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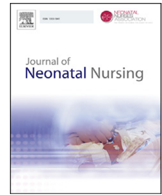

Letter to the Editor

Letter from Africa: Academic-practice partnering in neonatal nursing: A capacity building strategy

Introduction

Academic teaching and clinical practice often operate in isolation and as separate entities, instead of complementing each other. The teaching and clinical practice partnering described in this article, provide a record of the process followed, challenges identified and future initiatives for enhancing quality teaching, patient outcomes, and clinicians' capacity building (Beal, 2012), since academic-practice partnerships are essential in influencing change (Gale and Beal, 2013).

Context and data collection

The healthcare and education sectors in South Africa is a mix between developing and developed country resources and services and service providers in the academic and clinical service setting may vary significantly. The non-variables in this context are as follows: academic institutions present basic nursing courses, including the four-year Baccalaureute degrees and four-year diplomas. After completion of both these qualifications, nurses are licensed by the statutory body (the South African Nursing Council—SANC) as nurses (general, psychiatry and community) and midwives. No differentiation is made between graduates and diplomandi from a clinical point of view. The basic theoretical training includes an average of 16 credits (160 notional hours) related to healthy newborn and high-risk or ill neonates, as part of the midwifery component of the qualification. The practical component, done in simulation or in the clinical setting may range between two and 16 credits. Subsequent to their basic training, nurses can enrol for a post-basic qualification in advanced midwifery comprising another 16 credits of neonatal care. Post basic qualifications include post-basic diplomas, honours degrees, structured master's degrees or master's degrees by dissertation (without any clinical teaching component). The qualification Medical and Surgical Nursing Science: Neonatal Nursing, was offered in South Africa until 2012. The statutory body restructured the specialization areas and neonatal intensive care (NIC) no longer has an independent status, but was incorporated into paediatric intensive care or advanced midwifery (in future this will be known as midwife specialist). The result of this changed structure is that neonatal intensive care nursing is not currently offered at any training institution in South Africa. However, the need for NIC trained (and experienced) nurses did not decrease, but rather expanded due to the non-delivery of this category of professionals by training institutions. Both academia and clinicians voiced their concerns about the effect of shortages of these specialised skills on infant mortality and morbidity rates. The **first step** towards addressing the problem was taken when the question was raised within the context of neonatal care and training: "How do we ensure evidence-based skills and knowledge for clinicians even in the absence of any formally recognised specialization training programs?" (Lubbe, 2010b).

Step two involved the identification of challenges faced by academia and clinicians. Faculty from the university (academia) hosted a stakeholders' meeting including academics, nurse clinicians and relevant industry partners to explore the challenges from different role-players' perspectives. A one-day meeting was attended by 30 delegates (Lubbe, 2010a). The aim of this meeting was communicated as: "… the start of a better relationship between practice and the university. A place where challenges and problems can be tabled and solutions can be obtained that will be in the best interest of all the parties involved" (Lubbe, 2010b).

The objectives aimed to provide an overview of training, projects and research at the university with regards to neonatal care (healthy, high risk and ill newborns and neonates); determine needs regarding training and development from the perspective of all the participating stakeholders (Flores et al., 2013); discuss the contributions towards the improvement of neonatal care from the stakeholders' perspectives; and suggest a plan for future neonatal training and development (Lubbe, 2010b).

After academics' presentations, group discussions followed. The presentations included the current training presented by the university related to healthy, high risk and ill neonates and infants. The discussed training included the undergraduate neonatal modules of the midwifery component, the neonatal module comprising part of the advanced midwifery training and short learning programs ranging from one to five days, on selected neonatal topics, such as neonatal resuscitation, neurodevelopmental supportive care and breastfeeding.

Projects which were led by the university included a Maternal-Child Health Nurse Leadership Academy (Lubbe et al., 2011), presented in collaboration with an international industry partner and nursing organisation, through which dyad-pairs in non-management positions were guided by faculty to initiate a research project through which leadership skills were acquired. A second project concerned the validation and implementation of best practice guidelines for neurodevelopmental supportive care (Lubbe, 2011) and a third project, NECQIP, aimed to support clinical units to develop towards becoming units of excellence (Lubbe, 2010a).

Step 3 involved obtaining feedback from the stakeholders, including current initiatives, needs, and gaps experienced with regard to neonatal care. The facilitator initiated the discussions about needs and gaps, and analysed the challenges and solutions for improving academic-clinical partnerships.

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The discussions were directed by pre-set questions which included expectations from the academia and clinicians with regard to students' clinical accompaniment and mentorship by posing four questions:

Question1: '*What do you expect from students when they are in your facility?*'

Question 2: *'What do you expect from a clinical preceptor?'*

Question 3: *'What do you expect from a [nursing/midwifery] clinician?'*

Question 4: *'How can we strengthen midwifery [and neonatal care] in the North West Province of South Africa?'*

Since the midwife is often also the neonatal care provider the questions were directed towards the midwifery clinician, because by implication neonatal nursing is regarded as being 'part' of midwifery in South Africa. The group of delegates, was divided into smaller chat-groups of about five participants each. The first question was posed and participants were asked to write down at least one expectation per person (on sticky notes) and then share these with the whole group.

