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Title:

Quality in the Time of Chaos; Reflections from teaching, learning and practice

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Abstract

Purpose

The Global Pandemic has significantly disrupted clinical practice and health professional education. In this commentary article, we describe our experiences from the perspectives of a student, a practice educator and a lecturer in the Republic of Ireland as we adapted to online clinical practice, teaching and learning. We outline the challenges as well as the shared learning that we experienced during this time of significant change.

Conclusion

The global pandemic has necessitated a significant change in practice and health education. Our struggles and successes during this challenging time have highlighted the importance of relationships and peer-support in professional education and practice. Going forward we must find a new balance in order to optimise in-person and online interactions as we attempt to navigate a post-Covid educational environment.

Introduction

The Republic of Ireland has a population of just under five million people and a health system that incorporates public, voluntary and private elements. The health service capacity and low number of intensive care beds were significant concerns at the beginning of the Covid-19 pandemic (Kennelly et al., 2020). Widespread drastic public health measures were introduced (Kennelly et al., 2020) alongside redeployment of healthcare staff including Speech and Language Therapists (SLTs) to support testing and tracing services (Crowley & Hughes, 2021). The impact of the response included significantly increased waiting lists (Crowley & Hughes, 2021) and high levels of concern among clinicians (McDonagh & Cullen,

2020; Sweeney, 2020) which in turn resulted in a sudden and dramatic reduction in SLT placement provision for qualifying SLTs (IASLT, 2020).

In 2019, the Speech and Language Therapy profession in the Republic of Ireland celebrated 50 years of professional education. There are four universities that provide professional qualification programmes. Three of these run four-year Bachelor of Science Programmes and are located in city locations in Dublin, Galway and Cork. The Masters in Speech and Language Therapy (professional qualification) programme has been running at the University of Limerick in Limerick, a city the Mid-West of Ireland, since 2003. This accelerated programme is an intensive undertaking with a combination of academic and practice modules including a final year research project, all completed within 5 semesters. Covid-19 posed numerous challenges for those involved with the programme in the academic year 2020/2021. For final year students, the pandemic hit towards the end of their academic journey, but at a critical point in their practice education. For the first year students who started in September 2020, their entire academic experience has been online.

Clinical experience is core to the education of student SLTs and provides an opportunity for students to transfer theory into practice, while learning through their interactions with supervisors, peers and community members (Held et al., 2019). Covid-19 has had a significant impact on service delivery and student placements internationally (Salas-Provance et al., 2020; Salter et al., 2020; Staley et al., 2020), and disruptions to placements are likely to continue for some time (Hays et al., 2020). Prior to the Covid-19 pandemic, student SLTs on the MSc programme were allocated to placements across a variety of caseloads and practice settings. Due to Covid-19 restrictions, many services ceased in-

person appointments and/ or implemented significant adaptations for in-person appointments in order to adhere to public health guidelines. In addition, many healthcare professionals, including SLTs, were redeployed to different healthcare settings, including testing and contact tracing. This meant that Practice Educators, the SLTs who provide supervision to student SLTs, were no longer available to support this role.

Telepractice can provide an alternative to face-to-face services (Regina Molini-Avejonas et al., 2015; Weidner & Lowman, 2020) . It was a novel avenue of service delivery for many practitioners and brought with it numerous challenges relating to assessment, therapy and building rapport with clients. The move to telepractice provided an alternative opportunity for placements for student SLTs. Prior to student SLTs commencing placement, it is important for students to create learning goals in clinical areas that they see as a priority for their own learning. The change from onsite placements to telepractice placements for the final year students in 2020 necessitated a review of some learning goals, as they may not have been possible due to the confinements of telepractice. Below, we describe the experiences of a student, a practice educator and a lecturer during the first year of the Covid-19 Crisis, adapting to online teaching, learning and assessment.

The Student

The uncertainty regarding final placements caused considerable amounts of anxiety for our 2020 cohort of about thirty students. This uncertainty related to when the placement would take place, as well as the potential for the placement to be working with a different population to what had originally been assigned pre-Covid-19. These concerns were discussed amongst students via social media messaging groups and video calls and although

many students had different concerns, there were many obviously common ones. Personally, my anxiety centred on when the placement would take place, as I was eager to complete my studies and begin the registration process as well as seeking employment opportunities post-qualification. The potential for a change in placement population meant it was difficult to prepare the resources for any specific population. Once placement offers started to return, it became apparent that the original placements may not have been available. This caused anxiety in terms of preparation, as there was no certainty that I would be working with the same population.

