Report of the JPNC Nursing Education for a Sustainable Healthcare System Work Group

Presented to: Joint Provincial Nursing Committee

Sept. 2015

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Background

Clinical competencies are an important aspect of nursing education and are required for new nurse graduates to practice in Ontario (CNO, 2014). The College of Nurses of Ontario (CNO) describes a competency as "the knowledge, skill, ability and judgement required for safe and ethical nursing practice" (CNO, 2014, p. 4). Nursing education programs aim to teach these competencies through a combination of classroom education, simulation labs, and required clinical education/placements.

Nursing educators in Ontario have been concerned for some time about increasing challenges with finding quality clinical placements for nursing students. The Council of Ontario Universities published a policy paper in 2013 analyzing the reasons for the challenges, the initiatives that have been undertaken by educators and government to date in order to address the challenges, and where work still needs to be done.[1]

Parallel to the development of the COU paper, the Nursing Education for a Sustainable Health Care System Work Group was established by JPNC in the fall of 2012, with the support of the Nursing Policy and Innovation Branch in the Ministry of Health and Long-Term Care. The primary objective of the work group was to provide recommendations to JPNC regarding how to develop the clinical education system in a manner that addresses: a) patient needs across the continuum of care; b) interprofessional care; and c) the availability and accessibility of quality clinical placements. The work group was conceptualized during a JPNC retreat in 2011 that identified new areas for nursing stakeholders to work on together.

The work group was composed of representatives from nurse educators, health care organizations that receive nursing students, nursing student groups, CARE Centre for Internationally Educated Nurses, the Ontario Nurses' Association, the Registered Nurses Association, and government representatives from MOHLTC and MTCU. The following individuals participated in the group on behalf of their organizations:

Agency representatives

- Debra Cooper-Burger, Ontario Association of Non-Profit Homes and Services for Seniors
- Chris Dalglish, Ontario Long Term Care Association
- Winnie Doyle, Academic Hospitals of Ontario
- Darlene Furlong, Community hospitals of Ontario (til November 2014), Doreen Armstong-Ross (from November 2014)
- Dilys Haughton, Community Care Access Centres
- Lyn Lynton, Community Health Centres
- Joyce See , Association of Public Health Nursing Leaders of Ontario (until March 2013), Mary Jean Watson (from March 2013)
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Association Representatives

- Irmajean Bajnok, Registered Nurses Association of Ontario
- Zubeida Ramji, CARE Centre for Internationally Educated Nurses

[1] http://cou.on.ca/papers/integrating-clinical-education-into-ontarios-changing-health-care-system/

- Brandon Sheptika, Ontario Nurses' Association
- Linda Haslam-Stroud, Ontario Nurses' Association

Educational representatives

- Sandra DeLuca, Chair, Provincial Heads of Nursing, Colleges of Applied Arts and Technology
- Jennifer Medves, Chair, Council of Ontario University Programs in Nursing (from July 2013)
- Alice Ormiston, Council of Ontario Universities
- Monica Reilly, Colleges Ontario
- Catherine Tompkins, Chair, Council of Ontario University Programs in Nursing (to July 2013)

Government representatives

- Agnese Bianchi, Nursing Policy and Innovation Branch (to August 2014)
- Jennifer Chau, Nursing Policy and Innovation Branch (from September 2014)
- Barbara Gough, Ministry of Training, Colleges and Universities
- Nelsa Roberto, Ministry of Training, Colleges and Universities

Student representatives

- Janny Lee, Nursing Students of Ontario
- Carly Whitmore, Canadian Nursing Students Association, Ontario Delegate

In order to fulfill its mandate to develop recommendations on clinical education, the work group decided to gather more information on areas of shortage, by region and sector, in clinical education opportunities (including placements and simulation), and barriers and facilitators to developing clinical education in these areas of shortage. The work group developed, administered, and analyzed the results of two large surveys—one for health care agencies and one for nursing educational programs. A third survey to gather the perceptions of nursing students on their clinical placements was developed, administered and analyzed for the work group by Jenn Salfi, a nursing professor from Brock University, with the assistance of Corrine Davies-Schinkel, Mary Crea-Arsenio, and Andrea Baumann from the Nursing Health Services Research Unit, McMaster site. The reports for these three surveys are provided in Appendices A-C of this report.

The results of the surveys were reviewed by the work group and final recommendations developed based on these discussions.

Findings

Overall, the work group identified the excellent work that is being done by agency, school, student, and Ministry partners in the clinical education enterprise, and the generally high quality of student clinical experiences. Through analysis of the survey results, the work group also identified several weaknesses in the system:

- the clinical education system is overtaxed across the province as a result of rapid growth in nursing educational programs, restructuring of the health care system, and constrained public funding;
- the immense amount of nursing clinical education work that health care agencies are undertaking is not financially recognized by MOHLTC;
- health care agencies have a limited capacity to expand clinical education capacity under current conditions;
- the contributions of nursing students to clinical agencies are not well understood;
- there is a lack of consistency amongst schools and agencies in implementing clinical education best practices;
- there are inconsistencies in the quality and diversity of student clinical experiences, including the quality of the clinical environment more generally; and
- no overarching clinical education coordinating body exists to create efficiencies, ensure consistency across the province, and build capacity in the system as a whole.

The recommendations set out below seek to address these weaknesses by building on and ensuring consistency in the excellent work that is already being done in the clinical education field, and by filling gaps that have been identified in terms of provincial coordination, research, and funding.

Recommendations

Timeline definitions

Short: in the next 2 years
Medium: 2 to 5 years
Long: more than 5 years

Recommendation		Target group	Timeline for implementation	Supporting evidence/rationale
Provincial coordination, standardization, streamlining				
1.	Identify a provincial planning and oversight mechanism or body for clinical education in order to create provincial efficiencies and consistency, and build capacity • Involve this body/mechanism in implementing and maintaining recommendations 2 and 6 to 8 below • Explore MOHLTC, HealthForce Ontario, LHINs, and other bodies as possibilities for this mechanism • Ensure mechanism/body has authority to create incentives for stakeholders to work together	MOHLTC, MTCU	Short	Other provinces have health authorities that take responsibility for regional or provincial planning and streamlining of clinical education, e.g., BC, AB, SK, QC, with significant economic and consistency benefits Decentralization of clinical education in Ontario makes it difficult to create systematic approaches and streamlining, leading to lack of efficiencies and consistency (e.g., in preceptor training, student and placement tracking, evaluation, and capacity building)
2.	Implement welcoming practices for students at the beginning of clinical placements.	Agencies	Short	• Students' survey indicated a challenge for some students in feeling welcomed and thereby able

Recommendation		Target group	Timeline for implementation	Supporting evidence/rationale
				to maximize the placement opportunity • Welcoming practices are in effect at many sites and are effective at supporting a positive learning experience.
3.	Work towards consistency in orientation and training for clinical instructors and preceptors across the province, in order to foster excellence and create efficiencies • Establish minimum expectations, based on best practices, for clinical instructors and preceptors by putting these expectations into MOUs between agencies and schools • Harness CNO Practice Guideline on supporting learners as part of preceptor training • Include: a. anti-bullying training b. student's rights and responsibilities c. *Occupational Health and Safety Act* requirements to ensure	schools, agencies, professional associations, unions	Medium	• Students' and schools' surveys show quality of clinical instructors and preceptors to be a major factor in quality learning experiences, and possibly the major factor • Training for instructors and preceptors currently siloed, duplicated, and not consistent • Funds from Nursing Career orientation, mid-career and late-career nursing initiatives are currently not fully utilized; could be optimized by focusing them on preceptor training initiatives and student welcoming practices at agencies (see recommendation 4 below)

Recommendation		Target group	Timeline for implementation	Supporting evidence/rationale
	a safe working environment d. training for diversity of learners (e.g., internationally educated nurses) e. review of JPNC work group students' survey results f. a focus on student learning objectives • Explore redirecting some existing funds from Nursing career Orientation, mid-career initiative, and Late Career Initiative, to facilitate this • Explore RNAO clinical fellowships to help facilitate this	MOHLTC RNAO		
4.	Establish a common framework as a basis for building quality indicators for clinical education, in order to develop consistency in evaluation practices across the province • Include components for clinical instructors, preceptors, placement settings, schools, student	Schools, agencies, CASN	Medium	• Currently quality is measured locally and inconsistently. A common framework will form a foundation for consistency in measurement of quality, while allowing sensitivity to local contexts and individual program missions.

Recommendation		Target group	Timeline for implementation	Supporting evidence/rationale
	perspectives • explore document the Canadian Association of Schools of Nursing is developing as a template for assessing quality • Synchronize with clinical instructor and preceptor training content and objectives			
5.	Provide training for students on anti-bullying legislation, students' rights and responsibilities on placements,[2] and expectation for student feedback to school on negative incidents, in order to ensure that all students are prepared if they encounter less than optimal working environments Incorporate within agency / school agreement that agency policies and training on anti-bullying are implemented and supported within the agency	COUPN, CAATs, Agencies	Short	• Students' survey showed those who have poor experiences most frequently attribute it to the workplace environment and/or clinical instructor; need to ensure that students are prepared with awareness and advocacy skills related to this, and that agency policies related to this are being implemented.
6.	Establish common student	Schools,	Medium	• Each agency has own template;

[2] Many schools have students' rights and responsibilities in course syllabi; make consistent as part of orientation for placements.

Recommendation		Target group	Timeline for implementation	Supporting evidence/rationale
	placement agreements (by region, sector, provincially), in order to decrease administrative burden and inefficiencies involved in numerous, individual contracts currently negotiated between schools and agencies	agencies		colleges and universities negotiating multiple, individual agreements—work is duplicated and not streamlined
7.	Establish provincial guidelines on sharing of clinical education spaces across schools, particularly tertiary acute, mental health acute, and other hard to find placements, in order to ensure equity of access for students/programs • explore embedding guidelines in placement agreements between schools and agencies	Agencies, schools	Medium	• Lack of equity identified by schools and students as a factor for some students in access to diverse placement settings and populations • Some institutions have historically negotiated preferential treatment for their students and other students are excluded
8.	Expand use of HSPnet to 100% adoption by all Schools of Nursing and large receiving agencies in order to: • create a common, reliable data source on clinical education • optimize the streamlining effects of HSPnet for: o communications	COUPN, CAATs, Agencies, JPNC	Medium	• HSPnet already used by 70% of Schools of Nursing and 122 placement organizations. • Benefits of expanding use and functionality in one system vs. multiplying systems and work. • Can house e-learning modules and track compliance for e-learning and student prerequisites—this is being implemented in Ontario

Recommendation		Target group	Timeline for implementation	Supporting evidence/rationale
	between schools and agencies o housing orientation modules and tracking of completion o tracking of clinical instructor and student pre-requisites o enhancing student choices o flagging of placement request conflicts amongst different schools and programs to facilitate conflict resolution o evaluation • help identify unused capacity in the system • manage risks related to infectious disease outbreaks that can interrupt placements, pre-requisite and orientation compliance, and protection of privacy for students and patients • shift provincial governance and management functions of HSPnet from Council of Ontario Universities to a more			• Currently being expanded to house and track evaluation modules • Currently being enhanced to flag unused capacity and enhance student choices • Used in BC as trusted site to link students to e-health records while maintaining privacy • Data potential to be realized with expansion of use

Recommendation		Target group	Timeline for implementation	Supporting evidence/rationale
	central body (see recommendation #1) COUPN and CAATs should provide an annual report to JPNC on use and potential of HSPnet for clinical education			
9.	Establish clear HHR strategy so that schools and placement partners can manage number of PN, baccalaureate, and IEN students, optimize existing clinical placement capacity, meet employer demand, and create space to integrate the large numbers of IENs seeking access to the nursing workforce	MOHLTC, MTCU, MCIIT	Medium	• Over past 15 years government has had a growth model for nursing enrollment; more recently, some programs may be growing out of alignment with employer demand and employment rates. • Competition for placements is very high and major factor in challenges with finding quality placements (factor identified in all 3 JPNC work group surveys) • Need to synchronize supply with demand in order to optimize placement capacity.
10.	Add CAHO representative to JPNC committee	JPNC	Short	• CNE academic hospital voice on JPNC is critical in helping to address nursing education and research issues.
Research				

Recommendation		Target group	Timeline for implementation	Supporting evidence/rationale
11.	Conduct research on efficacy of simulation and other alternative clinical education and curricular models that could expand capacity. The results of the research would be widely disseminated with placement partners.	Schools, agencies, CNO SIM One	Medium to Long	• There is one important US study on simulation as substitution for clinical education, but more is required to move forward • A lot of alternative models being tested by schools but not a lot of systematic evaluation is being done
12.	Conduct research on nursing students' contributions to agencies in terms of knowledge exchange, transfer of clinical expertise, enhancing currency of preceptor and staff nurses, recruitment, and other relevant outcomes, in order to clarify the benefits to agencies of taking students, help determine costing amounts (recommendation # 12), and foster a culture of teaching	Schools, agencies, government	Medium to Long	• Currently very limited research on this topic
13.	Investigate barriers and facilitators to expanding placement capacity in the home care sector, and develop recommendations related to this	Schools, agencies	Medium	• The Agencies survey was not successful in gaining evidence from the home care sector. Data is still needed for this sector.
Funding/Recognition				
14.	Build clinical education into agency funding, such as Health Based	MOHLTC	Medium	• Agencies survey shows little visibility or recognition for clinical

Recommendation		Target group	Timeline for implementation	Supporting evidence/rationale
	Allocation Model (HBAM)for LHIN-funded organizations, and as part of base funding for primary care, public health and other non-LHIN funded organizations, in order to recognize work being done in agencies, increase clinical education capacity by creating incentives, recognize the link between quality education and quality patient care, and reduce the disparity between nursing and medical education • confirm a cost per nursing student per year or per preceptor shift for each sector (acute, primary care, community, long-term care), using JPNC agencies survey results as a starting point • incorporate benefits realized by having students to identify a net cost to the agency • ensure all sectors across the continuum of care are recognized • ensure equity across sectors in recognition activities			education contributions • Agencies survey shows limited capacity to expand under current system • Schools and students survey show shortages exist in most learning areas, with impact on student learning outcomes and student experience • Precedent set with medical trainee days in Health Based Allocation Model for hospitals, and principle can be extended to other health sectors.
15.	Index nursing school clinical education grants to inflation and enrollment in order to maintain quality clinical education programs and build capacity, e.g., payment to	MTCU	Short	• Current clinical grants not indexed to inflation or enrollment growth; value erodes over time • Review of school reports on use of

Recommendation		Target group	Timeline for implementation	Supporting evidence/rationale
	clinical instructors for group placements, preceptor training and recognition, systematic quality assurance, development of new sites and placements			these funds show excellent value for money (see COU paper)
Implementation				
16.	Create an implementation steering committee to coordinate and oversee recommendation activities and report to JPNC on progress	Schools, agencies, government	Short	• Ensure the work continues

Next Steps

The report of the work group encompasses a vast amount of work conducted by a large number of committed members over a period of three years. It is extremely important that these recommendations be recognized not as the end, but as the beginning, of a movement to enhance clinical education capacity and quality in the province. We are seeking a new, provincial approach to clinical education, which needs to be acted upon and implemented.

To this end, the work group is asking JPNC to endorse the recommendations, submit them to MOHLTC, and continue to advocate for their implementation. The work group is also looking for JPNC, MOHLTC and MTCU support in carrying out recommendation #15—the creation of an implementation steering committee to oversee progress on the recommendations.

Finally, in recognition of the large numbers of individuals who participated in the three surveys undertaken by the work group, we would like permission to disseminate the results of the surveys, in the form of the report to JPNC here, to the schools, agencies, and students who contributed so importantly to the work.

Acknowledgements

Thanks are due to the JPNC work group members for their hard work and commitment in the development of this report, Prof. Jenn Salfi of Brock University and the Nursing Health Services Research Unit at McMaster for volunteering their valuable time and energy to undertake the students study, the Nursing Policy and Innovation Branch at MOHLTC for the support they provided to the work group, and the Joint Provincial Nursing Committee for sponsoring this initiative.

Appendices

Appendix A: JPNC Work Group Schools Survey Report

Appendix B: JPNC Work Group Agencies Survey Report

Appendix C: JPNC Work Group Students Survey Report

Appendix A

JPNC Education Working Group 2014
Survey of Nursing Educators

September 2014

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Key Findings

- Challenges with finding quality clinical learning opportunities across the province have grown in the past five years for the majority of nursing schools in the learning areas of:
    - maternal newborn
    - children
    - mental health and addictions
    - acute care, and
    - community care
- Between 40% and 50% of respondents identified increased challenges in areas of:
    - Adolescents
    - Families
    - interprofessional, and
    - primary care settings
- Very few respondents said finding placements has become easier in any of the learning areas
    - For most learning areas, only 0-5% of respondents said it had become easier
    - An exception is seniors and long-term care where 23 and 25% respectively said it had become easier
- Major reasons identified by schools for the challenges include:
    - scarcity of available settings
    - scarcity of qualified preceptors
    - competition with other educational programs, and
    - health system restructuring
- Clinical placement challenges are having an impact on student learning outcomes in two ways:
    - 69% (25/36) indicated an impact on student learning as a result of clinical placement challenges
        - In many programs, some or all students do not having opportunities to apply their knowledge in practice for various learning areas, receiving theory only or theory and simulation
    - a small number of students in some schools are delayed in completion of their program due to their inability to find placements.
- Schools estimate that more than 16 000 placements would be required each year across the province to overcome the challenges with finding quality clinical placements
- Major recommendations from school survey respondents included:
    - more development of simulation
    - more support and incentives for preceptors
    - more collaboration amongst schools
    - more research on clinical education outcomes
    - alternative models of clinical education

Introduction

This survey was carried out on behalf of the Joint Provincial Nursing Committee "Nursing Education for a Sustainable Health Care System" Work Group. The work group was tasked with identifying learning areas and settings where Ontario nursing schools find it particularly challenging to find quality clinical placements, barriers and facilitators to developing clinical education in these areas of challenge, and recommendations to address the challenges. The survey was developed to gather quantitative data on the challenges and to solicit the recommendations of educators on ways to enhance clinical education in particular learning areas. A parallel survey was developed for agencies that offer placements or have potential to offer placements. A separate report is being developed for the agencies survey.

