



A research centre of La Trobe University Health Sciences

Best Practice Principles for Undergraduate Nursing Students in Aged Care Clinical Placements

Final Report

Contact:

Professor Rhonda Nay
Australian Centre for Evidence Based
Aged Care
Ph: 03 9495 3141
Fax: 03 9495 3154
Email: r.nay@latrobe.edu.au

1231 Plenty Rd
Bundoora VICTORIA 3083
Tel +61 3 9495 3118
Fax +62 3 9495 3154
<http://www.latrobe.edu.au/acebac>

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**Best Practice Principles
for Undergraduate Nursing Students
in Aged Care Clinical Placements**

A project conducted for the Australian Government Department of Health
and Ageing by:

Associate Professor Susan Koch

Ms Linda McAuliffe

Professor Rhonda Nay

Dr Bill Koch

Ms Megan O'Donnell

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Professor Jenny Abbey	Professor of Nursing, Aged Care Queensland University of Technology (QUT)
Mr Rob Bonner	Federal Education Officer Australian Nursing Federation (ANF)
Ms Janet Casey	Aged Care Advisor Aged Care Association of Victoria (ACAV)
Ms Karen Cook	Chief Executive Officer Australian Nursing and Midwifery Council (ANMC)
Professor John Daly	Chair Council of Deans of Nursing and Midwifery (DNM)
Mr Richard Gray	Director, Aged Care Services Catholic Health Australia (CHA)
Professor Tina Koch	Chair, Older People Nursing University of Newcastle
Dr Tracey McDonald	Professor of Ageing, ACU Royal College of Nursing Australia (RCNA)
Adj Professor Belinda Moyes	Chair Nurse Education Taskforce (N ³ ET)

Australian Government Department of Health & Ageing (DoHA)

Ms Lisa Leifheit Project Officer

James Cook University

Professor Kim Usher Project Coordinator

Ms Pauline Taylor Project Officer

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Executive Summary

Introduction

With a rapidly ageing population and more frail older people accessing health services, it is imperative that nurses are adequately prepared during their undergraduate education to meet the needs of these clients.

In order to address this need, along with issues such as recruitment and retention, the Australian Government Department of Health and Ageing (DoHA) commissioned the development of the *Aged Care Core Component in Undergraduate Nursing Curricula Principles Paper* (Queensland University of Technology, 2004). To promote the adoption of the Aged Care Core Component in Undergraduate Nursing Curricula Principles, the Australian Government further commissioned the development and implementation of four initiatives. James Cook University (JCU) was contracted to oversee the execution of these initiatives. In late 2005, the Australian Centre for Evidence Based Aged Care successfully secured tender for two of these initiatives, namely, the *Development of Best Practice Models for aged care clinical placements for undergraduate nursing students* and the *Development of an on-line clearing house of aged care education material for use and access by university Schools of Nursing*. This document reports on the results of the first of the above named initiatives.

The project on which this report is based was conducted during the period between January and September 2006, and followed the project outline and steps detailed in the *James Cook University Aged Care Core Component in Undergraduate Nursing Curricula Principles Initiative 2 Request for Proposal*: ‘conduct a review of the literature for evidence on key elements and Best Practice Models of aged care clinical placements; consult with key informants to identify key elements of best practice for aged care clinical placements and Best Practice Models of aged care clinical placements in Australia [including representatives from the Council of Deans of Nursing and Midwifery (CDNM), people with relevant expertise in education, and aged care nursing industry representatives]; collate and analyse the data gathered in the proceeding steps; identify key elements of best practice for aged care clinical placements and Best Practice Models in Australia; develop outlines of Best Practice Models for aged care clinical placements and publish in forms suitable for promotion and dissemination throughout all Schools of Nursing and health service providers; identify practical recommendations for implementation of best practice aged care clinical placements for all Schools of Nursing and health services providing clinical placements; compile a report of results.’

Project Objective

The aim of this project, as guided by the *James Cook University Aged Care Core Component in Undergraduate Nursing Curricula Principles Initiative 2 Request for Proposal*, was to ‘identify key elements of best practice related to aged care clinical placements and best practice models of aged care clinical placements to provide a stimulating learning environment for undergraduate nursing students’. This report has therefore been prepared for Australian Schools of Nursing and aged care facilities, in addition to Australian hospitals, institutions, clinicians and educators involved in the

delivery of undergraduate aged care clinical placements. It is envisaged that the elements of best practice identified through this project, and the subsequently developed outline of best practice, will be adopted by those involved in undergraduate aged care clinical placements in order to ensure best practice and thereby enhance the clinical placement experience.

Method

The project team liaised with James Cook University and DoHA throughout the project. The following methodology was adopted:

1. A review of the literature was conducted for evidence on key elements of best practice and best practice models of aged care clinical placements.
2. A National Reference Group (NRG), including representation from key stakeholder groups identified by the project team and JCU as having relevant expertise in education and the aged care industry, was established in March 2006 and consulted via teleconference at two crucial points during the project. The first teleconference was held in March 2006, in the early stages of the project; the NRG was presented with an overview of the project, the key findings of the literature review, and asked for their comments and to also nominate individuals or organisations with relevant expertise in aged care that might be interested in participating in a focus group for the project. The second teleconference was held in June 2006, following the focus group consultations and collation of findings; the NRG was presented with the main findings from the focus groups and asked to comment on the findings. Communication with the members of the NRG was also maintained throughout the project through email correspondence, and all members were invited to comment on the outline of best practice and the draft of the final report.
3. In order to ensure wide stakeholder contribution, focus groups were conducted with:
 - a. representatives from Australian Schools of Nursing
 - b. representatives from aged care facilities, hospitals, professional organisations and industry nominated by the NRG as experienced in aged care nursing and/or education.A total of 12 focus groups were conducted, 11 via teleconference, during April and May 2006, with a total of 56 participants. The information obtained during each focus group was built upon to inform subsequent focus groups.
4. An email based publicity campaign was conducted for on-line submission of innovative clinical placement practices.
5. Collation and analysis of data gathered in the preceding steps was undertaken, revealing a preference for best practice principles.
6. Key elements of 'best practice' for aged care clinical placements in Australia were identified.
7. An outline of 'best practice principles' for aged care clinical placements was developed
8. The outline of 'best practice principles' for aged care clinical placements was distributed to all Australian Schools of Nursing, as well as health service providers for comment.

9. The Final Report was compiled, taking account of feedback and including recommendations for implementation of best practice and further considerations.

Data Analysis

Qualitative data from the National Reference Group, focus group interviews and web based responses were transcribed and analysed using constant comparison methods developed by Glaser and Strauss (1967) to identify concepts and then develop codes and themes. Once analysis was complete, the arising key themes were consolidated into principles of best practice.

Findings

The literature search revealed that there are currently no published journal articles reporting models of 'best practice' for aged care undergraduate clinical placements. Moreover, only five models of undergraduate nursing clinical placement were found. Whilst these were not models of 'best practice', each of the models contained elements that should be considered when developing such a model. It was found that an Australian model of best practice for undergraduate aged care clinical placements in residential aged care is currently being developed. The literature highlighted a number of areas for consideration in a 'best practice' model of undergraduate aged care clinical placements.

Consultations with both the National Reference Group and focus groups identified a preference for 'principles', which included elements of models regarded as successful, rather than any one particular 'model', and highlighted key principles associated with better practice that could inform any model and varying contexts. The results from the literature and the consultations were sufficiently consistent to allow the development of an agreed set of principles.

Conclusion

This report documents the results of an investigation into best practice undergraduate clinical placements in aged care nursing. The outcomes of the literature review and consultations with stakeholders that were conducted as part of this project did not reveal a preference for any particular model (setting non-specific) of aged care clinical placement delivery; however, they did reveal a preference for a set of 'best practice principles' that can be applied to models and address the unique circumstances of each university and health care service offering undergraduate aged care nursing clinical placements.

While it is clear that more research is required and current successful practices need to be made more available through publication as articles in peer reviewed journals, it is recommended that for implementation of best practice aged care clinical placements for all Australian Schools of Nursing and health services providing clinical

placements, these principles are adopted. Of equal importance is that models that incorporate these principles undergo future evaluation.

Several vignettes are included in this report as examples of how these principles may be practically adopted. Recommendations for further considerations are also made.

Best Practice Principles

1. All stakeholders should agree and mutually understand definitions related to clinical placements.
2. Universities and industry organisations should have formal agreements/contracts that specify clearly the respective roles and responsibilities.
3. Reciprocal arrangements should be put in place to facilitate ongoing collaborative partnerships both during and between clinical placements.
4. All stakeholders should have a shared understanding of clinical placement requirements, student scope of practice and expected student learning outcomes.
5. Academics should be easily assessable to clinical facilitators and industry organisations.
6. Students on gerontic nursing (see definitions p 10) clinical placements should be exposed to the continuum of care for older people.
7. Academics responsible for gerontic placements should ensure objectives relate to person-centred, holistic care rather than tasks.
8. Person centred care should take account of cultural, spiritual, sexual and religious differences and preferences.
9. Standards, criteria and processes should be agreed upon and published to guide selection of clinical placement venues.
10. Provided objectives can be achieved, clinical placements should be arranged near to where students live – particularly in rural areas.
11. Industry organisations accepting students should demonstrate positive attitudes and practices toward older people, and invest in gerontic nursing education for their staff.
12. Industry organisations should ensure appropriate orientation for students and where relevant facilitators.
13. Students should have access to IT while on placement.
14. Students should be provided with a list of responsibilities they are expected to fulfil to enhance their placement experience.
15. Academics and facilitators should have credible gerontic nursing and clinical teaching skills and knowledge and a positive approach to older people and gerontic nursing
16. Facilitators should be familiar with all relevant structures, processes and policies of the industry organisation and university
17. Expected outcomes of the clinical placement should determine selection of venues/ shifts worked;
18. Expected outcomes should be clearly articulated, published and made available to all stakeholders.
19. Collaborative approaches to teaching and learning should be established and sustained.
20. Where possible, interdisciplinary learning should be encouraged and supported.

Definitions

The term ‘aged care’ is often misinterpreted as being synonymous with care in residential aged care facilities and may refer to any discipline. In this report, the term ‘**aged care**’ is used interchangeably with ‘**gerontic nursing**’ to refer to the nursing care of older people, regardless of setting.

Focus group and NRG participants agreed that the ‘devil is often in the definition’ and questioned what was meant by ‘**a model**’. They raised the differing ways in which it might be interpreted and the various aspects that may or may not be included, for example: financial, interpersonal, philosophical, year of placement, meshing of pedagogical theory and practice and approaches to supervision.

The term ‘model’ could be seen as somewhat limiting in flexibility. Participants argued that a ‘model’ implies there is one model that will work in all contexts and/or several models recognising different contexts but this still suggests a limit on flexibility. There was support for general principles that could inform but be adaptable and applicable to different models at different times depending on the context.

Terminology used across universities and organisations in reference to staff involved in the gerontic nursing clinical placement was also perceived to be confusing and inconsistent. For simplicity, ‘facilitator’ is used to cover these terms in this document. However it is recommended for ‘best practice’ that definitions be agreed by the university, industry partners and students involved in gerontic clinical placements so as to delineate the difference (if any) in roles and responsibilities between clinical mentors, coaches, teachers, facilitators and preceptors.

