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Learning and teaching in clinical practice

Evaluation of a clinical needs assessment and exploration of the associated supports for students with a disability in clinical practice: Part 2

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ABSTRACT

Engagement and successful completion of nursing and midwifery programmes may be predicated on the identification and implementation of reasonable accommodations to facilitate clinical learning for students with a disability. This qualitative study aims to evaluate a clinical needs assessment for students with a disability and explore their experiences of support in clinical practice. A purposive sample of year one undergraduate students was used. Four students consented to participate and undertook an individual interview. Their disabilities were categorised as specific learning disability (dyslexia) ($n = 3$) and mental health ($n = 1$). Data analysis revealed two main themes 'students' experiences of disclosure' and 'receiving support'.

Findings revealed that all students disclosed on placement, however, the extent of disclosure was influenced by personal and environmental factors. Students used the clinical needs assessment to highlight accommodations to clinical staff on placement. Issues of concern that arose, included communication between all key stakeholders, negative staff attitudes and the need to improve the provision of accommodations.

This preliminary evaluation indicates that the Clinical Needs Assessment bridges the gap in provision of student support between higher education and healthcare institutions. Findings suggest that competence based needs assessments can identify individualised reasonable accommodations for students undertaking clinical placements.

Introduction

The complexity and uncertainty of clinical practice creates a challenging learning environment for student nurses and midwives (Newton et al., 2012). In addition, a number of factors have heightened concern regarding the need to support nursing and midwifery students with a disability in clinical practice including the need to comply with equality and disability legislation, increasing numbers of students with a disability, concerns regarding patient safety and the need for students to meet professional regulatory requirements (Kane and Gooding, 2009; Storr et al., 2011; Hargreaves and Walker, 2014). Students with a disability may experience difficulties that have a negative impact on their practice indicating the need for support on placement (Sanderson-Mann and McCandless, 2006; Price and Gale, 2006; White, 2007; Hargreaves and Walker, 2014).

Literature addressing supports for students with a disability in clinical practice has done so in the context of specific learning disabilities and does not address other types of disabilities (Illingworth, 2005; Price and Gale, 2006; White, 2007; Royal College of Nursing (RCN), 2010a, 2010b, 2010c). Various models and methods of support have been described for use in clinical practice, including the introduction of Student Practice Learning Advisors, a tripartite model of support and a principles-based approach to risk assessment (Tee et al., 2009; Griffiths et al., 2010). Although informative, these papers did not detail the development of a clinical needs assessment or evaluate the effects of these supports from the perspective of the student. In a review of the literature, Storr et al. (2011) concluded that there was a lack of evidence regarding the effectiveness of supports for students with a disability once implemented.

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This article, the second of two, reports on a qualitative exploratory study that aims to evaluate the effectiveness of the clinical needs assessment tool (CNA) in the provision of support and also explore the meaning of support in clinical practice for students with a disability to increase our understanding of this important area. The previous article (Part 1) addressed the development and implementation of the CNA and discussed supports for students with a disability in higher education and healthcare institutions (Howlin et al., 2014).

Background

Nursing and midwifery are degree level programmes delivered by higher education and healthcare institutions across Ireland. The University offers four undergraduate Bachelor degrees, composed of academic and clinical modules, in adult, psychiatric and children's nursing, and Midwifery. Programmes are delivered by an undergraduate team of academic and clinical staff from the higher education and healthcare institutions. Student learning and support in clinical practice is delivered by a range of staff including Clinical Placement Coordinators (CPC's), registered nurses or midwives, preceptors and a personal tutor at the University.

University practices ensure that students, who disclose and register with disability services, have a needs assessment to identify reasonable accommodations for their programme. The undergraduate and Disability Liaison Team (DLT) recognised that many of these University supports were not transferable into clinical practice. This led to the implementation of a number of initiatives, including the development and implementation of a clinical needs assessment (CNA) for students, registered with a disability, undertaking a Bachelor of Nursing or Midwifery programme in University College Dublin, Ireland. The CNA aimed to ensure that students with a disability received reasonable accommodations to facilitate engagement and learning on placement. The development of the CNA was informed by the literature, in particular the Workplace Needs Assessment Model (Association for Higher Education Access and Disability (AHEAD), 2009) and the domains of competence framework from An Bord Altranais (2005), the Nursing and Midwifery Board of Ireland. The latter enabled the identification of accommodations in defined areas of competence. See Table 1.