Response rate

The overall response rate in terms of number of institutions was 60% (23 /38 institutions), representing a total student headcount of 13 823 for academic year 2012-13, or 57% of the head count of all nursing students for that year.[1] Eleven out of 14 universities or 78% responded and 12 out of 24 colleges or 50% responded. A total of 43 responses were received. Not all responses were complete.

Surveys were completed by a range of personnel—from Chairs, Directors and Deans of programs to practicum coordinators.

All types of nursing programs are represented except post-RN and most of these programs have been phased out (see table 1 below). Some of the 4 year BScN program responses are from the same program but filled out by different partners for different years of the program; hence the 26 responses for four year BScN do not represent 26 different programs.

All LHINs are represented with the exception of one where one college resides.

Overall, this is an excellent response rate.

Response	Chart	Percentage of total responses	Count
4 Year BScN		61.9%	26
Compressed BScN		7.1%	3
Second Entry BScN		14.3%	6
RPN to BScN		11.9%	5
Post RN		0.0%	0
PN		28.6%	12

[1] Total headcounts for PN and BScN students in 2012-13 provided by MTCU.

Bridging to RN for IENs		4.8%	2
Bridging to RPN for IENs		7.1%	3
	Total Responses		**42**

Table 1. Response by program type

Current status of clinical placement challenges

Respondents were asked to rate whether finding placements has become easier, remains the same, or become more challenging for each learning area identified over the past five years. In the vast majority of learning areas, finding placements has remained the same, or become more challenging than it was five years ago. Only in a few learning areas such as **long-term care (10 or 25%)** and **seniors (9 or 23%)** and to some extent in **rehabilitative** (6 or 15%) and **palliative care** (5 or 12.8%) have a number of schools found it easier to get placements, as shown in the chart below. Beyond this, the vast majority of respondents did not find that securing clinical placements has gotten easier for any of the learning areas. There was no notable pattern by region in terms of the level of challenge.

In some areas, quite a number of program respondents indicated that they did not place students in a particular learning area. Some of these responses were from a partner in a collaborative program where that learning area was not taught in the years that they are responsible for.

	Easier	Remains the same	More challenging	We do not place students in this area	Total Responses
Maternal Newborn	0 (0.0%)	10 (25.0%)	26 (65.0%)	4 (10.0%)	40
Children	0 (0.0%)	9 (22.5%)	24 (60.0%)	7 (17.5%)	40
Adolescents	0 (0.0%)	9 (23.1%)	17 (43.6%)	13 (33.3%)	39
Families	1 (2.7%)	11 (29.7%)	16 (43.2%)	9 (24.3%)	37
Communities (as recipient of care)	2 (5.1%)	12 (30.8%)	15 (38.5%)	10 (25.6%)	39
Populations (as recipient of care)	0 (0.0%)	16 (41.0%)	11 (28.2%)	12 (30.8%)	39
Palliative Care	5 (12.8%)	22 (56.4%)	6 (15.4%)	6 (15.4%)	39
Curative	2 (5.4%)	17 (45.9%)	12 (32.4%)	6 (16.2%)	37
Supportive	3 (7.9%)	21 (55.3%)	9 (23.7%)	5 (13.2%)	38
Rehabilitative	6 (15.4%)	22 (56.4%)	7 (17.9%)	4 (10.3%)	39
Mental Health & Addictions	2 (5.3%)	10 (26.3%)	23 (60.5%)	3 (7.9%)	38
Seniors	9 (23.1%)	23 (59.0%)	3 (7.7%)	4 (10.3%)	39
Interprofessional	2 (5.1%)	15 (38.5%)	18 (46.2%)	4 (10.3%)	39
Acute Care Settings	1 (2.5%)	16 (40.0%)	23 (57.5%)	0 (0.0%)	40

Community Care Settings	1 (2.5%)	15 (37.5%)	21 (52.5%)	3 (7.5%)	40
Long-term Care Settings	10 (25.0%)	20 (50.0%)	5 (12.5%)	5 (12.5%)	40
Primary Care Settings	1 (2.5%)	17 (42.5%)	17 (42.5%)	5 (12.5%)	40

Other learning areas:

Respondents were given the opportunity to identify other learning areas that were not identified in the table above, and to assess the level of challenge in finding placements within these other areas.

Easier to find placements--other:

Respondents mentioned research, clinical trials, medical imaging, corrections, and public schools or school health as having become easier to find placements over the past 5 years.

More challenging to find placements--other:

The following were mentioned as more challenging:

- Integrated practicum (final placement)
- Medical/surgery
- Preceptorships at a distance
- In-patient acute mental health
- Spaces for IENS
- Complex chronic care
- Schools-school age children and adolescents
- Vulnerable populations (homelessness), aboriginal health
- Placements out of surrounding area and out of province
- Global Health

Reasons why finding clinical placements in some areas has gotten easier

Survey respondents were provided with a list of possible reasons why finding clinical placements in a learning area has become easier, and were asked to identify "yes" or "no" as to whether this was a reason. The responses are discussed below by reason. There was no notable pattern by region in the responses.

Greater availability of settings for placements

For seniors and long-term care settings, up to 25% of respondents found that placements had gotten easier due to a greater availability of placements. Fourteen per cent (14%) of respondents found greater availability of settings in rehabilitative care and 9.3% found greater availability in palliative care.

	YES	NO	Total Responses
Maternal Newborn	0 (0.0%)	43 (100.0%)	43
Children	0 (0.0%)	43 (100.0%)	43

	YES	NO	Total Responses
Adolescents	0 (0.0%)	43 (100.0%)	43
Families	1 (2.3%)	42 (97.7%)	43
Communities (as recipient of care)	2 (4.7%)	41 (95.3%)	43
Populations (as recipient of care)	0 (0.0%)	43 (100.0%)	43
Palliative Care	4 (9.3%)	39 (90.7%)	43
Curative	1 (2.3%)	42 (97.7%)	43
Supportive	3 (7.0%)	40 (93.0%)	43
Rehabilitative	6 (14.0%)	37 (86.0%)	43
Mental Health & Addictions	2 (4.7%)	41 (95.3%)	43
Seniors	10 (23.3%)	33 (76.7%)	43
Interprofessional	1 (2.3%)	42 (97.7%)	43
Acute Care Settings	1 (2.3%)	42 (97.7%)	43
Community Care Settings	1 (2.3%)	42 (97.7%)	43
Long-term Care Settings	11 (25.6%)	32 (74.4%)	43
Primary Care Settings	1 (2.3%)	42 (97.7%)	43

Greater availability of qualified preceptors in each learning area

Five or 11.6% of respondents found there was greater availability of qualified preceptors in long-term care and four or nine percent (9%) found this in placements related to the seniors population more generally. Three respondents or seven per cent (7%) found that there was greater availability of preceptors in palliative care.

	YES	NO	Total Responses
Maternal Newborn	0 (0.0%)	43 (100.0%)	43
Children	0 (0.0%)	43 (100.0%)	43
Adolescents	0 (0.0%)	43 (100.0%)	43
Families	0 (0.0%)	43 (100.0%)	43
Communities (as recipient of care)	0 (0.0%)	43 (100.0%)	43
Populations (as recipient of care)	0 (0.0%)	43 (100.0%)	43
Palliative Care	3 (7.0%)	40 (93.0%)	43
Curative	1 (2.3%)	42 (97.7%)	43
Supportive	1 (2.3%)	42 (97.7%)	43
Rehabilitative	2 (4.7%)	41 (95.3%)	43
Mental Health & Addictions	1 (2.3%)	42 (97.7%)	43
Seniors	4 (9.3%)	39 (90.7%)	43
Interprofessional	0 (0.0%)	43 (100.0%)	43
Acute Care Settings	0 (0.0%)	43 (100.0%)	43

Community Care Settings	0 (0.0%)	43 (100.0%)	43
Long-term Care Settings	5 (11.6%)	38 (88.4%)	43
Primary Care Settings	0 (0.0%)	43 (100.0%)	43

Competition with other education providers has decreased

Only one respondent in community care indicated that competition had decreased.

Competition with other health professional disciplines has decreased

No respondent indicated that competition with other health professional disciplines had decreased.

Greater number of qualified academic clinical instructors

One respondent indicated that it was easier to find placements because of greater numbers of qualified academic clinical instructors in the area of Communities (as recipient of care), one in Curative, one in mental health and addictions, one for seniors, and one in Community Care Settings.

Greater interest of clinicians to engage in student teaching

Two respondents indicated there was greater interest of clinicians to engage in student teaching for seniors, two for long-term care settings, and one for palliative care.

More clinicians are available to supervise students

One respondent indicated there were more clinicians available to supervise students in the area of palliative care.

Improved processes (e.g. technology) make it easier to coordinate quality placements

In some learning areas, between one and three respondents (2.3% to 7%) indicated that improved processes make it easier to coordinate quality placements.

	YES	NO	Total Responses
Maternal Newborn	0 (0.0%)	43 (100.0%)	43
Children	0 (0.0%)	43 (100.0%)	43
Adolescents	0 (0.0%)	43 (100.0%)	43
Families	0 (0.0%)	43 (100.0%)	43
Communities (as recipient of care)	1 (2.3%)	42 (97.7%)	43
Populations (as recipient of care)	0 (0.0%)	43 (100.0%)	43
Palliative Care	2 (4.7%)	41 (95.3%)	43
Curative	1 (2.3%)	42 (97.7%)	43
Supportive	1 (2.3%)	42 (97.7%)	43
Rehabilitative	2 (4.7%)	41 (95.3%)	43
Mental Health & Addictions	1 (2.3%)	42 (97.7%)	43

	YES	NO	Total Responses
Seniors	3 (7.0%)	40 (93.0%)	43
Interprofessional	0 (0.0%)	43 (100.0%)	43
Acute Care Settings	0 (0.0%)	43 (100.0%)	43
Community Care Settings	1 (2.3%)	42 (97.7%)	43
Long-term Care Settings	3 (7.0%)	40 (93.0%)	43
Primary Care Settings	0 (0.0%)	43 (100.0%)	43

Other reasons why an area may have become easier

Besides the reasons offered in the survey, respondents were given an opportunity to identify other reasons why an area may have become easier. Some respondents suggested that staffing challenges within LTC promoted this sector to allow more students. One respondent suggested that a pilot with public schools had helped open up more opportunities and another that enhancements to their community nursing course and relationship building had made it easier to find placements in school health.

Reasons why finding placements has become more challenging

Respondents were provided with a list of possible reasons why finding clinical placements in a learning area had become more challenging, and were asked to identify "yes" or "no" as to whether this was a reason for the increased challenges. The responses are discussed below by reason. There was no notable pattern by region in the responses.

Scarcity of Settings for placements

Scarcity of settings for placements was noted as a major factor for placements becoming more challenging for many respondents in most learning areas, the exception being seniors and long-term care. Maternal Newborn (23 or 53%), children (22 or 51%) and Mental Health & Addictions (19 or 44%) were the most challenging to find placement sites, but also high were families (34.9%), communities (34.95%), curative (25.6%), interprofessional (37.2%), acute care settings (32.6%), community care settings (41.9%) and primary care settings (34.9%).

	YES	NO	Total Responses
Maternal Newborn	23 (53.5%)	20 (46.5%)	43
Children	22 (51.2%)	21 (48.8%)	43
Adolescents	18 (41.9%)	25 (58.1%)	43
Families	15 (34.9%)	28 (65.1%)	43
Communities (as recipient of care)	15 (34.9%)	28 (65.1%)	43
Populations (as recipient of care)	12 (27.9%)	31 (72.1%)	43
Palliative Care	8 (18.6%)	35 (81.4%)	43
Curative	11 (25.6%)	32 (74.4%)	43
Supportive	9 (20.9%)	34 (79.1%)	43

	YES	NO	Total Responses
Rehabilitative	6 (14.0%)	37 (86.0%)	43
Mental Health & Addictions	19 (44.2%)	24 (55.8%)	43
Seniors	2 (4.7%)	41 (95.3%)	43
Interprofessional	16 (37.2%)	27 (62.8%)	43
Acute Care Settings	14 (32.6%)	29 (67.4%)	43
Community Care Settings	18 (41.9%)	25 (58.1%)	43
Long-term Care Settings	1 (2.3%)	42 (97.7%)	43
Primary Care Settings	15 (34.9%)	28 (65.1%)	43

Scarcity of qualified preceptors

A less significant factor than scarcity of settings, but still a major issue for many learning areas and settings, was scarcity of qualified preceptors including in community care settings (13 or 30%), primary care settings (12 or 28%), Mental Health & Addictions (11 or 25%), acute care settings (11 or 25%), 'maternal newborn' (11 or 25%), 'children' (11 or 25%), adolescents (10) or 23%.

	YES	NO	Total Responses
Maternal Newborn	11 (25.6%)	32 (74.4%)	43
Children	11 (25.6%)	32 (74.4%)	43
Adolescents	10 (23.3%)	33 (76.7%)	43
Families	6 (14.0%)	37 (86.0%)	43
Communities (as recipient of care)	9 (20.9%)	34 (79.1%)	43
Populations (as recipient of care)	7 (16.3%)	36 (83.7%)	43
Palliative Care	4 (9.3%)	39 (90.7%)	43
Curative	7 (16.3%)	36 (83.7%)	43
Supportive	6 (14.0%)	37 (86.0%)	43
Rehabilitative	4 (9.3%)	39 (90.7%)	43
Mental Health & Addictions	11 (25.6%)	32 (74.4%)	43
Seniors	2 (4.7%)	41 (95.3%)	43
Interprofessional	9 (20.9%)	34 (79.1%)	43
Acute Care Settings	11 (25.6%)	32 (74.4%)	43
Community Care Settings	13 (30.2%)	30 (69.8%)	43
Long-term Care Settings	3 (7.0%)	40 (93.0%)	43
Primary Care Settings	12 (27.9%)	31 (72.1%)	43

Competition with other education providers

Competition with other education providers was a factor for a substantial number of respondents for acute care (21 or 48%), maternal newborn (19 or 44%), children (17 or 40%), community care (18 or 42%) and primary care (16 or 37%).

	YES	NO	Total Responses
Maternal Newborn	19 (44.2%)	24 (55.8%)	43
Children	17 (39.5%)	26 (60.5%)	43
Adolescents	12 (27.9%)	31 (72.1%)	43
Families	8 (18.6%)	35 (81.4%)	43
Communities (as recipient of care)	11 (25.6%)	32 (74.4%)	43
Populations (as recipient of care)	7 (16.3%)	36 (83.7%)	43
Palliative Care	7 (16.3%)	36 (83.7%)	43
Curative	10 (23.3%)	33 (76.7%)	43
Supportive	9 (20.9%)	34 (79.1%)	43
Rehabilitative	7 (16.3%)	36 (83.7%)	43
Mental Health & Addictions	14 (32.6%)	29 (67.4%)	43
Seniors	4 (9.3%)	39 (90.7%)	43
Interprofessional	13 (30.2%)	30 (69.8%)	43
Acute Care Settings	21 (48.8%)	22 (51.2%)	43
Community Care Settings	18 (41.9%)	25 (58.1%)	43
Long-term Care Settings	7 (16.3%)	36 (83.7%)	43
Primary Care Settings	16 (37.2%)	27 (62.8%)	43

Competition with other health disciplines

Competition with other health professional disciplines was a factor for some programs across learning areas. Community care (12 or 28%), primary care (12), acute care (12), maternal newborn (11 or 26%), children (11) and communities as recipient of care (11), Mental Health & Addictions (11), and Interprofessional (11) were areas that were competitive for many respondents.

	YES	NO	Total Responses
Maternal Newborn	11 (25.6%)	32 (74.4%)	43
Children	11 (25.6%)	32 (74.4%)	43
Adolescents	9 (20.9%)	34 (79.1%)	43
Families	6 (14.0%)	37 (86.0%)	43
Communities (as recipient of care)	11 (25.6%)	32 (74.4%)	43
Populations (as recipient of care)	6 (14.0%)	37 (86.0%)	43
Palliative Care	6 (14.0%)	37 (86.0%)	43
Curative	7 (16.3%)	36 (83.7%)	43
Supportive	7 (16.3%)	36 (83.7%)	43
Rehabilitative	4 (9.3%)	39 (90.7%)	43
Mental Health & Addictions	11 (25.6%)	32 (74.4%)	43
Seniors	3 (7.0%)	40 (93.0%)	43
Interprofessional	11 (25.6%)	32 (74.4%)	43

	YES	NO	Total Responses
Acute Care Settings	12 (27.9%)	31 (72.1%)	43
Community Care Settings	12 (27.9%)	31 (72.1%)	43
Long-term Care Settings	3 (7.0%)	40 (93.0%)	43
Primary Care Settings	12 (27.9%)	31 (72.1%)	43

Scarcity of qualified academic clinical instructors

Scarcity of qualified academic clinical instructors was a factor for some respondents in some learning areas, notably in mental health and addictions (9 or 21%), maternal newborn (14%), children (11.6%) and acute care (14%).

	YES	NO	Total Responses
Maternal Newborn	6 (14.0%)	37 (86.0%)	43
Children	5 (11.6%)	38 (88.4%)	43
Adolescents	4 (9.3%)	39 (90.7%)	43
Families	1 (2.3%)	42 (97.7%)	43
Communities (as recipient of care)	1 (2.3%)	42 (97.7%)	43
Populations (as recipient of care)	2 (4.7%)	41 (95.3%)	43
Palliative Care	0 (0.0%)	43 (100.0%)	43
Curative	1 (2.3%)	42 (97.7%)	43
Supportive	1 (2.3%)	42 (97.7%)	43
Rehabilitative	2 (4.7%)	41 (95.3%)	43
Mental Health & Addictions	9 (20.9%)	34 (79.1%)	43
Seniors	1 (2.3%)	42 (97.7%)	43
Interprofessional	2 (4.7%)	41 (95.3%)	43
Acute Care Settings	6 (14.0%)	37 (86.0%)	43
Community Care Settings	1 (2.3%)	42 (97.7%)	43
Long-term Care Settings	0 (0.0%)	43 (100.0%)	43
Primary Care Settings	2 (4.7%)	41 (95.3%)	43

Reluctance of clinicians to engage in student teaching

Reluctance of clinicians to engage in student teaching was a factor for some respondents across learning areas, notably in acute Care Settings (14 or 32%), Primary Care Settings (11 or 25%), and Mental Health & Addictions (11 or 26%).