1. Introduction

1.1 Background to the project

In first world countries, ageing populations and their attendant increases in chronic illness are well established as key future challenges for the informed planning of health care delivery. Research shows that there is a strong correlation between increasing age and functional decline, with an associated increased in the use of health services (Barrowclough, 1982; Joy, Carter & Smith, 2000; Primomo, 2000). With more frail older people accessing health services, it is imperative that nurses are adequately prepared during their undergraduate education to meet the needs of these clients. As such, research into aged care and aged care nursing is of great importance in Australia.

In order to address this need, along with issues such as recruitment and retention in aged care nursing, in 2003 DoHA commissioned the development of the *Aged Care Core Component in Undergraduate Nursing Curricula Principles Paper*. To promote the adoption of the Aged Care Core Component in Undergraduate Nursing Curricula Principles, the Australian Government commissioned the development and implementation of four initiatives:

- (i) a stocktake of existing aged care clinical placements for undergraduate nursing students in Australia;
- (ii) the development of 'best practice models' for aged care clinical placements for undergraduate nursing students;
- (iii) the development of an on-line clearing house of aged care education material for use and access by university Schools of Nursing; and
- (iv) the development of a web-based learning tool and educational video resource material in relation to nursing care for older people.

The Australian Centre for Evidence Based Aged Care (ACEBAC) was contracted to explore the second and third of these initiatives, and it is the second initiative that is the subject of this report.

The need for excellence in nursing education is well established, however, in practice some sectors may be portrayed in a more complimentary light. In sectors such as aged care, a traditionally less favoured discipline, the promotion of skilled practice and positive role models are doubly important. Evidence suggests that clinical placements are of prime importance in structuring nurses' beliefs and values. In light of this, improving the aged care placement must be seen as one of the key areas for improvement in modern nurse education.

This report builds on and complements the *Aged Care Core Component in Undergraduate Nursing Curricula Principles Paper* (Queensland University of Technology, 2004).

1.2 Project Objective

The aim of this project, as guided by the *James Cook University Aged Care Core Component in Undergraduate Nursing Curricula Principles Initiative 2 Request for Proposal*, was to ‘identify key elements of best practice related to aged care clinical placements and best practice models of aged care clinical placements to provide a stimulating learning environment for undergraduate nursing students’. This report has therefore been prepared for Australian Schools of Nursing and aged care facilities, in addition to Australian hospitals, institutions, clinicians and educators involved in the delivery of undergraduate aged care clinical placements. It is envisaged that the elements of best practice identified through this project, and the subsequently developed outline of best practice, will be adopted by those involved in undergraduate aged care clinical placements in order to ensure best practice and thereby enhance the clinical placement experience.

2. Project Methodology

The project team liaised with James Cook University and DoHA throughout the project. The following methodology was adopted in order to accommodate the project timeline (January 2006 – September 2006):

1. A review of the literature was conducted for evidence on key elements of best practice and best practice models of aged care clinical placements.
2. A National Reference Group (NRG), including representation from key stakeholder groups identified by the project team and JCU as having relevant expertise in education and the aged care industry, was established in March 2006 and consulted via teleconference at two crucial points during the project. The first teleconference was held in March 2006, in the early stages of the project; the NRG was presented with an overview of the project, the key findings of the literature review, and asked for their comments and to also nominate individuals or organisations with relevant expertise in aged care that might be interested in participating in a focus group for the project. The second teleconference was held in June 2006, following the focus group consultations and collation of findings; the NRG was presented with the main findings from the focus groups and asked to comment on the findings. Communication with the members of the NRG was also maintained throughout the project through email correspondence, and all members were invited to comment on the outline of best practice and the draft of the final report.
3. In order to ensure wide stakeholder contribution, focus groups were conducted with:
 - a. representatives from Australian Schools of Nursing
 - b. representatives from aged care facilities, hospitals, professional organisations and industry nominated by the NRG as experienced in aged care nursing and/or education.

A total of 12 focus groups were conducted, 11 via teleconference, during April and May 2006, with a total of 56 participants. The information obtained during each focus group was built upon to inform subsequent focus groups.

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8. The outline of 'best practice principles' for aged care clinical placements was distributed to all Australian Schools of Nursing, as well as health service providers and the NRG for comment.
9. The Final Report was compiled, taking account of feedback and including recommendations for implementation and further consideration.

3. Literature Review

3.1 Literature review search strategy

In order to benefit from the lessons learned from aged care clinical placement models currently in existence both nationally and internationally, a critical review of literature on models for the delivery of aged care clinical placement and identification of the key elements of best practice related to aged care clinical placements was undertaken. The literature search was performed using the computerised databases CINAHL, Medline, AgeLine, PsycInfo, and the Google search engine, and searches were restricted to the English language and articles written since 1994. Seminal material outside of this year range was also included. There was a particular focus on published journal articles reporting research regarding the development and implementation of models, including any obstacles encountered and the successful strategies used to overcome these difficulties. However, due to the limited number available the search included published reports.

3.2 Literature review key findings

The literature search revealed that published journal articles on 'best practice models', or indeed any model, of aged care undergraduate clinical placements are lacking. Even in terms of models of undergraduate clinical placements in nursing more generally, only five reports were found, and of these, only three reported a model for undergraduate nursing that had undergone some form of evaluation. These models are reported on below.

Existing models of undergraduate nursing clinical placement

The Dedicated Education Unit (DEU) was developed and later implemented by academics from the School of Nursing at Flinders University at the Flinders Medical Centre (Edgecombe, Wotton, Gonda & Mason, 1999). Dedicated Education Units were active units in which staff were given training to assist them in teaching placement students. In addition, students were given preparation classes prior to commencement on the ward to ensure that all parties were aware of their duties and responsibilities (Edgecombe et al., 1999). As implied by the name, these units had students and teaching entrenched in their ethos so students were not regarded as guests or outsiders, but rather as an integral and useful element of the unit (Edgecombe et al., 1999). Evaluation of the DEU indicated that it is a highly appropriate clinical placement model (Gonda, Wotton, Edgecombe, & Mason, 1999). The DEU was found to facilitate the transfer of theory into practice for students more effectively than previous models used by the School of Nursing, and also enhanced partnerships between the University and local health care providers. Although students cited an increased workload as a drawback, both students and clinicians alike shared positive perceptions of the DEU.

Using a different approach, Grealish and Carrol sought to develop a model that incorporated elements of both clinical supervision and preceptorship. By doing so they aimed to preserve positive aspects of clinical supervision such as financial efficacy and maintain the greater learning opportunities offered by preceptorship (Grealish & Carrol, 1998). While their study found that both preceptors and clinical supervisors found their roles professionally and personally satisfying, their participants highlighted the preparation of clinical supervisors as an area for concern (Grealish & Carrol). In an adaptation of a North American model, the authors suggest a model in which the student works shifts under a traditional preceptorship model (Grealish & Carrol). However, the duties of evaluation are undertaken by a faculty supervisor, who holds weekly seminars with students in which they can discuss their experiences. By sharing the roles, preceptor burn out may be reduced and student assessment and transference of theory into practice may be enhanced (Grealish & Carrol).

Another model reported on the literature is the Preceptoring Map for RN-to-BSN students, a collaborative development of the Division of Nursing at Regis College, Weston, Massachusetts, and the research department of the Massachusetts General Hospital (Bittner & Anderson, 1998). Based on Benner's novice to expert theories, the Preceptoring Map uses two tracks, the N track and the P track. The tracks differ in terms of stage of learning, with the N track combining novice and advanced beginner stages and the P track combining competent and proficient stages. A multifaceted approach is adopted in order to determine which track is most suited to a student, including consideration of the student's work experiences and expertise, assessment of critical thinking skills, and self-assessment. These aspects are reviewed and combined with an in-depth interview with the placement coordinator in order to arrive at the best match of student and preceptor. The model allows for flexible clinical placements to be negotiated by students and preceptors once the match is made. The authors report that a pilot of the model was successful based on outcome evaluation by students, faculty, and clinical agencies.

In the United States, the University of Missouri Sinclair School of Nursing endeavoured to make the clinical experience more interesting and challenging for undergraduate nursing (and other) students by using Senior Care as a clinical site (Marek, Rantz, & Porter, 2004). Senior Care was established by the School of Nursing as an alternative to institutional placement for long-term care, based on the principles of Ageing in Place, and was designed to support older adults by providing services that enable them to live independently. Working from the perspective that students often prioritise hands on skills over other skills required to care for older people, students are involved in clinical exercises associated with the role of the Senior Care nurse, focusing on comprehensive assessment, including medication management, and the environmental, psychosocial and physiological related behaviours of their clients. No evaluation of this model of clinical placement was reported.

An interesting model developed by three collaborative institutions in England, Holland, and Spain aimed to achieve culturally sensitive care by way of a clinical exchange program (Scholes & Moore, 2000). In this model, students were introduced to transcultural nursing principles in both theory and practice, participated in shared learning, and learnt a second language prior to their three month clinical placement. The authors concluded that the transcultural nursing experience had a profound effect on students, who responded enthusiastically to the program. Student self report outcomes included that they were more culturally sensitive carers, and were able to establish therapeutic relationships with patients by demonstrating emotional presence and empathy.

Other evidence

The overwhelming bulk of material retrieved for this literature review consists of qualitative studies and expert opinion rather than quantitative data, evidence that would be considered of low quality according to the National Health and Medical Research Council levels of evidence (NHMRC, 1999). This indicates that although many universities may be currently trialling novel approaches to nursing clinical placement, the availability of actual published findings on the effectiveness of these approaches is scarce.

A recent systematic review into clinical placements for undergraduate students in aged care supports this finding (Abbey et al., 2006). The review, *Modelling Connections in Aged Care: Clinical Placements for Undergraduate Students in Aged Care – A Systematic Review* investigated five key research questions:

- What are the attributes of a quality clinical placement for undergraduate students?
- What factors facilitate or obstruct the creation of quality clinical placements for undergraduate students?
- What instruments have been developed to measure the presence, absence, or changes in the attributes of a quality clinical placement for undergraduate students?

- Are there any models for ‘best practice’ in undergraduate nursing clinical placements that have been tested?
- Are there any models for ‘best practice’ in undergraduate nursing clinical placements that have been tested in the aged care setting?

Despite the comprehensiveness of this systematic review, no recommendations could be made as little quality evidence was unearthed. The reviewers did, however, comment that the literature reviewed was helpful in indicating the areas that a clinical placement model would need to address. The systematic review concluded that there was considerable (although low level) evidence that improved outcomes of undergraduate nursing clinical placements could be achieved by the following:

- a raised profile for aged care nursing within university Schools of Nursing
- improved aged care clinical education prior to the commencement of placements
- improved assessment of the training capabilities of sites
- better preparation of students, site staff, and clinical teachers
- improved partnerships between universities and clinical sites
- a client-driven model of clinical education
- improved communication within the site and between the site and the academic staff
- planned times for individual and joint debriefing for all parties involved.

The review also concluded that although scant progress has been made to date in terms of developing evidence-based models of clinical education in nursing in general, and aged care nursing in particular, there is a strong and apparent need for such a guideline.