The transition to telepractice in our clinical placements introduced significant challenges that included the selection of the most suitable online therapy platform and additional stress related to using the technology to conduct assessment and intervention with clients. These technological difficulties would prove stressful for both the student SLT and the client engaging with the service. Such technological issues are almost universal in telepractice service delivery models (Boisvert & Hall, 2019; Carlin et al., 2013; Chipchase et al., 2014; Nagarajan et al., 2016). These difficulties, in my experience, varied from bad audio quality to the client not being familiar enough with technology and having difficulty accessing their emails, following links and logging on to the platform. One of the most prominent issues encountered in relation to technology was getting the client connected and logged on to the platform. Hines et al. (2019) state how significant effort is required of the clinician to support the family and the service user in engaging in the telepractice process and this effort was challenging. The most challenging aspect was having to provide explanations over the phone to the client/family while not being able to see what they were seeing on their screens. Due to many of the clients having acquired communication disorders, they also had

difficulties expressing and describing what they could see on their screens. An additional challenge was that different devices had different software so therefore different interfaces, meaning the directions given would also differ.

The differences in online versus face-to-face service delivery also posed challenges. Assessment of clients was often challenging, as some subtests from standardised assessments had to be converted in a way that made them suitable for online use. Some receptive elements, such as spoken word to picture matching, were not possible with the technology as the clients did not have their own cursor to virtual 'point' at items on screen. Building rapport with clients was also challenging, as often-important non-verbal social communication cues are missed when communicating with someone online and it can sometimes feel artificial and rigid in its approach. This "development of rapport in a virtual space required concerted effort due to the lack of face-to-face interaction" (Salter et al., 2020). As the weeks progressed, both parties (student SLT and clients) became more accustomed to and aware of the limitations of virtual communication, but also the many possibilities and opportunities of such interactions. The share-screen function allowed both student SLT and client (with some support) to share photographs, maps and news articles which allowed for meaningful and enjoyable interactions.

My final placement was a paired placement, with a shared practice educator providing supervision to both students. A change in my pairing with a fellow classmate for the telepractice placement also occurred. For my original placement, I had been paired with a different classmate, but placement site changes also meant changes to placement suitability based on students' learning needs. Suitability of placements was determined by previously

obtained professional and clinical competencies as well as the number of clinical hours needed to fulfil registration criteria with the regulatory body for allied healthcare professionals. Peer-support during any clinical placement is invaluable and “peer-learning benefits include enhanced learning opportunities and student autonomy, improved self-reflection and feedback skills, and increased student confidence via the mutual support of a peer” (Salter et al., 2020). Telepractice placements were no different in relation to the importance of peer support, and if anything, allowed for experimentation with technology as well as preparation of resources and adaptations of assessments prior to engaging with clients. It was also reassuring to know somebody else was having a similar experience especially regarding the uncertainty of how the placement would unfold. With the placement being online, both myself and my fellow student SLT were able to ‘sit in’ and observe each other’s sessions, with the consent of the client and having both the camera and microphone switched off. This allowed us to learn from each other, “discuss our experiences, examine our reactions and support each other through challenges” (Mackenzie et al., 2019).

In spite of the many challenges posed by the telepractice placement, there were many learning moments that will be valuable to my future practice as a now qualified Speech and Language Therapist. Firstly, the option of a telepractice placement meant that my final placement was completed in a timely manner, only a couple of months later than originally planned. I was able to meet my curriculum and clinical learning needs during the placement, despite there being a high cancellation and change of placements due to COVID-19. As the placement progressed, I became more focused on developing my clinical skills, as I was no longer anxious about difficulties with technology occurring. The problems with technology

and the worry around whether something was going to go wrong subsided, and I focused on engagement with the client and improving my assessment and intervention skills.

The relationship between my supervisor and I was very positive; in that the novelty of this type of clinical placement was a learning experience for us both. We had established from the outset that there would be challenges but that effective communication and good problem-solving skills would help overcome any obstacles. This “attitude of learning together and nobody being the expert of facilitating an online placement created a safe space for mistakes and promoted greater flexibility from all parties” is also seen in other literature (Salter et al., 2020).

