

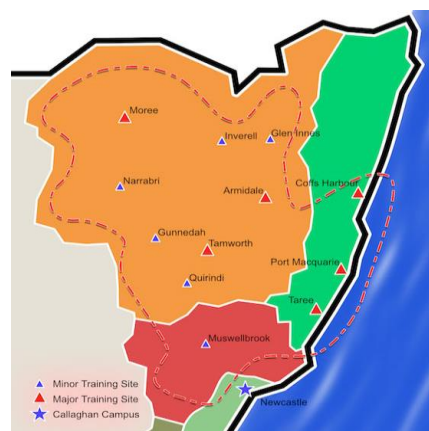
## REVIEW OF NURSING EDUCATION: EDUCATING THE NURSE OF THE FUTURE DISCUSSION PAPER

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### The University of Newcastle Department of Rural Health

The University of Newcastle Department of Rural Health (UONDRH) is funded by the Australian Government Department of Health under the Rural Health Multidisciplinary Training (RHMT) program. The RHMT program encourages students of Medicine, Nursing and Allied Health professions to pursue a career in rural practice by increasing aspiration in rural high school students, providing opportunities for students to complete part of their studies in rural locations and promoting and supporting opportunities for long term rural careers.

The UONDRH covers a substantial area in NSW as shown on the map. We support students doing placements across this region in the disciplines of Medicine, Nursing, and a range of Allied Health disciplines. The UONDRH employs 3 general nursing academics and 1 mental health nursing academic to support students and clinicians within this footprint. This discussion paper is a collaboration by the UONDRH nursing academics and the UONDRH director Professor Jenny May.



## Summary

With the international nursing shortage looming, and the continued debate regarding new graduate nurses not being “practice ready”, this is a timely review into nursing education in Australia. The improvement of the education, recruitment and retention of nurses requires a multifaceted approach with strategies along the pipeline. The concept of skills escalator from AIN to EEN to RN to NP should be explored. This discussion paper will review the UONDRH’s current concerns about the educational preparation of undergraduate nursing students and also the support of new graduate nurses in Australia and the potential impact of a “business as usual” approach in entrenching a maldistributed workforce.

The key issues in this document describe practical strategies and responses considering the adequateness of educational preparation and readiness for practice and whilst relevant in metropolitan areas the impacts are magnified in rural areas when there is often a greater mismatch between the educational aspiration of nursing education and the work ready staff member.

## Issues

### 1. *Educational preparation*

- The current Nursing curriculum identifies a minimum 800 hours. Clinical placements are considered essential to the successful preparation of graduate nurses (**Ajiboye, 2000; Conway & McMillan, 2000**). However, evidence from graduating nursing students and supervisors indicate significant concern that the clinical hours are not sufficient for appropriate priming clinical exposure (**Milton-Widley et al.,2014; Forbes & Hickey, 2009**)
- Nursing courses often provide limited opportunity for participation in **quality** Labs/simulation due to cost and high number of students.
  - Laboratories not well equipped and often over crowded.
  - Students not given time to practice skills more than once. This is due to time as well as due to cost of consumables.
  - Students are marked off as competent completing the task, even though in the real world environment or on clinical practice they might require multiple

experiences to demonstrate competency at a task (e.g. priming an IV line, or mixing up IV antibiotics).

