Primary Health Care Research & Development 2012; **13:** 193–203
doi:10.1017/S1463423611000569

DEVELOPMENT

An educational partnership in health promotion for pre-registration nurses and further education college students

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This paper describes a partnership between a university and a college of further education, whereby first-year nursing students administered health checks to college students. Despite many challenges, the experience was positive for both sets of students and has been mainstreamed. Many lessons were learnt about how best to support nursing students to ensure a good quality experience for both student groups. Data gained from the health checks are also presented, and the programme is compared with the brief community placement that previous nursing students had undertaken at this stage of their training. Theoretical underpinnings for the programme are discussed.

Key words: education; health check; health promotion; partnership; young people

Received 8 March 2011; accepted 28 October 2011; first published online 24 November 2011

Introduction

This paper describes a partnership in education between a college of further education and a university, designed simultaneously to provide professional nurse training to university students and health promotion to college students. It offers an innovative model of local collaboration across sectors and organisations. The paper describes the background to the project, its implementation and the results of a limited evaluation. It identifies underpinning educational principles and considers the degree to which these were upheld by the programme; it concludes by considering the benefits and disbenefits for college students, the limits of the evaluation and reviews plans for the future.

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Background

Nursing students at City University London (CUL) undertake their 3-year diploma programme in the School of Community and Health Sciences. The autumn intake is usually around 170, but unusually in 2009 the intake size was 240. It was very difficult to arrange additional student placements, thus a programme of simulated practice was arranged instead. The use of simulation has been sanctioned by the Nursing and Midwifery Council (NMC, 2007), and the need for it in this context was welcomed by champions of simulation in the School as an opportunity to demonstrate its power as a teaching method.

Each student experienced 6 weeks of simulated practice, including practical simulation sessions about a range of clinical skills and scenarios in a simulated ward, as well as 2 weeks relating to public health. One of these weeks was spent completing a community workbook (visiting health

centres/pharmacies/leisure centres, etc.) and the other week was spent learning about and administering health checks. This paper describes and reflects on the second week's programme only.

The health check programme

The programme was developed in partnership with Hackney Community College (HCC), a local further education college, which welcomed the chance to promote health among its students.

The week-long placement for CUL students was structured as follows:

- Mondays: preparation of nursing students for the health check (knowledge and skills training) at CUL;
- Tuesdays and Thursdays: health checks at HCC;
- Wednesdays: health promotion sessions; and
- Fridays: evaluation of the week, presentations and debates.

This programme was run for 6 consecutive weeks, one for each of the six cohorts of students. The checks gave CUL students a chance to learn and practice clinical and communication skills (measuring blood pressure manually, measuring height and weight, sensitive questioning, assessment, information- and advice-giving, referring on).

The health promotion sessions on Wednesdays were provided by personnel from CUL and from the local primary care trust (including specialist staff working with young people). These were on subjects chosen by HCC and CUL staff. Topics included alcohol, smoking, healthy eating, sexual health and contraception, mental health, keeping fit and taking exercise and illegal drugs. The sessions are not described in detail here, although it is worth noting that CUL students valued highly the new knowledge gained.

In the absence of a general health check designed for young adults, it was decided to use the National Health Service (NHS) Health Check as a basic framework (http://www.nhshealthcheck.nhs.uk/Default.aspx). Although this was intended for adults of middle and older age, use of it in an adapted form would give CUL students some insight into the national health check programme. The check includes

- age, sex, ethnicity;
- family history;
- medicine management;
- weight/height body mass index (BMI);
- blood pressure; and
- cholesterol.

The cholesterol check and medicine management sections were removed as they were of little relevance to the majority of HCC students. Sections on exercise, sexual health and contraception were added, as both CUL and HCC staff believed these to be the health issues of particular relevance and concern to young people. For example, leaving school is a life-stage where young people often drop out of regular physical activity (Department of Health (DH), 2009). Because of the sensitive nature of sexual health and contraception as areas for questioning, HCC students were asked to choose whether or not to discuss these topics. Completed forms were anonymous: no identifiable records were kept.

