to be effective is below. It works best if the staff workshops can be held just prior to the implementation and that staff relief is available for them to attend at that time.

1. Facilitator/coordinators representing school and health authority meet with an interested manager and others the manager has identified as key staff people, e.g., clinical nurses' direct supervisor, clinical educator, and/or nurse from unit. The purpose of this meeting is the same as that in #2 and #3 in Option 1.
2. Prior to the implementation on the unit, each nursing staff member is provided with an opportunity to take part in a workshop which provides information about the philosophy behind the CLU model and what it looks like. The staff attending these workshops help to determine how the CLU will work on their unit (e.g., communication methods, key information to cover in student orientation to the unit, some aspects of the unit culture which will be useful to students).
3. When the CLU is implemented on the unit, additional workshops are held as required for the nursing staff and short information sessions are held with other unit staff to familiarize them with the CLU model.

Appendix C i
Example of Feedback Form (UVic/VIHA) – developed collaboratively by VIHA clinical nurses and UVic Victoria faculty and students during pilot term (2002)

Nursing Practice Feedback

Feedback for (name): Re: Shift/Time:

From (name): Date:

Give example(s) of strength and/or area to focus on:

Knowledge Base

Decision making

Professional Responsibility and Accountability

Practical Skills

Communication with clients/families, with staff/others, with faculty

Teaching

Organization and Priority Setting

Using the form is meant to be a quick and easy process. Please write **one or two words as a memory prompt** or to guide a conversation about the larger story. Use of this form is **optional**: it is **not** an assignment for students, staff or faculty. Communication through using the form is intended to be **confidential**, and does not replace face to face communication. If indicated, place the completed form in a sealed envelope for the intended recipient.

Appendix C ii
Example of Feedback Form (MUC/VIHA) - adapted by Malaspina University College from a preceptorship document

Collaborative Learning Unit: Feedback to Student

Student's Name_____ **Date:** _____

Thank you for taking the time to provide constructive feedback to this student. Your feedback will be used by the instructor as part of student evaluation and by the student as they develop their nursing practice.

PLEASE RATE EACH CRITERION FROM 1 TO 5, *WITH 1 BEING THE LOWEST AND 5 BEING THE HIGHEST*. CIRCLE THE NUMBER YOU FEEL IS APPROPRIATE. PLEASE ADD YOUR COMMENTS BELOW EACH CRITERION.

KNOWLEDGE/UNDERSTANDING OF RATIONALE FOR ACTIONS:
1 2 3 4 5
COMMENTS:

TEACHING OF PATIENTS AND/OR FAMILIES:
1 2 3 4 5
COMMENTS:

RAPPORT WITH PATIENTS, FAMILIES, OTHER HEALTH CARE PROVIDERS:
1 2 3 4 5
COMMENTS:

ORGANIZATIONAL SKILLS:
1 2 3 4 5
COMMENTS:

PSYCHOMOTOR SKILLS:
1 2 3 4 5
COMMENTS:

CRITICAL THINKING/JUDGEMENT:
1 2 3 4 5
COMMENTS

Feedback to Student continued….

What are 2 - 3 things you think I do particularly well?

What are 2 – 3 things you think I should work on in order to improve my nursing care?

Other comments about my nursing practice?:

Thank you for your comments and feedback!!

Nurse's Name;_____

Appendix Di
Examples of Fact Sheets and Posters for Disseminating Information - based on similar sheets developed by Fraser Health Authority and University of Victoria School of Nursing (Lower Mainland Campus)

FACT SHEET
Collaborative Learning Unit (CLU):
A Practice Education Model for Nursing

What is a CLU?	CLUs are patient care units that have agreed to participate in this type of nursing student clinical practicum. To date there are 8 CLUs in South Island – 2 Royal, 3 Royal, 4 West, 6C, 2 West, SPH acute, EMP 5AB, and EMP 4A. In a CLU a student group is assigned to a specific unit rather than to individual preceptors, and their instructor visits the unit regularly. While the arrangements are different than preceptorship or teacher supervised practicum, the focus remains STUDENT LEARNING. The **goal** of a Collaborative Learning Unit is to foster a positive learning environment for all.
Why have a CLU?	To: • increase capacity to mentor RN students and potential to recruit new staff • reduce demand on individual preceptors as "mentoring" of students becomes unit responsibility • increase individual student responsibility for learning and resultant readiness to practice as a new graduate/new employee • recognize and share clinical wisdom of experienced RN staff
How does a CLU work?	On the unit: • Students are oriented to collaborative learning approach by UVic faculty prior to placement. • Students are oriented to the unit by UVIC instructor and unit staff. • On an established CLU, staff new to the model learn about how it works during orientation to the unit, and have the UVic faculty and the Unit's RN CLU rep, as primary resources for clarifying their understandings. • Usually 6 to 8 students are assigned to the unit, in their own 'rotations', for 6 – 12 weeks. The number of students and their rotation reflects the unit's capacity. • Criteria for appropriate patient assignments are developed by UVIC faculty and students in collaboration with unit leaders. • Daily patient assignments are selected by students (using pre-defined criteria and prior discussion with instructor) and may be approved by the unit leader. • UVIC instructor is responsible for student evaluation and facilitating learning and is on unit at least twice per week. • RN staff are responsible for patient care. • Students are responsible to share care with RN within their own level of competence.
To find out more contact:	• VIHA: Arlene Galloway Ford (Professional Practice Office) 544-2555 • University of Victoria School of Nursing: Mary Lougheed 721-6466 **Fact sheet based on sheet produced by Fraser Health Authority and UVic LM**