In line with best practice, a formal evaluation process was initiated between April and June 2012. The purpose of the evaluation was to explore the experiences of students with a disability in relation to receiving a clinical needs assessment, disclosure and the provision of support in clinical practice.

Methods

A qualitative descriptive design was chosen as this approach enabled a comprehensive understanding of experiences from the perspective of those being studied. As little primary research existed on this topic, a flexible qualitative strategy enabled in-depth exploration of factors influencing the supports provided to students with a disability in clinical practice.

Table 1
Competence standards for nursing and midwifery.

An Bord Altranais (ABA) (Nursing and Midwifery Board of Ireland)
Professional/ethical practice
Interpersonal relationships
Holistic approaches to care and the integration of knowledge
Organisation and management of care
Personal and professional development

Participants were recruited using a purposive sample of first year nursing and midwifery students who were registered with the University disability support service, had a completed clinical needs assessment and disclosed their disability, on at least one occasion, to a member of the clinical staff ($n = 11$). All first year students who met the inclusion criteria ($n = 11$) were e-mailed an invitation to participate in the evaluation, and offered a focus group or an individual interview. These low numbers of nursing and midwifery students ($n = 11$) are reflected generally in higher education where, despite the entry of increasing numbers of students with a disability, the numbers remain relatively low in undergraduate programmes (AHEAD, 2011). Although, seven students expressed an interest in participating; only four participants from three programmes (General, Children's and General, and Midwifery) consented to be interviewed. Various factors may have contributed to this low response rate including: the timing of interviews, students' availability, competing University demands or their experience of disclosure and supports on clinical placements. Reluctance to disclose was evident in an Irish study where nine out of twelve students with dyslexia chose not to disclose in clinical practice due to fears of being misunderstood (Evans, 2013).

All of the participants were of Irish nationality, female, and had been diagnosed with the disability prior to entering the University. Please see Table 2 for a more detailed profile of participants, including a sample of the recommended accommodations.

Ethical permission to conduct the study was not required as evaluations are considered exempt from ethical approval from the University. However, as the sample included a vulnerable group (student, and a student with a disability), and the potential for unequal relationships (lecturer/student), ethical procedures were implemented including measures to prevent harm and ensure safety. Students were provided with information about the evaluation in advance of the interview and agreed to consent to being interviewed. The researcher who contacted the students, and conducted the interviews, had no existing relationship with the student which prevented undue influence, or unintentional pressure to participate. Prior to the interview, all students were advised that participation was voluntary, refusal would not result in any disadvantage or penalty and that their grades would not be affected by participation or non-participation. In addition, a psychologist was available should they recount a difficult experience and become distressed. Confidentiality and anonymity were also maintained via the elimination of names and identifiers from transcripts and the omission of demographics that might link the participants to the data. Records and all data associated with the evaluation were only accessible to the DLT and were locked in an office cabinet.

Following consent, data was collected by one researcher using semi-structured interviews. Interruptions were minimised by conducting the interviews in a private, quiet office in the University. A topic guide was used to assist the researcher to cover all of the key issues from the literature and CNA. All participants were asked an open ended question to enable them to freely describe their experience of support, '*Tell me about your experience of support received in relation to your disability while on clinical placement?*' Data collection continued until no new information was being obtained and notes were taken following each interview. All interviews were digitally recorded and then transcribed *verbatim* by a professional transcriptionist for analysis.

Data analysis

Data analysis was conducted using inductive content analysis as this approach is recommended when there is insufficient or

Table 2
Profile of participants.