This was not a screening programme: attendance by HCC students was dependent on the willingness of their teachers to bring them, and the selection of HCC students was therefore in no way systematic or comprehensive. On the one hand the programme was meant simply to be a learning opportunity for CUL students; on the other hand a chance for some HCC students to receive some basic information about health issues in general and their own health in particular. No follow-ups to the health check were offered: HCC students were advised to consult relevant NHS services where appropriate.

HCC is situated in Hackney, a diverse, densely populated inner London borough with a population of about 230 000. It has a young population with more than one in four (27%) residents aged under 20 years and only 15% aged over 55 years. One of its most striking characteristics is its rich ethnic diversity: only half (48%) of Hackney residents identify themselves as White British. Hackney is the second most deprived borough in the country (out of 353): one in four (22.4%) of the Hackney resident working population in early 2009 claimed benefits, far higher than the London and national averages of about 15% (NHS City and Hackney (NHSC&H), 2009).

There are approximately 9000 students at the college, of whom the majority (~75%) are aged 19 years and over. Students reflect the ethnic diversity of the local area with 57% from minority ethnic groups (Hackney Community College, 2011).

Implementation

The first day of the project was dedicated to introducing CUL students to the programme and the health check document. In the morning, the session focused on the need to establish a rapport, and students were asked to consider matters such as personal appearance and the physical environment. The importance of interviewing skills was discussed at length: the use of open ended and closed questions to expand and clarify answers (Silverman *et al*., 1998; Northouse and Northouse, 2004), and how to ask potentially sensitive questions (Burnard and Gill, 2008). Lecturers demonstrated the heath check, and students then practised on each other, followed by peer feedback on their communication and interpersonal skills (Kurtz *et al*., 1998). Students learnt how to interpret results and calculate the BMI (Macdonald, 2004), as well as how to signpost participants to sources of further advice. They familiarised themselves with a variety of health promotion leaflets and other resources that were available for HCC students (eg, about healthy eating, cervical cancer screening, testicular self-examination, contraception, exercise, smoking, alcohol, sexually transmitted infections).

The college had no rooms available for CUL students to use, therefore a marquee was erected in the college campus. The 2nd and 4th days were then spent in the marquee administering the health checks. HCC students were brought to the marquee by their teachers in groups, and each HCC student was allocated a CUL student to carry out the health check. Each HCC student was offered a brief written summary of their own results. CUL students normally worked in pairs: one interviewed the HCC student and the other observed and gave feedback to the interviewer afterwards. Most staff who brought students to the session also agreed to undergo a health check themselves. There were some unplanned quiet times when no HCC students were available; CUL students decided to invite HCC students and staff who were passing by the marquee for a check, which successfully increased the numbers of health checks performed.

Despite the first day's training, some CUL students were not fully competent to complete the health check document as intended and/or to take relevant measurements. For example, there were more borderline blood pressure readings than they had expected, and they often called lecturers to help them decide what to do (usually, the advice was to wait 10 min and measure it again). Similarly, some found reading BMI charts difficult (see the section 'The evaluation').

The evaluation

The evaluation initially had two aims:

- to explore college students' experience of the health checks they received and
- to explore nursing students' experience of the programme.

Evaluation by HCC students

The method chosen for the first aim was to administer a brief, structured interview. On five mornings, the interviewer stood outside the marquee stopping college students as they left after their check and asking them to take part. The brief interview consisted of nine questions inviting short answers that were recorded in tick-box fashion. Interviews typically took about 60 s. Students were asked about whether CUL students had been friendly and polite, whether they had found the check enjoyable and useful and whether they knew how to live a healthy life. The last question was included at the request of the college; otherwise, the questions were intended to be a brief quality check on CUL students' interactions with HCC students.

Ninety-eight interviews were carried out. The results were all very positive, but should be treated with caution; the reasons are outlined in the 'Discussion' section below.

Evaluation by CUL students

The method chosen for the second aim was a modified form of nominal group technique (Stewart and Shamdasani, 2006). This method was chosen to engage groups of students interactively in the evaluation process in contrast with the usual practice of distributing evaluation forms for individual completion. We wanted a method that allowed students to say what they chose, rather than to have their thinking steered by agree/disagree statements or tick boxes, as in questionnaires. In allowing for students to generate their own categories, we hoped to capture informal and formal learning (Eraut, 2004). However, we also wanted to be inclusive

rather than communicating with just a sample, as would have been necessary had we chosen semi-structured interviews. We adapted nominal group technique by using written sheets and group debate: this facilitated contributions from everyone, and enabled individual choice about how much to write and how much to contribute orally.