FACT SHEET: Collaborative Learning Units
Roles and Responsibilities

Roles and Responsibilities	• Within this particular learning environment, there are specific roles for each person to play as staff, students or faculty members. In working toward the goal of *creating a positive learning environment,* everyone has a job and responsibilities.
Roles and responsibilities of *Staff Nurses*	• Give and supervise the giving of high quality nursing care • Share their expertise in patient care within the context of their particular unit • Provide insights into nursing and opportunities to learn about nursing by sharing their perspectives with students and faculty • Provide feedback to students and faculty • Staff are responsible to the public and to the employer • Several nurses participate in a preparatory Workshop and provide coaching to other nursing staff about working with students and facultyfaculty facultyon the unit • One staff nurse from each CLU represents the staff on the CLU Working Group
Roles and responsibilities of *Students*	• Present as a learner and assess and identify own learning needs to staff and faculty • Take responsibility for own learning and seek appropriate resources and guidance as required • Seek feedback from staff and instructor as routine part of learning • Develop evidence of learning • Students are responsible to the public, and to the university • One student from each CLU represents the students on the CLU working group
Roles and responsibilities of *Faculty*	• Evaluate student learning by collecting evidence that students are providing high quality health care and meeting competencies • Ensure students are meeting the course requirements • Strategize with staff and students to promote high quality nursing care • Establish strong working relationships with staff and give ongoing support in ways to mentor students • Be present on the unit on a regular basis every week • Faculty are responsible to the public, and to the university • The faculty from each CLU is a member of the CLU working group

Fact sheet based on similar sheet produced by Fraser Health Authority and UVic LM

FACT SHEET: Information about UVic Students

Who We Are:

- 4th year University of Victoria students in the Collaborative Nursing Program who came from various colleges in BC including:
  - * Langara College
  - * Camosun College
  - * Douglas College
  - * Selkirk College

Overall Learning Goals:

- "Become critical thinkers and caring practitioners"
- "Establish strong working relationships with staff & faculty in a supportive learning environment"
- "Provide high quality nursing care while meeting competencies and course requirements"
- "Gain valuable insights through constructive feedback and reinforcements from staff & faculty to enhance nursing practice"
- "Gain hands on experience and become practice-ready upon program completion"

Practice Hours & Experiences:

Practica during College portion of program

* **Year 1**
  Focus: Chronic Health Challenges
  Placements: Extended care, Rehabilitation
  Hours: 329 hours
* **Year 2**
  Focus: Complex Episodic Health Challenges
  Placements: Acute Care
  Hours: 504 hours
* **Year 3**
  Focus: Prevention
  Placements: Acute Care & Community (peds, mat/child, psych)
  Hours: 180 hours

Practica during University of Victoria portion of program

* **Year 3**
  Focus: Health Promotion & Community Empowerment
  Placements: Community agencies
  Hours: 78 hours
  Focus: Societal Health and Nurses Influencing Change
  Placements: Acute/extended care, Community agency
  Hours: 78 hours

- Accrued a minimum of 1169 practice hours to this point
  * **Year 4**
    Focus: Consolidating practice experiences (CPEs)
    Placements: Acute care, Extended Care, Mental Health facilities; Community and Public Health
    Hours: 570 hours minimum
    Focus: Specific Area of Practice (Transition to Professional Practice)
    Placements: as indicated for readiness to practice as a generalist
    Hours: 190 hours minimum
- Accrued a minimum of 1929 practice hours prior to graduation

Other Experiences:

Some of the students have worked/are working in various health care fields as Licensed Practical Nurses (LPNs), Care Aides, or Undergraduate Nurses (UGNs). Students have their own individual resumes and other experiences, which they are happy to share with you.

Adapted from original document developed by UVic Lower Mainland Campus students – June 2004 in conjunction with work in Fraser Health Authority