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Review

The context, influences and challenges for undergraduate nurse clinical education: Continuing the dialogue☆

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SUMMARY

Introduction: Approaches to clinical education are highly diverse and becoming increasingly complex to sustain in complex milieu
Objective: To identify the influences and challenges of providing nurse clinical education in the undergraduate setting and to illustrate emerging solutions.
Method: A discursive exploration into the broad and varied body of evidence including peer reviewed and grey literature.
Discussion: Internationally, enabling undergraduate clinical learning opportunities faces a range of challenges. These can be illustrated under two broad themes: (1) legacies from the past and the inherent features of nurse education and (2) challenges of the present, including, population changes, workforce changes, and the disconnection between the health and education sectors. Responses to these challenges are triggering the emergence of novel approaches, such as collaborative models.
Conclusion(s): Ongoing challenges in providing accessible, effective and quality clinical learning experiences are apparent.

Introduction

Undergraduate nurse clinical education is acknowledged for its role in socializing nursing students to professional practice and standards and nurturing the thinking, doing and emotional attributes needed to assimilate learning and integrate into the workforce (Willis, 2012). Yet, this component of nursing programs can lack critical leadership and focus, be difficult to manage and is becoming more challenging, as demand for student placements intensifies (Smith et al., 2010). Critical commentary in the literature (Allan, 2010; Jackson and Watson, 2011), highlights concern that preparatory nurse education is facing emerging challenges from evolving healthcare policy, staff shortages and population changes, and these challenges are of local and international concern (Daly et al, 2008).

In this current climate, stakeholders risk looking for a 'quick fix' to what Jackson et al. (2013, p. 150) aptly call the "Achilles' heel of health care professional curricula", and seek reactive and short-term solutions. Donnelly and Wiechula (2012) caution that the nursing profession must seize the opportunity to engage in stimulating discussion on clinical education before political or financial constraints stifle creativity. To meet future demand for quality clinical experiences for students requires clear leadership with a vision of change to drive sustainable and future proof innovation (Clinton and Jackson, 2009; Keighley, 2013). 'Future proofing', according to Keighley (2013) is a process which determines future trends and generates forward thinking based on what is known today. The essence is that by future-proofing something – in this case clinical education – it will continue to be of value in the future.

Objective

This paper sought to develop a snapshot roadmap to contextualize the barriers and facilitators to the clinical education of nurses. The overarching research questions were:

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What are the inherent features in undergraduate nurse clinical education that impact its delivery?

What are the emergent challenges in the governance of undergraduate nurse clinical education?

How are innovations being implemented to address these challenges?

Method

The literature was reviewed using electronic search engines (CINAHL, Medline and Scopus) and using the following search terms—Undergraduate[All Fields] AND ("nurses"[MeSH Terms] OR "nurses"[All Fields] OR "nurse"[All Fields]) AND clinical[All Fields] AND ("education"[Subheading] OR "education"[All Fields] OR "educational status"[MeSH Terms] OR ("educational"[All Fields] AND "status"[All Fields]) OR "educational status"[All Fields] OR "education"[All Fields] OR "education"[MeSH Terms]). The World Wide Web was searched for English language literature to generate findings on nursing clinical education. These findings were synthesized using a generalized inductive technique using the overarching research questions.

The findings are presented in a discursive style to act as a primer for debate, continued dialogue and foundation to inform future scholarship in this intricate area. The discourse is presented in three parts, beginning with understanding legacies of the past and the inherent features in clinical education that influence its provision. A summary of factors indicative of the contemporary challenges follows, relating to: influences on supply and demand; the disconnect between healthcare and education; healthcare reforms and changes to the nurse's role; and the determination of fitness for practice. Finally, examples of innovative approaches conceived for future undergraduate nurse clinical education are summarised.

Legacies of The Past

Internationally, multiple approaches as to how the clinical component of undergraduate nurse education programs are conceptualized, described and delivered make this a challenging area for collective review. In many countries, including Australia, Canada, and the United Kingdom nurse education has evolved from the hospital-based apprentice training of the past to degree level preparation. Degree program curricula are frequently guided by education *standards,* issued by accrediting bodies, such as the UK's Nursing and Midwifery Council (NMC, 2010) and the Australian Nursing and Midwifery Accreditation Council (ANMAC, 2012). These standards guide the requirements for students to achieve the necessary beginning level competency for registration, yet provide scope for flexibility and differentiation in local program content. With reference to the Australian context, Walker (2009) questions this flexibility as a potential risk, allowing for variable curricula able to produce a variable 'product'—the nurse graduate.