It is worthwhile to note here that the systematic review described above identified a recent multi-staged Australian project to be the ‘most comprehensive and fertile of those [studies] reviewed’ (Abbey et al., 2006; p.41). The four year project, entitled *Building Connections in Aged Care: Developing Support Structures for Student Nurses on Placement in Residential Care* (Robinson et al., 2005), researched support structures for undergraduate nursing students on clinical placement in residential aged care facilities, and involved the participation of six residential aged care facilities. The interventions were designed to generally improve the quality of student practicum and included:

- A specific academic being allocated to communicate with each Residential Aged Care Facility (RACF), such that RACF staff liaise with a designated person to facilitate communication and continuity.
- The academic allocated to the RACF visiting the site to support preceptors rather than teach students.
- The language used in the documentation provided by the university to RACFs was developed to embrace the principles of Plain English.

The project found that the support structures put in place helped develop quality clinical placements in aged care. Furthermore, they had a very positive impact on the students, with the large majority expressing an interest in working in aged care upon graduation, which is clearly a most favourable outcome given the currently experienced problems of recruitment and retention of nurses in aged care. Evaluations

of the project have also been positive, highlighting the sustainability of the impact of the intervention on the residential aged care facilities and students. Whilst the outcome of this effort is awaited with much interest, the findings will only refer to those aged care placements that occur in residential aged care facilities.

The literature reviewed for this current report echoes the Abbey et al. (2006) systematic review assertion that there is a very real need for the development of guiding principles or models in order to address the problems experienced by the parties involved in aged care undergraduate clinical placement education. The current project would add that these principles or models need to be applicable to all settings where aged care nursing clinical placements take place, not just in residential aged care. The remainder of this review will report on the key areas highlighted in the literature as needing urgent attention.

Areas to address in order to achieve best practice

Clinical placements are dualistic in nature; not only do they foster the nursing student's practical competency but they also develop the student's beliefs and values regarding nursing. These may remain constant for much of the individual's career. While this must be remembered in the introduction of the student nurse into any clinical setting, it is of particular importance in aged care as perceptions of gerontic nursing are often not favourable.

The seminal work of Howden and Baggaley (1989) concluded that positive socialisation improved attitudes and beliefs concerning older adults in undergraduate nursing students. More recently, this work has been extended. Brown (1999) monitored students' self reported perceptions of older people and nursing older people pre and post gerontic clinical placement and lecture delivery. The study found that perceptions were slightly less negative at post test, however the study contains methodological weaknesses, such as exposure to some lecture content prior to pre-test. Rogan and Wyllie (2003) explored the effect of an educational program on the attitudes and knowledge of undergraduate nursing students undertaking clinical placements in nursing homes. The study found that the structured education program modified negative attitudes towards older people and created interest in aged care. In another study, a comparison of nurse teachers' and student nurses' attitudes toward hospitalised older adults revealed that the attitudes of nurse teachers were more positive than both students who had received a theory component only and students who had undergone both theory and gerontic placement (McLafferty, 2005). The nurse teachers were, however, less positive about their role in promoting the profile of older people, which is of concern as many of the student nurses brought myths and stereotypes into their nursing practice. Another area of investigation has been the effect of faculty staff attitudes towards older people on the attitudes of student nurses, with faculty members with higher attitude scores found to have students who also hold more favourable attitudes towards older people (Sheffler, 1998).

Beyond undergraduate application, Hope (1994) found that aged care nurses scored more favourably in their beliefs regarding older people than their acute medical counterparts and attributed this to post-basic aged care training and knowledge of older people. He suggested that this difference was unacceptable since care of older

people is now part of every nurse's work, and pointed out that because aged care education has been a post-basic specialty, there are many nurses who do not have the necessary knowledge to care for older people. He recommended that aged care education be incorporated into mainstream nursing.

The use of nursing homes for clinical placements has also been a topic of debate in the literature. It has been argued that although nursing homes provide exposure to a wide range of health needs, there are disadvantages associated with clinical placements in nursing homes, such as the lack of adequate role models, lack of preparation, lack of interest of staff in working with older people, and the danger of perpetuating negative attitudes towards caring for older people (Chen, Melcher, Witucki, & McKibben, 2002). However Robinson et al (2005) have found that where there are sustainable interventions this assists in building about a positive shift in attitudes toward working in the aged care sector. The year placement of nursing home clinical placements has also been raised as an issue of concern in the literature. It has been argued that nursing home placements in the first year of the undergraduate program focus on basic care and therefore provide an inaccurate picture of what caring for older people entails, and that aged care clinical placements should therefore occur in later years either instead of, or in addition to, first year (Nazarko, 2002). Irrespective of year placement, it has been argued that the most important concern is that the placement focuses on the development of skills (Nazarko). Student feedback regarding the nursing home clinical placement experience reinforces skill development as a major benefit, in addition to improved organisation, communication, and interpersonal skills (Fuggle, 1999).

Both transitioning into the workforce and commencing clinical placement can be difficult and confronting. This may be due to social impediments as well as more practical issues (Jackson & Mannix, 2001). In their 2001 study, Jackson and Mannix found that some nursing students experienced their placement as intimidating and alienating. Commonly this was due to time constraints imposed on nursing staff and the perception of students as a costly intrusion. Similarly, Elliott (2002) reported that the clinical environment can be a cause of stress and anxiety for students due to a number of factors, including staff ignorance regarding student goals and roles, students' limited knowledge, and the nursing hierarchy. He argued that a more positive clinical placement experience could be achieved by adequate preparation prior to the commencement of placement, adequate clinical supervision, and stronger collaboration between universities and health care providers. This is also supported by Robinson et al. (2005).

There are a number of other areas that have been highlighted in the literature as requiring improvement in order to maximise positive outcomes of the aged care clinical placement. These include: the preparation of both students and facility/hospital staff, the importance of ensuring the quality of the facility/hospital, and raising the profile of caring for older people (Pearson, 1998; Wade & Skinner, 2001; Robinson et al. 2005); ensuring appropriate clinical supervision by preceptors of communication between student nurses and the older people in their care, increasing delivery of interpersonal skill education, and ensuring clinical placements provide an appropriate learning environment (Tuohy, 2003); and providing opportunities for group supervision (Lindgren, Brulin, Holmlund, & Athlin, 2005).

The Nurses Board of Victoria Review of Aged Care Nursing Component of the Undergraduate Nursing Program (2002) made several recommendations in regard to gerontic clinical placement. These included that initial clinical placements occur over a wide range of clinical areas to help dispel the commonly perceived wisdom that gerontic nursing required only basic skills, and that at least 15% of clinical placements time in the final year be undertaken in care of older people (Nurses Board of Victoria, 2002). The report also identified a need for greater support and education of clinical teachers and preceptors.

The plight of undergraduate education in aged care was also highlighted in the Senate inquiry into nurse education (Senate Community Affairs Reference Committee, 2002). Among their recommendations was that universities review the content and quality of clinical placements and experiences of student nurses and, furthermore, that clinical placements include a range of aged care settings.

Another recent report is the *Aged Care Core Component in Undergraduate Nursing Curricula Principles Paper* (Queensland University of Technology, 2004), which is the project on which this report is based and was commissioned to help promote. The paper outlines aged care content for undergraduate nursing curricula, relevant resources to support the principles, barriers to implementation, and strategies for implementation in the future. The paper is based on a project that involved consultation with both university and industry representatives focusing on aged care.

As discussed earlier, the work of Robinson et al. (2006) indicates that since the implementation of their recommendations, university staff have more contact with the facilities, and there has been a positive impact on the providers' commitment to support students and facilitate teaching and learning. Overall there has been a positive outcome for the university, students and the recruitment and retention of staff.

3.3 Summary of literature review

This review of literature concerning nursing clinical placements revealed that whilst there are models for nursing clinical placements in general, aged care nursing clinical placement models are scarce. There are currently no published journal articles reporting research into aged care specific undergraduate clinical placement models. There are five reports of more general undergraduate nursing clinical placement models, only three of which comment on outcomes, mostly in the form of self report evaluations.

There are currently no models (non-specific setting) of 'best practice' for undergraduate clinical placements that can be said to have undergone evaluation vigorous enough to make evidence based recommendations grounded in findings of effectiveness. There is, however, a promising on-going Australian multi-phase project in progress centred around developing an evidence-based model of aged care clinical placement, although this project is residential aged care specific.

The models reported in this review do, however, contain elements worthy of consideration as necessary for 'best practice'. Most of these elements are further

highlighted in the broader literature as areas that would require consideration in the development of an outline of 'best practice' for undergraduate aged care nursing clinical placements.

4. Consultancy with key informants

This project involved consultations with representatives from key stakeholder groups (the National Reference Group) in addition to wide stakeholder contribution from university and industry representatives (focus groups and web based submissions). Detailed information obtained from consultations can be found in Appendix 1.

4.1 National Reference Group

A National Reference Group (NRG) was established in March 2006, consisting of nine industry stakeholders identified by the project team and JCU as having relevant expertise in education and the aged care nursing industry.

NRG representation included: DoHA; Royal College of Nursing Australia (RCNA); Australian Nursing and Midwifery Council (ANMC); Australian Nurses Federation (ANF); Aged Care Association of Victoria (ACAV); Catholic Health Australia (CHA); Council of Deans of Nursing and Midwifery (CDNM); National Nursing and Nurse Education Taskforce (N³ET); Queensland University of Technology (QUT); and the University of Newcastle.

The NRG was consulted via teleconference at two crucial points during the project. The initial meeting occurred in March 2006, following the literature review but prior to the commencement of focus groups. During the first meeting of the NRG, the project was introduced and the project methodology outlined. NRG members were presented with the key findings from the literature review and invited to comment on the scope of the review, and more generally. NRG members were asked to comment on whether they were aware of any existing aged care clinical placement models, how 'aged care' and 'aged care clinical placements' should be defined, and their thoughts as to what should be the main focus of the Best Practice Model. The NRG was also invited to nominate individuals and/or organisations with relevant experience in aged care nursing and/or education suitable for focus group participation.

The second meeting of the NRG was held in June 2006, once focus groups had been conducted and collation of findings had commenced. The purpose of the second meeting of the NRG was to provide feedback regarding the main themes arising from the focus groups and to invite the NRG to comment on these findings. As each theme was presented, the NRG was asked to comment on whether or not they concurred with the finding.

NRG members were encouraged to email or telephone the project team with further comments and suggestions throughout the duration of the project, and were invited to comment on the outline of best practice and draft of the final report.

4.2 Focus Groups

Invitations to participate in focus groups were sent in early April 2006 to all Australian University Schools of Nursing, as well as individuals and organisations nominated by the NRG.

A total of 12 focus groups were conducted for this project, including stakeholder representation from each Australian state and territory and across metropolitan, rural and remote areas. Representation from Aboriginal and Torres Strait Islander and other ethno-specific communities were included. One focus group was conducted face to face (in metropolitan Melbourne, where the project team is based), and eleven focus groups were conducted via teleconference. The information obtained during each focus group was built upon to inform subsequent focus groups.

