

Submission

Review of Nursing Education

2019

This submission focuses on the TOR;

“the effectiveness of current educational preparation of and articulation between enrolled and registered nurses and nurse practitioners in meeting the needs of health service delivery.”

Background

I have been directly and continually involved in tertiary Nurse Education since 1986, the second year of the transfer in NSW. During this time I have been employed full time at: Charles Sturt University (formally Mitchell College of Advanced Education) 1986 – 2001; UTas 2001 – 2002, Monash University 2002 – 2011, University of Newcastle (UoN) 2012 – 2019 (retired last month). My final appointment was as an Associate Professor. It also should be noted that I also remained in my clinical area (critical care/ ED) part time from 1988 – 2010. I hold the following degrees; B.App.Sci., GradCert E.P.(Emergency)., GradDipC.P.(Emergency)., M. H.Sc (Education)., Ph.D..

Initially I was teaching theory and supervising clinical practice I soon became involved/ chaired the curriculum development of the second Diploma in Nursing, the inaugural and subsequent Bachelor of Nursing (pre-registration) and post-registration undergraduate and masters' programs. Later I chaired the program development of Graduate Diploma/ Certificates in Emergency, Critical Care and Med/Surg Nursing at UTas, Monash and UoN. In addition, chaired formal reviews of nursing programs. I have been the program convenor of the pre-registration degrees and the Masters' and Graduate programs at **all** universities. The post-graduate programs were based on the results of either a needs survey or consultation with industry.

This submission will be organised into two main sections; undergraduate and post graduate.

Undergraduate

Introduction. In 1985 NSW moved nurse education from hospital apprentice system into the Colleges of Advanced Education as a 3-year Diploma. This level was soon changed to a 3-year degree qualification, this move was a lost opportunity as in the review at that time a 4-year degree was put forward and rejected. Nursing in the **only** profession that remains with a 3-year degree.

Theory: In these early programs students studied supporting/ foundational subjects that provided a springboard for nursing knowledge. These subjects included; biological sciences, sociology, foundations and abnormal psychology. Currently all but rudimentary biological science has been removed from most programs to make way for more nursing content. Some educators may argue that these subjects are now integrated within nursing subjects, however it has been my experience that the integration has failed. Nurses teaching these areas are not adequately educated (or qualified) in these areas and can diminish the value to the student

also they demonstrate a dismissive attitude to the topics. Consequently in current programs students are struggling as with nursing concepts as they do not have the fundamental knowledge required.

In the remaining biological sciences the content has been simplified to a less than adequate level. Students then come to their nursing content either not understanding or with a misunderstanding of the physiology and pathophysiology and most nurse educators are unable to adequately relate the nursing concepts as they do not have a suitable background in biological sciences. The human sciences are often seen as been 'too hard' and students have agitated to have content changed. In my experience the scientists teaching science to nurses just need guidance in the learning outcomes required and these conversations are often avoided. There are only a few nurse educators with an undergraduate science degree and these nurse educators are better able to guide science educators as they can speak a common language. The nurse educator with a science background understands the scientific concepts that students need to link. I believe it is critical that students have the opportunity to understand the science before introducing nursing knowledge. Students that have completed all their science subjects before their nursing subjects struggle less with the nursing content as they are not trying to learn two new related concepts at the same time. At one university I worked a nurse/ scientist ran the tutorials and the final science subject cross taught – this was a great success.

The nursing concepts have become fragmented in many programs and the content tend to reflect the background of the lecturing staff rather than the knowledge required for a novice registered nurse. As the student no longer have the foundation subjects the nursing content appears more complex than it actually is. The increase in the acuity of the patient population is not appropriately reflected in current nursing programs, managing the deteriorating patient tends to be taught as a 'between the flags' or DETEC approach rather than an identification of trends before the patient becomes a MET call. When developing nurse programs the debate on content needs to focus on a work ready graduate and the competencies set down by AHPRA. Most graduates are initially employed in medical/ surgical areas which should provide the opportunity to consolidate knowledge and skills. The reality of the graduate year for most graduates and institutions is that the hospitals are filling in the significant gaps in concepts absent in their basic education. There needs to be consensus on basic nursing content with room for each institution to have some flexibility on other topics.