Evaluation sessions were held on the last morning of each of the 6 weeks. CUL students were asked for individual responses to four requests:

- Please write down the three best things about this week.
- Please write down the three worst things about this week.
- If you were running this course, what would you do differently?
- Any other comments.

Students were then asked to read out their answers to the first two questions: their answers were collated and arranged into short-lists of the most popular answers. They then voted on what was best, second best, third best, worst, next to worst and so on. (The number of preferences voted on varied from session to session, depending on time available and levels of student engagement.) Their answer sheets were collected. After all six evaluation sessions, the results of the six votes were then combined. The 202 individual answer sheets were studied, and illustrative detail about some of these themes were identified. Both sets of findings have been combined here, grouped into three themes:

- skills;
- interactions with HCC students; and
- working with other CUL students.

Of the six 'best things' about the week, four related to skills:

- the chance to build confidence by practising;
- the chance to use communication skills;
- the chance to acquire clinical skills and knowledge; and
- administering health checks and giving advice.

In particular, students often mentioned that it was useful to practice manual blood pressure. Thus, the practical aspects of the programme (practice, carrying out actions) were valued.

The fourth 'best thing' was the opportunity to interact with HCC students. CUL students enjoyed meeting them, partly because the latter tended to be friendly, and partly because they tended to be young and relatively healthy, and therefore very different from patients whom students meet in wards. Some students wrote that they had enjoyed working in a community setting, others valued the opportunity to meet people from a wide range of backgrounds and cultures and one or two mentioned that they had found Hackney a much pleasanter place than they had expected.

The sixth 'best thing' was working with peers. Students had welcomed the opportunity to meet other CUL students, and had enjoyed working in pairs to administer the health checks.

The worst things about the week were:

- shortage of clients, resulting in a lot of waiting;
- the marquee, which was noisy and uncomfortable in hot, cold or rainy weather; and
- shortages of and failures in equipment.

An interesting minority comment was that the worst thing about the week was the reluctance of many HCC students invited opportunistically to agree to a health check. CUL students appeared to expect compliance in the same way as hospital patients generally comply with staff requests that form part of diagnosis or treatment. Beginning to understand the rather different relationship with clients in the community and in health promotion work is an important piece of learning.

Results and accuracy of recorded health checks

Data were recorded on a Statistical Package for the Social Sciences database from 738 health checks: 676 with HCC students, 62 with staff. This was not a screening programme or an epidemiological study and CUL students were not trained as data gatherers. The data that follow are therefore not offered as reliable population data, but as a partial indicator of the learning and skills achieved.

Tables 1 and 2 show the age, gender and ethnicity of the two groups, where numbers in the tables do not sum to these totals, this is usually because of missing data; although in the case of the questions about personal and family medical history, low rates of 'don't know' have been omitted. It will be clear that the sample is not representative of the general population or of the

Table 1 Hackney college students and staff: gender and age

	College students			College staff		
Age	Male	Female	Total	Male	Female	Total
18 years or under	118	49	167	–	–	–
19–20	66	44	110	–	–	–
21–30	52	65	117	3	7	10
31–40	53	81	134	5	10	15
41–50	31	63	94	7	8	15
51+	13	22	35	10	10	20
Total	333	324	657	25	35	60

Table 2 All participants, by ethnicity: numbers and percentages

Ethnicity	College students, $n = 676$	College staff, $n = 62$
White	172 (25.4)	28 (45.2)
Black/Black British	287 (42.5)	21 (33.9)
Asian/Asian British	105 (15.5)	5 (8.1)
Mixed race	46 (6.8)	2 (3.2)
Other	40 (5.9)	3 (4.8)
Prefer not to say	11 (1.6)	1 (1.6)
Total	661	60