Participant	Disability disclosed	Programme	Sample of reasonable accommodations
1	Dyslexia	BSc Nursing (General)	**Responsibility UCD** Provide learning disability awareness Provide alternate exam location **Responsibility Clinical Area** Allow extra time to write nursing notes Provide additional checking of nursing notes with preceptor Allow the use of an address book (notebook) to record difficult words and medications Allow student time to write down information given over the phone Provide additional support with organisation and management of patient care. Demonstrate nursing skills rather than verbally describing the skill to the student Provide written information on the lecture/skill to the student in advance **Responsibility Student** Use a highlighter pen on patient notes to highlight priorities
2	Dyslexia	BSc Nursing (General)	**Responsibility UCD** Extra time in exams Lecture notes in advance Photocopy cards **Responsibility Clinical Area** Provide a template for nursing handovers Provide a list of commonly used abbreviations Check notes with preceptor before transferring onto the patient or nursing records. Additional check of her calculations of medications and/or fluids to ensure accuracy **Responsibility Student** Use a medical dictionary Use of a calculator when doing medication calculations
3	Dyslexia	BSc (Midwifery)	**Responsibility UCD** Opportunity should be provided for additional practice time for clinical skills. Use of the video for reviewing skills should be encouraged. Where possible, information should be presented in diagrams or using audiovisual mediums Provide an exam reader Provide learning support sessions Provide Assisted technology (Texthelp) **Responsibility Clinical Area** Provide a Pre-placement visit Where possible allow the student to write her notes in draft format and a preceptor to check before transferring into patient records Allow student to write down patient information, including information given over the phone, before recording this information in the patient records or handing it over to another member of staff. Allow extra time to read patient notes Provide a list of commonly used abbreviations Information should be presented in diagrams or using audiovisual mediums Provide educational material in advance of clinical teaching sessions **Responsibility Student** Use the SMART pen and electronic paper provided for patient handovers Use an alphabetical notebook to record difficult words (e.g. address book) Use an electronic dictionary Use a coloured pen/marker in notes to highlight areas of importance
4	Mental Health	BSc Nursing (General)	**Responsibility UCD** Extend deadlines for assignments Provide mental health awareness Increase awareness of possible psychological difficulties during exams times Provide alternate exam location **Responsibility Clinical Area** No accommodations identified at this time **Responsibility Student** Continue with own self care Continue to use medication

fragmented knowledge about a phenomenon (Elo and Kynga, 2008). Initially two researchers repeatedly read all data to achieve immersion and obtain a sense of the whole (Tesch, 1990). The data was then read to derive codes (Miles and Huberman, 1994; Morse and Field, 1995). Notes and headings were written in the margins and the headings were then recorded onto coding sheets. The notes taken following the interviews were also taken into account. During this process different codes began to emerge. Codes were compared and the researchers agreed to collapse the different codes into similar or dissimilar categories that belonged to a particular group. This abstraction process continued until two main meaningful categories emerged – *Process of Disclosure* and *Receiving Supports*.

Findings

Process of disclosure

Students disclosed on at least one occasion, however, the extent of disclosure was variable. Most students had difficulty disclosing to clinical staff for a variety of reasons, including environmental and personal factors, and staff attitudes. Environmental issues clearly

affected disclosure, particularly in relation to frequent changes in clinical support staff, and preceptors:

> 'I had a different preceptor almost everyday, which I found really difficult because you were constantly explaining to someone about your difficulties …and you were nearly starting from scratch every day' (Int 2).

This student clearly recognised the impact of changes in staff on her learning and support on placement. The student also believed that she should have continued disclosing despite staff changes and seemed to blame herself for non-disclosure '*my fault was not really telling people*' (Int 2). The busy clinical environment also prevented disclosure for some students because of time pressures and worries about appearing different from other students:

> 'When you are on the ward, there isn't time to be discussing things like that (disability)…' (Int 2).

> '…when you first go into placement, there is so much to take in and you don't want to single yourself out' (Int 1).

Issues with disclosure were not just limited to environmental factors, but were individual to each student. Feelings of not being confident enough to approach the preceptor, and not having sufficient time alone also adversely affected disclosure:

> '…unless you are really confident enough to go up to your preceptor and say, can I have a word with you, you are not ever going to be by yourself with her….I never actually got the opportunity to just say it to her' (Int 1).

This same student seemed uncomfortable and unable to disclose her disability:

> '…someone would ask you to write a note for them and you don't want to stand there in front of everyone going, oh do you mind checking the spelling because I am dyslexic' (Int 1).

One student indicated that she chose to disclose so that if something negative happened the staff would know that she had dyslexia.

> 'I decided to tell them just,… not to watch my back,… but say if something did happen, at least I would know that I have told them I have dyslexia' (Int 3).