There are two subjects that must remain separate aged care and mental health. Unfortunately students are resistant to these subjects as many students do not aim to work in these areas. However the reality is that an RN should be assessing and managing the mental health of each patient as an example anxiety can affect post-operative pain. Further the majority of inpatients are older, and the numbers are increasing with the 'baby boomer' group hitting retirement age, most students dislike age care immensely. In aged theory student are usually only exposed to mental health issues such as dementia and have an illness focus. This focus has the potential to bias students' perceptions of aging. However, if aged care is taught from a healthy aging perspective, students tend to have a more positive view of aged care which includes the health issues of the aging, students may view aged care in a more positive light.

The use of integrated subjects has failed as most tutors/ lectures do not have a formal background in the topics of integration mainly lifespan issues, ethics, research and law. When separated students had a better understanding. If integration is to remain it should be

developed and written by experts in the area where the students can clearly identify where the topic sits within their practice, as an example a workbook that has a component for each semester (the completed workbook would be equivalent to a short course in that topic ie ethics). Research could be integrated into clinical subjects in a similar manner to social science programs.

There has been a major push by students and Universities to move to more online modalities of teaching. There are some subjects that are appropriate for this mode of teaching nonetheless nursing is a human interactive profession and students need to interact with their lecturers/ tutors to develop their communication skills. Clinical subjects especially can utilise some online/ virtual methods however students still need to practice their skills on real not virtual people. A virtual environment is unable to develop the fine and gross motor skills required in clinical practice.

Some universities are moving towards online examinations/ tests which are open to cheating. One subject I taught had a 10 questions quiz worth 10 marks, I discovered students were working in a group with 1 doing the quiz and others providing the answers. I took action however most academics are either unable (computer literacy) or unwilling to manage this situation. Formal examinations are becoming less frequent, this is of concern as nurses are required to hold basic and complex information in memory eg normal vital signs. Additionally, an examination is the only form of assessment that the university can guarantee is the student's original work. A formal Australia wide examination would ameliorate concern and improve confidence.

Over time, and as more nurses have completed higher degrees and have entered teaching positions with minimal clinical experience. Nursing appears to be the only profession where clinically inexperienced educators are employed by universities especially if they have been fast tracked to PhD via honours programs. It is hard to teach nursing with limited clinical experience. This issue becomes highlighted when nurses are introduced to critical thinking and/ or clinical decision making. Some staff do not have the clinical background to deconstruct 'real' situations with the student.

One of the issues that needs to be addressed is the entry level of students. Historically nursing has attracted a more mature aged student, which can have advantages such as life experience most enrol in entry programs, but the drawback is usually significant gaps in knowledge compared with the higher ATAR school leavers. School leavers are admitted based on their ATAR however the drive for enrolment numbers there are times when the ATAR score is inappropriately low. Nursing programs tend to have an excessive number of students who struggle academically. The consequence of this struggle is that subjects have been oversimplified. This change has affected the standard of the graduate and placed pressure on employers to remediate new graduates rather than support the role development.

Enrolled nurses aiming to become registered usually enter into 2nd year. This appears to be appropriate however some issues do occur but can be easily managed. The difference between TAFE and University learning is significant, as it should be however EN students need a different orientation to university life. A compulsory orientation to provide access to the academic skills gained by 1st year students and how their roles will change is required (the benefits are found in my as yet unpublished research). In addition I propose that a different first placement where all the ENs are in one group and the focus is examining the RN role in practice.

Some forward-thinking universities have developed a 'Fitness for Practice' document and students' progress can be determined if they meet these requirements. Issues such as mental and physical disability can be addressed, and students advised early in the program. For example, I had two students enrol with Tourettes Syndrome one had a significant hand/ arm tic which would be a safety issue in patient care, she was advised that nursing was not suitable. The other student had a verbal tic which was able to be managed.