	YES	NO	Total Responses
Maternal Newborn	9 (20.9%)	34 (79.1%)	43
Children	10 (23.3%)	33 (76.7%)	43
Adolescents	7 (16.3%)	36 (83.7%)	43

	YES	NO	Total Responses
Families	6 (14.0%)	37 (86.0%)	43
Communities (as recipient of care)	8 (18.6%)	35 (81.4%)	43
Populations (as recipient of care)	5 (11.6%)	38 (88.4%)	43
Palliative Care	4 (9.3%)	39 (90.7%)	43
Curative	7 (16.3%)	36 (83.7%)	43
Supportive	5 (11.6%)	38 (88.4%)	43
Rehabilitative	2 (4.7%)	41 (95.3%)	43
Mental Health & Addictions	11 (25.6%)	32 (74.4%)	43
Seniors	2 (4.7%)	41 (95.3%)	43
Interprofessional	7 (16.3%)	36 (83.7%)	43
Acute Care Settings	14 (32.6%)	29 (67.4%)	43
Community Care Settings	8 (18.6%)	35 (81.4%)	43
Long-term Care Settings	3 (7.0%)	40 (93.0%)	43
Primary Care Settings	11 (25.6%)	32 (74.4%)	43

Response	Chart	Percentage	Count
Yes		**15.8%**	**6**
No		**84.2%**	**32**
	Total Responses		**38**

Clinicians available to supervise but over utilized leading to burnout

	YES	NO	Total Responses
Maternal Newborn	8 (18.6%)	35 (81.4%)	43
Children	9 (20.9%)	34 (79.1%)	43
Adolescents	6 (14.0%)	37 (86.0%)	43
Families	8 (18.6%)	35 (81.4%)	43
Communities (as recipient of care)	7 (16.3%)	36 (83.7%)	43
Populations (as recipient of care)	5 (11.6%)	38 (88.4%)	43
Palliative Care	3 (7.0%)	40 (93.0%)	43
Curative	4 (9.3%)	39 (90.7%)	43
Supportive	3 (7.0%)	40 (93.0%)	43
Rehabilitative	3 (7.0%)	40 (93.0%)	43
Mental Health & Addictions	8 (18.6%)	35 (81.4%)	43
Seniors	4 (9.3%)	39 (90.7%)	43
Interprofessional	7 (16.3%)	36 (83.7%)	43

	YES	NO	Total Responses
Acute Care Settings	12 (27.9%)	31 (72.1%)	43
Community Care Settings	9 (20.9%)	34 (79.1%)	43
Long-term Care Settings	4 (9.3%)	39 (90.7%)	43

	YES	NO	Total Responses
Maternal Newborn	7 (16.3%)	36 (83.7%)	43
Children	10 (23.3%)	33 (76.7%)	43
Adolescents	6 (14.0%)	37 (86.0%)	43
Families	5 (11.6%)	38 (88.4%)	43
Communities (as recipient of care)	10 (23.3%)	33 (76.7%)	43
Populations (as recipient of care)	8 (18.6%)	35 (81.4%)	43
Palliative Care	6 (14.0%)	37 (86.0%)	43
Curative	9 (20.9%)	34 (79.1%)	43
Supportive	8 (18.6%)	35 (81.4%)	43
Rehabilitative	5 (11.6%)	38 (88.4%)	43
Mental Health & Addictions	13 (30.2%)	30 (69.8%)	43
Seniors	2 (4.7%)	41 (95.3%)	43
Interprofessional	8 (18.6%)	35 (81.4%)	43
Acute Care Settings	16 (37.2%)	27 (62.8%)	43
Community Care Settings	9 (20.9%)	34 (79.1%)	43
Long-term Care Settings	3 (7.0%)	40 (93.0%)	43
Primary Care Settings	9 (20.9%)	34 (79.1%)	43
Primary Care Settings	9 (20.9%)	34 (79.1%)	43

Clinicians available to supervise but over utilized leading to burnout was a factor for some respondents across learning areas, but more so for acute care (16 or 37%) and mental health & addictions (13 or 30%).

Extraordinary amount of time and effort needed by clinical coordinators in order to find enough quality placements

This was a factor for some respondents across learning areas and settings, but higher for acute care (12 or 28%), children (9 or 21%), primary care (9 or 21%), community care (21%) and families (8 or 18%).

Other reasons given for clinical placements becoming more challenging

Respondents were given the opportunity to identify other reasons not already identified in the survey regarding why clinical placements have become more challenging. **Restructuring** was a major theme including consolidation of multiple hospital units into one, changed staffing ratios, bed reductions, and less professionals within the working environment.

Measuring the impact of the challenges

Impact on Student Learning Outcomes

More than two thirds of those who responded to the question of whether challenges with finding quality clinical learning opportunities for students were having an impact on student learning outcomes answered in the affirmative.

Yes	No
25 (69.4%)	11 (30.6%)

At least one program in every region indicated that there was an impact. In some regions, one schools reported an impact on learning for their program, while another school in the same region did not report an impact. Indeed, within one school of nursing different responses were received regarding this question, with some suggesting negative impacts on student outcomes for one or two of their nursing program but not for another. There was no correlation with type of nursing program—PN or BScN. Both had impacts on student learning outcomes for particular programs.

The details of the impacts for each learning area are described in Appendix A. The impacts fell into two themes.

Students do not get placements at all for particular learning areas

By far the most significant theme in the description of impacts is that some or all students in particular programs do not receive *any* clinical placements in some of the identified learning areas, or students receive classroom learning augmented by simulation but not by actual clinical or practice experience in the field. The extent of this problem varied widely, depending on the program.

# of learning areas and settings out of 17 where many or all students are not getting a clinical placement	# of programs where this is the case (N=25)
2 or less	7
3-5	8
6-10	2
11-15	8
More than 15	0

Maternal newborn and children were two of the most prevalent gaps, but families and acute care settings were also common.

Students who do not get placements in an area do not have sufficient opportunity to apply their learning in actual practice. For the one IEN program that reported, the lack of practice experience was seen by the respondent to be linked to less success for the IENs on registration exams and on finding employment. No such correlation between registration exam success and larger numbers of clinical

gaps could be established in the data here. Some programs that reported gaps in a large number of learning areas had good results on the licensing exams, whilst students from other programs that reported large gaps were less successful on the exam. In spite of this, the lack of adequate clinical placements in many programs and in particular learning areas is a significant cause for concern.

Students get reduced hours on placement or observational experience only

This theme was less prevalent, but was present, and meant that students get less continuity in the learning and less robust experiences.

Overall, the challenges with finding placements are leading to less robust learning experiences for many students, and a lack of equity amongst programs, between students within programs, and between regular students and IENs in terms of the quality of students' learning experiences.

Delays in student completion

Five respondents representing five different institutions, indicated there were delays in student completion of the educational program in the past five years due to challenges with finding quality clinical learning opportunities for students. BScN, PN and IEN students were affected. No pattern by region was discernible.

Responses for number of students and amount of time delayed are below:

- 3 or 4 a year by as much as 6 months ;
- 8 students;
- 5-10 students; usually have to sit out a semester;
- 2 students who delayed so that they could get the placement of choice;
- A few months - no count indicated;
- 10 students are now delayed one year due to not being able to find placements.

Number of additional placements needed to overcome the challenges

This survey sought to quantify the size of clinical placement challenges by asking respondents to identify the number of *additional* placements each programs would need for three consecutive years in each of the learning areas in order to overcome challenges they might be experiencing in that area. This question elicited a smaller number of responses (ranging from 6 to 18 for each learning area—less than half of the response rate for other questions). Subsequent feedback from COUPN, as well as two comments in the "other" section for this question in the survey, indicated that the question was challenging to answer. This would account for some non-responses. However, others may not have answered because they did not need "additional" placements in learning areas.

Overall, the higher numbers of responses clustered around learning areas that had already been indicated elsewhere in the survey as the most challenging. This helps to validate the representativeness of responses for this question, even given the smaller response rate.

The table below sums the numbers for each learning area and shows the number of responses to each question in brackets. Large numbers of placements are needed in each area, with the possible exception of seniors and long-term care settings. The learning areas with the highest need include maternal newborn, children, adolescents, mental health and addictions, acute care, community care, and primary care settings.

Learning Area	# OF ADDITIONAL PLACEMENTS NEEDED, 2013/14 TO OVERCOME CHALLENGES	# OF ADDITIONAL PLACEMENTS NEEDED, 2014/15 TO OVERCOME CHALLENGES	# OF ADDITIONAL PLACEMENTS NEEDED, 2015/16 TO OVERCOME CHALLENGES
Maternal Newborn	645 (15 responses)	739 (16 responses)	692 (13 responses)
Children	559 (15)	678 (18)	607 (13)
Adolescents	559 (10)	678 (10)	607 (8)
Families	391 (7)	465 (7)	505 (7)
Communities (as recipient of care)	487 (9)	497 (9)	537 (9)
Populations (as recipient of car	475 (7)	491 (8)	530 (8)
Palliative Care	530 (6)	406 (6)	421 (6)
Curative	408 (7)	423 (7)	463 (7)
Supportive	408 (6)	423 (6)	463 (6)
Rehabilitative	369 (6)	369 (7)	369 (7)
Mental Health & Addictions	588 (15)	674 (16)	638 (14)
Seniors	225 (1)	225 (1)	225 (1)
Interprofessional	410 (6)	495 (8)	465 (7)
Acute Care Settings	560 (13)	620 (16)	580 (14)
Community Care Settings	503 (11)	589 (14)	559 (13)
Long-term Care Settings	228 (3)	231 (4)	231 (4)
Primary Care Settings	547 (10)	630 (12)	600 (11)
Other (please specify)*	(2)	(1)	
Total	**7893**	**8633**	**8492**

*For the other category, one respondent indicated an extra 25 placements per year across each learning area. These have been added into the totals above. Another respondent indicated that the question was too challenging to answer. Another said that numbers will depend on curriculum revisions that are underway.

The chart below provides an estimate of the total numbers of placements needed for schools to overcome the challenges, by extrapolating from the headcount of students represented in the survey to the total student population for 2012-13.

Learning Area	# OF ADDITIONAL PLACEMENTS NEEDED, 2013/14 TO OVERCOME CHALLENGES	# OF ADDITIONAL PLACEMENTS NEEDED, 2014/15 TO OVERCOME CHALLENGES	# OF ADDITIONAL PLACEMENTS NEEDED, 2015/16 TO OVERCOME CHALLENGES
Maternal Newborn	1270	1455	1362
Children	1100	1335	1195
Adolescents	1100	1335	1195
Families	770	915	994
Communities (as recipient of care)	959	978	1057
Populations (as recipient of car	935	967	1043
Palliative Care	1043	799	829
Curative	803	833	911
Supportive	803	833	911
Rehabilitative	726	726	726
Mental Health & Addictions	1157	1327	1256
Seniors	443	443	443
Interprofessional	807	974	915
Acute Care Settings	1102	1220	1142
Community Care Settings	990	1159	1100
Long-term Care Settings	449	455	455
Primary Care Settings	1077	1240	1181
Total	**15535**	**16994**	**16717**

The numbers are conservative because, except where explicitly stated otherwise, the non-responses for this question are assumed to indicate a need for zero additional placements. In fact, we know that some schools did not respond because they had difficulties estimating the numbers. It was impossible in most cases to differentiate those who needed additional placements but didn't answer the question, from those who didn't answer the question because they don't need additional placements. Hence the conservative assumption was used.

Data Limitations

The data for this question is limited by the difficulties that some schools experienced in answering the question. As well, the nature of the question—to identify how many additional placements are needed in order to overcome challenges—could be subject to differing interpretations by different schools. Nevertheless, this is the best data we have on this important question of the size of the challenges with clinical placements that schools are experiencing.

Strategies to develop more quality clinical learning opportunities

The survey asked respondents what had helped or enabled them to develop quality clinical learning opportunities. This was an open-ended question. There were 37 responses to this question, a relatively high number. The practices were not specific to RPN or BScN.

The top strategies were:

- Outreach/building relationships with placement sites, partners (18 responses);
- Hiring staff (coordinators) (related to above)(7);
- Simulation and virtual learning technologies to facilitate complementary placement experiences (7)
- Consultation with practice partner advisory/clinical resource committees (6);
- Coordinating with other local nursing programs about how placements are shared (4);
- HSPnet (4)

Other, less prevalent strategies included:

- Out of region placements (2);
- Assistance of qualified clinical instructors to build placements (2);
- Central placement office to streamline relationships and processes and reduce competition and conflicts (1);
- Standardized training for clinical instructors to keep evaluation and instruction consistent (1);
- New program model where students are matched to preceptors in an affiliate health care organization as a base unit. Preceptor evaluations are garnered mid-term and final to build academic relationships and future placement considerations (involves small program cohort)(1).
- Finding ways to meet course outcomes when no placements exist (1);
- Meetings with all of the level coordinators and course leaders to try to match appropriate placements with the curriculum (1);
- Hospitals having a specified contact person to coordinate student placements (1);
- Creative thinking regarding how students are scheduled (1);
- Capitalizing on long-term care and rehabilitation units increased need for staffing as well the skills required of new grads in order to get more placements (1);
- Capping total number of students admitted to the program (1).

Innovative clinical learning opportunities

Schools were asked to describe innovative learning opportunities that have helped them to develop more quality clinical learning opportunities. There was some overlap between the responses for this question and the question on strategies above. The “innovative” question elicited a broader range of responses and may be more useful for schools. Responses that add to those already listed in the strategies section are listed below according to theme.

Innovative settings

- Military resource centre
- Public school placements (health promotion and prevention)
- Student residence
- Corrections Canada
- Outpatient clinic care with a local hospital;
- Occupational health preceptors;
- On-site health promotion activities aimed at faculty and staff at the post-secondary institution
- Identified a community wanting a community assessment of their town and offered problem-based learning scenarios to address any gaps.
- Development of community shadowing experiences to expand mental health placements and maternal child
- Developed an on-site community placement for 3rd year BSc students at the college where they set up, market and deliver health promotion programs for students and staff.

Innovative models

- Splitting preceptors and placements between students (two students and two preceptors and they switch midway through
- Linked the distance community students with the on-campus community students for their final project presentation which enhanced a sense of professional community
- Added a fourth semester mandatory long-term care placement for all students. This has allowed the students to return to LTC with a greater scope of practice, confidence and allow for them to practice in a multidisciplinary, leadership type position.
- As students embed into clinical departments, they explore further areas of clinical interest and facilitate future clinical placement offers, either within affiliate organizations or outside affiliate sites. (e.g., research departments, remote nursing placements)

Supportive activities

- Preceptor recognition and appreciation events
- Clinical instructor support:
    - orientation for all new clinical instructors at the school
    - support them if they need paid orientation at the agency where they are assigned
    - annual professional development day.
- Continuous program review of current opportunities and evaluations to ensure best practices.
- Joint clinical placement coordination committee for BScN and PN placements
- Developed a working group to map out clinical learning that could be learned in real vs. simulated contexts. This has provided a clearer picture of potential shifts in curriculum content in order to maximize learning in the lab context
- Encouraged graduates to network with us after graduation (re placements)

Recommendations

Respondents were asked to provide recommendations for building clinical placement capacity with reference to each learning area. Some recommendations applied to all or most learning areas, while others were area specific. General recommendations are summarized by theme, and recommendations specific to an area are listed below.

Recommendations--general

- **Simulation** was a major emphasis in the recommendations, to replace and/or as adjunct to clinical placements across various learning areas, including:
    - more recognition by CNO of simulation
    - additional simulation funding
    - program of progressive practice from knowledge learning through simulation to actual practice
    - more lab time, more interview rooms, clinical learning centres
    - learn from international schools' use of simulation
- **Preceptors** were a major focus in the recommendations:
    - Incentives or funding for preceptors to take students
    - More student opportunities in order to become qualified preceptors;
    - reduce instructor/preceptor paperwork;
    - more support for preceptors.

- **Collaboration at the schools level:**
    - Collaboration amongst educational programs so that we can know each other's clinical requests, potentially facilitated by HSPnet
    - a provincial collaborative strategy
    - Centralized placement processes and offices across a collaborative program rather than this happening at each of the sites independently

- **Research:**
    - evidence based research in different clinical modules other than the medical model;
    - research that looks at clinical outcomes with various clinical placement processes (i.e. preceptored versus group, sizes of groups, SIM used in adjunct and SIM used in replacement of clinical).
    - Research that looks at consolidation of clinical at the end of each term to support academics in the beginning of the term.

- **Alternative models of clinical education:**
    - Offer the preceptored experience in Level II and Level III not just in Level IV.
    - Different types of clinical and community experiences are needed for preventative and therapeutic care; application of the determinants of health rather than focus on medical model;
    - Create formal joint appointments with practice agencies so that qualified teachers are also actively in practice in the same setting that students learn;

    - Flexibility in scheduling , including weekends, evenings, condensed courses etc.
    - Support faculty specialists in the clinical area and have students on various units with the faculty rotating through to the students.
    - Maximum use of the agency with groups of students decreasing in size, for example, if a unit can only accommodate a group of 4 students perhaps they could offer 1-2 additional spots for students in clinics which would increase the total number of students in the group

- **Other**
    - Faculty Professional Development.
    - Prioritize baccalaureate students in all hospital settings for education.
    - More funds to educational institutions to develop scenarios that meet the learning objectives specific to a clinical area.
    - Increase RN ratio on the floors to increase preceptor capacity
    - Capitalize on interprofessional opportunities to learn with other students in health sciences.

Recommendations--specific

Maternal Newborn

- Working with midwives where possible for shorter clinical placements;
- working with public health to follow be Healthy Babies Healthy Children Program
- Preceptorship for PNs in this area
- Using more distant community placements

Children

- Work with public health to take more students
- Work with community agencies (inter-professionally) regarding child development programs.
- Preceptorships for PN students in this area
- Develop more partnerships with the private and public school boards and other community agencies to build capacity for pediatric placements in the community.

Adolescents

- A return to school settings

Families

- Simulated patient/family scenarios

Communities (as recipient of care)

- Working with agencies that contribute to determinants of health for communities (versus medical model);
- Expand placements to community care access center providers;
- Project work available in all Health Units for students.