In another excerpt, a student highlighted that, despite disclosure, her preceptor seemed unaware of her needs relating to her disability and did not seem to have sufficient knowledge to provide adequate acknowledgement or support:

> 'I don't think that the person I was placed with [preceptor], I don't think that she knew to be honest. I mentioned it to her a few times, but a lot of people say, oh I have a difficulty in writing and stuff like that' (Int 1).

The student's expectation that the preceptor would know about her dyslexia arose because the clinical contact person would normally provide the list of accommodations to key placement staff. The fact that this did not occur may highlight poor communication between staff within the healthcare institution and also the DLT and the Clinical Contact person. The preceptor's lack of knowledge, regarding the disability related issues faced by this student, may identify the need for further disability awareness education.

The support role of the CPC in relation to disclosure is evident in the following student account where, despite assistance with disclosure by her CPC, the preceptor demonstrated a negative attitude towards the student:

> 'The CPC came down and explained to my preceptor that I have a learning disability and when she left, I was told by the preceptor, yes you have a learning disability but don't become a victim about it' (Int 2).

One of the student's found that completion of the CNA was positive because the identified accommodations assisted the process of disclosure:

> 'I found that the forms that we filled out were helpful so the pressure was taken off me. We didn't have to verbally disclose, I just handed the sheets [CNA] and then they could ask me questions if they needed to…' (Int 4).

This student also indicated that the CNA meant that she did not have to explain her disability which enabled her to avoid '*getting all worked up and embarrassed and psyching [herself] up to disclose*' (Int 4). The use of emotive words highlighted that she found disclosure personally very challenging and difficult. Another student indicated that discussing her dyslexia could be seen as drawing inappropriate attention to her disability:

> '…you didn't want to, in front of everyone say, well actually I have dyslexia, it might take me a couple of minutes to catch up. You don't want to be making an issue of it again' (Int 2).

This student seemed to equate disclosure with making an issue of her disability as though it was not acceptable to have a disability and receive support. The above, and some of the previous excerpts indicate that students equated disclosure with explaining the nature of the disability rather than specifying the required accommodations. The DLT had advised students to disclose their accommodations rather than their disability to protect them from having to discuss personal information about their disability which was not required by clinical staff.

Receiving support

The students' experience of receiving accommodations was both positive and negative. Positive aspects included the teaching and support role played by key clinical staff:

> 'Definitely the CPCs coming down … and going through things with me, different clinical issues …. And I just wanted to say it was absolutely fantastic' (Int 2).

This student also stated that the provision of small group teaching, in addition to the provision of individual tuition, by the CPC's meant that the student didn't feel that she was being singled out as requiring special treatment. Interestingly, it was again the CPC who provided crucial support for a student experiencing difficulty on placement:

> 'When I was on placement a few things happened that could have knocked me back, that could have made me ill again…I got upset one day in clinical placement and my CPC came to me and made me a cup of tea and calmed me down and was someone to talk to. And I found that was really, really helpful for me' (Int 4).

This same student emphasised that she found other students supportive because their similar experience on placement resulted in an enhanced understanding of her experiences and feelings.

Unfortunately, not all interactions between staff and students were supportive as is evident in the following excerpt from this student's review in the Occupational Health Department:

> 'But I found that interview really terrible, it was really stressful…. I came out nearly in tears, it was dreadful… he [Doctor] was very blunt and not sensitive to my disability. … I think what he was trying to do was to see how far he could go before I cracked, to see if I would be able for the pressure of nursing… knock my confidence and it did take me a while… I was questioning myself again, was I actually able for this course, was I able for this nursing?' (Int 4).

The teaching methods used by staff were not always a positive experience for the students as is described in the following excerpt:

> '…and the nurses were really good like they'd quiz you and you are kind of put on the spot and you feel a bit like, oh, oh, when someone is throwing a question at you. You just have to get on with it and it's probably better that you have to try' (Int 1).

This student's experience resonated with that of another, who experienced difficulty with terminology and having to grapple with simultaneous instructions.

> '…she'd [nurse] say a big long word and I'd try and keep repeating it and then someone else might say, oh can you grab this when you are in there as well' (Int 3).