Regardless of the ideological shift from 'training' to 'education' (Bradshaw and Merriman, 2008), and the 'model' of clinical education, features emanating from the hospital apprenticeship models still prevail. This is evident in the common term 'clinical placement' which Roxburgh et al. (2012) suggest implies that learning can be contained within the boundaries of a physical location, specific team or time. As part of a rotational access model, students are allocated to various placements in different settings, with diverse patients and supervisors. The model may be driven by availability and competition rather than the educational needs of the curriculum or learner (Holland et al., 2010). This can result in disconnected experiences (Campbell, 2008) with students unsure how particular settings meet their specified or personal learning objectives (Mannix et al., 2006).

Historically, rotational models have centred on the acute care sector where high acuity, rapid patient turnover, specialization, patient safety and numbers of learners may not guarantee appropriate learning opportunities avail themselves. Lauder (2008) comments that acute care settings emphasize 'illness' and 'patients', thus promoting the medical model rather than person centred, social models of health. Continued reliance on the acute care setting will not adequately prepare students for primary healthcare or community based employment, growth areas within healthcare provision. Another common practice is for students to provide total patient care to increasing numbers of patients as they progress through their program of study. Benner et al. (2010) caution that there is a misguided assumption that this makes students more 'work ready' on completion and they suggest that alternate ways for students to progress, develop and increase independence are needed.

The move to tertiary education conferred supernumerary status on students, giving rise to the need for models of student supervision. In their review, Budgen and Gamroth (2008) identified 10 clinical (or practice) education models, which often emphasize the mode of student supervision, rather than an overarching approach to teaching and learning. A spectrum of differing models and definitions of student supervision has evolved with a variety of terms used, sometimes interchangeably, including 'supervising', 'mentoring', 'facilitating' and 'preceptoring'. As examples, mentoring utilizes clinically based nurses—the nurse *mentor*, with student supervision part of the nurse's standard role (Jokelainen et al., 2011). Alternatively in the *clinical facilitator* models, registered nurses (RNs) are employed by the higher education institution (HEI) to supervise students, typically in a 1:8 ratio and over several wards (Courtney-Pratt et al., 2012).

The preparation and governance of student supervisors, regardless of the model, also differ. In the UK, the Nursing and Midwifery Council's (NMC, 2008) *Standards to Support Learning and Assessment in Practice* detail a formalized, nationwide structure. In contrast, with no formalized national structure in Australia, the need for greater consistency in supervisor preparation and governance has been identified (Andrews and Ford, 2013).

Further variables are the numerical parameters of undergraduate clinical education. These include the total practice hours stipulated by governing bodies; the duration, number and type of placements or experiences; the range of shifts; and number and type of patients a student cares for. Illustrative of this is the disparity in student clinical practice hours within preparatory programs; the European Union requirement of 2300 h, for example, contrasts with Australia's minimum of 800 h (EU, 2005/36; ANMAC, 2012). The duration of clinical exposure, along with its organization and the complex issue of assessment of competence are factors to consider when student exchange and, more significantly, potential mobility of the global nursing workforce are considered (Dobrowolska et al., 2015). This may be particularly pertinent to countries reliant on a migrant workforce to sustain the nursing workforce.

These facets exemplify the complexities and anomalies that intrinsically exist in undergraduate nurse clinical education. In addition, the provision of clinical learning experiences is also challenged by more contemporary issues such as healthcare, workforce and population changes.

Challenges of the Present

Supply and Demand

The nursing workforce is aging, with the median nurse age, for example reported by the Australian Institute of Health and Welfare as 44.5 years and the Canadian Institute for Health Information stating 45.4 years (AIHW, 2012; CIHI, 2011). As this sector of the nurse workforce moves towards retirement, a looming void contributes to projected nursing workforce deficits in countries including Australia, the United Kingdom and US (NHWT, 2009; Sherman et al., 2013). In addition, high rates of attrition, especially amongst early career nurses further compound predicted workforce shortfalls (Doiron et al., 2008).