Table 3 Questions on health and health behaviour

Question	Students, $n = 676$	Staff, $n = 62$
Own medical history		
None	457 (67.6)	30 (48.4)
Asthma	63 (9.3)	2 (3.2)
CVD/heart disease	27 (4.0)	1 (1.6)
Diabetes	8 (1.2)	4 (6.5)
Other	121 (17.9)	25 (40.3)
Family medical history		
None	245 (36.2)	20 (32.3)
Diabetes	207 (30.6)	17 (27.4)
Blood pressure/hypertension	144 (21.3)	21 (33.9)
Asthma	29 (4.3)	
Cancer	77 (11.4)	13 (21.0)
CVD/heart disease	97 (14.3)	11 (17.7)
Other	44 (6.5)	5 (8.1)
Cigarettes per day		
None	492 (72.8)	53 (85.5)
10 or fewer	120 (17.8)	4 (6.5)
11 or more	30 (4.4)	4 (6.5)
Body mass index		
Normal	331 (49.0)	26 (41.9)
Overweight	169 (25.0)	26 (41.9)
Obese	91 (13.5)	9 (14.5)
Underweight	8 (1.2)	0

CVD = cardiovascular disease.

college's students in general (75% of who are 19 years or over compared with 65% in our sample). Table 3 shows other findings for these groups: ethnicity, and selected answers to questions about health and health behaviours.

As expected, less than a third of students reported having medical problems, although nearly two thirds were aware of health problems in their family. Relatively high rates of reported family morbidity among students probably reflect the high levels of socioeconomic deprivation in Hackney, given the association between deprivation and morbidity (Marmot and Wilkinson, 2001).

Estimated local prevalence of smoking at all ages is 32.2%, which is slightly higher than HCC student data, but much higher than staff data (NHSC&H, 2009). The staff rate may reflect age factors: smokers in Hackney are mostly young (under 35 years) or old (over 55 years) rather than middle aged (NHSC&H, 2009), and participating staff were much more likely than students to be middle aged (see Table 1). A sixth (17.5%) of local adults were estimated to be obese (NHSC&H, 2009), which is reasonably close to the rates in our data. These findings suggest that the health checks yielded broadly valid results in respect of these health issues.

However, certain common errors in completing the document were observed at the data-entry stage. For some questions, data had not been recorded in quite a high number of instances: for example, 10% of cases omitted data about alcohol consumption, whereas 30% omitted replies to some or all of the multiple questions about exercise. Such levels of missing data may reflect that first-year students have little experience of completing forms. However, they appear also to be related to throughput, as, broadly speaking, more data were missing from checks carried out on busier days.

Some BMI results were wrong (calculations recorded in Table 3 have all been checked). Analysis showed that of 402 results, 18.3% (90) were inaccurate. In a further 106 cases (15.7%), calculations were not recorded, whereas no measures were recorded in 71 cases (10.5%). These results may indicate a degree of incompetence and/or carelessness, the latter perhaps reflecting the noisy environment. Some HCC

https://doi.org/10.1017/S1463423611000569 Published online by Cambridge University Press

students declined to be measured, and some CUL students commented that they found the BMI calculator charts provided difficult to use. It may also be that CUL students were embarrassed by the potentially sensitive issue of weight, as BMI was more likely to be wrongly calculated when participants were obese or overweight.

Discussion

This discussion section first considers the educational theories underpinning the programme, including the degree to which it can be considered to be simulation and how it compares with clinical placements. The programme's educational limitations are identified, as are the limitations of the evaluation. The discussion then considers the programme from the point of view of HCC students. Key points of learning for future development are identified.

As already noted, the programme was developed rapidly as a practical solution to an urgent problem. However, it was developed by a team that included experienced and qualified teachers familiar with educational principles, who recognised from the start the programme's potential to enhance the first-year curriculum.

Clinical placements are designed to enable students to learn by experience (Boud, 1993), with the support and guidance of the clinical team and in particular the designated mentor (NMC, 2010). As this programme was to be a substitute for clinical placement, learning by experience was at its heart. Practical knowledge, as distinct from technical knowledge, can only be learnt by experience with practice (Eraut, 1994: 65). Practice outside the clinical setting allows repetitive practice that would be inappropriate in direct patient care, for example, in clinical skills laboratories, which students are known to value (Freeth and Fry, 2005; Baillie and Curzio, 2009). The feedback from CUL students (above) confirmed that they valued the chance to improve skills by repetition.