Both excerpts indicate that some clinical staff members may not have a full understanding of the challenges experienced by students with particular types of disabilities. Students with dyslexia may have slower processing speeds and reduced working memory and may require additional time and support to process questions, terminology, abbreviations and long sets of instructions.

Again, the environment, in terms of its busyness and unfamiliarity with the ward environment, seemed to have a negative impact on the students' experience of teaching and support on placement:

> '…they are all so busy and not everyone remembers or whatever…I found in some situations the nurses just didn't have the time to take us on, and in your first placement, you take a little more time … you don't know how to do everything … Sometimes the nurses would be like; oh I will do it, instead of taking the time to teach you or whatever' (Int 1).

Challenges on placement also included long, tiring shifts and the students' own health when communicating with, or delivering care to patients. This is described by the student with mental health difficulties as follows:

> 'If a student had self esteem issues or they weren't feeling well that would affect them with their communication. And because the patients are older than you as well, like you have to be confident and feeling well and you have to be in your full, to communicate with them and mind them' (Int 4).

Documentation was mentioned by the three students with dyslexia as creating particular difficulties. Although two of these students did not indicate difficulties in other areas of care delivery, they experienced problems in relation to reading nursing and patient records and terminology on placement:

> 'I only ever had a difficulty…when I started doing the nursing notes…writing in the records of the patients, you have to spell things right' (Int 1).

> 'I didn't find there was any difficulties as such only when it came to reading… a handover sheet and some of the words … I didn't even know where to start pronouncing them. That would have been difficult' (Int 3).

One student specifically mentioned the CNA and indicated that the specified accommodations were not provided when on clinical placement:

> '…I kind of felt when that [CNA] was done there was a lot of things mentioned that didn't really happen. There wasn't much put in place if you know what I mean' (Int 2).

This same student did however state that "*they photocopied the handover sheet and that was very helpful*" which indicated that some of the supports were put in place. She also attributed difficulties using the assistive technology pen to insufficient practice time before placement and not getting '*the time and a quiet space…to listen back to it*' (Int 2) when on placement. This student's experience is echoed by another who noted that:

> 'I did get a few different allowances, but I never saw them or I was never given the opportunity to use them' (Int 3).

On a more positive note one student did receive her accommodations and noted that being provided with more frequent breaks during the day, and off duty that facilitated having days off together, significantly helped her to cope on placement. Another student explained that '… *I didn't get the best out of the support… but at no point did I feel there was no support if I didn't go looking for it*' (Int 1). This student also had knowledge of her own abilities which enabled her to request support if required:

> 'you know what you are able to do and what you are not able to do…if I had a huge difficulty I would have said it to them' (Int 1).

Despite variability in supports received from clinical staff, the findings also revealed that some students actively engaged in self support strategies in clinical placement. For example, although student (3) stated that she did not use her accommodations for placement, she implemented her own support strategies, including writing out and reviewing challenging words, looking up definitions and practicing the pronunciation of words. Other reported self support strategies by students included getting documentation in advance, going over the ward routine and bringing lists of words onto placement:

Discussion

Disclosure was difficult and, although all of the students disclosed at some point on placement, the extent was variable. This finding is consistent with research on disclosure which found that most health care professionals, including student nurses, disclosed despite challenges and inconsistencies in the extent of disclosure (Stanley et al., 2007, 2011). Students in this evaluation tended to describe barriers rather than facilitators of disclosure and these have been grouped using guidance from the National Disability

Authority (2012) as occurring on a personal and workplace level. Some students found disclosure personally challenging. In part, this may have arisen because students conceptualised disclosure as disclosure of disability rather than disclosure of accommodations. Indeed, some professionals with a disability described disclosure in terms of wanting to explain their disability to enable others to understand what it was like to have a disability and to achieve support (Stanley et al., 2007, 2011). These disabled professionals protected and maintained their sense of self by engaging and owning the disability label and integrating honesty, disclosure and a responsibility to their profession and clients (Stanley et al., 2011). These findings are supported by Evans (2013) who found that disclosure of dyslexia depended on whether each nursing student situated their dyslexic identity on the embracer, passive engager or resister continuum (Evans, 2013). Embracers disclosed their dyslexia while those described as either passive engagers or resisters refrained from disclosure (Evans, 2013).