- There remains a lack of **quality** clinical placements especially in non-metropolitan areas, aged care, mental health, primary care and general practice.
  - Due to limited number of placements students often being given unsuitable placements. Some third year students arrive on placement having never been in a hospital on a previous placement.
  - Wards in acute hospitals may suffer from overcrowding of wards by students
  - Lack of quality supervision/facilitation – Whilst there is variability there can be situations where there is no formal performance assessment of facilitators, with poor on boarding procedures and training provided for facilitators. Often agency staff who are unfamiliar with the ward and hospital are utilised for facilitation.
  - Some universities do not provide a facilitator at all. Therefore when there are issues with a student they are often not performance managed due to lack of time by clinical staff, who are already managing their own daily workload.
  - Rising costs of clinical placements and facilitation are a major factor.
- With negative or minimal exposure, unfortunately students often view aged care, primary health care, general practice and mental health nursing positions unfavourably and see them as a last resort if they can't get an acute care new graduate position.
  - There remains a great deal of focus on acute care employment as this is where the majority of new graduate positions are offered. There needs to be a higher number of funded and supported new graduate position in the aged care, primary health care, general practice and mental health sectors which will have the secondary impact of supporting depth of clinical supervision
  - Student experiences in aged care are often suboptimal and perceived negatively as universities will send 8 students (equivalent to 1 facilitator for supervision) to an aged care facility to work with 1 registered nurse. The students often end up working with AIN's and feel this is a waste of their limited clinical placement hours as they are not learning "how to be an RN". They don't get to see the full RN role in aged care as they are "laboured" to work with the AIN's and get the showers completed.

- There are a lack of general practice clinical placements. Nursing opportunities will increase to the future in primary care. The lack of exposure is hampering the available workforce. This is an area needing future development.
  - There is also lack of training for staff in these areas to provide good quality clinical supervision and support students.
- Also problematic is that of “masters” students entering the workplace as 2<sup>nd</sup> year students with any degree prior to undertaking masters (i.e. not a health degree). This problem is accentuated with international nursing students as commonly there are issues with English language proficiency and culture that impact upon their clinical placement. However because they enter at 2<sup>nd</sup> year they often miss the foundational nursing skills taught in 1<sup>st</sup> year.
- There is a lack of inter professional education. Health education is now consistently recognising the importance of team work and collaboration in the delivery of quality health care. Inter professional education is assessable and valued in other allied health and medical curricula however nursing has done little to incorporate inter professional education into the undergraduate curriculum. The size of the intake of students and issues with timetabling with other disciplines is often cited as the reason for this at the main campus.
  - Students on placement at University of Newcastle Department of Rural Health sites are offered the opportunity to participate in inter professional training. However, due to students from most universities only completing the minimum number of hours to register (800hrs), students often cannot participate. This is due to the lack of recognition of inter professional training as contributing to clinical placement hours as it is not deemed to be “face to face” clinical learning

## **2. Acute Care facilities placement issues**

- ***Clinical placement issues***
  - Students are often being used to backfill shortages of qualified staff on the wards (sitter for confused patients/escorts/take full load with only CNE supervision)

- Students are often not exposed to full RN role (being laboured – make beds/do showers/take observations while the RN does the “registered nurse jobs”)
  - High volume models with large number of students approved to be on placement, and continual “streams” of students leading to burnout of good clinical staff who support students
  - There remains some negative workplace behaviour and bullying towards students on placements. Students are often made to feel unwelcome and not allowed to use lockers or tea room, belittled for lack of knowledge, made to do the “dirty” tasks.
  - Structural lack of support and training or remuneration for staff to take on a student. Currently there is no incentive to precept a student as nurses are still expected to complete their own full patient load whilst also training a student.
  - Lack of training opportunities particularly in regional and rural areas for nurses to improve their clinical supervision skills.
- ***Clinconnect issues***
    - In NSW there is a state based program for the allocation of clinical placement positions to the tertiary and TAFE sectors. However, there does not appear to be enough specific training for health service staff on how and when to use clinconnect to approve student placements. Often in the rural and regional areas this task is allocated to someone outside the hospital within a “cluster”. This person often does not liaise with the smaller hospital/units and has little awareness of ward capacity and often over allocates students or the wrong type of student to a ward. This disconnect of this process to the clinical workplace can result in placements being poorly targeted.
    - University representatives also often request and take more placements than needed on clinconnect and then do not actually fill the places. These placements are then not able to be used by other universities. The clinconnect approval process and placement by exception to refill with another university is time consuming and difficult as only HETI can approve past a certain date point. Surely, this system can be made more responsive to actual need. The cancelation of clinical placement requests impacts in particular upon rural/regional areas. These placements are the first ones to be cancelled as it is seen easier to cancel rural placements as students “don’t want to go” rather

than encourage students to go rural for placements. Goodwill and support for student placements such as provision of accommodation by departments of rural health is a fixed cost. We continue to lobby with university providers to say that our places should be filled first and cancelled last.