Skills laboratories use simulation, and the programme described here was part of a larger sequence of simulated learning, yet it was not straightforwardly simulation itself. If simulation is

> a technique, not a technology, to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner (Gaba, 2004: i2),

then conducting health checks with college students is not simulated practice, as actual health checks were carried out with real clients. However, the overall situation was not realistic, as healthy students do not usually receive general health checks, and CUL students' activities were more restricted than in real life health checks (eg, lecturers dealt with all complex issues raised).

A key function of simulation is that it provides 'an opportunity to practise the skills under controlled and safe conditions' (Maguire and Pitceathly, 2002: 698). In this programme, safety was provided not – as in skills laboratories – by the use of part-task trainers or mannequins, but by the reality that clients were not ill and the 'intervention' was very low risk. Although the learning situation was not controlled as in a skills laboratory and the reactions of HCC students were not scripted (as are those of actors or computerised patients in simulated scenarios), it was nevertheless expected that HCC students would not act in challenging or disruptive ways, and this was the case. Referral to lecturers ensured that unusual or complex health problems were adequately addressed.

Another key aspect of simulation learning is the use of debrief to promote reflective learning (Ker and Bradley, 2007). The pairing of CUL students so that they could alternate the roles of observer and practitioner was designed to build continuous debrief into the programme. There were thus opportunities for reflection in and on action (Schőn, 1987) and opportunities to provide feedback, which is known to enhance reflection and motivation (Nicol and Macfarlane-Dick, 2004). Observation also permitted social learning ('learning by watching the behaviour of others'; Hinchcliff, 1999). By giving a key debrief role to students themselves and by not providing intensive staff supervision, the programme observed the principles of adult learning (Knowles 1984): it assumed intrinsic motivation and a degree of self-direction (eg, whether to refer or get help).

The programme was also underpinned by the belief that nursing students should learn about health and about illness. Such a shift of emphasis has long been advocated. Macleod Clark (1993: p. 256) describes the need to move 'from sick nursing to health nursing'. This view underpinned

Project 2000, which informed the whole pre-registration curriculum, but, which, according to Macleod Clark (1993), was not successful in making the sick model of nursing less pervasive. 'Health nursing' may be offered to both sick and healthy patients, and this programme offered an opportunity to first-year CUL students to work with the latter. It gave students a taste of supporting individuals to live in a healthy way in line with government policy (DH, 2010). The programme thus represents a significant enhancement of the previous first-year curriculum, which was more restricted to 'sick nursing'. CUL students study the community theoretically in their first-year sociology module, therefore exposure to a community setting and to a 'normal' population was particularly timely.

How did the experience the programme offered CUL students compare with that in community placements? Such placements would normally require them to shadow a community nurse, working in clinics or patients' homes. Both settings offer some similar experiences:

- working in a non-hospital environment, and in settings where privacy may be limited (the presence of friends or relatives);
- taking basic measures such as blood pressure and calculating body mass index;
- using communication skills to discuss issues of health and illness.

The health check programme had advantages over placement learning in two respects. First, practical experience with healthy clients is not normally available to most students in their first year (although a few may be placed in health promoting settings such as with health visitors or school nurses). Second, all CUL students took responsibility for clients for a whole episode of direct contact with clients, which is less likely to happen on placement, depending on the morbidity of patients, the clinical skills required, etc. Health care students value the opportunities for responsibility that simulation affords (Abbott *et al.*, 2009).

In contrast, there was no opportunity for CUL students to observe or learn common practices in community nursing (eg, dressings, catheterisation, development checks on babies); further opportunities do of course arise in subsequent years of training. The programme gave students no contact with typical community health service clients. Lastly, the simulation did not give CUL students contact with health professionals as clinical placements do: they did not participate in a community of practice (Lave and Wenger, 1991).

To what extent did reality meet the expectations underpinning the programme?

As well as a large number of administrative challenges not reported here, several key deficits became apparent.