Personal factors such as confidence and feeling comfortable also influenced disclosure. Confidence to disclose is facilitated by seniority and experience (Stanley et al., 2007), attributes which the first year students in this study did not possess. Students expressed worries about feeling different from other students and not wanting to be singled out as a result of disclosure. This finding is supported by Morris and Turnbull (2006, 2007) who found that reluctance to disclose was not unusual because students wanted to be perceived as being the same as their colleagues. Evans (2013) also found that nursing students with dyslexia did not disclose in practice settings because of concerns about being viewed differently from their peers, being labelled as stupid and not being understood.

Positive facilitators of disclosure were less evident in the students' accounts. However, being able to present the list of accommodations to staff on placement was found to assist the provision of supports and reduce the stress of frequent verbal disclosure. Anecdotal evidence from Tee et al. (2009) supports this finding in that students noted that identified supports increased their confidence in practice, enabling them to openly discuss their disability. In this evaluation disclosure gave another student a sense of security that in the case of an adverse event the staff knew she had dyslexia. This finding is supported by Price and Gale (2006) who found that students with a disability worried about errors in practice and being unsafe and, therefore, tended to prioritise safety in the delivery of patient care.

The findings of this evaluation endorse those of other researchers that challenges on placements were individual to each student and their disability (Price and Gale, 2006; White, 2007). This lends weight to the argument that individuals with a disability know their own capabilities and limitations and are best placed to advise on the support they need (Stanley et al., 2007). In addition, students also have a responsibility to communicate their needs to relevant staff and to participate in modification, implementation and evaluation of their supports (Storr et al., 2011; Hutchinson and Atkinson, 2010). Utilisation of a principles based approach, incorporating support and acknowledgement of barriers and perceived risks may ensure that supports for students with a disability are understood and successfully implemented (Walker et al., 2013; Hargreaves and Walker, 2014).

This evaluation provides evidence that students used self support strategies to manage their challenges, a finding supported by other studies (Price and Gale, 2006; White, 2007; Doyle and Treanor, 2011). However, self support strategies were not used to the exclusion of the supports identified by the disability team as highlighted by Doyle and Treanor (2011) who found that students relied on self-identified or self developed strategies (87%) rather than formally identified supports.

Students with dyslexia are more likely to disclose if the healthcare culture is open, friendly and relaxed and they had a good relationship with their mentor (White, 2007). In this evaluation, students identified that environmental factors, including the busyness and fast pace of the clinical environment, coupled with lack of privacy and frequent changes in support staff, led to insufficient time for disclosure or having to constantly re-explain difficulties and/or request supports. These students were able to externalize their difficulties to the workplace, a finding in contrast to Price and Gale (2006) who noted that students with dyslexia frequently conceptualized situations egocentrically whereas non-disabled students tended to externalize their difficulties to the workplace and system. In addition, the evaluation revealed that the teaching methods used by clinical placement staff were not always conducive to maintaining reduced stress levels and effective clinical learning for the student. The complexity of clinical environments, and changes in the provision of clinical care, have resulted in busy ward environments and decreased clinical teaching (Hays, 2006). Tension between meeting the learning needs of students and the demands of practice continue to generate difficulties in clinical practice environments (Newton et al., 2009).

Successful provision of accommodations, and support for disclosure, is dependent on the implementation of a disability friendly environment which involves shifts in attitudes and behaviour rather than radically changing the environment (Stanley et al., 2007; National Disability Authority, 2012). Ways of achieving 'disabled friendly' environments include having a key contact person to advise and support disclosure; providing disability awareness training, especially for managers and those supervising placements, and through publicising positive experiences (Stanley et al., 2007).

The Disability Liaison Team (DLT) created a 'disability friendly' environment through the delivery of disability awareness workshops for University and clinical staff, and students, and the provision of key Clinical Contact Persons (CCP) to act as a point of contact between the University and the healthcare institution. Disability awareness training and ongoing staff support are central to the success of disability support in the clinical environment (White, 2007; Storr et al., 2011). Ongoing disability awareness training for staff and students, by the DLT, enables an exploration of attitudes and challenges within the practice environment for students with a disability to enhance student learning, disclosure and the provision of accommodations. In particular, students with a disability need to be aware that disclosure is not a single event, but rather a series of disclosures, repeatedly undertaken, with different staff in each placement setting and that the provision of accommodations requires disclosure (Stanley et al., 2007, 2011).

