Nurse Education Today 69 (2018) 48–52

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/locate/nedt

Intellectual disability content within pre-registration nursing curriculum: How is it taught?

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ARTICLE INFO

Keywords:
Intellectual disability
Nursing education
Curriculum design
Health inequalities
Teaching methods

ABSTRACT

Background: Despite experiencing higher rates of physical and mental health conditions compared with the general population, people with intellectual disability face inequitable access to healthcare services. Improving education of healthcare professionals is one way to reduce these inequalities.
Objective: To determine how intellectual disability content is taught within Australian nursing schools.
Design: A two-phase audit of Australian nursing curricula content was conducted using an interview and online survey.
Setting: Nursing schools Australia-wide providing pre-registration courses.
Participants: For Phase 1, course coordinators from 31 nursing schools completed an interview on course structure. Teaching staff from 15 schools in which intellectual disability content was identified completed an online survey for Phase 2.
Methods: Methods used to teach intellectual disability content and who taught the content were audited using an online survey.
Results: Across the 15 schools offering intellectual disability content, lectures were the most common teaching method (82% of units), followed by tutorials (59%), workshops (26%), then other methods (e.g. e-learning; 12%). Approximately three-quarters of intellectual disability teaching used some problem-and/or enquiry-based learning. Only one nursing school involved a person with intellectual disability in delivering teaching content. Six (19%) participating schools identified staff who specialise in intellectual disability, and seven (23%) identified staff with a declared interest in the area.
Conclusion: While some nursing schools are using diverse methods to teach intellectual disability content, many are not; as a result, nursing students may miss out on acquiring the attributes which enable them to address the significant health inequalities faced by this group. A specific deficit was identified relating to inclusive teaching and clinical contact with people with intellectual disability.

1. Background

Despite facing considerable physical and mental health issues compared with the general population, people with intellectual disability (ID) encounter inequitable access to quality healthcare services (Emerson et al., 2012). Current levels of preventative care, health promotion, and general healthcare in Australian primary care are not optimal for people with ID, and could be improved with targeted interventions (e.g. Lennox et al., 2010; Lennox et al., 2016). A leading barrier to people with ID accessing services is a lack of workforce capacity in ID and low levels of confidence in providing treatment (Ali et al., 2008; Krahn et al., 2006). As health professionals lack awareness about what they can do to reduce these barriers (Department of Health, 2008), this challenge requires particular focus from health professionals

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https://doi.org/10.1016/j.nedt.2018.07.002
Received 9 January 2018; Accepted 1 July 2018

and systems (Maulik et al., 2011).

Although the National Disability Strategy (Commonwealth of Australia, 2011) has provided objectives which aim to improve health standards for people with ID in Australia, mainstream Australian services are ill-equipped for this task at present (Jess et al., 2008; Krahn et al., 2006; Weise and Trollor, 2017). Since the closure of institutions across Australia, people with ID rely heavily on mainstream services for their healthcare, yet in contrast to developments internationally, Australia has not invested in large scale equipping of the workforce and services in this area. People with ID and those who support them report that health professionals often exhibit poor communication during hospital visits, an inability to deal with challenging behaviours, and unfamiliarity regarding health conditions affecting them (Iacono et al., 2014). Other progressive jurisdictions have extensive education for key professional groups, including specialist ID nurses in Ireland (Doody et al., 2012) and in the UK (Nursing Midwifery Council, 2010), general practitioner trainees in the United States (AADMD, 2014), and ID physicians in the Netherlands (Evenhuis and Penning, 2009). There has been some progress made toward addressing inequitable access in Australia, such as the development of the Intellectual Disability Mental Health Core Competency Framework, which describes the core attributes required to deliver quality services to people with ID (Department of Developmental Disability Neuropsychiatry, 2016). However more is required to address the health gap for people with ID.

Nurses are key healthcare providers in mainstream services (Heath, 2002). In Australia, there is no national nursing education curriculum, but pre-registration nursing programmes must meet the standards set by the Australian Nursing and Midwifery Accreditation Council (ANMAC, 2012). The standards state that nursing education should include simulated learning, extensive workplace experience, and assessments that evaluate stated learning outcomes (ANMAC, 2012). The ANMAC standards do not refer to ID specifically, but are based on the Registered Nurse Standards for Practice (Nursing and Midwifery Board of Australia, 2016), which do explicitly reference the care of people with ID (Cashin et al., 2016).