First, the mechanisms to support reflection by students were rather weak. This was partially because the flow of HCC students was more irregular than expected, so that when numbers were large all CUL students were needed to carry out checks. Nor is it clear that peer feedback was of high quality: health care students may find being critical difficult (Cushing *et al.*, 2011). This may explain some of the inaccuracies in carrying out the checks.

The educational environment (Hutchinson, 2003) was sub-optimal. The marquee was unsuitable in a number of respects. It offered no protection against fluctuating temperatures, and was at different times too hot and too cold. There was no privacy: HCC students often had to watch each other being weighed and measured, for example, or found themselves eavesdropping on other health checks. The lack of privacy may have influenced both the answers HCC students gave and the questions and advice that CUL students felt able to voice.

Perhaps as a consequence of the lack of privacy, and of the relative informality of the marquee, the atmosphere was high-spirited: CUL and HCC students were visibly exhilarated and enjoyed meeting each other. This atmosphere is likely to have limited opportunities to instil high standards of professionalism in CUL students, for example, in attempting to maximise privacy and confidentiality when discussing individual health. Thus, the programme provided a restrictive learning environment (Fuller and Unwin, 2003).

In itself, this was a modest health promotion programme, which was based on a short contact time and limited to individual risk reduction, rather than seeking to embrace more ambitious modes of health promotion such as community development or social advocacy (Beattie, 2001). Furthermore, CUL students gave only the most limited health information face-to-face, relying on information leaflets. Such printed information is not enough to ensure health knowledge (Coulter *et al.*, 1999) or to change behaviour (Coulter and

Ellins, 2007). Students thus had exposure to a limited range of health promotion activities. However, this is not inappropriate for first-year students who have not yet formally studied health promotion in the classroom.

The evaluations undertaken were limited, as no dedicated resources were available. Sampling the responses of HCC students to the health checks proved to be a strategy of doubtful value, because:

- in the high-spirited atmosphere, it seemed unlikely that interviewees would report negatively;
- HCC students were often in a hurry, with friends waiting for them, and thus tended to give immediate and brief answers rather than considered ones;
- a few students appeared to have language difficulties in relation to some questions.

In any case, they were only asked for their immediate impressions: no attempt could be made to assess in detail the effects on knowledge or attitudes, or any longer-term outcomes.

The evaluation methods used with CUL students were more thorough, and more trust can therefore be placed in them, not least because they confirmed the comments made by students during the weeks. However, again, there was no opportunity to assess medium- or long-term outcomes in terms of skills, knowledge, understanding and confidence.

How did the programme benefit HCC students? At an institutional level, HCC values the programme as a way of raising the healthy living agenda with its students. This is in line with the current and previous government's recommendation that 'those working with young people aged 16–19… should exploit opportunities to offer health information, advice and support as appropriate' (DH, 2009: 51). The data gathered during the checks were summarised at CUL, and passed in aggregate form to HCC to inform other health promotion work.

At an individual level, benefits can only be speculative, but inevitably these will have to be limited. For a minority of HCC students, the identification of potentially serious issues of health and an immediate referral to an experienced CUL staff member for discussion and information is likely to have had some value, although we have no data to confirm this. Those who received general health advice about smoking, alcohol or weight status are unlikely to have been given information that is new to them, as such advice is common in the media; nevertheless, repetition is an intrinsic feature of health promotion. The provision of leaflets may have given some clients new or more detailed information about some issues.

HCC students brought by their teachers in class time cannot be said to have given free informed consent. The ethical bases for health care and education are somewhat different. It is expected that by joining a class for a structured learning experience, individuals accept the leadership of the teacher, and, consequently, it limits the exercise of their own autonomy. Learners do not expect to be given specific information about the expected consequences of educational interventions before signing a consent form. In this respect, health–education partnerships may compromise to a degree the ethical basis of health care (Seedhouse, 2009).

Evidence of the inaccuracies for a minority of health checks, for example, BMI calculations, suggests that some clients may have been misinformed. Giving wrong BMI results is potentially serious in creating unwarranted reassurance or alarm. Because the forms were anonymous, there is no means of advising those whose BMI were miscalculated. That apart, though it is unlikely that CUL students did any significant harm, they may have missed opportunities to do good, for a number of reasons:

- their own lack of experience in conducting potentially sensitive interviews;
- their limited knowledge about healthy lifestyles;
- the lack of privacy in the environment.