Populations (as recipient of care):

- Expand capacity with public health agencies, including for PN students

Palliative

- Increased and continued funding by government for residential hospices in order to facilitate placements for students
- Palliative care simulation

Rehabilitative

- Increased beds in hospital settings and end early discharge

Mental Health & Addictions

- Working inter-professionally in community;
- Use alternative settings such as Methadone clinics.
- advocate for longer stays in acute psychiatric settings
- Increase mental health addictions support;

Interprofessional

- Use Community Health Centres, Family Health teams

Acute Care Settings

- We are looking to move many of our 4th year preceptored experiences into the 3rd year curriculum as our students receive their "Community as Client" theory course in the winter semester of their 3rd year. As clients are being discharged earlier from acute care hospitals with increasingly acute medical concerns, we hope that having 3rd year students in home visiting agencies will increase their ability to manage clients with complex issues and build on their skills. This may help to ease the competition for placements that we are experiencing in our town;
- Increase beds and length of stay;
- Improve consistency in clinical instructor performance.

Community Care Settings

- Greater consistency from smaller community agencies in taking students (currently very inconsistent)

- As health care shifts to the community, policies need to be put into place so clients are more receptive to students working with them in the field. This requires support from the health care agencies. Community agencies can be designated as teaching agencies and be recognized monetarily similar to the large teaching hospitals;
- Stable work environments for community nurses that allow for time to assist with students.
- Increase the use of student placements within the public and high school settings (e.g. opportunities for health promotion and health prevention).

Long-term Care Settings

- Allow students to practice. They are reluctant to let nursing students provide basic care and practice new skills (for example not allowed to take the blood pressure) so students are not practicing;
- Ensure PN students can work to full scope of practice. For example in the spring an issue arose that withdrew them from being able to give meds. This is now changed, however, there are concerns that educators that scope of practice may be limited again;
- Additional staffing levels in LTC to support the increased efforts required in having students present in the environment.

Primary care settings

- Greater consistency from year to year of FHTs in taking students

Other:

- More placements in NICU
- Cohorts have increased steadily—we cannot ask more of our partner agencies than we are now
- Maintain steady state enrollment

Summary and Analysis

The survey shows that finding quality clinical learning opportunities across the province and across learning areas remains a major challenge for the vast majority of nursing schools, and that in some learning areas the challenges have grown in recent years. An exception to this is in the area of seniors and long-term care, where some schools have found it easier to get placements in the past five years.

These findings confirm what schools of nursing have been reporting in recent years, and support the importance that schools have been placing on clinical education as a policy area that continues to need attention from government and nursing education stakeholders, as well as from educators themselves.

Schools identified scarcity of available settings, scarcity of qualified preceptors, competition with other educational programs, and health system restructuring as the major reasons for the challenges they

face, particularly in some learning areas. Again, this provides quantitative confirmation of what was already known from previous work done on the subject.[2]

The survey revealed important information about the impact of clinical placement challenges on student outcomes, by showing the extent to which many students do not having opportunities to apply their knowledge in practice for various areas, as well as the reality that a small number of programs and students are experiencing delays in student completion of program due to inability to find placements.

While the data was limited, the survey provides an estimate that more than 15 000 placements are needed across the province, divided up by various learning areas, in order to overcome challenges and optimize student learning. This number helps to reveal the magnitude of the issue.

The dominant strategies for schools to find placements shows that the system remains based largely on relationship-building between schools and agencies. The wide range of innovative placements identified in the survey also confirms how schools have expanded the parameters of traditional placements and sought learning opportunities in diverse settings, as well as how they have built up infrastructure to support and streamline the clinical education enterprise.

The recommendations show that there is still an interest from schools in working within their own sphere to enhance clinical education—through developing more innovative placements and models, greater coordination, greater use of simulation, and more research into most effective practices in clinical learning. At the same time, the recommendations from schools point to the need to go beyond this and to work with government and stakeholders to create more incentives for preceptors and for community agencies to take students on a consistent, ongoing basis, more government funding for simulation, more recognition of simulation, and structural changes in health care delivery that will facilitate more opportunities for student learning.

[2] E.g., Council of Ontario Universities, "Integrating Clinical Education into Ontario's Changing Healthcare System," 2013 policy paper, http://cou.on.ca/publications/reports/pdfs/integrating-clinical-education-into-the-changing-h

Appendix A: Impact of challenges on student learning by learning area

Maternal newborn

- Not all students receive a placement in maternal newborn setting (8);
- Learning is augmented by simulation, other lab experiences, shared presentations and guest speakers (8);
- Theory only (3);
- Lack of application would affect clinical judgment;
- Inequitable across students (only some get clinical exposure);
- Go to observation areas on rotation;
- Have had to split clinical professor assignment into single day assignments - decreases the continuity within the learning experience.

Children

- Theory only, no application for all students (10);
- None of the IES get this experience so limits employment as well as success on registration exam;
- Have had to cut back hours which impacts students in terms of getting a thorough clinical experience on Pediatrics;
- Increase simulation experiences instead of clinical.

Adolescents

- Theory only, no application for some or all students (9); knowledge not reinforced with direct application in practice setting;
- Increase simulation experiences to provide adolescent skill sets.

Families

- Theory only, limited exposure with some student getting no experience (5);
- None of the IENs get this experience so limits employment as well as success on registration exam.

Communities

- Theory only, no application for all students (8);
- Had to develop alternate learning assignments (2);
- More frequent out-of-town settings are required resulting in student transportation issues.

Populations

- Theory only, not all students get opportunity to apply the knowledge (7);
- Essay Assignment substituted;
- More frequent out-of-town settings required resulting in student transportation issues.

Palliative Care

- Fewer students able to access opportunities in palliative care. (7)
- Interest in palliative care by students has increased and we cannot fulfill the requests;
- Increase simulation experiences to provide skills sets in preparation for the CPRNE.

Curative Care

- Adding simulation to compensate for the lack of available placement;
- Theory only (4);
- Have had to defer placement to another semester for when the agency could accommodate our students. This resulted in adjustment of their plan of study for the upcoming semester;
- Restricted opportunities for students to work with RNs in hospital settings due to changing staff mix

Supportive Care

- Theory only, no application for all students (4);
- Theory plus simulation (1)
- Only some students get placements in this area (1)

Rehabilitative

- Theory only (3)
- Theory plus simulation (1)
- Only some students get placements in this area (1)

Mental Health and Addictions

- Not all students get the opportunity to apply their knowledge (9);
- None of the IENs get this experience so limits employment as well as success on registration exam;
- Have had to do creative scheduling and increased travelling for students;
- Local programs are in transition; limited exposure to best practice opportunities.

Seniors

- Insurance coverage has impacted our ability to place students for home visits and evaluation components have required changing;
- Theory only, no application for all students (1);
- There is a poor fit between student knowledge of gerontology and the care of older adults. As students move to upper levels of the program and develop a deeper knowledge of older adult changes and health needs, there are fewer RNs working with that age group.

Interprofessional

- Universities without other health care programs are disadvantaged as OT, PT, SW, nutrition students are not readily available.
- Theory only, some students get no application (2);
- Very limited opportunities for IPE experiences due to mismatches with health professional curricula structures and goals;
- Limited well- organized settings and funding for community advisor role.

Acute Care Settings

- Less in-patient areas for student placements, taking fewer students, simulation has augmented past experience that students would have had in these areas i.e. cardiac care; skill development, medication administration, IVs, suctioning, central lines;
- Students learn from what they observe. The lack of responsive and ethical practice (from staff and managers alike) sends a message that quality and safe patient care is not important even though it is taught in the classroom;
- Theory only, no application for all students (4);
- We have had to defer placement to another semester for when the agency could accommodate our students. This resulted in adjusting their plan of study for the upcoming semester;
- They are not able to practice their skills and therefore are completing clinical courses and coming out less prepared than they should be at each level;
- limited exposure to RN role;
- Limited exposure with students getting most of their experience in medical units;
- Students are unable to practice psychomotor skills and experience the applied aspect of learning when appropriate medical and surgical placements are not found. At times, the challenge with appropriate placements does not allow a seamless continuum between curriculum in lab and real contexts.

Community Care Settings

- Lack of opportunities to apply theoretical concepts (8);
- Essay Assignment;
- A struggle to find appropriate community settings that have RNs employed;
- Not all students receive a placement opportunity in this area so it is inequitable as far as student learning;
- Large focus on preventative and holistic care with limited if any Professional Practice experiences.

Long-term Care

- Theory only, no application for all students;
- Fewer RNs employed in long-term care settings.

Primary Care Settings

- The content is covered in the course(s) but we are not able to provide the Professional Practice experience to all of the students (8).

Agencies Survey Report

3/12/2015

Table of Contents

Key Findings

- Over 90% of agencies who responded offer placements to BScN students, a majority to Master's student, approximately half to PN students, and a small percentage to IENs.
- Agencies that are not formally designated as teaching institutions make a significant contribution to clinical education, but are still much less likely to take PN and IEN students.
- There is some capacity in the system to expand numbers of placements, in terms of agencies who do not currently offer placements but who are interested to do so, and agencies who are offering placements and could expand these offerings in particular learning areas.
    - There is less capacity for BScN students, as the system is more saturated
    - There is more capacity in learning areas of adults, seniors, primary care, care related to chronic conditions, health promotion, mental health and addictions, and interprofessional care.
- In most learning areas, agencies tend to offer relatively small numbers of placements. The exceptions are Adult, Seniors, and Long-term care.
- Factors that are particularly important in helping agencies to take students include:
    - Organization mission or goals include a teaching mandate
    - Students oriented prior to arriving on placement
    - Support from nursing leadership at the organization
    - Support from school for preceptor
    - Commitment of preceptors to the clinical teaching enterprise
    - Full nursing complement (i.e., no shortage of nursing staff)
    - Time allotted to preceptor to support their role
- Factors that are particularly important in helping agencies to expand the number of students they take include:
    - Teaching mandate for the organization/agency
    - Additional support from senior management of the organization/agency
    - Additional support from nursing leadership at the organization
    - Payment or increased payment for potential preceptors
    - Interest from staff in being preceptors
    - Support from school for preceptors
    - Data about the impact of students on workload (either reducing it or increasing it)
    - Data about the effect of students on patient outcomes and care delivery
    - Availability of enough nursing staff for appropriate supervision
    - Resources at agency for a paid clinical placement coordinator
    - Students oriented prior to arriving on placement
    - Better/more physical space
    - Clinical placement database/communication system to streamline requests and reporting
    - More time allotted to preceptors to support their role
- The majority of agencies identify a financial cost to their organizations for taking students on placement. The biggest cost factor is labour. Space and materials are also significant.

- Major recommendations identified by agencies to increase capacity for clinical placements include funding, preceptor training, a provincial strategy on clinical education, and more support from schools.
- Internationally educated nurses on clinical placements tend to have specialized needs

Background

This survey was developed as part of the work of the Joint Provincial Nursing Committee "Nursing Education for a Sustainable Work Force" Work Group. Nursing schools have encountered growing challenges with finding quality clinical education placements over the course of the past 15-20 years, and agencies have been under increasing pressure to accommodate demands for placements. Challenges are due to growth in enrollments, restructuring of the healthcare system, requirements for students to meet the entry-to-practice competencies in Ontario, and increasing regulation surrounding students on clinical placements.[1]

Clinical placement requirements for baccalaureate nursing programs in Ontario are established with reference to the CNO Competencies for Entry-level RN Practice, the CNO Program Approval Standards and Framework, the national program accreditation standards (set by the Canadian Association of Schools of Nursing, or CASN), and the individual mission, philosophy and program outcomes identified by each school of nursing. Requirements for PN programs are set by the CNO entry to practice competencies for RPNs and the CNO Program Approval Standards and Framework.

Neither the CNO nor CASN prescribe a set number of clinical education hours in particular learning areas or practice settings in order to meet standards. Rather, programs must demonstrate that their programs provide learning opportunities that will enable students to achieve the competencies, and these opportunities are assumed or implied to include clinical placement opportunities.[2] Hence nursing schools have a fair degree of discretion in determining how much and what types of clinical placements are required, and how much can be done through simulation and classroom learning, as long as the competencies and learner outcomes are met.

In spite of this lack of prescription from external bodies, nursing schools themselves continue to require students to have a large number of clinical experience hours in the field—with an average of 1,234 hours per student over a four-year baccalaureate program--in order to ensure the meeting of learning outcomes. In light of shortages in traditional settings, and the growing emphasis on

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[1] For an elaboration of the larger context behind the clinical education challenges in Ontario, see the Council of Ontario Universities policy paper, Integrating Clinical Education into Ontario's Changing Healthcare System http://www.cou.on.ca/publications/reports/pdfs/integrating-clinical-education-into-the-changing-h. Increasing regulation includes criminal record check requirements, student workplace training requirements under Bill 18, and CNO requirements around gaps in practice and bridging for internationally educated nurses.

[2] The most recently updated CNO entry to practice competencies document for RN practice, which in its previous version used to have some limited stipulations about clinical education, has entirely eliminated these. The new CNO Program Evaluation Standards and Framework simply states that clinical coursework must be "at the appropriate educational level for the category and/or class of registration" and that "academic, scholarly and clinical coursework are integrated to facilitate students' application of theory to practice." Similarly, the CASN standards are very process oriented and speak more frequently of "learning opportunities" across the continuum of care, for types of care and with different types of client, rather than "clinical placement experiences." When they do talk about practice experiences CASN does so in a non-prescriptive way—the school must show that "a sequential plan for practice experiences links to expected outcomes, and indicates that practice experiences support learner outcomes." Overall, then, it is increasingly left up to schools to determine how they provide students with opportunities for students to meet the competencies.

community care, schools have sought out "non-traditional" placements in shelters, schools, prisons, retirement residences, and other locations to meet curricular requirements. In addition, nursing schools have increasingly moved towards a greater emphasis on simulation, and the Ontario government has financially supported this.

The question of whether simulation could substitute for placements has been a growing one in recent years. Currently there is evidence that simulation can play a role in helping students attain learning outcomes. However, more research is needed to determine the extent of the role it can play and under which conditions it is best used.[3] Schools will likely increase the use of simulation as a learning modality for some learning areas in particular, but it cannot wholly replace the need for students to experience care in "real-life" clinical environments as a part of their nursing education. One drawback of simulation is that it tends to be an expensive learning modality, possibly more expensive than traditional clinical placements, and will need to evolve gradually in concert with evidence on outcomes. In the mid-term, we can anticipate that schools will maintain robust clinical practice requirements in order to ensure that learning outcomes are met.

In order to develop recommendations for the Joint Provincial Nursing Committee on clinical education, the work group identified that more information was needed on the subject. Under the guidance of the work group, the agencies survey sought to identify:

- What categories of nursing students are being taken on placement and how many
- whether agencies have capacity, under current conditions, to expand their clinical placement offerings and in which learning areas
- factors that affect the capacity to take students or more students
- cost elements and amounts for taking students
- enabling factors and innovative strategies used to expand capacity for clinical placements, and
- agencies' recommendations to provide more quality clinical placements.

The results of the survey will be combined with the results of a similar schools survey and findings from a students' survey in order to develop recommendations to JPNC regarding the clinical placement system for nursing students in Ontario.

Survey Administration and Response Rate

The work group sought to administer the survey to all agencies across the continuum of care that currently take nursing students/IENs on placement or have potential to take such students. This included community hospitals, academic teaching hospitals, long-term care facilities, mental health agencies, community health centres, community care access centres, children's treatment centres, mental health and addictions agencies, family health teams, public health units, home care agencies, nurses in CCACs who work with schools, retirement homes, hospices, nurse practitioner led clinics, and remote nursing stations. For public health units, academic teaching hospitals, community

[3] A recent study by the National Council of State Boards of Nursing that looked at a 50% substitution of clinical with simulation showed equivalent learning outcomes. However, the study was circumscribed to particular types of schools and best practices in simulation.

hospitals, community health centres, nurse practitioner led clinics, CCACs and remote nursing stations, members of the work group helped to disseminate the survey. For Family Health Teams, Hospices, Home Care, Long-Term Care Homes and Retirement Homes, we requested associations from these sectors to distribute the survey. We were unable to administer the survey to correctional institutes or telehealth Ontario, so these two agency types are not represented. There were 126 responses to the survey. Not all responses were complete.

Agency types

A wide variety of agency types were represented in the survey responses. Respondents could identify themselves in more than one category, so the total number of responses was higher than the total number of respondents. Several academic health science centres identified themselves with multiple categories.

The chart below indicates the percentage response rate from within each agency category. There were excellent response rates for Community Care Access Centres (CCACs), Public Health units, Community Health Centres (CHCs), NP led clinics, and Cancer Centres. Academic health science centres were analyzed as an additional category and had a response rate of 9/24 or 37.5%. Good response rates were experienced for Childrens' Treatment Centres and Family Health Teams. For some sectors where agencies could fall into multiple categories (e.g., both acute care hospital and addiction and mental health or complex continuing care) it was difficult to know the total population for that category and hence to judge the response rate. Overall, the primary health care sector had the highest response rate and the long-term care sector the lowest.

Agency type	Percentage of each agency type that responded	Count
Acute Care Hospital	*%	13
Acute Care Hospital--community	14%	7
Addiction & Mental Health Centre/Psychiatric Hospital	*	6
Complex Continuing Care Hospital	*	9
Rehabilitation Hospital	*	7
Other Hospital (describe)	*	2
Cancer Centre	23.1%	3
Children Treatment Centre (CTC)	15%	3
Community Care Access Centre (CCAC)	64.3%	9
Community Health Centre (CHC)	96.9%	31
Community Mental Health Program	*	8
Diabetes Education Centre (DEC)	5.3%	8

Family Health Team (FHT)	13%	24
Hospice	*	7
Nurse Practitioner Led Clinic	29.6%	8
Physician's Office	*	1
Public Health Unit/Department	41.7%	15
Remote Nursing Station	*	1
Other Community Agency Type (describe)	*	1
Long-Term Care Facility	3.5%	22
Retirement Home	*	1
Other Long-Term Care Facility (describe)	*	3
Other, please specify...	*	14

'*'=total population unavailable

Other types of agencies that filled out the survey included:

- Aboriginal Health Access Centre
- Palliative Care
- Pediatrics
- Community Support Services
- Ambulatory Care, Outpatient Clinics, Outreach Services
- Non-profit Supportive Housing

Regional representation

All LHINs were represented in the survey, as reflected in the chart below.