### **3. Endorsed Enrolled Nurse to Registered Nurse Pathways**

- Due to allocation of workloads in current healthcare system in NSW Health an Endorsed Enrolled Nurse (EEN) takes their own load same as a Registered Nurse (RN) makes own decisions (without supervision of RN) – Only having the Nursing Unit Manager (NUM) as overarching supervision for ward. A lot of clinical staff don't see any difference between EEN and RN role (except for pay) and do not understand delegation as there is a lot of blurring between the roles. An EEN or RN is seen as just a number on the floor for a patient load. This issues arises from our current nurse hours per patient day staffing system, which does not take in account patient acuity or skill mix to safely care for those patients.
- There is very little support or incentive for EEN staff to upskill and complete Bachelor Degree. EEN staff from rural areas could be sent anywhere to complete their required clinical placements and this is often a deterrent. Supporting remote supervision and accessible affordable pathways for EEN's to RN's is likely to increase workforce retention in non-metropolitan areas
- No support for new graduate EEN's. Very few formal transition programs are offered at hospitals. This group of professionals often require to earn income while they are learning and are much less mobile than the school leaver aspiring to RN training.

### **4. New graduate readiness for practice/support**

- What is readiness for practice? There is a lack of agreement between the universities re: preparedness at a "novice" level, and what is required/needed by the health service (to hit the ground running) (**Burns & Poster, 2008; Greenwood, 2000; Hickey, 2009**).
- New graduates are expected to manage the same patient loads equivalent to that of their senior colleagues. The impact of nurse to patient ratios upon new

graduates is greater due to their increased need for support whilst their confidence and competence develops. This impact is great in NSW where there are no current mandated nurse to patient ratios.

- Understaffing and inadequate skill mixes are prevalent in the rural setting. Often the new graduate nurse is one of only 2 RN's on the ward or may in fact be the only RN on shift **(Lea & Cruickshank, 2015)**.
- There are significant patient safety implications when a “novice” nurse is the most senior nurse.
- Lack of structure of transition to practice programs
  - No consistency between hospitals or even between wards within the same hospital re: new graduate support.
  - Study days often cancelled due to short staffing
  - No CNE support on the ward for new graduates as in rural/regional areas as CNE's are often working on the floor to cover staff shortages or take patients on escorts.
- Negative workplace behaviour – Bullying and uncivil behaviours tolerated as a “rite of passage”.
  - Senior nurses are burnt out and stressed and report having no time to assist novice nurses with their workload as they often busy trying to complete their own workload. This leaves novice new graduate nurses feeling like they have no support and no option/avenue for assistance **(Hawkins et al., 2019)**.
  - New graduate retention is directly related to their first year experiences **(Hawkins et al., 2018)**

## Recommendations

### 1. National Curriculum change

- More focus upon areas where there is nursing shortage. There is good evidence that positive early exposure to areas of workforce shortage increases long term recruitment. Valuing rural and remote, primary health

care, aged care, general practice and mental health career pathways and improving the quality of clinical placements in these areas is important.

- Improving the utilisation of laboratories for teaching students. Including a capped number of students per lab, and skills should not be able to be signed off only in the lab setting after seeing the student complete the skill once.
- Considering competency based training -Students to complete a skills passbook as a part of their degree over the three years of their clinical practice. All skills to be signed by the end of the three years. The skills are to be signed off when an RN deems they can competently complete the core skills in the clinical setting.
- Students should have equitable access to quality clinical placements. Some students sent to all community and aged care placements, without exposure to acute care, and vice versa. There should be a clear tracking program where students need to complete a minimum number of hours in certain types of locations.
- The cost of facilitation at a casual rate is what costs the universities the most money to support students on placement. This facilitator very rarely sees or works with students and it is often the front line nursing staff signing off the student's competencies and reports. The money spent on facilitation would be better spent providing remuneration for preceptors (front line RN's) who are doing the bulk of the education. This could be like an "in charge" shift allowance.
- There should be a limit put on the number of students that universities can accept into the nursing program. Admittedly, we need nursing graduates but the throughput of so many students is resulting in poorly prepared students, overworked clinical staff, and new graduates who do not remain in the profession. The focus should be on quality not quantity.