International Undergraduate

International students have become a financial life line for some universities and consequently rules for admission are often interpreted inappropriately. Many international students have chosen nursing as a way to permanent residency for themselves and their families only a small proportion plan to return to their home country. In response to the increasing international demand admission criteria are liberally applied, often to the students' overall disadvantage. Entrance criteria can be manipulated to admit students who subsequently struggle

The veracity of overseas English testing has to be questioned especially in Asian countries where sending another person to sit your test is culturally acceptable. English entry requirements are based in either a formal test eg IELTS or completion of a program in English. Most IELTS requirements for university admission are IELTS 6.5 with some as high as IELTS 7 however the reality is very different. One method of manipulation is when the criteria is successful completion of a program studied and assessed in English. The English quality of many of these programs especially those conducted by private colleges is questionable. The English requirements for these programs can be as low as an IELTS 5. Therefore an international student can be admitted to a university with very low initial IELTS. Language and communication then become a significant barrier for student learning and professional outcomes. Many students struggle with even the most basic of English communication and given that an IELTS of 7 is a registration requirement the flow on is that these students then are unable to register with AHPRA despite multiple attempts at meeting the English requirements.

Many universities circumvent this English requirement by offering on campus programs aimed at achieving an equivalent of IELTS requirements. In theory this seems to be a suitable accommodation however the standards used for equivalence to IELTS are flimsy and the variation is too wide between universities. Some universities even guarantee admission if a student passes their program. Students who have achieved the appropriate English standard prior to admission still have issues however are less likely to have communication/ language problems. There is often pressure placed on academics to be more lenient on international students and are constantly reminded of the financial aspects. Pressure is exerted from the student (and their families) and from the university. The university sees international students as a source of income and failing students are not good for business or the KPIs.

International students have both significant financial and academic pressures, and some push their boundaries when faced with failure. For example, an international student came into my office as program convenor and demanded that I change his fail grade as he has paid a great deal of money to study. He was not going to take no for an answer and even complained to the Dean of Faculty (his grade was not changed). However there are situations when international students who are borderline have been successful in have fail grades changed. This situation is both a professionally and ethically unacceptable.

International students may struggle on clinical placement not only with communication but with the culture of Australians and the health care system. Colloquial language from patients (and academics/ students) is particularly confusing for international students. Some education in this regard is critical before the first clinical placement.

A special group that need to be considered in this section is international students who have registered nurse qualification in their home country. Many universities allow this group to enter into the 2nd year of the program which is problematic. Similar to the EN cohort they have difficulty adjusting to the style of study required at a university. This group rarely have an adequate background in science or an understanding of the differences in scope of practice in Australia. Carefully consideration of credits (for prior study) needs to be addressed.

International RNs come with a range of skills and knowledge that is only equivalent to our EN graduates. However as they are registered in their home country they often (initially) see our requirements as excessive. Their knowledge and skills should be recognised however they do lack the understanding of the scope of practice for RNs and the culture of healthcare in Australia. A 2-year program using the BN undergraduate subjects and others specifically developed to address unique needs. These programs should be approved by ANMAC.

The placement of students for their clinical experiences needs careful consideration as students have been racially harassed. Most students do not report this as it is culturally unacceptable to do so, we often find out from other students who have witnessed the abuse and are unsure of what to do. It should also be noted that some institutions welcome international students and work hard to ensure they have an appropriate learning experience; it should be noted that these institutions are more likely to be private or large tertiary hospitals.

Clinical

Adequate and appropriate clinical experiences is a constant struggle for the sector, in addition, the cost of placing students continues to place stress on nursing budgets and staff. There is a fundamental problem in large student numbers and the regions may not have an adequate number of appropriate student placements. This dilemma has multiple factors, these include:

- a nursing shortage and the need to graduate large numbers to fill vacancies which are about to hit a greater crisis with the last of the hospital trained nurses close to retirement,
- The manner in which universities disperse funding,
- Hospitals restricting access for student placement, and
- 13-week semesters.

The minimum hours required by AHPRA has reduced significantly overtime as the ability to place students have become a significant issue for the universities. The push to reduce clinical hours impacts on the confidence and competence of the students and there has been a gradual erosion of graduates been work ready. A four-year program would provide greater scope in clinical placement as well as a positive impact on the theory component. Using the medical model of timetabling, a 40 – 48 week year would reduce timetabling stress.

Each state has a different method of placing students in public hospital and some private hospitals have an= responsible organisational department. In NSW ClinConnect is used this

program has a number of issues including requiring information before the university knows the student numbers for each semester, they rely on (often incorrect) estimations. The ability to negotiate with institutions with specific needs has disappeared. Some private hospitals charge per student and will only have one of their staff supervising the cohort. This situation removes the responsibility for assessment and learning from the university.