Response	Chart	Percentage	Count
Erie St. Clair		5.6%	7
South West		8.7%	11
Waterloo Wellington		7.1%	9
Hamilton Niagara Haldimand Brant		7.1%	9
Central West		3.2%	4
Mississauga Halton		0.8%	1
Toronto Central		15.9%	20
Central		4.0%	5

Central East		6.3%	8
South East		7.1%	9
Champlain		11.9%	15
North Simcoe Muskoka		3.2%	4
North East		11.9%	15
North West		8.7%	11
		Total Responses	**126**

Teaching designation

The majority of the responses were from agencies that are not designated as teaching institutions.

Response	Chart	Percentage	Count
Yes		18.4%	23
No		60.0%	75
Don't know		21.6%	27
		Total Responses	**125**

Types of nursing students that agencies accept on placement

Approximately half of the agencies who responded offer placements to PN students, most offer to BScN students, a majority to Master's students, and a smaller percentage to IENs. A smaller number of respondents commented with respect to IENs.

	Yes, we offer placements	No, we don't offer placements	Total Responses
Practice Nurse (PN) students	52 (51.5%)	49 (48.5%)	101
Baccalaureate nursing students	117 (93.6%)	8 (6.4%)	125
IENs—PN role	19 (22.1%)	67 (77.9%)	86
IENs—Baccalaureate role	26 (31.3%)	57 (68.7%)	83
Masters students	78 (70.9%)	32 (29.1%)	110

All categories of agency offered placements to all types of student. There was no pattern by LHIN.

Percentage who take students by teaching designation

Those formally designated as teaching institutes are more likely to take students than those not designated. However, the difference between teaching and non-teaching institutes is not very high in terms of taking baccalaureate students. Teaching institutes are twice as likely to take PN students. Teaching institutes are far more likely to offer placements to IENs in both categories of

placements. As indicated under "capacity" below, there may be untapped potential for non-teaching institutes to take IENs.

	"Teaching" institute	"non-teaching" institute
Take PN students	16 (70%)	27 (36%)
Take Baccalaureate students	23 (100%)	67 (89%)
Take IENs in PN role	10 (43%)	9 (12%)
Take IENs in Baccalaureate role	13 (57%)	11 (15%)

Overall, the amount of teaching being done in agencies not formally designated as teaching institutions show how clinical education is being undertaken in a very significant way across the continuum of care.

Division of teaching institutions by sector

	% teaching institute	% non-teaching institute	% don't know
Acute	62% (18/29)	28% (8/29)	10 % (3/29)
Community	7% (2/27)	93% (25/27)	0%
Long-term Care	8% (1/12)	67% (8/12)	25% (3/12)
Primary Care	3% (2/58)	57% (33/58)	40% (23/58)

Teaching designation is heavily concentrated in the acute care sector. Respondents from community, primary care and long-term care tended not to have this designation, even though they are making a major contribution to the teaching enterprise. There is no formal recognition of this contribution in the health care system.

Capacity for more placements in the current system

There were two indicators of capacity for more placements in the survey. One asked respondents who did not take students in a particular category whether they would be interested to do so, and another asked whether they could expand the number of placements they currently offer.

Agencies who do not currently take students but who are interested to do so

Respondents who did not take students on placements were asked if they would be interested to do so. Quite a high percentage said they would be interested, as shown in the chart below. There was no pattern by teaching designation, by sector, or by region.

	No. of respondents who do not take students	Number who would be interested to take students	Percentage of total who would be interested to take students
PN Students	49	18	37%
BScN Students	8	6	75%
IEN Students in a PN Role	66	31	47%
IEN Students in a BScN	56	31	55%

Role			
McMaster's Students	32	15	47%

These findings are significant because they show that there is some capacity in the system for more placements, particularly for IEN students. The capacity to expand for BScN students is more limited, as most agencies already take students in this category. A majority of those who said "no" they do not take students currently but would be interested to do so were community agencies that would likely not be able to offer great numbers of placements. However, particularly for the IENs there were some larger hospitals and institutions that would be willing to take students.

Capacity to expand clinical placement offerings by learning area

Participants were asked whether they could offer *more* clinical placements for PN or BScN level students in each learning area than they do currently. The response rate for this question was relatively small, considering all types of agencies were asked to fill it out. For those who did respond, the table below indicates that there is some capacity to expand placements, particularly in learning areas of adults, seniors, primary care, care related to chronic conditions, health promotion, mental health and addictions, and inteprofessional care. There was no pattern by agency sector or by region.

	Yes	**No**	**Total Responses**
Maternal Newborn	15 (22.7%)	51 (77.3%)	66
Children	12 (19.4%)	50 (80.6%)	62
Adolescents	14 (22.2%)	49 (77.8%)	63
Adults	27 (40.3%)	40 (59.7%)	67
Seniors	29 (40.8%)	42 (59.2%)	71
Families	13 (22.8%)	44 (77.2%)	57
Communities (as recipients of care)	14 (23.0%)	47 (77.0%)	61
Populations (as recipients of care)	8 (14.3%)	48 (85.7%)	56
Curative Care	7 (13.7%)	44 (86.3%)	51
Supportive Care	9 (18.0%)	41 (82.0%)	50
Primary Care	28 (40.0%)	42 (60.0%)	70
Rehabilitative Care	8 (15.4%)	44 (84.6%)	52
Care related to complex chronic conditions	20 (33.3%)	40 (66.7%)	60
Health Promotion	19 (32.8%)	39 (67.2%)	58
Prevention of injury and illness	15 (27.3%)	40 (72.7%)	55
Palliative, end of life care	15 (25.0%)	45 (75.0%)	60
Mental Health and Addictions	19 (33.3%)	38 (66.7%)	57

Long-Term Care	19 (29.2%)	46 (70.8%)	65
Public Health	4 (6.8%)	55 (93.2%)	59
Interprofessional or collaborative care	19 (32.8%)	39 (67.2%)	58
Acute care	10 (19.2%)	42 (80.8%)	52
Other	3 (8.6%)	32 (91.4%)	35

Willingness to share name of organization with schools

This question was asked of respondents to see if there is potential to facilitate connections between agencies that have some capacity to expand placements, and schools who need placements. A little over half of respondents answered "yes" to this question. Many respondents answered "no" to this question did so because they do not have capacity to expand. Others answered "no" because they have formal partnerships with particular schools, and already existing communication networks. Of those who answered "yes," a few put conditions on sharing, such as capacity of students to speak French, willingness to place students outside of Monday to Friday days during the academic year, need for more information, and priority for local schools.

Response	Chart	Percentage	Count
Yes (provide comments if applicable)		57.3%	51
No (provide comments if applicable)		42.7%	38
		Total Responses	**89**

Number of PN-level placements currently offered by learning area

The data here and for the BScN placements below gives some indication of the range of number of placements offered by agencies, divided up by learning area, as well as the average number of placements offered. Response rates are smaller, probably indicating that many respondents did not fill in for each learning area if they could not offer placements there. The average number of placements offered tended to be quite small, with the exception of adults, seniors, and acute care.

Learning Area	No. of responses	Range	Average
Maternal Newborn	25	0-60	4.8
Children	29	0-64	8.6
Adolescents	29	0-64	8
Adults	34	0-375	61
Seniors	36	0-519	51.3
Families	27	0-50	5.3
Communities (as recipients of care--see definition	27	0-302	12.2

Learning Area	No. of responses	Range	Average
above)			
Populations (as recipients of care--see definition above)	26	0-410	30.5
Curative Care	22	0-302	36.4
Supportive Care	23	0-90	9.9
Primary Care	33	0-302	11.1
Rehabilitative Care	22	0-190	20.5
Care related to chronic health conditions	27	0-233	22.5
Health Promotion	25	0-41	3.3
Prevention of injury and illness	22	0-50	1.8
Palliative, end of life care	25	0-75	6.7
Mental Health and Addictions	23	0-100	16.9
Long-Term Care	32	0-160	23.6
Public Health (please identify program area)	19	0-2	0.1
Interprofessional or collaborative care	25	0-415	42.8
Acute Care	24	0-530	60.7
Other *	16	0-45	3.6

For the "other" category, responses included "ambulatory care" (45 placements), community care (1 placement) and prevention and education issues (3-5 placements).

Number of baccalaureate-level placements currently offered, by learning area

Learning area	No. of responses	Range	Average no. of placements provided
Maternal Newborn	38	0-210	16.3
Children	43	0-200	20.9
Adolescents	45	0-165	11.1
Adults	53	0-966	91.6
Seniors	54	0-784	38
Families	46	0-949	28.4
Communities (as recipients of care--see definition above)	42	0-949	26
Populations (as recipients of care--see definition above)	32	0-949	46.9

Learning area	No. of responses	Range	Average no. of placements provided
Curative Care	25	0-914	66.1
Supportive Care	26	0-225	21.1
Primary Care	62	0-932	19.4
Rehabilitative Care	23	0-244	38.1
Care related to chronic health conditions	41	0-194	21.7
Health Promotion	45	0-43	5.3
Prevention of injury and illness	35	0-34	4.6
Palliative, end of life care	31	0-78	6.4
Mental Health and Addictions	31	0-275	82
Long-Term Care	26	0-189	16.2
Public Health (please identify program area)	30	0-24	2.4
Interprofessional or collaborative care	37	0-949	49.3
Acute Care	27	0-1143	172.7
Other (please specify)	15	0-68	5.8

"Other" learning areas included ambulatory care (68 placements), and care co-ordination (2).

Factors that have helped organizations/agencies to provide clinical learning opportunities for nursing students/IENs

The chart below identifies the range of factors that respondents considered as important to extremely important in facilitating student placements. All factors were considered important by a substantial number and percentage of respondents. Respondents were split in their experiences of how much experienced students help with workload, which could reflect the varying educational level of students on placement. Many respondents indicated that they did not know whether the ONA supplement, a paid clinical coordinator at the agency, or a clinical placement database/communication system facilitated placements. This could reflect the position level of the person who filled out the survey.

	Extremely important	Very important	Important	Not very important	Not at all important	Don't know/not applicable	Total Responses
Organizational mission or goals include a teaching mandate—students placements recorded and recognized in reporting	25 (23.6%)	25 (23.6%)	34 (32.1%)	10 (9.4%)	3 (2.8%)	9 (8.5%)	106

mechanisms							
Students oriented prior to arriving on placement	27 (25.7%)	36 (34.3%)	24 (22.9%)	9 (8.6%)	4 (3.8%)	5 (4.8%)	105
Support from senior management of my organization/agency	39 (35.5%)	44 (40.0%)	21 (19.1%)	4 (3.6%)	1 (0.9%)	1 (0.9%)	110
Support from nursing leadership at my organization	53 (49.5%)	36 (33.6%)	12 (11.2%)	1 (0.9%)	1 (0.9%)	4 (3.7%)	107
Support from school for preceptor	47 (42.7%)	37 (33.6%)	17 (15.5%)	4 (3.6%)	1 (0.9%)	4 (3.6%)	110
Commitment of preceptors to the clinical teaching enterprise	66 (60.6%)	34 (31.2%)	7 (6.4%)	1 (0.9%)	0 (0.0%)	1 (0.9%)	109
Experienced students help with workload	7 (6.7%)	11 (10.5%)	30 (28.6%)	38 (36.2%)	11 (10.5%)	8 (7.6%)	105
Full nursing complement (i.e., no shortage of nursing staff)	38 (35.2%)	36 (33.3%)	20 (18.5%)	1 (0.9%)	1 (0.9%)	12 (11.1%)	108
Preceptor paid the Ontario Nurses' Association (ONA) negotiated supplement	10 (9.7%)	11 (10.7%)	15 (14.6%)	11 (10.7%)	8 (7.8%)	48 (46.6%)	103
Time allotted to preceptor to support their role	28 (26.4%)	37 (34.9%)	35 (33.0%)	2 (1.9%)	0 (0.0%)	4 (3.8%)	106
Paid clinical placement coordinator at agency	11 (10.8%)	15 (14.7%)	16 (15.7%)	15 (14.7%)	8 (7.8%)	37 (36.3%)	102
Physical space	31 (27.9%)	30 (27.0%)	37 (33.3%)	7 (6.3%)	2 (1.8%)	4 (3.6%)	111
Clinical placement database/communication system, e.g., Health Sciences Placement Network (HSPnet)	8 (8.0%)	10 (10.0%)	14 (14.0%)	18 (18.0%)	6 (6.0%)	44 (44.0%)	100
Other (please describe in box below)	5 (25.0%)	3 (15.0%)	2 (10.0%)	0 (0.0%)	0 (0.0%)	10 (50.0%)	20

Other factors not included above that were identified as important for taking students included:

- Assessment of student for fit with the placement

- Accommodations for students on placements
- Extra support for struggling students
- More electronic medical record licenses
- Availability of project work for students
- Student has own transportation
- More advance notice for placement requests

Supports helpful to organizations'/agencies' ability to offer MORE clinical placements for nursing students

All factors listed below were identified by the majority of respondents as helpful to offer more placements.

	Extremely helpful/ influential	Very helpful/ influential	Somewhat helpful/ influential	Not very helpful/ influential	not at all helpful/ influential	Don't know	Total Responses
Teaching mandate for the organization/agency	22 (21.2%)	27 (26.0%)	29 (27.9%)	11 (10.6%)	7 (6.7%)	8 (7.7%)	104
Additional support from senior management of my organization/agency	20 (20.2%)	25 (25.3%)	20 (20.2%)	16 (16.2%)	12 (12.1%)	6 (6.1%)	99
Additional support from nursing leadership at my organization	19 (19.2%)	24 (24.2%)	24 (24.2%)	16 (16.2%)	9 (9.1%)	7 (7.1%)	99
Payment or increased payment for potential preceptors	23 (21.1%)	30 (27.5%)	26 (23.9%)	8 (7.3%)	11 (10.1%)	11 (10.1%)	109
More interest from staff in being preceptors	42 (39.6%)	31 (29.2%)	21 (19.8%)	6 (5.7%)	2 (1.9%)	4 (3.8%)	106
Better support from school for preceptors	33 (32.7%)	24 (23.8%)	25 (24.8%)	14 (13.9%)	3 (3.0%)	2 (2.0%)	101
Data about the impact of students on workload (either reducing it or increasing it)	18 (17.1%)	35 (33.3%)	26 (24.8%)	12 (11.4%)	11 (10.5%)	3 (2.9%)	105
Data about the effect of students on patient outcomes and care delivery	19 (18.6%)	24 (23.5%)	28 (27.5%)	19 (18.6%)	8 (7.8%)	4 (3.9%)	102
Availability of enough nursing staff for appropriate supervision	62 (56.9%)	28 (25.7%)	9 (8.3%)	6 (5.5%)	2 (1.8%)	2 (1.8%)	109
Resources at agency for a	28	27	22	7 (6.9%)	10	7	101

paid clinical placement coordinator placements	(27.7%)	(26.7%)	(21.8%)		(9.9%)	(6.9%)	
Better/more physical space	34 (31.5%)	30 (27.8%)	23 (21.3%)	10 (9.3%)	9 (8.3%)	2 (1.9%)	108
Students are better oriented prior to arriving on placement	21 (20.8%)	31 (30.7%)	31 (30.7%)	11 (10.9%)	6 (5.9%)	1 (1.0%)	101
More support from the school for preceptors	23 (22.5%)	33 (32.4%)	26 (25.5%)	12 (11.8%)	3 (2.9%)	5 (4.9%)	102
More time allotted to preceptors to support their role	40 (36.4%)	42 (38.2%)	19 (17.3%)	5 (4.5%)	1 (0.9%)	3 (2.7%)	110
Clinical placement database/communication system to streamline requests and reporting	16 (15.4%)	25 (24.0%)	26 (25.0%)	20 (19.2%)	8 (7.7%)	9 (8.7%)	104
Other (please describe in box below)	2 (16.7%)	2 (16.7%)	1 (8.3%)	1 (8.3%)	1 (8.3%)	5 (41.7%)	12

"Other" factors influencing organizations' ability to offer more clinical placements to students

Most respondents indicated in this section that they are already at capacity in terms of providing placements, and cannot offer more. Several identified lack of funding specific to clinical education as a factor. And several suggested more support from schools would help in terms of previously orienting students to electronic medical records and other software, or a more streamlined system of requesting placements with more notice and more consistency in agreements and expectations across schools.

Financial cost to organizations for taking students

A strong majority of respondents said there was a financial cost to their organization for taking students.

Response	Chart	Percentage	Count
Yes		70.2%	87
No		29.8%	37
		Total Responses	**124**

Elements of costs and cost per year by organization type

Respondents who said "yes" to the above question were asked to identify the cost elements for taking students and the cost per student per year. A great deal of information was reported. It has been grouped and thematized by sector. Identifying a distinct cost per sector would require further discussion and analysis.