There has been continuing change in nursing pedagogy, especially with the transfer from hospital-based education centred on didactic models, to tertiary education resulting in endeavours to move toward using more learner-centred education models (Allen, 2010). Increasing healthcare demands and economic considerations has meant that graduates need to be lifelong and autonomous learners (Allen, 2010). To help address this goal, problem-based learning (PBL) and enquiry-based learning (EBL) have been introduced into nursing education (Beers, 2005; Shin and Kim, 2013; Zhang, 2014). A survey of 51 undergraduate nursing students indicated that PBL enhanced problem solving and motivation, and encouraged group collaboration (Yuan et al., 2011). However, the respondents were uncertain the information they were learning was correct. Regarding specific teaching methods, traditionally lectures have been used to present new core concepts to student groups, but they are a passive learning method and do not encourage critical thinking (Meehan-Andrews, 2009; Ramsden, 2003). In contrast, tutorials and small group learning can encourage deeper learning, and practical sessions allow students to master skills. The disadvantages of these methods are that they require greater resources than traditional lectures, and are dependent on the leadership of the tutor and group dynamics (Meehan-Andrews, 2009; Ramsden, 2003). Still, there is some evidence that they are favoured by students. Meehan-Andrews (2009), for example, surveyed first year nursing students completing a physiology and anatomy course at an Australian university and found that their favoured teaching method was practical laboratory sessions, followed by lectures, then tutorials.

There have been few studies examining how ID (or disability, which includes ID) is taught in pre-registration nursing courses. From an earlier audit, Scullion (1999) found that in the College of Nursing and Midwifery pre-registration course in the UK, simulation was the most widely used method to teach disability, but seminars, case studies and lectures were often used as well. Further comprehensive audits of how undergraduate students are taught about ID health issues have not been published, but a variety of different approaches to teaching have emerged in the literature. These include a 3-day programme planned by community ID nurses and a self-advocacy representative involving lectures, case-scenario discussions, videos, and role plays with people with ID (Gibson, 2009); experiential placements, such as students visiting clients' homes or workplaces (Beacock et al., 2015; Goddard et al., 2010); and an interprofessional practice course in ID healthcare (Jones et al., 2015). After completing these courses, students have indicated on evaluation surveys that they felt more confident in providing care to people with ID, better understood the need to adapt their practice, and were more positive about their perceived skills and knowledge around ID healthcare (Beacock et al., 2015; Gibson, 2009; Goddard et al., 2010; Jones et al., 2015).

Inclusive teaching, which involves people with ID in the development and delivery of ID education, has been argued to encourage a sense of working partnership, to help students understand the need for communication modifications, and improve knowledge and confidence (Bollard et al., 2012). It is used successfully in other professional settings, such as in the medical programmes at St George's Hospital London (Thacker et al., 2007) and at University College London (Thomas et al., 2014). Inclusive teaching with people with ID is not widely used in nursing education, but it is emerging (Bollard et al., 2012). At one UK university, people with ID regularly help to teach the 'BSc in Integrated practice in learning disabilities nursing and social work' programme, which is 'highly valued' (Adshead et al., 2015).

In mainstream services, a shortage of health professionals, such as nurses, with sufficient education and skills in ID healthcare, is one barrier that perhaps can most readily be addressed during undergraduate education. Providing future nurses with knowledge and skills to work with people with ID is a fundamental way for the government and community to meet their obligation to ensure that people with disability have equal access to healthcare (Commonwealth of Australia, 2011; UN General Assembly, 2006). There have been no identified formal published audits as to how ID is taught in Australian nursing schools. Comprehensive audits can identify education that is available today, identify gaps and help determine how teaching can be improved to enhance future workforce capacity. The aim of the present study was to conduct the first national audit of pre-registration Australian nursing school curricula to determine how ID content is taught. *What* is taught was reported by Trollor et al. (2016a), while in this report we address *how* ID related curricula content is taught.

2. Method

2.1. Recruitment and Materials

An audit of Australian nursing school curricula evaluating ID content took place in 2013/14. The recruitment procedure and materials employed have been described in detail in Trollor et al. (2016a). Of the 34 nursing schools providing ANMAC accredited degrees, the Deans/Heads of School of 31 nursing schools (91% response rate) agreed to participate in Phase 1, which involved course coordinators completing an interview. ID related content was identified in 15 nursing school curricula (48% of participating schools). Teaching staff and unit coordinators from these schools then completed a survey addressing how ID content was taught (Phase 2).

As previously reported (Trollor et al., 2016a), participating schools offered a total of 33 compulsory and 1 elective units that contained some ID content (referred to as ID units, discrete teaching components containing some auditable content specific to ID). The number of nursing students enrolled in each school ranged from 60 to 700 (M = 300). Time dedicated to teaching ID content in compulsory units ranged from 10 min to 12 h per unit (M = 3.6 h). One elective ID unit (which contained 9 h of ID content) was provided by one school, in which one