Lastly, it was important to learn invaluable skills in relation to telepractice, as well as make mistakes along the way and reflect and learn from these mistakes. The additional flexibility and patience needed when dealing with technology was also invaluable learning for my current and future practice. Following the response to service delivery needs in the pandemic and the possibility of expanding services, it is likely that telepractice will become a significant part of professional reality going forward and the academic environment, though clinical placements, provides the potential for developing these professional competencies (Fernandes et al., 2020).

The practice educator

By the beginning of March 2020, we were aware of the presence of Covid-19 and although we could see it was shutting down parts of China, we naively went about our business unaware of what was to come. I was still scheduling placement orientation calls for the

placements due to start later that month. We frantically searched for sufficient placements for the next placement due to start in May. It was business as usual. Then, in advance of the government-imposed restrictions that moved education online, we experienced the first impact on placements. A placement, split between two locations, wished to delay, citing concerns about the student crossing between sites. A second placement, with similar circumstances quickly followed. Then on March 12th the directive came from the government and all placements were cancelled, all teaching moved online and the doors to all universities and many service providers who support placements shut.

In the following weeks, we tried to support students to be ready to go when things opened up again by providing online case-based learning opportunities. We continued to link with our placement providers. We offered support by circulating any relevant information that might help sites develop telepractice and deal with the impact of Covid-19. We developed information sheets and accessible post cards for residents in long term care settings that could no longer receive visitors. We heard about SLTs being redeployed to contact tracing and swabbing. Whole services were shut or attempted to move online virtually overnight with no infrastructure to support them. We worried as we were still short of placements for the placement cycle in May but we could do nothing about it. We had to prioritise the final year students who now only needed to complete their placement in order to graduate. Eventually, we decided that the first year placement would move online. We liaised with our colleagues in the other Irish Universities to plan a virtual placement to be examined with components of our national competency form. We sought guidance from our professional body to ensure these changes would be acceptable. We mapped learning outcomes against

clinical activities and pulled any available digital and online resources together to make it work.

It would be almost 3 months before any students would start an onsite placement. A small number would return to their original allocations but it became clear very quickly that most sites could no longer fulfil their original offers. Students faced the prospects of new sites, new caseloads, new locations and new worries. New opportunities appeared. We had limited experience of placements provided by private practices but these were the innovators in the crisis. They could quickly implement technological change. We faced a new world of telepractice and the opportunities this could provide for placements. In the practice education team, we had previously visited all sites at least once during placements, in order to complete the placement exam. Travel and public health restrictions prevented this so all exams were adapted to an online format. It took six months from recommencement of placements until the final student's examination was complete. This was immediately followed by rolling placements for the next student cohort. A situation that required changing the structure and format of academic content to facilitate the rolling allocation of students to placements as offers come through. This has been impacted by subsequent surges and placement pauses during outbreaks. It has necessitated significant collaboration and problem solving between the practice educators, students and the university in order to meet the requirements of the placement module. This continues as we write this commentary and we are grateful to the placement providers and students who tirelessly work together to make placements work in these challenging conditions.

I coordinate the Conversation Partner Scheme, which runs from September to December. I could see in May that this would be impacted by the public health restrictions. So, I set up a placement with two final year students who were originally allocated to a site that could no longer facilitate their placements due to space constraints. We ran a fully online training programme for conversation partners with an acquired communication disability in order to familiarise them with an online platform and therefore access the conversation partner scheme with the first year students. I'd previously had very limited experience of telepractice and yet I found myself supervising this placement and learning on the go. It was challenging, stressful and very rewarding. Reflecting on this now, it's been frantic and I've no idea when this roller-coaster ride will come to an end!

The lecturer

I sit and wait. Nothing. With the headphones on I feel like I am underwater, I can hear my own breathing but nothing else. I wait some more. Tumbleweed. I panic. Are they still there? Have I closed the meeting by mistake? Can they hear me. Can they see the slides? There is no laughter and no chat. There is no sound of feet shuffling, coffee slurping or chair legs scraping off the ground as students reconfigure the room to work in pairs. I hear an argument brewing somewhere in the house related to a piece of Lego- the self-directed 'home-schooling' has hit a rocky patch.