Community care sector

Elements of Cost	Cost per Student per year and Method of Calculation

• staff time
  o coordination including legal agreements, WSIB, liability
  o preceptor orientation
  o preceptor recognition
  o student supervision
  o student orientation
  o evaluations
• IT—laptops
• Lost direct care productivity
• Space
• phone
• Materials
• Printing
• Backfill of staff
• Preceptor premium
	Laptops--$500/student
	$2550/preceptor , $48,450/year
	Lost productivity—4 hours per week @$40/hour
	$593.98/student
	$120/placement for coordination and materials—doesn't include preceptor time
	$200/student per 8 week placements
	8 hours per student * hourly wage of RN or RPN

Acute care sector

Elements of Cost	Costs (range)
• Preceptor premium • Preceptor time for development workshops, student supervision, meetings with schools • Backfill when staff seconded as clinical instructors • Backfill for preceptors for performance appraisals of students • Orientation materials for students (e.g., ID badges) • Staff time for orienting students • HSPnet fees • Clinical materials (gloves, mask, etc.) • Student placement coordinator • Physical space requirements—lockers, centralized student centre • Maintenance costs for equipment in skills labs and classrooms • IT costs • Educating workplace about students	$102/student (not including quality improvement or equipment) $800/student $35,000 per year altogether $120,000K coordination/year Preceptorship costs $100,000/year Support costs $50,000/year Coordination/support $105K/year Preceptor workshops ($10,000) $2000 $75,000 not including preceptor time $89,434 in premiums alone $400/student 30 hours per student for one placement $259 per preceptor per placement (premiums only)

• Educational materials for students • Student affairs office space • Student affairs website • Coordination/development of placements • Orientation packages for workshops • Adverse events investigation • delay to patient care during teaching	

Primary Care

Elements of Cost	**Cost ranges**
• Lost staff time • Computer/related EMR costs • Insurance • Coordination • Supervision, evaluation • Orientation • Preceptor orientations • Rent for additional space • Lost productivity • Supplies	• $150 in total • $1200 to $1300 overall • $3000 overall • $7525 overall • $1000 up front

Long-term Care

Elements of Cost	**Cost per Student per year and Method of Calculation**
• Preceptor premium • Preceptor development workshops • Staff time to work with students • coordination • backfill of staff • student orientation to facility • materials for orientation • space • office materials • clinical materials • IT setup and orientation	• $400/student • 30 hours / student—amount depends on whether RN or RPN in preceptor role • $500 for supplies on a 3 month placement • $500 • 4 hours per placement or $200 per student

Strategies and practices used by organizations/agencies to expand the number of clinical placements offered

This question sought to get at strategies that agencies have used to expand placements. A number of themes emerged:

- The importance of preceptor support - Development of a preceptor strategy focusing on orientation and training, resources, networking opportunities and formal recognition for the role of the preceptor is viewed as having an important influence on increasing placement opportunities.

  > "Preceptor training modules [are] offered…We also provide recognition to those public health nurses that precept students."

- Placement coordinator positions - Having designated individuals to coordinate student placements and communicate with preceptors, students, and others can lead to more efficient and effective management of placements and better tracking of students.

- Involvement of Nursing leadership – Nursing leaders who make it known that the nursing staff is expected to participate in student education as a part of professional practice responsibilities generally offer a greater number of meaningful placement opportunities for students.

  > "The single greatest factor that impacts the kinds of clinical placements we can offer is the expectation of the clinical leader that their nurses will support nursing student placements."

- Agencies are resourceful and innovative. A number of strategies are already being employed by agencies to increase clinical education/placement capacity, such as sharing preceptors, offering placements during evening and weekend shifts, adding ambulatory care and offering non-traditional placements.

  > "We are exploring the possibility to use our Veterans Care Program as a community type of placement for second year nursing students since the Veterans home is within the institution. The clinical coordinators are very supportive…"

- Clinical education opportunities are ultimately impacted by external factors - Limited preceptor availability, the lack of physical space to accommodate students, the number of postsecondary institutions competing for placements and budget cuts all impact the agency's ability to offer opportunities. These are just some examples of limitations.

  > "Our placement numbers are directly impacted by space, number of preceptors available and the flexibility of the academic facility"

  > "We don't have any plans to expand since we are no longer an official xx teaching unit….Since that funding was withdrawn from the Ministry…the education across the province is significantly weakened for nursing students"

Innovative strategies and practices that *could* help organizations expand the number of nursing clinical placements offered

This question sought to give respondents the opportunity to identify additional strategies that could help to expand placements. Hence this question sought to go beyond what is actually happening already with clinical placements, to identify what would be helpful *if* it were possible.

The most common response from survey respondents concerned financial incentives.

- Some suggested that honoraria could be paid to preceptors.
- Others recommended payments to cover the cost of back-filling preceptors, and/or payment of the incremental costs of teaching students.
- Related ideas were for academic institutions to offer tuition reimbursement for agency staff enrolling in courses.

  "Funding provided to both the care facility for the coordination and professional staff for the precepting would be an innovative strategy. Incremental increases for precepting and performance evaluation that recognizes the engagement of these professionals and student training. Physician assistant program model may be helpful to understanding some of the system imbalance nurses are experiencing."

  ..."funding to allow time to work with persons"

- Recruitment and advertising were also mentioned frequently. Suggestions for recruitment tours to increase staff interest, visits by academic staff to agencies, community engagement sessions with local community agencies.

- Other suggestions:
  - interprofessional placements, in which schools have a common rotation time so that the RN students could be placed with students in other disciplines such as pharmacy, dietetics, and social work, at the same to work in a "mini-team."
  - [agencies could]..."create new kinds of collaborative partnerships with academics where our own nurses would supervise the student placement experience and the faculty could provide mentorship to them and to the rest of our nursing staff in terms of evolving practice, research ideas, strategies for utilization of research and development of research questions."
  - Consider re-establishing a previous practice of giving RPNs some academic credit toward an undergraduate degree for supervising students in an integrative practicum.
  - Sharing/combining placement opportunities; sharing students between sites;
  - use of more simulation to decrease the number of clinical hours needed;
  - use of a database for distributing placements;
  - greater flexibility about non-traditional placements among educators; and
  - more tools and resources for preceptors and managers

What it would take to implement these innovative strategies and practices?

Major themes here included:

- funding
- more staff or more time for staff to supervise
- space
- more creative timing of placements—weekends, evenings, staggering of specialized placements, shorter placements, combining placement opportunities across more than one organization
- better or more communication between agencies and schools in terms of learning objectives, needs, availability and so on
- more streamlined preceptor education
- incentives for staff to take on students such as credit towards a university course, joint appointment, tuition reimbursement or course discount
- better preparation of students in particular subject areas prior to coming on placement
- more simulation

Other interesting suggestions included:

- "create new kinds of collaborative partnerships with academia where our own nurses would supervise the student placement experience and faculty could provide mentorship to them and to the rest of our nursing staff in terms of evolving changes in practice, research ideas, strategies for utilization of research, and development of research questions."
- "placements that are long enough that student is a contributing team member"
- "interdisciplinary health professional schools to have 'common' rotation time so that we could have a RN student at the same time as a RD, pharmacist, SW etc."
- "Students speaking the languages of the patients that we serve"
- "other allied health professionals take students for placement (dietitian, NP's, pharmacists, SW's, etc)"

Recommendations for organizations/agencies to provide more quality clinical learning opportunities

Recommendations offered for increasing BScN-level student placements and PN-level placements were very similar, and so have been analyzed together. Several themes emerged in the recommendations.

- Perhaps the strongest theme was for more **funding or support for clinical education** which could include money to pay preceptors, to backfill staff, for space, for students to go on rural placements, for staff to organize and evaluate students.
- A second major theme was the importance of **preceptor orientation and training.** Suggestions here included more school support for preceptor training, training offered on-site, consistency in training and dedicated time for preceptors to be trained.

- A third theme centred on **measures that schools could take** including providing more information to agencies and preceptors on expectations, requirements, commitments to take on a students. This would include clarity on learning objectives and evaluation of students. Other sub-themes included a coordinated asks for student placements, more support from faculty while students are on-site, more instruction to students about what to expect in practicum, and more student knowledge of the sector before going on practica.
- A fourth theme was the need for a **provincial strategy regarding student placements.** Points here included the need for provincial expectations to be articulated for agencies and schools, and the need for stronger provincial leadership on initiatives that would help all schools and agencies, such as shared orientation materials and coordinating schedules to address the competing demands on agencies for placements from multiple schools.
- There were a number of recommendations regarding **internationally educated nurses.** These included the need for:
    - Stronger culture understanding/competence by preceptors for working with IENs and a smaller staff component
    - More language training for IENs prior to coming on placements
    - More specific information from schools about the specialized learning needs of IENs

Awareness of HSPnet (Health Sciences Placement Network)

Respondents were asked if they were aware of the Health Sciences Placement Network, a web-based practice placement management system that facilitates communication between schools and agencies and tracks student placements and requirements. Most schools of nursing and many large hospitals have adopted HSPnet. Organization types that seemed particularly unaware of HSPnet included CHCs, FHTs and NP led clinics. This makes sense, because these smaller, community-based organizations tend not to be users of HSPnet currently.

Response	Chart	Percentage	Count
Yes		31.1%	38
No		68.9%	84
		Total Responses	**122**

Appendix C

JPNC Education Working Group
Survey of Nursing Students' Experiences with their Clinical Education

July 2015

Contents

Background

Clinical competencies are an important aspect of nursing education and are required for new nurse graduates to practice in Ontario (CNO, 2014). The College of Nurses of Ontario (CNO) describes a competency as "the knowledge, skill, ability and judgement required for safe and ethical nursing practice" (CNO, 2014, p. 4). Nursing education programs aim to teach these competencies through a combination of classroom education, simulation labs, and required clinical education/placements.

Each clinical practice environment has the opportunity to offer rich learning experiences, which is why several investigators have explored and reported on students' perspectives of their clinical learning environment. They have found that senior nursing students can offer valuable insight into the quality of their clinical placements (Edwards et al, 2004; Hartigan-Roger, Cobbett, Amirault, & Muise-Davis, 2007; Newton & McKenna, 2007; Watt & Pascoe, 2013).

Currently there is a gap in literature on students' perceptions of quality clinical placements and innovative clinical placements, using a sample of students from across Ontario, and from both baccalaureate and practical nursing programs. There is also a gap in literature on how internationally educated nurses (IENs) perceive their clinical education experiences.

Purpose

The purpose of this evaluation was to gather data on Ontario nursing students' perceptions of their clinical education experiences. Students were asked what they consider to be a "quality clinical placements," to describe their experiences with quality placements as well as experiences with clinical placements they were not satisfied with. The survey concluded with a question about students' experiences with "innovative" placements.[1]

The data from this evaluation will be combined with data already collected from agencies and schools across Ontario to help inform Joint Provincial Nursing Committee Education Work Group recommendations on how to develop the supply of quality clinical placements in the future.

This evaluation was made possible with support from the Nursing Health Services Research Unit (NHSRU).

Data Collection and Survey Tool

The survey tool was developed with input from a nurse educator, a student nurse, a health services researcher, two senior policy analysts, and co-chairs of the Council of Ontario University Programs in Nursing (COUPN) and the heads of Nursing from the Colleges of Applied Arts and Technologies (CAATs). The results of the survey will serve as part of a larger initiative aimed at assessing the nature of shortages in quality clinical placements across Ontario,

[1] Innovative placements refer to placements that take place outside of the traditional hospital or other large health care institutions that have historically provided placements for nursing students. Innovative placements might include prisons, homeless shelters, daycares, international placements, remote community placements, etc.

and developing recommendations to manage and/or improve the situation. As such, the research team assessed the survey as a quality improvement initiative, and did not submit the project for review by Research Ethics Boards (REBs) across the province (as per criteria 2.5 of the *Tri-County Policy Statement on the Ethical Conduct for Research Involving Humans*)(CIHR, NSERC & SSHRC, 2010).

Responses from nursing students across Ontario were collected via the LimeSurvey online survey tool. The survey was administered through the Deans/Directors/Chairs of each nursing program across Ontario, in order to collect data from students who were in their final year(s) in either a Baccalaureate nursing program or a Practical Nursing (PN) program. The survey was also administered through CARE (Centre for Internationally Educated Nurses), in order to collect the perspectives of Internationally Educated Nurses (IENs). All students received a formal, online invitation to share their clinical education experiences from Dr. Jennifer Medves, Chair, Council of Ontario University Programs in Nursing; and Dr. Sandra DeLuca, Chair, Provincial Head of Nursing, Colleges of Applied Arts and Technology.

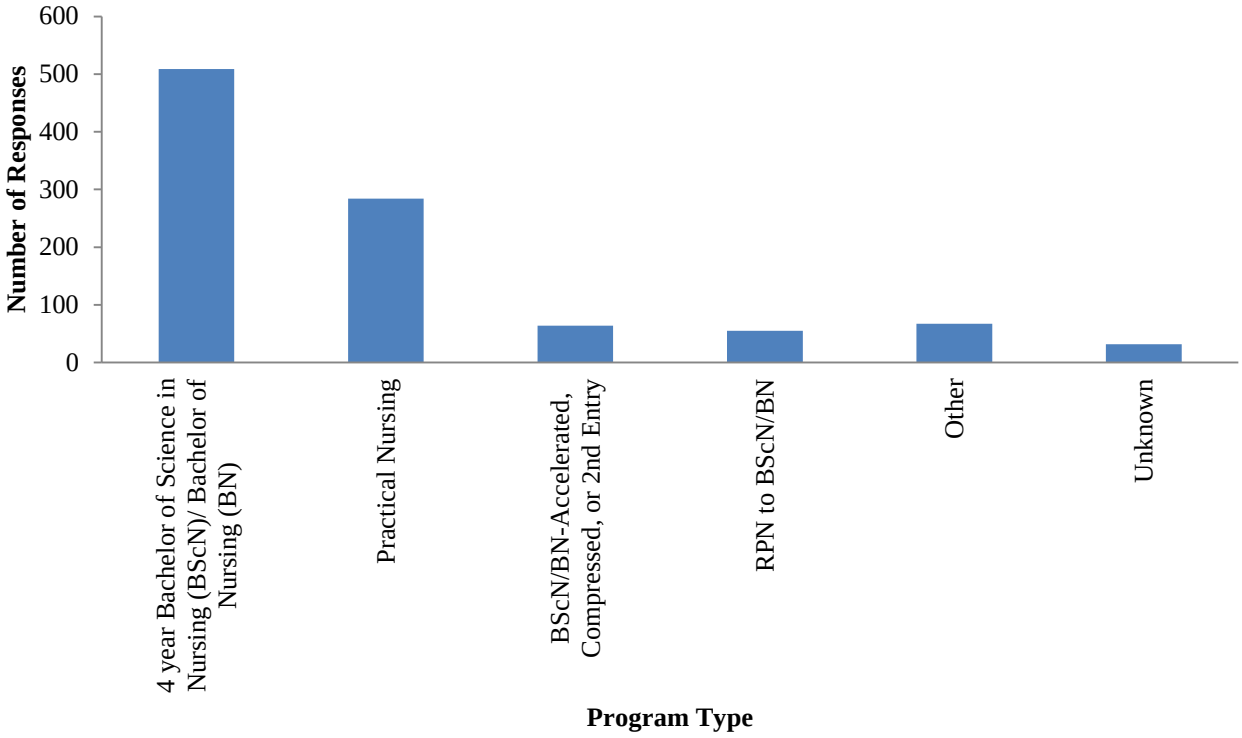
The survey consisted of a mixture of closed and open-ended questions, and collected demographic information relating to nursing school, type of program, year of program/semester of program, and number of completed clinical placements. Open ended questions asked nursing students (1) if they had ever experienced a *quality* clinical placement, including the key components of a quality clinical placement. They were also asked (2) if they had ever experienced a clinical placement that they were not satisfied with; and if so, to describe their experience. Third, students were asked (3) if they have experienced an innovative clinical placement; and if so, did they consider their innovative placement to be a *quality* clinical education experience?

The survey concluded with a question that asked students for (4) suggestions for clinical education (See Appendix A for survey tool). As a token of appreciation for their time and for sharing their experiences, students were given the option of providing their email contact information to be entered into a draw for an I-Pad Mini. They will also get the opportunity to view the findings from this evaluation once the report is complete, as they were key stakeholders in this process.

Participant Sample

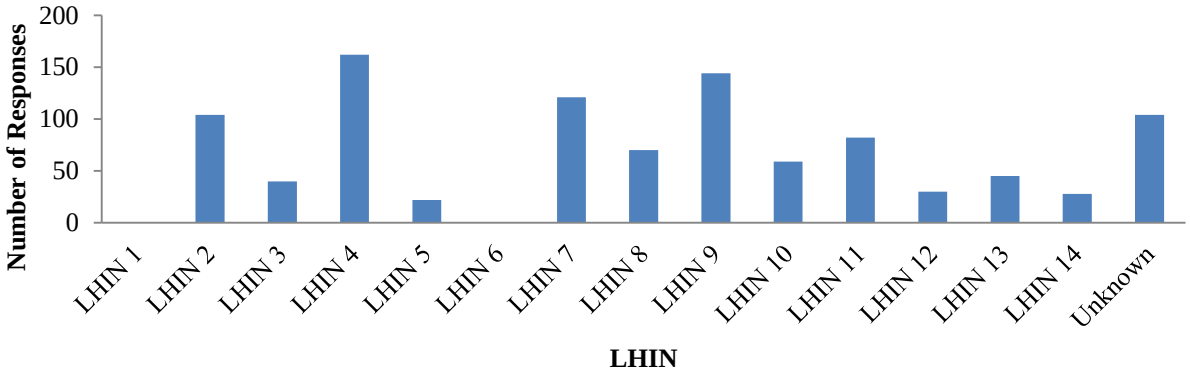
The participant sample was geographically representative, including nursing students from both rural and urban schools, as well as from schools spread across Ontario. The participant sample included representation from baccalaureate programs, practical nursing (PN) programs, as well as Internationally Educated Nurse (IEN) cohorts. There was representation of students from all curricular nursing streams, including students from Basic, Accelerated, Post RN, and RPN to BScN streams) (See Appendix B for definition of streams) (Table 1). The sample was comprised of “senior’ students who had experienced an average of 2-6 clinical placements (3rd and 4th year students, or final year PN and 2nd Degree students).

Table 1: Representation of Student Responses



There were 1012 survey respondents. Nursing students from schools situated within 12/14 LHINs participated in this evaluation (Table 2). Responses from students were collected from 12/13 university sites, and from 22/42 college sites (no responses from 13 PN programs and no responses from 7 baccalaureate collaborate programs).

Table 2: Representation from LHINs



Data Analysis

Due to the overwhelming number and length of the responses from the student participants, responses were divided between two members of the evaluation team for analysis. Each member read the responses, identified key themes that represented the data, and pulled quotes from the data (student verbatim) to help validate the themes. Saturation of data was achieved midway through this initial analysis.

Once the preliminary analysis had been completed, the evaluation "team" (comprised of a nurse educator, a BScN Level 3 student (also a research assistant with the NHSRU), and a health services research coordinator (NHSRU)) met on several occasions to discuss both the numerical as well as the written findings. The overall goal of these meetings was to collapse and achieve consensus on the final themes from the data.