Some hospitals are reluctant to have junior students. institution appear to have total control over how many students they take often leaving the university short on placement numbers. Some universities then assign students in alternate placement often in inappropriate areas for their level of study. Students have been placed in either GP practices or nursing homes for their acute (med/surg) experience. With this type of 'placement for placement sake' does not meet the students learning needs. In the 1980's public hospitals in the initial transfer were required to take students at all levels and could not refuse a reasonable request.

Many institutions appear to use students as labour with some private hospitals/ nursing homes reducing staff when students, especially senior students, are on placement. This situation directly impacts on the student's clinical experience and learning. The cost of placement in private hospitals further impacts on the economic viability of clinical placement.

To reduce the economic impact some programs are using simulation as a placement alternative. Simulation, correctly conducted, is an excellent learning tool however it does not replace actual patient care.

It is in this clinical space that an integrated research program can be instigated. The advantage of placing research within the clinical environment the perceived theory/ practice gap would be reduced and the students would have a better grasp on evidence-based practice. For example, one of the first skills taught in labs is vital signs. In this model students are required to conduct a descriptive project based on the vital signs of their entire cohort and prepare a research report. Not only will the student have practice in that skill and of recording data their understanding of range and age variations will improve. Finally the constructs of research and its various components is learned. Each semester a relevant (to learning outcomes) aspects of practice are research moving from descriptive to inductive and quantitative to qualitative research.

From a student's perspective clinical placements have additional concerns. Most students need to work to support themselves (and families), leaving their local area and the use of morning and afternoon shifts place their finances at risk. Those working in health care appear to have more issues getting time off for placement than those working in other industries. Add to this some student must also find and pay for accommodation while on placement. Students have been known to live out of their cars during this period, again, not conducive for learning. Some states do have a scheme/ grant for these students but it is inadequate to cover basic accommodation.

Recommendations for the Future

Theory

- Four-year degree
- Australia wide Fitness for Practice document
- Consensus on foundational nursing content
- A pre-registration Australia wide examination following completion of nursing degree

- Integrated subjects (ethics, law, research and lifespan issues) written by experts into whole of program workbook
- Retain mental health and aged care as stand-alone subjects
- Reintroduction of foundational subjects in science, psychology and sociology
- Compulsory orientation for ENs enrolling in BN programs
- Agreed minimum entry standards
- A Fitness for Practice declaration on admission and each academic year
- A judicious use of online learning with tutorials remaining face to face

Clinical

- An increase in clinical hours (four-year program)
- Simulation not be included in clinical placement hours
 - Simulation used as an in-house teaching tool only
- Use of virtual learning limited to no more than 10% of clinical laboratory hours
- Laboratory hours not counted towards clinical placement
- Government review of funding for clinical practice
- Universities work towards a model of placement based on 40-48 weeks
- Public hospitals required to take a certain number of students based on a (to be developed) formula that takes into account the size of the hospital (patient capacity)
- Increased financial grants to students travelling more than 50km from the University or home.
- Integrated research program
 - Learn research basics
 - Understand evidence-based practice
- The first clinical placement for ENs to be separate from normal 2nd year so that the focus can be on the RN role in practice
- More flexibility for the placement office to negotiate with hospitals directly to meet special needs
- Retain the current minimum IETLS 7 standard for registration
- Enable academics to maintain their clinical practice similar to a medical model not unpaid faculty practice

International

- Minimum IETLS 7 regardless of other criteria
- IETLS to be sat in Australia
- Compulsory health/ cultural orientation
- Compulsory pre-clinical workshops
- Develop a list of suitable (safe) clinical placements
- International RNs in UG programs have a modified 2-year program approved by ANMAC

Postgraduate

The postgraduate space in nursing was initially slow to develop as the first nurse academics initial degrees were not in nursing. Until the transfer to the tertiary sector a Diploma of Nurse Education or Nurse Management were the base academic qualifications and many hospitals

offered certificate qualifications in a range of clinical specialities. Once in the tertiary sector in 1985 it did not take long for hospital trained nurses to demand a degree so that they would be educational equivalents to the new Diploma graduates. Gradually programs were developed at Graduate, Masters and Doctoral levels.