A total of 56 individuals participated in the focus groups, which were held in late April and May 2006. Focus group participants included Directors of Nursing and Chief Nurses, in addition to broad university and industry representation, including the following: Victoria University, University of Notre Dame; Canberra University; University of Western Sydney; Charles Sturt University; Griffith University; Monash University; Edith Cowan University; University of Wollongong; Curtin University; University of Sydney; Central Queensland University; Australian Catholic University; University of Newcastle; University of Southern Queensland; James Cook University; The Alfred Hospital; The Canberra Hospital; New; South Wales Department of Health; Western Australian Department of Health, Wurli Wurlinjang Health Service Bairnsdale Regional Health Service, Royal College of Nursing Australia (RCNA), Aged Care Association (ACA), Nurse Education Taskforce (N³ET), Australian Nursing and Midwifery Council (ANMC), Australian Nursing Federation (ANF), Councils of Deans in Nursing and Midwifery (CDNM), Aged and Community Services Australia (ACSA), Victorian Department of Human Services (DHS), Congress of Aboriginal and Torres Strait Islander (CATSIN), Partners in Culturally Appropriate Care Victoria (PICAC-Vic), and Association of Australian Rural Nurses (AARN).

Interviews commenced with a brief overview of the background to the project, accompanied by an explanation of the project objectives. Focus group interviewees were informed that although prompt questions would be used, the aim of the focus groups was to have individuals participate freely and contribute their views and ideas. Prompt questions included the following:

- How should the ‘aged care clinical placement’ be defined – that is, should it be restricted to residential aged care, or should it be broadened to expand across the board?
- What is your understanding of what is meant by the term ‘model’ in ‘best practice models’ for aged care clinical placements?
- How does the year placement of gerontic nursing in the curriculum influence clinical placement?
- Where does/should clinical experience for students take place?

- What aspects of current clinical practice models are successful?
- What makes appropriate role models both at university level and in clinical practice?
- What preparation is required for clinical facilitators/facilities?
- What preparation is required for students prior to clinical placement?
- What university/ industry partnerships successfully support student placement and why?
- What profile does aged care nursing currently have within the Schools of Nursing?
- What is communication and coordination like within the site, and between the site and supervising academic staff?
- Are there adequate opportunities for joint and individual debriefing?
- Are there issues specific to rural and remote areas?

Participants were invited to raise the issues that they considered to be important and as new issues arose, these were explored further in subsequent focus groups.

4.3 Web-based submissions

To maximise interaction with key informants, web-based technology was employed. Using ACEBAC's existing web platform, a linked site was created to allow interested parties to submit summaries of their innovative placement approaches. It was reasoned that the use of this on-line mechanism would make submission of data rapid and easy for most institutions. An email based publicity campaign occurred in April 2006, and universities nation wide were invited to submit a summary of their innovative placement practice on-line.

Where information and course content was shared between universities, intellectual property rights were to remain with the university of origin and no modification of course material or resources was therefore to be permitted. The linked site was also used to publicise the project and make findings easily available. The email based publicity campaign did not yield a high return. Although email correspondence detailing programs or models of clinical placement was received, this correspondence came from stakeholders who were already involved as either members of the NRG or focus group participants. The nature of the information received was therefore not additional to that gathered during the NRG meetings and focus groups, but rather elaborated upon the issues raised during these meetings.

5. Data Analysis

Qualitative data from the NRG were transcribed and analysed using constant comparison methods developed by Glaser and Strauss (1967) to identify concepts and

then develop codes and patterns and themes. This method was also used to analyse the qualitative data from the focus group interviews. Once analysis was complete, the arising key themes were consolidated into main areas of best practice.

6. Results

As the findings from the literature and consultancies were complementary and internally consistent they have been combined under the following themes:

1. Partnerships
2. Clinical Venues
3. Roles and responsibilities
4. Achieving outcomes
5. Collaborative teaching and learning
6. Funding

6.1 Partnerships

Collaborative partnerships are essential between industry organisations offering clinical placement and universities placing undergraduate nursing students with them. The roles and responsibilities of clinical and academic staff and students involved in the undergraduate gerontic nursing clinical placement need to be clearly articulated, and solidified in a formal contract or agreement. The agreement should also provide details of the roles, responsibilities and expectations of each of the partners. Underlying 'best practice principles' is the necessity for clear and regular communication between partners. Examples of strategies that should be introduced to ensure that communication is sustained include: appointing a liaison person to be responsible for tasks relating to the distribution of information at the site level, such as posting notices to inform staff of when students are coming, as well as keeping updated with subject handbooks, and direct contact numbers for the subject coordinator.

As both partners have a responsibility for providing a positive clinical experience development and maintenance of a supportive clinical environment is required. Participants stressed that the partnership between the organisation and university needs to be sustained between placements. This could include some form of service provision by the university and perhaps research facilitation by the industry. This would also assist in university-industry partnerships working towards establishing a teaching/learning/research nexus.

Reciprocity that benefits both partners is important. There are some partnerships that use reciprocity where financial reimbursement is not preferred or possible. The arrangement may involve 'payment in kind' so that both parties benefit from the partnership. This may include the university providing continuing education for industry staff, assisting with funding a library for the facility; enabling industry staff to undergo a preceptor course; or arranging borrowing rights from the university library.

All participants agreed that both universities and industry should work to ensure that the curriculum and clinical placement requirements are consistent, and that students, clinical and university staff have a shared understanding of student knowledge and skill preparation and capacity to practise safely. It was felt that often where students and clinical staff are unsure of the clinical objectives of the experience this can mean the downfall of the experience for all concerned. Without compromising student learning, clinical placement timing and how the placement is executed (i.e., block placements versus continuously throughout the year) should be mutually negotiated and agreed. There was also discussion regarding continuity of experience; an example was provided where students from the university had most or all of their placements in the same organisation. This allowed students to become familiar with the industry staff, structures and processes and the industry to 'adopt' the students as members of their team.

Successful partnerships have accessible academics/facilitators, particularly during the course of the placement. Overwhelmingly it was considered important that active involvement of both parties and an environment of trust, willingness, and support is required.

6.2 Clinical Placement Venues

Views regarding clinical placement venues derived from the discussion on how aged care experience was defined. 'Better practice' in terms of clinical venues was based on gerontic nursing placements occurring across the continuum of care wherever older people and nursing services interact. However it was considered essential that when identifying clinical venues there needs to be agreed standards, criteria and processes for selection.

Rural clinical placements provide particular challenges and 'better practice' involves arranging placement where feasible in services close to where students live. It was agreed that, provided all objectives can be achieved within the geographical area, this rural experience could be open to all students. A benefit for the community is the boost for potential recruitment opportunities and for students it can broaden their practical knowledge.

6.3 Roles and Responsibilities

Universities/academics

Academic staff and the university have a major role in ensuring the quality of the clinical experience. To this end, academic staff responsible for the gerontic nursing placement must be credible, qualified gerontic nurses.

Academic staff should broaden clinical placements to expose students to the full range of skills and contexts required for nursing older people. This would include working in interdisciplinary teams, participating in case conferences, assessing older people in

the community, being exposed to a variety of therapies and to the implications of returning home with/without support. Objectives should reflect person centred care rather than just task competency.

Where possible rural students should be enabled to undertake their placement near to their place of residence and all students should be given the opportunity to undertake both metropolitan and rural placements.

Communication and administration of the clinical placement is crucial to success. The best practice principles can be divided into three time periods: communication/administration prior to placement; during placement and post placement.

Prior to placement

It is the responsibility of the academic/university to ensure that:

- Information regarding the placement is posted on university noticeboards as well as on the university server, and that this occur at the commencement of semester with the final notice posted four weeks prior to placement.
- Students and organisations have access to either electronic or hard copy of set readings, curricula, and learning objectives, assessments and other relevant information.
- Clinical staff are briefed regarding set learning outcomes, the knowledge base of students, what clinical skills students already have and what they are permitted to do, and what year of undergraduate study the students are currently undertaking, as well as the global areas of curricula;
- liaison between the university, student, organisation and clinical staff is efficient, effective, regular and timely.

During placement

Academic staff are responsible for the organisation of their workload so that they are available for the facility and are able to assist with trouble shooting. Generally they are required to liaise between the university, student, organisation and clinical staff. They should organise regular debriefing sessions between academic and clinical staff and students early on and throughout the placement so that any problems can be addressed promptly.

Post placement

Generally academic staff are required to liaise between the university, student, organisation and clinical staff and evaluate all aspects of the clinical placement. Adequate administration support by the university and the organisation is required to ensure the smooth execution of student clinical placements.

The academic's experience of better practice clinical placement

I use to hate clinical placement! It was always a hassle - students complained and whined about having to 'do older people again'. Now there is none of that. What changed? Well we got together with some organisations and formed a consortium. Together we agreed on all the processes and how we could make it a real learning experience for students. We were passionate about gerontic nursing and wanted them to be too. I won't pretend it was easy – it took a lot of work and compromise on all sides. But we are getting there. We have a formal contract and everything documented so there is no confusion about who does what. The organisations have supported and encouraged RNs to develop preceptorship skills. They have also invested in IT so if the staff need to get some information they can easily access the internet. I think they used to feel a bit scared of the uni students – especially those RNs who trained in the hospitals. We knew if this was to work we had to be regularly interacting with them and ensure they realized they did not have to know everything. Rather they had to be supportive facilitators.

We have meetings every semester to ensure we are all happy with the forms of assessment. The clinicians have had some great ideas and really improved the clinical relevance of the assessments. Because the students ask lots of questions it has also provided opportunities for research that are relevant to practice. There are, of course, a few nurses who complain about everything and give the students a hard time. Gradually they are becoming the minority as others move in to protect 'their students'!

We developed a plan for our partnership and every year we review and revise it based on the year's experience. The students input through formal evaluations and they have representation on the steering committee. There is just a really constructive relationship now. Rarely hear the staff complaining about 'your' students. They have adopted them as part of their team and there are lots of things the students learn about time management and working in the real world they never got before. With the building relationship and all of us contributing our bit I think we are building a culture which values care of older people as challenging and providing an exciting career path. Now who would have thought?

Industry Organisations

Organisations accepting students on gerontic clinical placement should ensure that the quality of the clinical experience provided reflects positively on care of older people. This includes having staff that are knowledgeable and skilled in gerontic nursing and a culture that values older people and contemporary nursing practice. Before accepting student for placement the organisation should be able to demonstrate that the experience they provide can assist the student to fulfil the clinical objectives and learning outcomes set for the placement and that there are sufficient staff to supervise students.

The environment provided for clinical experience is important and this includes a culture within the organisation that is free of horizontal violence. The environment should ensure that students are included as full members of the health care team and receive clinical supervision and support.

As information technology is being used more and more within the health care industry, it is important to ensure IT support is available to staff and students. This is of particular significance in rural and remote areas where access to materials may be limited.

A major principle of 'best practice' includes an adequate orientation for students prior to the commencement of the clinical placement. Suggestions include: providing orientation documents; taking students on a tour of the site and/or providing them

with a site map; providing general information regarding the site, including what services are offered, where to park and whether food services are available; providing computer logon details and library access if applicable; providing policy and procedure documents, and any other relevant material. In cases where the clinical teachers are not employees of the organisation, orientation and support and advice should also be provided to them.

Facilitators

As mentioned, the terminology used regarding industry supervision of students during placement varies, and for the purposes of this report clinical ‘teachers’ will be referred to as ‘facilitators’.

As with the academic staff involved in the gerontic nursing placement, facilitators need to have clinical credibility and a sound knowledge base. They are also required to act as positive role models for undergraduate students on gerontic nursing clinical placement and provide quality facilitation.

It is deemed ‘best practice’ for the facilitator to be familiar with guidelines for the clinical placement; this includes policies and procedures, the clinical site, and staff. As the major liaison person between the students and the organisation it is important for the facilitator to ensure that students feel welcome to the organisation. Suggestions were to: include them in team meetings; introduce them to other staff (including interdisciplinary); and treat them as part of the team and provide explanations of charts, abbreviations, and any unfamiliar terminology early in the placement.