Findings: Nursing Students' Experiences with their Clinical Education

1a) Have you experienced a quality clinical learning opportunity/placement? (N=1012)

Response	Total Number of Respondents	Percentage of Respondents
Yes	741	88.7%
No	94	11.3%

*Missing Responses (N=177)

A total of 741 respondents (88.7%) indicated that they had experienced a quality clinical learning opportunity/placement at some point during their program.

1b) If so, what made it a quality clinical learning opportunity? What are the key elements of a quality clinical learning opportunity/placement?

Respondents who answered "yes" to experiencing a quality clinical learning opportunity/placement were asked to give a written description of the experience. Of the 741 respondents who answered "yes", 705 provided a written description about the key elements of a quality clinical learning opportunity/placement. The key elements/findings from the written responses can be categorized according to

- Quality Clinical Instructor
- "Safe" Clinical Environment, and
- Opportunities for Learning

<u>Quality Clinical Instructor</u>

Students described a quality clinical instructor/preceptor as someone who: helps facilitate their growth as a professional; continuously looks for learning opportunities for the student; challenges yet also empowers them; maintains a positive and encouraging attitude around the student. Strong instructors/preceptors are mentally and physically present while the student is learning, and are considered to be a "safe" person to talk to. They will advocate for the student, if required.

"The biggest asset a student can have is an encouraging and supporting clinical instructor/ preceptor/ faculty advisor even if the students are placed in a not so welcoming placement. If you have someone you can go to, to share your concerns it makes all the difference. These individuals also go out of the way for students to gain new learning opportunities and are more than happy to answer any questions the student may have by being non-judgmental. These individual can "make" or "break" a student so it's really important you have a good instructor or preceptor."

(Baccalaureate student, LHIN 9)

A placement where your instructor both seeks out, and encourages you to seek out many learning experiences. The instructor will be there to guide you through each skill, but will also require you to think critically through each step." (Baccalaureate student, LHIN 10)

A "quality" clinical instructor/preceptor can make any placement a "quality" learning experience.

"I have had good clinical placements with mediocre instructors that did not allow us to practice our skills, and I've had bad clinical placements… with an amazing instructor who helped me get the most out of the limited opportunities. ***The good placements are really defined by high quality instructors*** *- instructors that challenge you, but don't belittle you. I have also had instructors who fail to allow students to have the opportunity to learn - that is what makes a placement truly "bad" when there are few learning opportunities combined with an instructor who doesn't challenge or support you."* (Baccalaureate student, LHIN 10)

"You can make a not so great placement great based on the instructor"

(Baccalaureate student, LHIN 13)

"A good clinical placement begins with a good, keen clinical instructor. If the instructor is well educated, passionate and enthusiastic about the placement then it does not matter the floor."

(Baccalaureate student, LHIN 10)

Another key criteria for a quality instructor/preceptor is that they act like a RN/PN "ought to act", exhibiting behaviors that are professional, ethical, safe, collaborative, caring, and client-centered.

"Professionalism and competence of the instructors. Great mentorship … and several opportunities to develop competence." (Baccalaureate student, LHIN 14)

"Very beneficial…as long as the clinical instructor is still a caring [professional]." *(PN* student, LHIN 8)

"Safe" Clinical Environment

Student responses also revealed that quality clinical placements are environments in which they feel "safe" to learn. "Safe" clinical environments are those where the mentors accept, understand, & appreciate the unique role of the student learner.

"To be an effective learner, it is imperative to feel that you are in a safe & supportive environment." (PN student, LHIN 4)

"*It's also extremely important to have a supportive environment. For instance, that clinical teachers and hopefully nurses on the unit understand that you are learning and have limited experience and it takes experience to become competent and efficient with things. Patience I think is paramount in clinical so that they don't shatter your confidence."*
(Baccalaureate student, LHIN 11)

"*In order to learn … we need to be treated and respected as real nurses. We need the independence to take care of our own patients and the actual nurses on the floor need to understand that we are just learning.*" (PN student, LHIN 10)

Safe environments were also described in terms of belonging and being accepted, as opposed to feeling alone and being excluded from the team.

"A placement which allows for growth of knowledge [in] a safe and comfortable environment, with staff and teachers who are willing to help, and easy to approach."
(Baccalaureate student, LHIN 13)

"Working alongside nursing staff, and learning from them is an essential part of the clinical experience." *(*PN student, LHIN 10)

"*When the nurses on the floor give nursing students space to grow. When the nurse managers and nurses work together with students, it makes clinical experience so memorable."*
(Baccalaureate student, LHIN 11)

"It is important to feel that you can approach people on the unit and are able to ask questions. It is also important to be able to generate a partnership with your instructor/preceptor so you both are able to trust each other and maintain a close professional relationship when caring for patients." (Baccalaureate student, LHIN 13)

Opportunities for Learning

Quality clinical education offers opportunities to learn and grow as a nurse professional. Students are looking to apply/integrate what they have learned in class - which is how they *ought to* practice as professionals (according to the College of Nurses of Ontario standards, Canadian Interprofessional Healthcare Collaborative (CIHC), nursing theories, evidence-informed practice etc.). As such, they are looking for mentors who are behaving how they "ought to behave", and

for care to be delivered in the way it "ought to be delivered". Students expect nurse professionals to be professional, competent, collaborative, and caring.

"Staff were friendly, caring to others, worked as a team, were professional, open to educating others in a professional manner … facility had ongoing training/in services to aid in keeping staff education to current practice standards." (PN Student, LHIN 3)

"… is hands-on experience that allows a student to apply the knowledge they have learned in the classroom while building new skills such as giving report…" (PN student, LHIN 3)

One predominant theme from the student responses was the distinction between "real" learning in a clinical environment versus a simulated environment, and how "real" learning clinical experiences are absolutely essential in a nursing curriculum.

"Clinical placements are the best part of this program … you learn the most in a real setting…" (PN Student, LHIN 4)

"Clinical is so important … hands on application and practice of skills. Real-world experience." (Baccalaureate student, LHIN 2)

"One that is practical and hands on that represents the real working world of nurses with clinical teachers who are nurses in that specific field of nursing." (PN Student, LHIN 11)

"A quality clinical placement is somewhere the student learns all the basic skills, techniques, and best practice. (Clinical) Skills are not the only thing that a student nurse learns at placement; other examples include teamwork, problem solving, ehealth (working with various technologies), and completing all required assignments to help benefit the learning at that placement." (Baccalaureate student, LHIN 13)

2a) Have you experienced a clinical placement that you were not satisfied with? (N=1012)

Response	Total Number of Respondents	Percentage of Respondents
Yes	446	55.5%
No	358	44.5%

*Missing Responses (N=208)

More than half (55.5%) of the respondents reported experiencing a clinical placement that they were not satisfied with.

2b) If so, please describe your experience.

Of the 446 respondents who identified experiencing a clinical placement that they were not satisfied with, 421 provided a written description of their experience. The key elements/findings from the written responses were categorized as follows:

- Unsupportive Clinical Instructor
- Unhealthy Workplace/Clinical Environment
- Unequal / Lack of Opportunities for Learning, and
- No Connection to Nursing

Unsupportive Clinical Instructor

In contrast to the finding that a quality clinical instructor/preceptor is critical to facilitating student learning and development, *unsupportive clinical instructors/preceptors* impede student learning and damage student confidence and self-esteem.

"Again, largely due to the instructor, I had a placement in which I did not feel comfortable enough to learn. Had an instructor that used fear and condescension to try to motivate rather than encouragement, inspiration, and good teaching. In these cases, I found myself avoiding the instructor. In those clinicals, I would simply go into "survival mode" and just try to get through it. I stopped caring if I was learning anything." (Baccalaureate student, LHIN 11)

"A clinical instructor I had was very rude and verbally abusive to me and this discouraged my learning and damaged my self-esteem. She would flip through magazines during our post-conference sessions and always hang over the heads of the nursing students that she could fail us. Teaching by intimidation is rarely effective." (Baccalaureate student, LHIN 7)

Unhealthy Work Environment

Student responses were screened specifically for comments relating to an emotionally and/or physically "unsafe" environment, working with an unsupportive clinical instructor, and/or working with unwelcoming and unsupportive floor staff. Findings revealed that 58% of nursing students who had experienced an unsatisfactory placement attributed it to an unhealthy work environment (s).

"I was placed on a general surgery unit in a hospital full of cliquey, catty nurses. They were unwilling to help, unwilling to share their facilities (we were forbidden from using the locker room even though the manager had pre-approved it, if we were in the staff room on our break and a nurse walked in we would be asked to leave) … I remember on my first day asking where the on button was for a sublingual thermometer (I had only used tympanic in the past) and the nurse saying "Wow. I hope you manage to graduate" and walking out, without explaining anything to me. I am happy with the skills I learned in this placement, but not the way I was treated as a future colleague and individual willing to learn." (Baccalaureate student, LHIN 7)

Students view their clinical experiences as an opportunity to apply knowledge that they have acquired in class, to their practice in a real setting. As such, they expect to see nurse

professionals behaving and delivering care as they "ought to be" delivering care; for example, exhibiting behaviors that are professional, ethical, safe, collaborative, caring, and client-centered.

"The staff on the floor were incompetent … and my peers and I witnessed multiple issues of ethics, lack of standard of care, and lack of willingness to include students on the floor. The floor taught me many things not to do, which although it is valuable to be reminded, did not encourage my practice in nursing." (Baccalaureate student, LHIN 4)

"A place where there is collaboration, patient-centered care, and continued learning is available." (PN student, LHIN 4)

This disconnect between knowledge and practice in the clinical setting has the potential to create great moral distress, as well as potentially have an effect on the retention of student and novice nurses.

"Floor nurses that dislike their job or dislike students can easily ruin a nursing student's perception of that specialty area, or of nursing in general." (Baccalaureate student, LHIN 10)

"Please! Please! Listen to us students. We are the ones having nurses/instructors eat their young. If we want to stop this trend it starts as early as education. Most nursing students in our program have such a negative outlook on nursing based on the way we have been treated." (Baccalaureate student, LHIN 13)

Another common theme arising from the responses from the PN students was abuse of the student role. Students reported being "used for hygiene/bed-making only"; "do their grunt work"; "feel like slaves"; "assigned menial tasks only" etc. (PN students, LHINs 3,4,7,9)

"The nurses there took advantage of us as students… I felt like a PSW" (PN student, LHIN 4)

"*I spent most of my days washing patients and not doing nursing skills … I was not learning"* (Baccalaureate student, LHIN 7)

<u>Lack of Diversity/Inequity of Access</u>

Although data was not analyzed specifically by geographic location, there were a large number of student responses from the schools in the areas represented by LHIN 7 and 9. The responses highlighted what students in the area perceive as unequal and/or lack of diverse settings – compared to students from other schools.

Students from LHIN 7 and 9 spoke about a lack of variety in clinical settings, with the majority of their placement taking place in a long-term care setting.

"Never had an experience in acute care setting … NURSING HOMES in all 4 PLACEMENTS." (PN student, LHIN, 9)

"I have had 3 long term care placements." (Baccalaureate student, LHIN, 9)

"I had too much exposure to the elderly and geriatric population, and not enough in other areas of nursing …. I do not feel prepared …" (Baccalaureate student, LHIN 7)

"For three years I have been working with the older adult population in long-term care or community settings. Very, very, unfortunate. Other programs offer opportunities to experience mental health, maternity, pediatrics, general surgery… only if you are "lucky", will you get a placement at a teaching hospital downtown." (Baccalaureate student, LHIN, 9)

Students from this area spoke about unequal opportunities for clinical education across nursing programs:

"It's unfortunate that [this institution] does not have many spaces/connections with the big downtown hospitals." (Baccalaureate student, LHIN 9)

"Unlike many other universities in the city, [this institution] pushes students towards LTC and do not give them a choice." (Baccalaureate student, LHIN 7)

There were also a collection of responses that revealed the differences in duration or number of clinical education experiences, depending on the nursing program.

"*I am lucky my school starts clinical in first year. I heard other universities do not start until later. I suggest all students begin clinical in first year for a better nursing education, also for the student to truly know if they would like to continue the nursing program."*
(Baccalaureate student, LHIN 13)

<u>No Connection to Nursing</u>

Multiple responses described students' perceptions of a lack of "connection to nursing" in their clinical nursing education experiences. Students in the baccalaureate programs in LHINs 7 and 9 described their entire third year of clinical nursing education in a community setting – without the presence of a nurse role model, or without the opportunity to act as a nurse professional.

"*Community placements should not be a year-long. If so, a valuable community placement alongside a public health nurse."* (Baccalaureate student, LHIN 7)

"*My third year community placement did not reflect a nurse working in the community… and a YEAR LONG placement."* (Baccalaureate student, LHIN 9)

The overall impression from the student responses was that service learning opportunities in the community setting were replacing clinical nursing education opportunities in the community setting, with no nursing role model on site, or no explicit connection to nursing.

"*My community placements did not help me in any way with regards to my nursing practice. I would not even consider them to be a nursing placement at all."*
(Baccalaureate student, LHIN 10)

"I had to work with PSWs … there were no nurses on site." (Baccalaureate student, LHIN 7)

"*My preceptor was a Vice Principal (elementary school)… didn't know anything about nursing"*
(Baccalaureate student, LHIN 9)

"I worked with the gym teacher to make gym lessons. That is not even related to nursing."
(Baccalaureate student, LHIN 9)

"I was teaching math and science to students because there was nothing to do"
(Baccalaureate student, LHIN 7)

"Elementary teacher being my preceptor….felt like she was treating me like one of her grade 3 elementary school students instead of an adult learner" (Baccalaureate student, LHIN 9)

As the result of no obvious nursing connection associated with some of the students' clinical nursing experiences, students begin to question the effort of nursing programs in finding quality clinical experiences.

"They'll pick just any placement in order to give us something."
(Baccalaureate student, LHIN NA)

"I felt as if the school just wanted to get all the students out and did not care where they were placed." (Baccalaureate, student, LHIN 9)

"Don't place students in placements just because they are there."
(Baccalaureate student, LHIN 10)

2c) Did you share these concerns with anyone? (ie. Program Lead, Clinical Partner?) (N=337)

Response	*Total Number of Respondents*	*Percentage of Respondents*
Yes	***273***	***81.0%***
No	***64***	***19.0%***

When asked for written responses to describe why/why not they chose to share their concerns, 337 students provided rationale; the majority of these responses were from the baccalaureate student cohort. There were two main findings from this data.

If students share their concerns, the students perceive that there will be

(a) consequences to them personally (ie. fail course); and/or
(b) no action.

"No, due to the fear of failing." (Baccalaureate student, LHIN 7)

"Yes, however, many students fear reprimand and backlash when raising concerns."
(Baccalaureate student, LHIN 4)

"No … it's been made clear that they don't care" (PN student, LHIN 9)

"We always voice ourselves regarding this as we are told students have voices. But we are never taken seriously. All we are are bums in seats that get them the next grant and paycheque."
(Baccalaureate student, LHIN 13)

Student perceptions also reflected a perception that there was fear among educators, in trying to maintain relationships with their existing clinical partners, at a time where "*it's hard to find placements for everyone*." (Baccalaureate student, LHIN NA)

"*Yes … she agreed …but just said "make the best of it.*" (Baccalaureate student, LHIN 9)

"*No. Recommendations always fall on deaf ears. The student's voice or concerns are generally not heard as the school is scared of jeopardizing the clinical relationship with the hospital*."
(Baccalaureate student, LHIN 9)

"*Nope - because they would definitely not like the idea of not running this placement anymore."*
(Baccalaureate student, LHIN NA)

There was only one student response that identified a positive outcome for sharing their concerns.

"*Yes. I shared with the lead of the program and the instructor was let go eventually (I think)…"*
*(*Baccalaureate student, LHIN NA)

3a) Have you ever had an "innovative" clinical placement (versus traditional placement)? (N=1012)

Response	*Total Number of Respondents*	*Percentage of Respondents*
Yes	***248***	***31.4%***
No	***542***	***68.6%***

*Missing Responses (n=222)

A total of 31.4% of respondents identified that they had an innovative clinical placement, based on the definition provided within the survey. The survey did not ask for "types" of innovative placements, however it did ask students to describe their innovative placement, and the following settings were identified as innovative:

Family clinical placements
Kindergarten class
Women's shelter
Daycare
Early Years Centers
Hospice
Canadian Blood Services

Canadian Lung Association
Adult Day Program
Meals on Wheels
Coffee House

3b) Would you describe it [the innovative placement] as a quality clinical learning opportunity? Why/why not?

Of the 248 respondents that identified having completed an innovative placement, 103 or 42% provided a written description describing their innovative clinical placements as "quality" placements.

Overall, innovative placements were considered "quality" placements when students could identify a "nursing' connection.

"I had a placement with the … committee of …. It was a very eye-opening experience to work with vulnerable populations and a great opportunity to see another setting where nurses are so valuable." (Baccalaureate student, LHIN 13)

"*I was placed at ..'s office in … to shadow one of their zone directors. It was an incredible experience. I was able to gain an understanding of the nursing situation in the far north and was able to meet and speak with many nurses being orientated to their new workplaces up north. My preceptor was also very helpful and willing to teach me all that she knew about managing nurses and supporting them when they are so far north. Excellent placement, one of my favorites.*" (Baccalaureate student, LHIN 13).

Even though some students responded that they appreciated the importance of the innovative clinical experience, they expressed the need for a *connection to nursing* - wanted to learn something related to nursing in their clinical education experience.

"During my community rotation, I was placed at an Adult Day Program where my preceptor was not a nurse but instead a clinical care coordinator (non-regulated staff with a background in activation/recreation) whose main function was to facilitate and carry out scheduled activities …karaoke, baking, arts and crafts, and playing games. Although I understand the importance of these stimulating activities for the elderly (especially those with dementia) … I feel that this was not a quality clinical placement for a nursing student." (Baccalaureate student, LHIN 9)

Another reason why students did not perceive their innovative clinical experiences as "quality" clinical placements, related to a lack of clear direction or guidance/objectives.