I check the chat box. They are there but not there. We are together but not connected. In this ghostly new space, we are estranged. I flip it around. 'All ok to keep going?' I ask. Someone puts a 'thumbs up' emoji in the text box, the moment where a connection is possible is gone. I move to the next slide and off I go. Something critical has been missed.

For me a relationship of trust and reciprocity, equality and respect between teacher and learner creates the social capital required to be able to provide quality learning experiences. Where these elements exist in the relationship, teacher and learner can both take risks. They will share their thoughts; they will work ideas out together. They will challenge one another, each will interrogate their own values and beliefs. Through this relationship, the learner begins to develop their identity as a healthcare practitioner. Over the past year, as these moments of silence have become the norm in my working day, I have begun to feel like the very possibility of such a relationship is gone forever.

Early on in the realisation that this virus was serious, I heard a public health scientist in the news say that we would come to reframe our whole lives in relation to two time periods; 'pre COVID' and 'post COVID' in the same way that Christians speak of the time before and after the arrival of Jesus. I remember being struck by the unusual nature of this discourse from someone who would usually talk of risk ratios and cost-benefit analyses. To me, looking back, I think that to fully understand how life has changed requires a more nuanced framing. There are layers upon layers of complex ways in which our world has changed and much of what is lost we may never know. It feels a bit like when your laptop crashes and you lose all your files. You have to work backwards to try to identify what you think is missing.

As someone who is in the privileged position to have the space to reflect in this time of crisis, I have noticed that my response during the past year has defaulted back to my pre-lecturing days when I worked as an SLT. I have tried to get to the bottom of what is important to me as a teacher in this new reality, and to set goals which are aligned with

these values. I have then researched new ways of achieving these goals and have made sure I have built in ways of knowing if I am getting there. In my teaching this has meant designing in new ways to build those relationships of trust be it by protecting extra time to get to know my students, spending time co-developing learning contracts, and assessment tools, or weaving more opportunities for peer-to- peer group work throughout the learning pathway. Maybe not all is lost. Maybe having had to reacquaint myself with my core values and re-aligning my practice with these values in mind, I have in some ways grown as a teacher. This learning I am pretty sure is limited to the context of my paid work as a teacher, and not, by all accounts, in relation to my abilities when it comes to homeschooling.

Conclusion

The extraordinary nature of the pandemic has had an unprecedented impact on every aspect of life, and teaching and learning in higher education is no exception. The pandemic presents us with many questions as student, practice educator and lecturer going forward. Of particular importance, is the question of optimum balance between virtual and face-to-face teaching and learning in academic and in clinical settings. The move to online teaching and clinical practice prompted anxiety (Staley et al., 2020) but also provided new learning opportunities. However, the potential for digital exclusion in education and practice must not be overlooked (Watts, 2020). The importance of ongoing communication for building and maintaining relationships within and across education and practice emerged as crucial. Yet, the stilted nature of communication online has had a clear impact in clinical practice, practice education and teaching and learning. In light of the importance of relationships and peer-support (Salter et al., 2020), we need to consider how to optimise in-person and online interactions as we move forward in a post-Covid educational environment.

The pandemic has facilitated shared learning experiences for us, as student, practice educator and lecturer, while we navigated a very uncertain path in an evolving crisis of unknown duration. Emerging from our initial naivety, we responded and adapted to the dramatic changes we faced by reacquainting ourselves with our core values. As education providers, all decisions we made regarding modifications to programme delivery were directed by public health guidance and our conviction to maintain quality standards of teaching and practice. Opportunities for telepractice placement experiences have helped graduates to overcome anxieties regarding technology and focus on work-readiness. This is particularly relevant as online service delivery is likely to continue and grow within the profession. Currently, Covid-19 continues to impact on placement offers, having a knock-on effect on progression and graduation timelines. This disruption in placement provision is likely to continue (Hays et al., 2020). It is clear that our work is not done. We will need to continue to reflect deeply on our core values, shared learning, and relationships in practice and education for the foreseeable future. As a profession that places immense value on communication, and recognises there are key differences between in-person and online interactions, we have a number of questions for reflection in this new era. How do we support and optimise meaningful engagement for students, clients and other professionals in a new hybrid environment? What will we keep, what will we shed and what opportunities for growth are available going forward?

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