While the university normally provides education on the role of a facilitator, ‘best practice’ facilitators should avail themselves of education regarding how to facilitate clinical learning, and what the role requires.

In keeping with the organisation’s philosophy of care and the clinical placement objectives from the university, the fostering of a holistic view of the client is seen as best practice. This involves students in all relevant aspect of client care. The emphasis should be on the person’s goals taking account of individual cultural, religious, spiritual and sexual differences and preferences.

The organisation experience of better practice clinical placement

Our organisation has a very detailed agreement with the university regarding the gerontic nursing clinical placement. We have a genuine partnership now. It used to be that the students just turned up and a supervisor employed by the university came with them, so apart from providing places we really didn’t have much to do with them. Then we set up a clinical school and agreed processes for decision-making. Now we have the academics onsite a lot of the time providing staff development for our clinicians and getting a bit of a reality check. We meet regularly at the senior level and decide together how to provide the best learning experience for the students. Because the organisation now feels some ownership we have invested in the education of our RNs so they feel confident to preceptor the students rather than have strangers coming in. It cost a bit upfront to set up the education, time release and backfill. But it has done wonders for recruitment and staff morale. We now feel they are ‘our’ students rather than visitors and where possible we offer them weekend and holiday work. The students seem to enjoy being part of the team also. The other advantage is that we can monitor their progression and enjoy their development. In fact we have a celebration each year and give awards to the most

improved and high-flyer students. The other interesting development is that they are working confidently with the other disciplines. In previous times they seemed a bit lost and afraid of the doctors. Now they contribute to case conferences, ask lots of questions and give us good ideas on the latest evidence. We are planning to have a team approach to clinical preceptorship where a nurse, doctor and social worker will work with a case management approach and team across community, acute and residential care.

The university staff are developing the clinicians' research awareness and engaging in interdisciplinary research. It really has started to change the culture. Now we have less trouble filling vacancies and they say it is because we have a reputation as an exciting place to work. Of course some staff don't like it – but you will always get those few!

Students

For a successful clinical experience; students must not be passive recipients but must also accept some responsibility. This would include making an appointment with the facility/ward prior to commencing placement to discuss roles, expectations, rosters, etc., and to clarify beliefs and values regarding caring for older people. Students should be actively engaging in orientation to the site prior to the commencement of their placement, which should include general site orientation as well as such topics as learning outcomes, etc. Finally students can improve their placement by accessing information on placement requirements and other relevant information such as conflict resolution procedures, as well as information relevant to the particular site where their placement is to occur.

A student's better clinical placement experience

My name is Jane. I am a Year 3 BN student and have just completed the BEST clinical placement! I thought it was going to be boring cos everyone hates gerontic nursing – I did my first placement in a nursing home and hated that – we just did bums, backs, feeds and showers. I guess we learned some skills, but the thought of going back did nothing for me. I knew all that stuff. Also, the staff were a miserable lot and kept sympathising with me about having to be there. They said 'when you finish, get into acute or you will be like us and lose your skills'. Anyway, back to this experience – it started differently. The academic and clinical nurse met with us together and were really enthusiastic about older people and all we could learn because of the complexities and co-morbidities. What I found different was that they focussed on the people and meeting their goals rather than doing the tasks and ticking off that we were competent. Of course we still had to be competent and I found it really challenging learning with the docs and physios. We all had to contribute our critical reflections at the case conferences and then we had a combined 'Grand Round'. That was excellent.

The ward staff were really good – they showed me around and included me in discussions. They didn't mind questions and if they did not know the answer they would help us look stuff up. I felt I knew exactly what was required of me and my preceptor and the academic supervisor met regularly to make sure we were all on the same page. Apparently the uni had run preceptorship courses for the clinicians and between them they decided to have preceptorship teams, so there was me, a first year student and the RN working together – sometimes we also had an EN or a PCA as well. I learned lots about delegating safely and leading teams. The first year said he liked it too cos he could see what would be expected of him and he felt okay asking me questions. I discovered just how much I had learned watching him struggling with things that are easy for me now.

This is such a great place - for once there was consistency between what I was learning at uni and what I did on clinical. No-one put me down and I felt encouraged and supported. In fact I am going to work here now in the holidays and they say I can have my grad year here. Who knows – just might end up a gerontic nurse practitioner!!

6.4 Achieving Outcomes

The expected outcomes of the clinical experience should be the driving force for the choice of venue. In some cases a negative experience is related to lack of understanding regarding the goals that are to be achieved on completion of the placement. Therefore it is important that learning goals and expected outcomes are negotiated in partnership by the university, organisation and student and made available to all stakeholders (this includes clinical staff who will be working with students during their placement). Outcomes should be clearly articulated and published for each placement and reflect the degree of difficulty and progression expected for the year of study, this will assist staff to work with the students and have realistic expectations of their involvement in the care of older people. Overall it is important that the outcomes reflect safe, competent, and holistic care of older people, not task competency. The assessment requirements should be directly linked to the gerontic nursing clinical placement.

While there may be a lack of available clinical venues for the numbers of students requiring placement, decisions should take account of available clinical support and the context providing the student with the opportunities to meet competencies. This may mean for some organisations night duty, weekends and public holidays are inappropriate whereas for others it is appropriate.

6.5 Collaborative teaching and learning

Overall it was considered that best practice clinical placements require collaborative approaches to teaching and learning. An example was provided where students were exposed to industry based learning. Classes are held at a hospital and teaching is delivered by academics and experienced clinical practitioners. Industry-university collaborations can reduce the academic/clinician gap. This reduces the tension when clinical staff consider what is taught in theory does not reflect the reality of practice, and academics consider practice is not based on best evidence.

There are several models that reflect this collaboration; these include clinical schools, nurse-led clinics, 'teaching nursing homes' and professional development units. As nursing is integral to an interdisciplinary model of care it becomes apparent that interdisciplinary learning should be considered as a 'best practice principle'. For example, medical, allied health and nursing students could undertake some of their learning together on clinical placement this would facilitate different levels of students to work together to develop leadership, teamwork and delegation skills.

6.6 Funding

Funding is a core issue for clinical placement. While DoHA has done much to provide financial support to those undertaking gerontic nursing education, there are other avenues that could be explored. Further reimbursement of travel and accommodation expenses for those students travelling to rural and remote areas to undertake their gerontic nursing clinical placement would encourage students to broaden their clinical experience. Where this is already available more prominent advertising is required.

Some organisations offering gerontic nursing clinical placements need funding for appropriate infrastructure to support the clinical placement (e.g., video conferencing, computer and internet access). This may require specific funding. Student scholarships and opportunities for employment may also enhance the gerontic nursing placement.

7. Further considerations

While not directly related to best practice principles for clinical placement, participants raised some thoughts for consideration.

There was discussion regarding the feasibility of a national register. The register would identify organisations willing to accept students on clinical placement. It would include details of the organisation's services, availability of clinical support, accreditation details and any regulatory approval to supervise students (e.g. from national registering bodies), and other relevant information, such as whether accommodation is available for rural/remote areas. Minimum criteria for inclusion on the register could assist positive student learning experiences.

It was seen that while partnerships between universities and organisations was more common in metropolitan areas there was the potential to develop opportunities in terms of partnerships between universities and organisations in rural and remote areas. There was also the potential for students to learn from each other. One model was described where senior students were working with junior students and the facilitator in teams. This model was assisting the senior students in the development of leadership, delegation, teamwork and appraisal skills. Junior students were able to see 'where they were progressing' and were less intimidated in approaching the other student.

Finally the feasibility of interdisciplinary models that involve interprofessional clinical placement was recommended. None of the participants were aware of any such models currently being used; however there was significant support for this model to be developed.

8. Summary and recommendations

This report documents the results of an investigation into best practice undergraduate clinical placements in aged care nursing. The outcomes of the literature review and consultations with stakeholders that were conducted as part of this project did not reveal a preference for any particular model (setting non-specific) of aged care clinical placement delivery; however, they did reveal a preference for a set of 'best practice principles' that can be applied to models and address the unique circumstances of each university and health care service offering undergraduate aged care nursing clinical placements.

While it is clear that more research is required and current successful practices need to be made more available through publication as articles in peer reviewed journals, it is recommended that for implementation of best practice aged care clinical placements for all Australian Schools of Nursing and health services providing clinical placements, these principles are adopted. Of equal importance is that models that incorporate these principles undergo future evaluation.

Several vignettes are included in this report as examples of how these principles may be practically adopted by universities and industry alike. Recommendations for further considerations are also made.

References

- Abbey, J., Parker, D., Abbey, B., Jones, J., Robinson, A., Toye, C., & Barnes, L. (2006). *Modelling connections in aged care: Clinical placements for undergraduate students in aged care – a systematic review*. Brisbane, Queensland: School of Nursing, Faculty of Health, Queensland University of Technology.
- Barrowclough, F. (1982). Be prepared. *Nursing Mirror*, February 24, 36-39.
- Bittner, N. P. & Anderson, A. (1998). The preceptoring map for RN-to-BSN students. *Journal of Nursing Education*, 37(8), 367-372.
- Brown, S. (1999). Student nurses' perceptions of elderly care. *Journal of Black Nurses Association*, 10(2), 29-36.
- Chen, S., Melcher, P., Witucki, J., & McKibben, A. (2002). Nursing home use for clinical rotations: Taking a second look. *Nursing and Health Sciences*, 3, 131-137.
- Edgecombe, K., Wotton, K., Gonda, J. & Mason, P. (1999). Dedicated education units: 1 - A new concept for clinical teaching and learning. *Contemporary Nurse*. 8(4), 166-171.
- Elliott, M. (2002). The clinical environment: A source of stress for undergraduate nurses. *Australian Journal of Advanced Nursing*, 20(1), 34-38.
- Fuggle, K. (1999). Student nurse placements in the care home setting. *Nursing and Residential Care*, 1(6), 343-346.
- Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory*. Aldine: Chicago.
- Gonda, J., Wotton, K., Edgecombe, K. & Mason, P. (1999). Dedicated education units: 2 - An evaluation. *Contemporary Nurse*, 8(4), 172-176.
- Grealish, L. & Carroll, G. (1998). Beyond preceptorship and supervision: A third clinical teaching model emerges for Australian nursing education. *Australian Journal of Advanced Nursing*, 15(2), 3-11.
- Hope, K. W. (1994). Nurses' attitudes towards older people: A comparison between nurses working in acute medical and acute care of elderly patient settings. *Journal of Advanced Nursing*, 20, 605-612.
- Howden, C., & Baggaley, S. (1989). Learning from the experts. *Nursing Times*, 85(25), 42-44.
- Jackson, D. & Mannix, J. (2001). Clinical nurses as teachers: Insights from students of nursing in their first semester of study. *Journal of Clinical Nursing*, 10(2), 270-277
- Joy, J. P., Carter, D. E., & Smith, L. N. (2000). The evolving educational needs of nurses caring for the older adult: A literature review. *Journal of Advanced Nursing*, 31(5), 1039-1045.
- Lindgren, B., Brulin, C., Holmlund, K., & Athlin, E. (2005). Nursing students' perception of group supervision during clinical training. *Journal of Clinical Nursing*, 14, 822-829.
- McLafferty, E. (2005). A comparison of nurse teachers' and student nurses' attitudes toward hospitalised older adults. *Nurse Education Today*, 25(6), 472-479.
- Marek, K. D., Rantz, M. J., & Porter, R. T. (2004). Senior Care: Making a difference in long-term care of older adults. *Journal of Nursing Education*, 43(2), 81-83.
- National Health and Medical Research Council (1999). *How to review the evidence: Systematic identification and review of the scientific literature*.
- Nazarko, L. (2002). Too much, too soon. *Nursing Standard*, 16(31), 24.