"As mentioned previously, I was in a developmentally delayed classroom, as well as a remote community placement. In the classroom, I acted as an EA, not a nurse. In the community placement, I roamed the neighborhood with my group until we found even the slightest area of interest." (Baccalaureate student, LHIN 2)

"I was placed at a shelter for abused women and children. What made it difficult was they had never had a nursing student before, so they didn't know what to do with me. They kind of tried to make me into a social work student … Not having an RN to shadow was hard, because I felt lost, not knowing what my role was." (Baccalaureate student, LHIN 7)

"The breadth and depth of a nurse's education should not be left to chance." (Baccalaureate student, LHIN 9)

Internationally Educated Nurses (IENs)

Of the 1012 students who responded to the survey, 87 respondents (8.6%) self-identified as an Internationally Educated Nurse (IEN). IEN students identified similar themes for quality clinical placements (quality clinical instructors, "safe" work environment, learning opportunities). A unique perspective from the IENs, was the desire for their clinical education and placements to "expose them to the Canadian health care system."

"My mentors cooperated with me and helped me to get to know the practices and procedures in Canada, which was new to me." (LHIN 2)

"A quality clinical placement enhances and polishes the skills of the students so that they can use it in dealing with their patients. This will give internationally educated nurses an opportunity to observe and blend with the clinical practices here in Canada." (LHIN 4)

"I have an excellent experience in my placement, but it will be helpful if my clinical placement would be in the same place where I was working before (operating room) in order to encourage me to go back to same department because I want to know if what I used to do is similar to what it is here." (LHIN 4)

Another key difference that was noted from the IEN cohort compared to students who did not identify as IENs, was the perception that clinical education is more important than theory. Several responses indicated that IENs come to Canada with adequate knowledge of "nursing" – what they want is hands-on experience with the Canadian health care system.

"It (clinical experience) is really helpful and it must be included in every program. I mean it is more important than [the] theory part for IENs because they already know the theory; what they want is Canadian exposure." (LHIN 4)

Some comments specifically indicated that IENs do not perceive or understand the importance of interprofessional education (IPE) (4 responses).

"My clinical practice at … was pretty good but it was not challenging enough because of the Unit I was placed in (Palliative). I wish I had the chance to experience their 1 on 1 clinical

consolidation which was implemented after I did my placement. The Interprofessional Education (IPE) took so much time away from our patients". (LHIN 7)

Summary of Qualitative Findings

When reviewing the student responses, all of the findings could be grouped into any one of the following categories:

- Preceptor/Clinical Instructor
- Clinical Environment/Culture (includes staff)
- Opportunities for Learning

A) Preceptor/Clinical Instructor

Although all cohorts of nursing students (baccalaureate, practical and IENs) identified the importance of a strong clinical instructor/preceptor in a quality clinical experience, there was a slightly higher emphasis on the quality of clinical instructor/preceptor from the baccalaureate student responses.

Nursing Students' Perception of a Quality Clinical Instructor/Preceptor:

Aids growth.
Instructor/preceptor seeks out and suggests learning opportunities for student; challenges student; encourages and empowers student; has all-around positive attitude.

Available/accessible.
Instructor/preceptor is both mentally and physically present for student.

Advocates.
Instructor/preceptor is considered a "safe" person to talk to; will advocate for/on behalf of student, if required; will listen to student and follow up on any concerns.

Acts like a RN/PN "ought to act".
Instructor/preceptor acts professional; practices evidence-based, safe and ethical care; is collaborative, caring, and delivers client-centered care.

B) Clinical Environment/Culture

All students identified factors relating to clinical environment/culture, when describing a quality clinical education experience. There was a slightly higher emphasis on the clinical environment/culture from the practical nursing student responses.

Nursing Students' Perception of a Quality Clinical Environment:

Welcoming/accepting of students.
Clinical environment accepts, understands, & appreciates the unique role of the student learner.

Safe.
Bullying or abuse of the student role is not tolerated within a quality clinical environment.

Aids student growth.
Staff and health care team (associated with the clinical placement) support and facilitate student learning within a quality clinical environment.

Care delivery & practice is as it "ought to be".
Health care delivery within a quality clinical environment is professional, ethical, safe, collaborative, and client-centered.

C) Opportunities for Leaning

Student responses stressed the importance of quality clinical education/placements in order to:

- ✓ learn about the role of the RN and PN;
- ✓ be able to practice and apply what they have learned in classroom and sim labs;
- ✓ work as part of the team (collaborative practice);
- ✓ develop competence, confidence and independence;
- ✓ prepare for NCLEX/Boards/OSCEs;
- ✓ prepare for their professional practice in a Canadian healthcare system.

When given the opportunity to share their clinical education experiences, all students (Baccalaureate, PN, IEN) revealed /alluded to the expectation to learn and acquire "nursing-related" knowledge in their clinical placements, and have the opportunity to apply and practice their skills. They identified a **quality clinical education experience** as including *a strong preceptor/clinical instructor* (or nurse role model), and a "*safe" clinical environment*. When these two elements are present, the *opportunity for learning* is maximized, thereby preparing nursing students for future registered examinations and their professional practice.

In contrast, the nursing students identified a number of reasons that interfere with, or prevent a quality clinical learning experience: *unsupportive clinical instructors/preceptors, unhealthy clinical environments, unequal/lack of varied learning opportunities,* and *clinical nursing education without a "nursing" connection.*

Other questions and areas of concern that the research team agreed on, after reviewing the nursing students' responses include:

- ➢ Unhealthy work environments being used as student learning environments.
- ➢ Community clinical education being replaced with service learning experiences?
- ➢ Unequal clinical education opportunities (quality, quantity & variety) for student nurses across Ontario.

- Fear/reluctance to speak up (students; instructors; educators).

Summary of Quantitative Findings

Percentage of Respondents who had experienced a quality clinical placement	**88.7% (741)**
Percentage of Respondents who had experienced a placement they were not satisfied with	**55.5% (446)**
Percentage of these who attributed it to an unhealthy work environment	**58%**
Percentage of Respondents who had shared their concerns with someone in authority	**81% (273)**
Percentage of Respondents who had experienced an "innovative" placement	**31.4% (248)**
Percentage of these who described their innovative placement as quality	**42% (103)**

Student Suggestions for Clinical Education

4) Based on your clinical education experiences, do you have any suggestions or comments for educators or clinical agencies regarding clinical learning opportunities and/or clinical placements for nursing? **(N = 318)**

Suggestions and comments for nurse educators and clinical agencies, from nursing students across Ontario, have been shared throughout this report and summarized in the *Summary of Key Findings*.

(Not listed in order of importance).

Suggestion 1:

Define/redefine what is meant by "Clinical Education" so that experiences such as Service Learning or Simulation are not used to substitute clinical placements.

Acknowledge key requirements/criteria in a clinical education experience (ie. a learning opportunity that allows one to apply nursing knowledge and nursing skills in a "real life" setting that is devoted to the care of others).

"Clinical placement is a valuable experience because it allows students to care for real patients which is ENTIRELY different than working on a mannequin." (PN student, LHIN 3)

Suggestion 2:

Ensure that when substituting a traditional clinical placement with an untraditional placement (ie. community and innovative placements) that there is an explicit "nursing" connection, and that the placement fulfills the criteria of "clinical education".

"I had a placement with the AIDS committee of North Bay. It was a very eye-opening experience to work with vulnerable populations and a great opportunity to see another setting where nurses are so valuable." (Baccalaureate student, LHIN 13)

Ensure that course manuals/syllabi contain objectives/aims that are clear and nursing-related; and that each placement has a nurse "role-model" who is accessible to the student at all times, and is able to offer effective guidance so that the student is aware of their role within the placement.

"Not having an RN to shadow was hard, because I felt lost, not knowing what my role was." (Baccalaureate student, LHIN 7)

Suggestion 3:

3a) Greater investment in recruiting, educating & developing, and retaining quality Clinical Instructors/Preceptors.

"A good clinical placement begins with a good, keen clinical instructor. If the instructor is well educated, passionate and enthusiastic about the placement then it does not matter the floor." (Baccalaureate student, LHIN 10)

Education and professional development opportunities for preceptors/instructors could include information on bullying/horizontal violence; effective teaching/learning strategies (how to educate young adult learners); conflict management etc.

Reconsider the use of incentives to retain quality clinical instructors/preceptors (reimburse professional fees? flexible and consistent (stable) workload? benefits? awards/recognition?)

Strengthening communication and collaboration between the agencies and school might also help with the development and retention of instructors/preceptors, thereby contributing to a quality clinical environment.

"Communication between the student, professor, and unit staff is crucial to a quality placement." (Baccalaureate student, LHIN 13)

3b) Education session(s) for the agency about the role of the student and their scope of practice, so that all staff can help facilitate student development (and potentially benefit from the student's help).

"Agencies: only offer placement options if your Nurses are willing and able to facilitate and enhance student learning. Create an environment that accommodates student learning and staff that work towards this." (Baccalaureate student, LHIN 14)

Suggestion 4:

Zero tolerance for bullying and adherence to strategies for preventing/combatting unhealthy work environments.

"There should be zero tolerance for bulling in any clinical placement by the nursing staff, instructor or preceptor. It creates anxiety and burnout of persons affected. This often goes unnoticed, even when it's constantly taught in schools." (Baccalaureate student, LHIN 14)

Zero tolerance for bullying – from staff at clinical agencies, preceptors/instructors, or educators. Strategies for preventing/combatting unhealthy work behaviors should be explicitly outlined and adhered to, with prescribed consequences.

Anonymous reporting system to alleviate fear of reprisal.

Suggestion 5:

Measures to better balance variety and quality of clinical education opportunities for all students across a LHIN.

Revisit "boundaries" as some schools are at a great disadvantage in terms of being able to provide a variety of clinical opportunities to students.

Perhaps add an element of choice for all students (i.e., implementing HSPnet student site selector across all schools), so that they have a voice in the process of allocation of placements.

"Take in student preferences and interests because placements are limited and so it would be nice for students who were interested in working in the OR for example, to have that experience to assist students in affirming where they would like to work." (Baccalaureate student, LHIN 11)

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Appendices

Appendix A: Survey Tool

1a) Have you experienced a quality clinical learning opportunity/placement?

1b) If so, what made it a quality clinical learning opportunity? What are the key elements of a quality clinical learning opportunity?

2a) Have you experienced a clinical placement that you were not satisfied with?

2b) If so, please describe your experience.

2c) Did you share these concerns with anyone (ie. Program Lead, Clinical Partner?)

3a) Have you ever had an "innovative" clinical placement (versus traditional placement)?

"Innovative placements" refer generally to placements that take place outside of the traditional hospital or other large health care institutions that have historically provided the placements for the many nursing students. Innovative placements might include homeless shelters, seniors' residences, daycares, international placements, remote community placements, and so on.

3b) Would you describe it as a quality clinical learning opportunity? Why/why not?

4) Based on your clinical education experiences, do you have any suggestions or comments for educators or clinical agencies regarding clinical learning opportunities and/or clinical placements for student nurses?

Appendix B: Nursing Education Streams

Basic Stream:	Students come directly from high school
Accelerated Stream:	Also referred to as “compressed” or “second entry” stream; students complete the program in an accelerated fashion/in a compressed amount of time; often includes mature students with another degree/partial degree
Post RN Stream:	Students are diploma-prepared Registered Nurses, who have returned to school to obtain a baccalaureate degree in nursing
RPN to BScN/BSN Stream:	Students are diploma-prepared Registered Practical Nurses (RPNs/PNs), who have returned to school to obtain a baccalaureate degree in nursing

Appendix C: Literature Summary

Author, Title, Journal	Purpose/Question	Methodology/Design/Sample Size/Subjects	Data Source or Instruments	Findings	Comments Limitations
Candela, L. & Bowles, C. (2008). Recent RN graduate perceptions of educational preparation. Nursing education perspectives, 29(5), 266-271.	To determine new graduate nurses' perceptions on how well their nursing education prepared them for practice.	Survey: 14 questions about the RNs first position post-graduation, 21 questions assessing perceptions on how prepared well their education prepared them for practice, and a section that collected demographic data. Participants: recently graduated nurses (within 5 years); 352 responses	The Survey of Nurses' Perceptions of Educational Preparation	Respondents felt least prepared in the areas of management, leadership, and organizational skills. Also, 67% of respondents felt they did not have enough clinical hours provided through their education. Also, respondents did not feel prepared to use electronic health records after graduating. Overall, respondents were satisfied with how their education prepared them for practice.	- Low response rate (12%)
Casey et al. (2011). Readiness for practice: the senior practicum experience. *Journal of Nursing Education, 50*(11), 646-652.	To examine factors that may influence senior nursing students' perceptions of readiness for practice and to determine their level of comfort performing clinical skills independently.	Mixed methods: Survey and two open ended questions. Participants: 429 BScN students from three nursing programs (80% response rate)	Survey (Casey-Fink Readiness for Practice Survey)	In regards to preparation to Enter the nursing profession, the majority of students did not feel that they were independent in all nursing skills. Respondents suggested that there is a need for more clinical hours, simulated practice, and skill practice in order to gain this independence. Respondents also indicated that they lack confidence in communicating with physicians, responding to changes in patient conditions, and conflict management.	- US based - High response rate (80%)
Corlett, J. (2000). The perceptions of nurse teachers, student nurses and preceptors of the theory-practice gap in nurse education. *Nurse Education Today, 20*, 499-505.	To establish the perceptions of students, teachers, and preceptors on the theory-practice gap.	Semi structured interviews. Sample: Teachers, students and preceptors	Interviews	Eight themes arose from the interviews: defining theory and practice, the theory-practice gap, idealism versus realism, lack of time (for preceptors to teach), sequencing (of learning and the safety implications of that), lack of communication (between clinical and teaching environments), the link teacher role, and strategies to close the gap.	- Small sample - Did not clearly discern student opinions in the write-up of this article
Dadgaran, I., Parvizy, S., & Peyrovi, H. (2012). A global issue in nursing students' clinical learning: the theory-practice	To collect global comments of the theory-practice gap from nursing students.	Semi structured interviews. Sample: 21 undergraduate nursing students.	Interviews	This study found that students believe the theory-practice gap is the result of many factors that are student-related, instructor-related, and staff-related. Learning styles of the students and clinical situations also were believed the	- Clear methodology - Description of themes/ interview data is very brief

Author, Title, Journal	Purpose/Question	Methodology/Design/Sample Size/Subjects	Data Source or Instruments	Findings	Comments Limitations
gap. *Procedia-Social and Behavioral Science, 47*, 1713-1718.				influence the theory-practice gap.	
Edwards, H., Smith, S., Courtney, M., Finlayson, K., & Chapman, H. (2004). The impact of clinical placement location on nursing students' competence and preparedness for practice. *Nurse Education Today, 24*, 248-255.	To examine the impact on clinical placement location on nursing student's experiences.	Pre-post test survey Sample: 212 final year baccalaureate nursing students	Survey. Asked demographic questions, questions about their preparedness for their clinical placement, and about their satisfaction with their clinical placements.	Students reported greater competence following their clinical experience, regardless of location. All students reported higher satisfaction with their clinical placements after completing their recent placement. Students identified the following as the most important factors that contribute to a positive learning environment: Support for learning, feeling part of the clinical team, feeling valued for their contribution to patient care, and obtaining diversity of clinical experience. This study suggests that more time in a clinical setting may be needed for students to develop confidence and organizational skills.	- Rural placements are voluntary self-selection
Hartigan, J.A., Cobbett, S.L., Amirault, M.A., & Muise-Davis, M.E. (2007). Nursing graduates' perceptions of their undergraduate clinical placement. *International Journal of Nursing Education Scholarship, 4*(1), Art 9.	To describe graduates' perceptions of third and fourth year clinical placements, including the advantages, disadvantages, and relevancy; and to capture recommendations for third and fourth year placements from these students.	Semi structured interviews Sample: 1999-2002 graduates from one school of nursing (70 participants)	Semi structured interviews	Four themes were identified from the interviews: developing nursing skills and knowledge, experiencing the realities of work-life, preparing for future work, and experiencing supportive relationships. Participants recommended that student's seek a supportive environment when choosing a clinical placement as this seems to lead to a more successful clinical placement.	- Only one school of nursing studied - Large sample - Canadian Context
Johanson, L.S. (2013). How do new BSN nurses perceive their nursing education? Nursing, 43(9), 14-20.	To determine if new BScN nursing graduates perceive their education to be relevant for the current demands of the nursing practice.	Survey Sample: 296 randomly selected BScN RNs who had graduated within 2 years (58 responses)	Mailed Survey	Overall, new RN graduates felt their education prepared them well for practice. Respondents felt the least prepared in the areas of: understanding and using research findings, preparation for holistic care, and managing the technology associated with practice. Respondents also felt unprepared for leadership roles, communicating with	- 20% response rate - Only mailed surveys (no electronic survey technology used)

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				physicians, and dealing with difficult patients. There was also a perceived lack of time during school dedicated to practicing clinical skills, which resulted in lower levels of confidence in new nurses.	
Newton, J.M. & McKenna, L. (2007). The transitional journey through the graduate year: a focus group study. *International Journal of Nursing Studies, 44*, 1231-1237.	To examine how graduate nurses develop knowledge and skills during their graduate programme (clinical placement after 3 years of schooling) and immediately after. Also, to explore what factors assist of hinder knowledge and skill acquisition.	Focus groups Sample: 25 nurses in a graduate program	Semi structured interview with focus groups.	Generally, participants did not feel prepared for clinical practice. Participants indicated that a supportive environment can assist in knowledge and skill acquisition and that transitioning into a new environment can be challenging for new nurses.	- Australian context (schooling slightly different than Canadian context)
Watt, E. & Pascoe, E. (2013). An exploration of graduate nurses' perceptions of their preparedness for practice after undertaking the final year of their bachelor of nursing degree in a university-based clinical school of nursing. *International Journal of Nursing Practice, 19*, 23-30.	To explore graduate nurses' perceptions of the readiness for clinical practice after completing their final year of their baccalaureate degree.	Semi structured interviews. Sample: 10 nursing students in their final months of their baccalaureate degree	Semi structured interviews	Participants identified that being familiar and comfortable in their environment (ie. Familiarity with the ward, knowing where supplied are, and knowing how to access resources) assisted in their knowledge acquisition and made them feel more ready for practice. Also, having an understanding of the way the organization worked prior to clinical placement increased the participants' confidence. Participants identified that being in a clinical setting that was geographically linked to their university helped to minimize the theory-practice gap as academic advisors were readily available and accessible and students were able to easily bring clinical experiences into the classroom (problem-based learning approach).	- Australian context (schooling slightly different than Canadian context) - Small sample size