Data analysis

The sticky notes were posted onto a flip chart and the larger group suggested which similar expectations could be grouped together thematically. This process was repeated for each question and the findings are summarised as follows:

Results

Question 1: The clinicians' expectations of students included that students should be able to provide health education of a high standard; demonstrate professional and positive attitudes towards working in the specific clinical area; be inquisitive and use the learning opportunities in the clinical setting; be treated as part of the work force, even though they are full-time students and not full-time employees. Show respect towards permanent employees and good communication skills with doctors, patients and family members. Work ethics were expected from students who had to be conversant with the policies and procedures of the clinical setting; demonstrate sound ethical conduct, understand their scope of practice and be safe practitioners familiar with all safety measures and procedures within the clinical facilities while they are active participants, take initiative, assist with administrative tasks and be critical-analytical thinkers who have management skills.

Question 2 related to the clinicians' expectations with regard to clinical preceptors, who were employed by the university for the purpose of student accompaniment in the workplace. The feedback included that preceptors should be familiar with the policies, procedures and equipment of the hospital and that they should have a working policy and know how to achieve outcomes. Preceptors were also expected to be subject experts in their clinical field with an additional qualification in nursing education, to be hands-on with both theory and practice, and to be up to date with the latest evidence in their subject field. With regards to working hours, the clinical setting expected preceptors to be available for day and night shifts and increase the hours currently spent accompanying students. The student-preceptor ratio was expected to be 1:15, which is also supported by guidelines from the statutory body. In the current nursing education model, the expectation is that preceptors should be employed by the university on a full-time basis. However funding for preceptors' positions posed challenges. Preceptors were expected to have passionate and positive attitudes towards clinical practice. Student education was regarded as being important, as well as the ability to guide young students patiently, while being a role model adhering to professional work ethics. Finally, the preceptor was expected to follow-up on students' absenteeism and to maintain an approachable attitude (Anon, 14 April 2010).

The *third question* focussed on the expectations academia had about the neonatal clinicians (for healthy and high risk infant care). The clinician was primarily expected to be a passionate mentor and role model for students and to regard his/her duty as a calling and not just a job; to be an approachable leader and advocate for students; to identify learning opportunities; to be willing to teach, being fully involved with learning opportunities and possessing good management skills. Ethics were further highlighted and the clinician was regarded as having a joint responsibility with preceptors and students with regard to ethical conduct. Clinicians were expected to be clinical experts in their field and the academics highlighted the importance for clinicians to obtain up-to-date evidence-based knowledge and skills, to be a theory and practice expert, to be able to explain legislation and guide students in the right direction. Finally, clinicians were expected to ensure alignment between the hospitals and university regarding procedures and to align the expectations and outcomes of the students when placed in clinical settings (Anon, 14 April 2010).

Operational challenges identified during this session included communication channels, off-duty arrangements, students'/preceptors' leave and students' assignments and record keeping.

The final question also addressed **step 4** of the partnering process by creating something new – a plan for the future to strengthen neonatal care in the province, even in the absence of the recognition of formal neonatal training by the South African Nursing Council. The primary challenges in this regard is that employers do not approve study leave for nurses for any training that is not recognised by the South African Nursing Council and that there is no incentive (financial or otherwise) for nurses who did any form of continues training in the field of neonatal care. However, the need for skilled neonatal nurse practitioners did not decrease, but rather increased.

The facilitator changed the method of 'data collection' for the last question by including creative solutions to address the identified challenges. Working in small groups, the stakeholders were given the following task: 'On the pink sticky-notes- write at least three training and development needs in neonatal nursing care from your perspective, such as ventilation workshops or best practice guidelines development for developmental supportive care'. These sticky-notes were then posted onto a flip chart and the group suggested which themes should be combined into groups. After this combination of similar topics, each group of topics was assigned a descriptive title. A follow-up question was posed: 'On the green sticky-notes, write down how you can contribute to address any of the identified training and development needs'. Stakeholders were further requested to prioritize their contributions from the most attainable contribution to the ones they would wish to implement, but which would require additional resources. After all the thoughts had been posted on the flip chart and everyone had a chance to read it, the final question was posed: 'In your capacity as representative from your company/hospital/training institution indicate at least three areas where you can contribute to address training and development needs already identified, for example, 'we have an online program available on neonatal drug administration'; 'we can support setting up a breast milk bank'; or 'we would like to fund the development of a feeding program for newborn/preterm infants'. The final findings were put up on a board where all participants could review and discuss the findings. These discussions stimulated new ideas for more effective solutions, after the different perspectives had been discussed. In this way solutions were found that were suitable for the specific

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