## 2. Improving the transition of new graduate nurses

- Students should be educated about the “theory-practice gap”, experiences of new graduates and given skills to speak up against negative workplace behaviour.
- Improvement in the recognition, reporting and management of negative workplace behaviour.
- Increasing the number of funded new graduate nurse transition programs. Including in areas such as aged care, mental health, primary health care and general practice
- Providing a “stepped” approach to the allocation of workload to new graduates. After their supernumerary days, new graduates should begin with a reduced workload, working up to taking a full RN workload by the end of 12 weeks.
- Ensuring that clinical nurse educators remain on the wards in their dedicated education position to always be a “safe person” for the new graduate to approach for support. Educators need to stop being used as clinical front line staff to fill shortages.
- More staff to be trained to preceptor/mentor both students and new graduates to improve the support they are given.
- Nurse to Patient Ratios need to be considered in all states, as it is impossible for staff who are currently overworked to provide quality training. If staff on the floor had more time to train students, one would hope it would lead to more exposure of the “full RN role” rather than students being used as an assistant nurse to complete laboured tasks such as showers and making beds. Appropriate nurse to patient ratios would also improve the support of new graduate nurses, allowing for their colleagues to have more time to assist new graduates with their workload. It would also be a more realistic workload for

new graduates who are sometimes expected to manage 6 – 8 patients with the assistance of an assistant nurse.

- Increase availability and offering of Employee assistance programs/ debriefing and avenues for support for new graduates.

### **3. Address the maldistribution of the nursing workforce by**

- More focus upon areas where the nursing shortage is affecting. Valuing rural and remote, primary health care, aged care, general practice and mental health career pathways and improving the quality of clinical placements in these areas
- Clinical placements should be of a longer duration. A lot of health degrees now incorporate yearlong clinical placements (in particular in rural areas). These longer placements will improve student belongingness, and assist with embedding students into the community and improvement of future recruitment
- Increase collaborative type model clinical placements where students belong to a hospital and complete all clinical placements at that hospital, with a view to employ those students post registration (pending successful completion of degree and clinical placement performance).
- Recognition of the wider scope of practice and multiple skills of rural nurses
- There needs to be improved consultation about and training for clinconnect, in particular for rural and remote sites.
- Increase training and support for nursing staff to provide clinical supervision. In particular areas such as aged care, primary health care, mental health and general practice. To improve student support and experiences in these areas.

## Conclusion

With the predicted nursing shortage of 110 000 nurses by 2025 weighing heavily (Health Workforce Australia, 2014), it is imperative and timely that this review into nursing education takes place. Whilst previously the answer has been to remove the cap upon nursing undergraduate numbers, it is evident that the throughput of nursing students is placing increased pressure upon the university sector to secure and support quality clinical education. The increased student numbers requiring clinical education also place increasing strain upon an already overworked and burnt-out nursing workforce. The focus of nursing education should be upon the quality of their graduates, not the quantity entering the workforce. With smaller nursing numbers and an improvement in the quality of clinical education, one would hope the outcome would be “work ready” graduates. These work ready graduates, provided they then receive appropriate support from organisations should transition relatively smoothly into the workforce. The recruitment, training and retention of work ready graduates should be a partnership between both the tertiary and clinical sectors. As the saying goes, “you reap what you sow”. It is time that the blame game between the tertiary and clinical sectors for the “lack of work readiness” came to an end, and both parties should be held accountable for their contribution towards the development of nursing graduates, the future of the nursing profession.

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