It is not possible to know how serious such omissions might be, but the risks are low: a single offer of information and advice is rarely life-changing, and the topics under discussion are widely discussed in the media, so that HCC students were not dependent on the health checks alone for information.

The programme has now become a regular feature of the first-year nurse training programme, even though the numbers of new students have reverted to earlier levels. Various adaptations have been made in the light of the experience reported here. A marquee is no longer used, but the learning environment is still sub-standard, as multiple rooms are not available, and thus the practical and ethical

problems about privacy persist. Staff now monitor the health checks more carefully (eg, by looking at samples of completed health check forms and by giving immediate feedback). Lecturers need at the same time to be available to CUL students who request help and to HCC students who need specialised health promotion advice: for a group of 30 student nurses, at least two lecturers are required.

Ideas for the future include the devising of a structured observation tool that could be used to improve peer feedback. This could improve both students' learning and the quality of the checks by making observer feedback more specific and more comprehensive. A more satisfactory way of getting clients' views of the experience also needs to be devised in collaboration with the college. HCC students studying health and social care would be well-placed to comment on how CUL students carried out the checks and gave advice: they could also be invited to be involved in eliciting the views of other HCC students. It would also be valuable to consider how to assess the longer-term effects of the programme for both groups of students and to seek resources for such a study.

Acknowledgements

We would like to acknowledge the assistance of the staff and students at Hackney Community College, and the two anonymous peer reviewers of this paper.

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Appendix: sample from health check

Health check

Here is the health check for you to complete. On the left are the questions and areas you need to cover and on the right the place where you should document the answers. You will give the person being interviewed a summary slip at the end of the interview. The observer will also complete a copy of this document and will carry out a peer review.

If a referral is required on any of the areas please tick the referral box on the right-hand side against the relevant area. The person conducting the interview should ask the questions and the observer should document the answers. The observer will conduct a peer review of the interviewer's consultation and communication skills.

	Item	Answer	R
1a	Tick whether male or female	Male ☐ Female ☐	
1b	Ask what their age is and write it down	.....years	
2	Ask them to choose their ethnic group. (It is relevant for BMI and diabetes risk) **A: White**: British; Irish; other **B: Mixed race**: White and Black Caribbean; White and Black African; White and Asian; other **C: Asian or Asian British**: Indian; Pakistani; Bangladeshi; other **D: Black or Black British**: Caribbean; African; other **E: Chinese or other ethnic group**: Chinese; other **F: Would prefer not to say**	Self assigned ethnic group: ……	
3	Ask them if they have had any past medical history that they would like to tell you about	Past medical history:	
4	Tactfully ask about the family medical history of their biological parents and siblings: Ask about heart attacks, strokes, blood pressure problems, diabetes. Please explain that there is an increased chance of developing these conditions if there is a family history.	Family history:	
	If there is a family history, ask if they are worried by this.	Refer to lecturer if they are worried that they are at risk	
5	Use the questionnaire on the attached sheet to assess how active they are. Young people are advised to aim for 60 min of moderate activity every day.	Number of times per week of more than 60 min physical activity	

https://doi.org/10.1017/S1463423611000569 Published online by Cambridge University Press

Continued

	Explain the link between inactivity and ill-health.	If less than recommended amount of physical activity give advice and leaflet
6	Ask if they drink alcohol and if so how much. Alcohol units are explained on attached sheet (relate to age). 15 to 17 year olds should not consume alcohol frequently and certainly no more than 1 day a week. **Men** should not regularly exceed more than **3–4 units** a day **Women** should not regularly exceed **2–3 units** a day. **You can use the Drinkaware wheel to help calculate the number of units** If drinking more than this, advise to reduce and explain about the risk of liver disease, mental health and accidents, etc.	Number of units per week ..... If regularly drinking alcohol (more than 1–2 days per week) then give advice and leaflet. If units are particularly high (**more than 30 units/week for men or more than 25 units/week for women**) then referral required

https://doi.org/10.1017/S1463423611000569 Published online by Cambridge University Press