- Nurses Board of Victoria (2002). *Review of Aged Care Nursing Component of the Undergraduate Nursing Program*. Melbourne, Victoria: Nurses Board of Victoria.
- Pearson, J. (1998). An exploration of the empowerment of nursing students in a clinical context. *Nursing Praxis in New Zealand*, 13(3), 45-55.
- Primomo, J. (2000). Nursing around the world: Japan - Preparing for the century of the elderly. *Online Journal of Issues in Nursing*, 31 May.
- Queensland University of Technology, School of Nursing (2004). *Aged care core component in undergraduate nursing curricula principles paper*. Brisbane, Queensland: Queensland University of Technology.
- Robinson, A., Venter, L., Andrews, S., Cubit, K., Menzies, B., Jongeling, L., Fassett, M., & Mather, C. (2005). *Building Connections in Aged Care: Developing Support Structures for Student Nurses on Placement in Residential Aged Care – Final Report*. Hobart, Tasmania, School of Nursing and Midwifery, University of Tasmania.
- Robinson, A., Andrews-Hall, S., Fassett, M., Venter, L., Marlow, A., Cubit, K., Menzies, B., & Jongeling, L. (2006). *Building Connections in Aged Care Follow Up Evaluation Final Report . SNM Aged Care Report No. 5*. Hobart, Tasmania, School of Nursing and Midwifery, University of Tasmania.
- Rogan, F. & Wyllie, F. (2003). Engaging undergraduate nursing students in the care of elderly residents in Australian nursing homes. *Nurse Education in Practice*, 3, 95-103.
- Scholes, J. & Moore, D. (2000). Clinical exchange: One model to achieve culturally sensitive care. *Nursing Inquiry*, 7, 61-71.
- Senate Community Affairs Reference Committee (2002) *The Patient Profession: Time for Action Report on the Inquiry into Nursing*. Canberra: Printing Unit, Parliament House, Canberra.
- Sheffler, S. J. (1998). Clinical placement and correlates affecting student attitudes toward the elderly. *Journal of Nursing Education*, 37(5), 216-218.
- Tuohy, D. (2003). Student nurse-older person communication. *Nurse Education Today*, 23, 19-26.
- Wade, S. & Skinner, A. (2001). Student placements in nursing homes. *Nursing Older People*, 13(2), 14-17.

Appendix 1: Consultation Details

Suggestions as to what aspects of current models work well included the following:

- a more sophisticated model at third year
- mentors for third year
- involving students in discharge planning
- ensuring there is academic support for buddying systems
- buddy first year students with a Division 2 nurse
- clinical facilitator as liaison across several facilities
- ensuring there are sufficient RNs to supervise
- third year Dedicated Education unit – student and staff build a good relationship and work well as team
- having a good facilitator
- supportive facility that provides high quality nursing care
- ensuring there is no horizontal violence within the facility/ward
- cluster students – max 8-10 students to a ward with a preceptor for the entire day for 4-8 patients
- holistic view, involve in every aspect of aged care
- preceptor and mentor as good role models
- uni prepares students and facilitators for the clinical experience
- send first years in groups of 6-8 with a facilitator - don't send as many in 2nd and third year, who should have a preceptor, and who should follow the roster of the supervising RN
- academics to call in to facility/ward at least a couple of times each week and provide contact details for staff in case of problems
- university needs to have knowledge of aged care – facilities invite universities to come and discuss how they teach aged care
- curriculum needs to directly address aged care in units
- good communication between facility and students, ability for facility to feedback to university, and for university to act on this feedback
- preceptor/facilitator needs to have worked in aged care
- preceptor/facilitator role needs to be recognised as a 'real role'
- ensure that students are not just used as extra pairs of hands
- ensure that supervision is of acceptable standard
- ensure objectives are clear
- have someone monitor/advocate for students so objectives are met
- buddy second year students with RN on shift
- buddy nurse needs to be keen, show students around, be open to questions
- supervising nurse should ensure that they are a teaching resource and facilitate learning rather than demanding answers/knowledge from students that the placement is supposed to help provide
- supervisors should not interrogate or bully students
- supervisor should be organised and know where students are at
- preceptor model requires sufficient staff for it to work effectively
- staff need adequate skills in order to give supervision to undergraduates
- train staff to be preceptors – educate re role in mentoring

- student initiated placement scheme where student finds placement and RN, submits an application and signs a contract
- one staff member to eight students
- clinical teacher and preceptorship
- preceptor model – assigned academic attached to each hospital
- preceptor models where universities prepare clinicians to be preceptors and there is a clinical deed that covers financial arrangements
- two week block, clinical supervisors go out, supervisor model first and second years, preceptor for third year

Examples of Good Models

The following were identified as good models:

- Dedicated Education aged care placement – student can choose community or institution setting, as long as there is an RN as preceptor for the entire length of placement
- Charles Sturt University student initiated placement scheme - a student finds their own placement and RN, submits an application and signs a contract
- Queensland Health Affiliation Agreement – could be used as the basis for facility affiliation agreements
- Fast Track Nurse, University of Tasmania/St Vincent's and Mater Health New South Wales – collaboration between University of Tasmania and the five hospitals that make up St Vincent's and Mater Health, teaching delivered by highly qualified academics supported by experienced practicing clinicians
- La Trobe University's ageing subject – was initially an elective but is now a core subject
- New South Wales career pathway - practical placements with returned to work. Trained staff to be preceptors. Education of staff/knowledge of their role in mentoring
- La Trobe University 3 tiered approach – student/university clinical staff; role of university is to prepare staff for students so staff understand learning outcomes (clinical coach model). Clinical staff work with one on one with student throughout entire placement
- Monash University (Peninsula campus) clustering model – clusters students grouped to hospitals within 20km of where they live so all objectives are achieved within a geographical area. This also has the advantage of students being seen as potential employees
- Adelaide University - Students work in the clinical area as full members of the health care team and additional clinical support and clinical lecturers provide supervision. Clinical placement undertaken in the Central Northern Adelaide Health Service. Students introduced to the practice environment in a structured manner and are able to integrate knowledge with practice. Annual clinical placements extend from 35 - 40 weeks (3 days per week). Placements vary across different practice settings from acute care tertiary to primary health care areas. Placements in both metropolitan areas and rural areas of South Australia.

Model – what should it look like?

The following were raised as issues requiring consideration when developing a ‘best practice model’ for aged care clinical placements for undergraduate students:

- Aged care placements should occur across all settings, including acute care.
- Aged care placements in first year need to be consolidated in later years.
- Aged care placements should not just be task oriented.
- Aged care placements should be well planned and based on a clear model that focuses on development of assessment skills of older people, regardless of setting.
- A ‘best practice model’ should be comprehensive, and represent opportunities for scholarships, future carer opportunities, and graduate programs.
- Aged care should be integrated into the curriculum; however it also needs to be kept visible by having discrete units that require knowledge.
- Curriculum should stress the importance of *knowing the person*, as well as assessment and care planning.
- Curriculum influences how placements are structured and should therefore be flexible.
- Facilities should take students continuously over the year.
- Education units should be developed.
- Placement with aged care teams would be ideal.
- Finances should be used efficiently and directly relate to what it is that is trying to be achieved.
- ‘Best practice models’ should reflect that some universities are able to pay/pay more for placements compared to others.
- Standards for clinical practice should be outcome driven.
- Clinical deeds should be signed and include any costs involved.
- Terminology should be consistent – need to define what is the difference between clinical mentors, coaches, teachers, preceptors in terms of roles and responsibilities
- Advisory groups should have an eclectic mix of people – leaders from organisations, but also clinical and student representatives.
- ‘Best practice models’ should incorporate a strong vision regarding the quality of the clinical experience, promoting care of older person, etc.
- Model should emphasise strong and closer industry and university collaborations.
- Staff facilitators should be prepared.
- Academic and faculty involvement should ideally occur on a daily basis and there should be shifts in resources (e.g. financial) to support this.
- Universities should try to build relationships with facilities that are research active and/or that have innovative programs.
- Mentorship – experts from a range of disciplines come forward to mentor – might be hospital based.
- Clinical placements should be broadened to include working as part of a multi disciplinary team, sitting in on case conferences, going into the community to perform aged care assessments, and being exposed to the implications of returning home etc.

- ‘Best practice models’ should emphasise the importance of working as part of a team.
- There may need to be an accreditation process for facilities in partnership with universities on the basis of ‘best practice models’.
- Clinical placements should expose student to forms of therapy besides medication that are used with older persons (e.g. environmental manipulation, music therapy, diversional therapy).
- ‘Best practice models’ should emphasise the importance of mental health nursing skills.
- Placements should address palliative and aged care together (i.e., rather than just cancer palliative) – palliative students could go into aged care placements.
- Course philosophy should place value on aged care.
- Rewards should be involved – professional recognition for staff, scholarships, opportunities for students to accelerate and for career and employment.
- 1:1 preceptor on placement is ideal; as this currently limits venues, universities should work with industry..
- Placements should not be confined to a two week block. Three week blocks and continuous placement throughout the year should also be considered as possible options, as they increase student familiarity with their placement environment.
- Competencies should be national.
- Mentorship should be seen as an opportunity to recruit future staff and to ‘sell’ aged care with enthusiasm.
- RNs should volunteer for their position as preceptor/mentor, and have a positive attitude towards this role as well as towards their specialty and the nursing profession.
- In a rural cluster of hospitals requests for placements would go to central place.

Year placement

Where the aged care clinical placement was positioned in terms of year, undergraduate education differed between universities. Some offered aged care placements across all three years, others in some years but not others, whilst others did not offer any aged care specific placement. Examples include:

- aged care placement occurs in first year, second semester in rehabilitation/residential settings (not acute) because students have limited clinical skills at this stage in the program, there are a lack of places in acute, and an absence of RNs. It also occurs in second year in second semester
- aged care placement is incorporated across all three years – first year foundations of nursing with aged care emphasis; third year chronic illness subject (incorporating aged related illnesses)
- health assessment approach – first year -first semester students go to one large aged care community with all levels of care; first year, second semester emphasis is on overall assessment of older person
- designated residential placement in first year – debate about whether residential should be in first year. Gerontics unit in third year

- aged care placement in first year only
- no aged care in first year other than skills development
- placements are aged care only in second and third year
- meeting older people in healthy state in the community in first year; second year focus on acute; third year across all areas.