Although the quality varies most registered nurses are able to find a post graduate program to suit their needs. However this is no longer on a level playing field and students mainly choose based on cost rather than quality. UTas is offering no fee postgraduate diplomas and Master's degrees this gives that institution an unfair advantage and has become a degree mill rather than encouraging learning and professional growth.

There is no academic standardisation by ANMAC for the designations of Clinical Nurse Specialist (CNS) Clinical Nurse Consultant (CNC) and Nurse Manager. The College of Mental Health Nurses has set up a credentialing pathway with minimum academic qualifications, thus providing a model for other clinical specialities and their respective colleges.

A clinically based Graduate Certificate/Diplomas that are aimed at a novice specialist/ Advance practice nurse which builds on knowledge gained in their UG degree and clinical practice this is an appropriate starting point. This should be the minimum qualification for CNS and include advanced clinical competencies. The clinical component can be based on the published competencies by the respective colleges. Study at this level should not have unrelated theoretical subjects, the focus needs to be on the theory and practice of the clinical speciality. These programs can be developed with industry input to ensure clinical relevance.

It is at the Masters' level that the deviation into a more analytical, theoretical award is required. Current Masters programs have an adequate amount of variety to meet the needs of nursing working their way up to a senior career path. A review of the core requirements is needed as some programs still have outdated subjects such as contemporary nursing or similar. Given the slow update of Government funding for pure nursing research Masters' programs should include research utilisation and/ or methods to pique the interest of potential researchers.

Research funding is limited reducing the capacity of nurses to have appropriate evidence for practice. Research master's degrees are a suitable alternative for those considering CNC or an academic position. There are many appropriately qualified supervisors providing a significant pool for potential students. These degrees are usually not managed within the Schools of Nursing (& Midwifery) but rather the higher degree department within the university. This ensures that the standard and quality is equivalent to other disciplines and should not be changed.

Studies at doctoral level has two pathways; a professional doctorate and a PhD. Despite arguments to the contrary there is a difference between the two. The main difference between a doctorate and a Ph.D. is in their respective meanings. A doctorate is an umbrella term for a degree or rank. On the other hand, a Ph.D. is a specific degree that falls under the doctorate category.

A doctorate is a program that can result in either a professional or an academic degree. Doctorate studies focus on two main categories of discipline: research and professional. Holders of a doctorate degree are considered scholars and experts in their field of study. The examination of the research can be internal to the university.

A Ph.D. is classified under academic degrees. Graduates with a Ph.D. also employ the same professional and scholarly characteristics of a doctorate. However, Ph.D. degree recipients are more concerned with conducting research and have the necessary skillset to do so. The examination of a Ph.D. is usually by international experts.

For the most part Australia has excelled especially given that in Australia nursing led doctorates and Ph.D s have only been available since the 1990s before that nurses had to study under non-nursing supervisors who usually had little or no understanding of nursing. This factor did have the advantage of our first nurse PhD supervisors were trained by the most experienced disciplines.

There is however a significant problem. As PhDs are managed by the university Higher Degree department nurses must compete with all other candidates for APA scholarships. Many nurses who are candidates for PhD often start part time then if they are financially able move to full time. This basically eliminates their chance of gaining an APA.

Nurse Practitioner

Although I am not a nurse practitioner I have been involved in the final examination of candidates for 7 years. Over this time there has been a subtle and gradual erosion of standards. A nurse practitioner is the highest clinical position and despite the objection of some medical professionals a critical part of our health care system. Universities are experiencing difficulties in finding suitably qualified Nurse Practitioners to convene the programs. Consequently they are resorted to employing NP graduates with little practice at that level. It is not unreasonable to consider that a qualified NP would choose to remain in practice compounding the issue of appropriate curriculum development and management. A solution would be to have a joint position between the institution and the university.

Recommendations for the Future

- Greater level of financial support for doctoral and PhD candidates
- Clinically based Graduate Certificate/ Diploma for novice specialist practice
- ANMAC to set minimum academic requirements for senior clinical nurses
- Nursing colleges design a credentialing mechanism with an academic component
- ANMAC and colleges work in concert to develop a credentialing model for speciality practice
- ANMAC set up competitive funding exclusively for nurse research
- Joint NP/ University appointment to manage NP program