The students in this evaluation indicated that support for disclosure and accommodations were undertaken by the CPC rather than the CCP or the student preceptor. Many CPC's were noted to promote inclusion and equality for these students, in addition to learning and emotional support. An Bord Altranais (2005, 2010) specify that the support and educative role for all students is to be undertaken by the student preceptor yet none of the accounts mentioned the preceptors' engagement in these roles. The role of preceptors/mentors in understanding individual student learning needs and the facilitation of learning is critical to the success of students in clinical practice environments (White, 2007; Tee et al., 2009). Future negotiations with central clinical stakeholders should emphasise the need to facilitate contact between students and preceptors to enable student learning and support.

Tee et al. (2009) also highlight that provision of accommodations requires attention to interdisciplinary communication. This evaluation highlighted the need for improved communication between all parties involved in the implementation of

accommodations including the DLT, CCP, and clinical staff, and between clinical staff and the student. This promotion of an improved educational and organisational partnership may, as stated by Newton et al. (2012), create an environment that supports learning for all students.

Limitations

A number of limitations are identified which may affect the generalisability of the study findings. First, the small sample size, and composition, Irish, female and from one student cohort, will limit the extent to which conclusions can be drawn. It is also possible that the experiences of these students may be different from those of other students, including those who chose not to be interviewed, or from students in other institutes of higher education. Second, as noted by Holloway and Wheeler (2010), students may have modified their accounts to please the researcher or appear in a more positive light. These limitations were addressed by the following measures: ensuring that the interviewer had no existing relationship with the students to prevent undue influence, in-depth exploration of the experiences, feelings and perceptions of the students and the presentation of thick descriptions of their experiences in the findings of the study.

Further research is required that includes a larger, and broader, sample including preceptors and clinical educators involved in supporting students with a disability in clinical practice. To that end, this article may only be the tip of the iceberg, but does go some of the way to providing a deeper insight into the experiences of those students who disclosed in clinical practice.

Conclusion

This paper evaluated a clinical needs assessment for students with a disability and explored their experiences of support in clinical practice. While student experiences of support require further exploration, this evaluation provides some evidence that the CNA bridges the gap in provision of student support between the higher education and healthcare institutions.

Disclosure was challenging and difficult for the majority of the students, and was influenced by the environment and the personal characteristics of the student. Prevention or reluctance to disclose due to environmental challenges requires the introduction of measures to minimize environmental impact, including education of staff, and students, and the need for preceptors to support student learning on clinical placement via the implementation of accommodations. Further research that specifically targets the impact of the environment on disclosure and the provision of supports is warranted.

The students' experience of receiving support was both positive and negative highlighting the need for improved support measures. In particular, student accounts detailed how some key staff were greatly supportive while others were not. Such findings may be reflective of the need to provide clinical staff with additional education to address personal attitudes to disability and strengthen their ability to facilitate learning and emotional support for disabled students. Education for all students will heighten awareness of disability and inculcate inclusivity and equality for students with a disability. These findings also highlight the need to continue to evaluate the CNA, and the students' experience of support, to improve existing supports and enhance the understanding of academic and clinical educators of the meaning of support for students with a disability in clinical practice.

The evaluation also found that students did not always receive their prescribed accommodations. This highlighted the need to recognise that supports are not unilateral, but rather are interdependent between clinical, academia and the student. This interdependency demands that current communication, between academia and clinical areas, regarding student reasonable accommodations, requires further improvement to ensure that the student has a positive experience of support when on clinical placement.

Regulatory organisations, including the NMC (UK) and An Bord Altranais, need to play a greater role in the endorsement of reasonable accommodations for students. Greater guidance for preceptors/mentors, and students with a disability, from regulatory organisations, is required in relation to the interrelationship between regulatory competency frameworks, patient safety and the students' right to disclose and receive support in clinical practice. Such guidance will assist clinical staff, who support students with a disability, to create a level playing field thus enabling the students to succeed and become a registered nurse and/or midwife.

Conflict of interest statement

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