The following opinions were given regarding in what year clinical placements should occur:

- In Victoria, the NBV has recommended that aged care placements occur across every year of the curriculum.
- Aged care clinical placements should occur across every year of the curriculum because skills and knowledge levels change.
- There should be a progression in aged care curricula and outcomes each year to match skill development, with a focus on different issues in each year.
- The first aged care placement should occur in semester 1 of first year, so as to 'confront students with the reality of aged care and weed out those who are unsuitable to practice in the area'.
- Following their first aged care placement, undergraduates often have the impression aged care is mechanistic and ritualistic and therefore need the opportunity to revisit and see the richness of aged care.
- Incremental across the program – conceptualised across the curriculum and across the sector, embedded and life span concepts integrated.
- Aged care should be threaded throughout the 3 years of undergraduate education.
- Aged care education can be incorporated into subjects such as polypharmacy, risk of falls, health, medication management, etc.
- First year students sometimes feel like 'floating wall hangings' on their first aged care clinical placement – they need support, an allocated person and preceptor.
- Have flexibility in program to include different models over years – e.g., facilitator in 1st year, preceptor in 3rd year.
- There are state irregularities across states regarding the amount of clinical placement time required to be spent in aged care – perhaps this should be regulated throughout Australia.
- Goals to be achieved in first year can be limited and so it is thought by some that residential care is suitable for learning basic skills - need aged care placement across years to broaden their ideas.
- Aged care is more complicated than it may appear, and requires knowledge of dementia etc – should be presented across curriculum as a specialty area.
- Having the first clinical placement in aged care is associated with several risks: it wrongfully implies that aged care is basic; the one-to-one supervision that is needed in the first few days of placement is not always delivered and thus risks patient safety; student perceptions of aged care may be influenced; they may become task oriented.
- An integrated vision of aged care placements across the three years is needed; however so too is something that is visible. Integration should therefore be accompanied by discrete units across the curriculum that stress aged care as outcome rather than setting specific.

- Education regarding ageing should occur across years, across curriculum, and incorporate the life continuum concept – segregating can be problematic.
- It is important to provide a good grounding of gerontic nursing in first year. This would enable students to understand gerontic nursing regardless of setting.
- Best practice models' should focus on learning outcomes rather than where or when the aged care placement takes place.
- In third year students are keen to gain acute experience before they register as nurses, however aged care skills can still be taught in an acute setting.
- If aged care is to be presented as a career opportunity then it needs to be positioned in third year.
- Quality of placement is important for aged care clinical placements in first year – need to ensure consists not just of 'bed and body' work.
- In first year, there is a need to teach understanding of ageing process, sensitising, and it is important to have exposure.

Interdisciplinary Models

No interdisciplinary models of clinical placement were identified. It was suggested that interprofessional collaborations would be beneficial so that teams can work together and learn together. It was also suggested that nursing could learn from the way other health professions conduct clinical placements.

Preparation

It was stressed that both facilities and universities need to be adequately prepared for the aged care clinical placement, and that this preparation should extend to all involved including students, facilitators, clinical teachers, nursing staff, etc.

Preparation suggested included:

- facility/ward staff having contact details including mobile phone numbers so that they can have immediate access to university staff in the event of any problems
- facility being briefed regarding the learning outcomes of the subject as a whole, what year the students are in, what clinical skills they have (i.e. what they are permitted to do), knowledge base, competencies
- students making an appointment with the facility/ward prior to commencing placement to discuss roles, expectations, rosters, etc
- orientation for students prior to the commencement of their placement, covering general site orientation as well as such topics as learning objectives, etc.
- tutorial on the first morning of the placement
- providing students with a booklet on their first day that is geared towards staff members (i.e. .not university based)
- guidelines for facilitators

- information regarding the placement needs to be posted on university noticeboards and on the server, and this needs to occur at least one week prior to commencement of the placement
- it would be ideal if each facility/ward had their own booklet to provide to students on clinical placement
- making expectations clear
- debriefing should be offered to all parties early on in the placement so that any problems can be addressed promptly
- students should have a biopsychosocial understanding of the ageing process and ageism prior to the commencement of the first aged care clinical placement
- educator/supervisor needs to understand aged care and have a sound knowledge base of gerontic nursing
- students need to read a pack and sign a deed
- clinical facilitators not from the actual facility need to make an effort to get to know staff, facility procedures, etc, so that students will not be caught between facilitator and facility
- in a broader context, RNs need to be supported so that they can pursue learning and attend on-site education – this support might consist of ensuring there are not staff shortages, allocating time to education, etc
- facilitators need education regarding how to facilitate clinical learning
- facilitators not from the facility need to meet with the facility and learn how things are run before students come to the site – university should ensure this happens
- all parties should be informed re the proper process of problem solving
- a discussion with students should occur prior to placement to clarify beliefs and values re aged care
- preparation of students is more difficult for large hospitals – e.g., one 450 bed hospital has in excess of 10,000 student days per annum – however orientation documents, library access, log on details can still be provided, and orientation can be provided to clinical teachers, who can in turn orient students
- preparation can be problematic due to costs involved – everyone expects to be reimbursed, however there is only a small percentage of hospital funding to support clinical placements. Universities may need to pay for student places. This is not done for medical placements but their numbers are lower than the numbers of student nurses requiring placements
- preparation should include ensuring the curriculum and placement requirements are consistent – i.e., students have appropriate knowledge base for tasks prior to commencing placement
- facilities/wards need to be informed regarding global areas of curricula, as well as learning outcomes
- assessment requirements should be written so that they are directly linked to the placement
- time should be allocated for debriefing prior to the commencement of placement
- academic staff involved should have clinical experience
- preparation may involve signing a contract between students and the facility/ward, and between the university and facility/ward

- facilities should provide guidelines regarding what they offer and what they expect from students/universities
- preparation of the clinical environment is ongoing, and requires an ongoing partnership between the facility/ward and university
- workshops could be run regarding the principles of adult learning, the role of leadership, conflict resolution skills, site specific issues (e.g. housekeeping)
- students should be provided with explanations of charts and abbreviations early on in the placement
- students appreciate orientation booklets and orientation to wards, procedure documents, terminology (including abbreviations used in charts), parking restrictions, whether there is a canteen, etc
- students appreciate a welcoming Director of Nursing being introduced to other staff (e.g. medical, physiotherapists, occupational therapists, etc), perhaps at team meetings, so that they do not feel left out and are welcomed as part of the team
- all parties should be clear regarding their roles.

Relationships – University/Industry Partnerships

It was generally agreed that although partnerships between aged care facilities/wards and universities had improved in recent years, further development is needed.

Some examples of good partnership models were suggested. An example that was reported to be working well was South Western Health in Sydney, where a health person acts as a connector. Another example provided was the Practice Learning Team Model, where there is an atmosphere of collegiality between practitioners and academics – academics show commitment to practice by being there for troubleshooting (e.g. returning phone calls), adjusting workload so they are available for the facility, etc. It was also suggested that a good model was the relationship between La Trobe University and the Alfred and Austin Hospitals, with clinical schools located on site, as this provides the benefits of being able to share staff and knowledge, ensure recency of practice, inform practice using evidence based research, etc.

Good relationships between university and industry were defined as having the following characteristics:

- reciprocity, where facilities on students in exchange for staff education by university
- support such as funding a library for the facility, enabling all staff to undergo a preceptor course (perhaps a course with modules to account for high turnover), providing assistance with upskilling, giving borrowing rights for the university library
- good communication between partners – introducing strategies so that communication is sustained - e.g., appointing a liaison person who is responsible for distribution of information at site level, post fliers on noticeboard informing staff when students are coming, provide liaison person

with subject handbooks and the direct phone number for subject the coordinator and the clinical unit/admin.

- clear and succinct guidelines regarding guidelines and criteria
- a Memo of Understanding or generic contract regarding what the university and facility/ward should provide
- reasonably frequent contact
- payment in kind
- a good relationship between the facilitator and ward staff
- sharing of information
- giving facility/ward flexibility regarding when they take students, e.g. continuously throughout year versus block placements
- maintaining links between university and facility/ward with regular meetings
- sending students back to the same facility/ward so that they can develop relationship with that facility/ward
- ensuring facilities/wards have access to computers so that they can access set readings, curricula, learning objectives, etc.
- joint appointments with active involvement by both parties and an environment of trust, support, and willingness
- collegiality between practitioners and academics – academics need to show commitment to practice, be there for troubleshooting, adjust workload so are available for the facility/ward
- create a presence - build teaching/learning/research nexus with partners
- leadership program – people in clinical settings with adjunct academic position – acknowledge commitment in a public way

Role Models

A good role model was defined as having the following characteristics: a positive attitude, particularly towards aged care; good communication skills; patience; empathy; calmness; vibrancy; motivation; interest; able to articulate their practice and validate it using research; have regard for what they do and who they do it for; has a good standard of clinical knowledge regarding aged care; has recency of knowledge; engages in continuing education (which may or may not include postgraduate studies); is an expert in their field; leadership skills; is student and patient focused; recognises the potential of older people to improve their health; advocates in terms of medication, pain relief, getting client mobilised; understands their role; practices safely; and promotes the profile of aged care.

Facilitators (academics) considered good role models were those who were inspirational and demonstrated their credibility as a nurse by making beds, talking to patients, and acting as a team member rather than sitting at the nurses' station.

It is ideal if clinical facilitators work in the facility (rather than academics), as these facilitators have a more intimate knowledge of the facility and procedures, staff members, management, etc. However, there is a need to provide on costs and pay for facilitating.

Clinical teachers were considered good role models if they: specialised in aged care; promoted the profile of aged care nursing; were supportive; and visited the facility/ward frequently. It was also suggested that there be a minimum standard for clinical teachers, such as Certificate Four.

Mentors/buddies/preceptors were considered good role models if they: were open to students' questions; were happy with their role as mentor (e.g., had volunteered rather than assigned to role); and helped to dispel myths re aged care.

Facilities were said to be good role models if they fostered the following: positive culture of aged care; culture of research; used quality indicators; supported the continuing education of staff; and promoted a wellness model of patients despite their age (i.e., focused on ways to improve health and quality of life).

Mobile Assessment Team was considered an ideal role model for aged care, as the nurses involved are specialists in aged and provide an interface between acute/community. However, not enough places are available.

Centralisation of Placement Allocation

There was support for a state and/or national level central clinical placement allocation unit. The advantages of this included: it would lessen the substantial workload of clinical placement coordinators; students would not have to worry about being placed in areas that they cannot get to; it would minimise the experience of students presenting for placement to an unsuspecting NUM; it would standardise how facilities/wards are approached to take on students; and it would standardise curricula, as there would need to be a closer alignment with university courses.

There was a mixed response to the proposal that students be allocated for their clinical placement to facilities/wards within 20km of their home. Advantages included not having to drive great distances (particularly in country areas where students are forced to travel many kilometres), which can be dangerous for mentally and physically exhausted P platers, whereas disadvantages included not providing students with diverse experiences (e.g. predominant culture often changes with location).

There was support for a national database of facilities and what is offered. This would simplify the placement process for all concerned, and would showcase rural and remote opportunities.

It was also thought that the database would help improve relationships between universities and facilities/wards and result in more students accessing quality placements.

It was stressed that there would need to be minimum standards for facilities/wards to meet in order to be listed in this database.

There was a concern that places would only be available to those universities who are able to pay for them.

It was reported that a database is planned for South Australia in 2007, and will be based on a database currently used in Canada (British Columbia Nursing Council – Health Professional Clinical Placement).

Profile of Aged Care

It is important for facilities and universities to recognise that providing clinical placements is not just about giving students clinical skills but also giving them a positive attitude towards aged care.

Undergraduate nursing students need to be imbued with the value of working with older people, irrespective of setting, and that residential aged care is not ‘second rate’.

Breaking the stigma of working in aged care is an important outcome.

Curriculum

Aged care needs to be directly addressed in the undergraduate nursing curriculum, i.e., discrete units of aged care are required. These discrete units should be core subjects rather than electives.

Ageing should also be integrated into the curriculum to reflect its role as a part of normal living.

Curricula development needs to be considered, not just clinical placements

Quality

Quality was identified as the most important issue when it comes to aged care clinical placements.

Quality was defined as: having knowledgeable and highly motivated staff who are competent and provide adequate supervision; offering educational programs within the facility; having a good working relationship between the facility and the university; and offering regular debriefing by someone qualified to do so.

Placements vary enormously in quality across facilities and wards.

However, obtaining quality placements for all students is difficult due to the sheer volume of places required – placement coordinators often do not have the luxury of refusing places.

Rural/Remote Specific Issues

Rural and remote facilities are keen to accept students for clinical placement but are often not approached; this is unfortunate as they would provide a unique experience

(e.g., facilities with a mix of indigenous and non indigenous residents, younger residents with dementia).

There is limited choice in where students go for clinical placement in rural and remote areas.

Although it is not desirable for students to undergo their clinical placement in the same facility/ward in which they are employed as personal care attendants (PCAs) etc., this is difficult to avoid in rural and remote areas.

Accommodation is a significant issue, and one that requires funding, as students would be more likely to travel to rural and remote areas for their placement if safe accommodation was available (and was reimbursed).

Funding should also be provided for improved IT infrastructure, such as video conferencing, and computer and internet access. This will allow facilities/wards to: have access to student clinical placement manuals and guidelines, curricula, and WebCT; to keep updated with the latest available research; and to run in services that might not otherwise be available to them.

A 'best practice model' needs to account for the higher proportion of older people in rural areas compared with metropolitan areas.

It was suggested that the rural and remote packages developed by the Commonwealth need to be written not only by academics but also by those involved in the rural/remote industry.

Quality supervision was identified as a problem for some facilities, and it was suggested that a clinical workshop for preceptors could help to overcome this.

Managers of services in Northern Territory experience difficulty with recruiting staff and seem to target their advertisements well beyond the Northern Territory hoping they find RNs with the clinical skills necessary. Clinical skills alone however are not sufficient to successfully work in aged care in the Northern Territory. Many RNs new to the area struggle due to the climate, remoteness and so turnover is high.

Services look for clinical skills and then 'train' newcomers in doing things the 'Northern Territory way' but there are issues of smallness, remoteness, indigenous issues, wearing many hats, needing to be resourceful, flexible, and dealing with conditions not seen in the south of Australia.

There are fewer links between facilities/wards and universities in rural and remote areas.

Cultural Issues

Cultural diversity is often seen as a lifestyle and recreational issue in aged care, rather than something that permeates across all areas – placements need to stress cultural diversity as a way of delivering work.

Placing students in ethno-specific services where the primary language spoken by clients is not necessarily one that the student speaks may help to prepare the student for a career working with clients from diverse cultures.

Cultural diversity needs to be addressed in undergraduate nursing curricula – students need to be sensitive and aware of cultural differences, the possibility that some clients have experienced histories of torture and trauma, etc.

Overseas students should be educated regarding cultural differences prior to their first clinical placement. Older people are cared for differently around the world (e.g., institutionalisation of older people in the western world), and overseas students should be oriented to these differences.

Partnerships

Collaborative partnerships are essential between organisations offering clinical placement and universities placing undergraduate nursing students with them. ‘Better practice’ partnerships should include the following:

- a formal agreement between university and industry partners regarding undergraduate gerontic nursing clinical placement education, detailing the roles, responsibilities and expectations of each
- university-industry partnerships working towards establishing a teaching/learning/research nexus
- clear and regular communication between partners. Strategies should be introduced to ensure that communication is sustained (e.g., appointing a liaison person to be responsible for tasks relating to the distribution of information at the site level, such as posting notices to inform staff of when students are coming, as well as keeping updated with subject handbooks, direct contact numbers for the subject coordinator, etc)
- development and maintenance of a supportive clinical environment – this is ongoing and requires a sustained partnership between the organisation and university. University-industry relationship should therefore be nurtured even when clinical placements are not in progress
- both universities and industry ensuring that the curriculum and clinical placement requirements are consistent, and that students, clinical and university staff have a shared understanding of student knowledge and skill preparation and capacity to practise safely
- reciprocity that benefits both partners – e.g. where financial reimbursement is not preferred or possible, partnerships may involve an arrangement of ‘payment in kind’ so that both parties benefit from the partnership. This may include: the university providing continuing education for organisation staff assisting with funding a library for the facility; enabling staff to undergo a preceptor course; or arranging borrowing rights for the university library
- without compromising student learning, clinical placement timing and how the placement is executed (i.e., block placements versus continuously throughout the year) should be mutually negotiated and agreed
- accessible academics/facilitators, particularly during the course of the placement

- continuity of students from the same university to the same organisation
- active involvement of both parties and an environment of trust, willingness, and support

Clinical Placement Venues

‘Better practice’ in terms of clinical venues involves:

- gerontic nursing placements occurring across the continuum of care wherever older people and nursing services interact
- agreed standards, criteria and processes for selecting clinical venues
- enabling rural group clinical placements in services close to where students live, provided all objectives can be achieved within this geographical area; this can boost potential recruitment opportunities and reduce costs to the student

Roles & Responsibilities

- Roles and responsibilities of clinical and academic staff and students involved in the undergraduate gerontic nursing clinical placement need to be clearly articulated, and should be solidified by a formal contract or agreement.

Universities/academics

Better practice for academic staff includes that they:

- be credible, qualified gerontic nurses
- ensure that information regarding the placement is posted on university noticeboards as well as on the university server, and that this occurs at the commencement of semester with the final notice posted four weeks prior to placement
- organise their workload so that they are available for the facility and are able to assist with trouble shooting
- ensure that students and organisations have access to either electronic or hard copy of set readings, curricula, and learning objectives, assessments and other relevant information
- ensure that they have adequate administration to support the organisation and execution of student clinical placements
- provide organisations with contact details including mobile phone numbers so that they can have immediate access to placement coordinators/academics in the event that problems arise
- brief clinical staff regarding: set learning outcomes; the knowledge base of students; what clinical skills students already have and what they are permitted to do; and what year of undergraduate study the students are currently undertaking, as well as the global areas of curricula

- broaden clinical placements to expose students to the full range of skills and contexts required for nursing older people, e.g., working as part of a multi disciplinary team, sitting in on case conferences, assessing older people in the community, the varying forms of therapy and being exposed to the implications of returning home with/without support
- generally liaise between the university, student, organisation and clinical staff
- organise regular debriefing sessions between academic and clinical staff and students early on and throughout the placement so that any problems can be addressed promptly
- ensure that the quality of the clinical experience provided is of a satisfactory standard. This may involve ensuring there is a good working relationship between the university and facility/ward; assisting with educating staff; and maintaining regular face-to-face contact
- evaluate all aspects of the clinical placement.

Industry Organisations

Better practice organisations accepting students on gerontic clinical placement would:

- ensure that the quality of the clinical experience provided reflects positively on care of older people. This includes having staff that are knowledgeable and skilled in gerontic nursing and a culture that values older people and contemporary nursing practice
- ensure that the experience they provide fulfils the clinical objectives and learning outcomes set for the gerontic nursing clinical placement
- ensure there are sufficient staff to supervise students and there is a culture free of horizontal violence
- ensure that students are included as full members of the health care team and receive clinical supervision and support
- ensure IT support is available to staff and students, particularly in rural and remote areas
- provide adequate orientation to students prior to the commencement of the clinical placement. This may include: providing orientation documents; taking students on a tour of the site and/or providing them with a site map; providing general information regarding the site, including what services are offered, where to park and whether food services are available; providing computer log on details and library access if applicable; providing policy and procedure documents, and any other relevant material
- in cases where the clinical teachers are not employees of the organisation, provide orientation and support and advice.

Students

Better practice would involve students:

- making an appointment with the facility/ward prior to commencing placement to discuss roles, expectations, rosters, etc., and to clarify beliefs and values regarding caring for older people

- actively engaging in orientation to the site prior to the commencement of their placement, which should include general site orientation as well as such topics as learning outcomes, etc.
- accessing information on placement requirements and other relevant information such as conflict resolution procedures, as well as information relevant to the particular site where their placement is to occur.

Facilitators

Better practice facilitators should:

- be familiar with guidelines for the clinical placement
- have clinical credibility and a sound knowledge base in gerontic nursing
- ensure that they are familiar with the site, staff, policy, and procedures
- avail themselves of education regarding how to facilitate clinical learning, and what the role requires
- provide quality facilitation
- act as positive role models for undergraduate students on gerontic nursing clinical placement
- foster a holistic view of the patient/resident that involves students in every aspect of patient/resident care, including discharge planning
- provide students with explanations of charts, abbreviations, and any unfamiliar terminology early on in the placement
- make students feel welcome, for example, by including them in team meetings, introducing them to other staff (including interdisciplinary), and treating them as part of the team.

Achieving Outcomes

To achieve better practice in clinical placement experiences:

- learning goals and expected outcomes should be negotiated in partnership by the university, organisation and student and made available to all stakeholders
- clinical placement decisions should take account of available clinical support and the context providing the student with the opportunities to meet competencies – this may mean for some organisations night duty is inappropriate whereas for others it is appropriate
- outcomes should be clearly articulated and published for each placement and reflect the degree of difficulty and progression expected for the year of study
- outcomes should reflect safe, competent, holistic care of older people, not task competency
- assessment requirements should be directly linked to the gerontic nursing clinical placement.

Collaborative teaching and learning

Better practices include collaborative approaches to teaching and learning such as:

- industry based learning, where classes are held at a hospital and teaching is delivered by academic and experienced clinical practitioners
- industry-university collaborations that reduce the academic/clinician gap, and include models such as clinical schools, nurse-led clinics, ‘teaching nursing homes’ and professional development units
- interdisciplinary learning, for example, medical, allied health and nursing students undertaking some of their learning together on clinical placement
- allowing different levels of students to work together to develop leadership, teamwork and delegation skills.

Funding

Better practice includes consideration of the following:

- funding for reimbursement of travel and accommodation expenses for those students travelling to rural and remote areas to undertake their gerontic nursing clinical placement, as this would facilitate more of these experiences
- organisations offering gerontic nursing clinical placements need appropriate infrastructure to support the clinical placement (e.g., video conferencing, computer and internet access) – this may require specific funding
- the gerontic nursing clinical placement should include student scholarships and, where possible, opportunities for future employment.

Further considerations

The following should be investigated as ways of facilitating better practice:

- the feasibility of a national register. The Register would identify organisations willing to accept students on clinical placement. It would include details of the organisation’s services, availability of clinical support, accreditation details and any Regulatory approval to supervise students (e.g. from Nurse’s Boards), and other relevant information, such as whether accommodation is available for rural/remote areas. Minimum criteria for inclusion on the Register would assist positive student learning experiences
- the potential development opportunities in terms of partnerships between universities and organisations in rural and remote areas
- the potential for students to learn from each other, as this has not been adequately exploited; for example, senior students working with juniors can develop leadership, delegation and appraisal skills
- the feasibility of interdisciplinary models that involve interprofessional clinical placement.