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Clinical placements in contemporary nursing education: Where is the evidence?

Clinical practice is fundamental to the learning of undergraduate and entry-level nursing students. It provides the milieu whereby students apply classroom theory and simulated practice to the real world of nursing and become socialised into the profession. In contemporary nursing education, there is often competition among tertiary education providers to locate quality, appropriate placements; substantial costs may be incurred to access suitable placements.

Placement supervision

Nurses in clinical care settings are often expected to undertake the complex task of helping students assimilate classroom theory into the practice environment. They undertake assessment of students' performance, often, with very limited staff training in supervision. While acting as clinical teachers, they may carry a patient load in addition to their supervisory role. Moreover, clinical educators are often assigned to the preceptor role by their health service without direct input from the education provider on their suitability. Hence, it can be unclear whether they are ideally suited to the role i.e. have they been suitably educated and prepared as clinical educators? have they the capacity to fulfil all aspects of the role? and have they adequate understanding of the curriculum that each student has undertaken and of the student's learning objectives?

Extensive descriptive research exists around the clinical placement experiences of students and educators, which generally informs positive and negative aspects of how clinical teaching and learning is delivered. Despite the abundance of literature in the area of clinical education, there is an evidence vacuum around structuring of the placements that should be shared across education and health care providers. In particular, this relates to methods that support the highest possible learning outcomes; what are optimal clinical learning environments (including simulation), how should exposure be structured (including the number of clinical hours, the timing, frequency, duration and modes of clinical placement).

In 2000, Wellard et al. (2000) asserted there was little empirical evidence to support any structure for clinical placement delivery and yet, almost twenty years on, we still maintain the same training model. In 2006, Mannix et al. (2006) argued for the development of alternate, sustainable models of clinical education, with no subsequent change visible.

In all, there appears to be a distinct pedagogical gap in our knowledge around clinical placement structures within nursing curricula. Much of the existing evidence is dated and it seems that the topic has been too hard for educationalists and clinicians to address. Health care has changed rapidly over recent decades, including the nursing scope of practice, however we continue to fall back on providing clinical education in ad hoc ways based on the way it has always been done.

Employers regularly assess new graduates as not being work ready and often report that students lack problem solving ability (Missen et al., 2016). However, whether they have the opportunity to practise this during clinical placements is unclear, unless their clinical educators are focused on facilitating students' development of independent clinical reasoning skills. Too often, time limitations mean the focus is on just getting the necessary work done. Much of the student experience revolves around a routine of planned patient care, and without expert clinical facilitation, this can be performed with no exertion of higher-level cognition such as clinical reasoning, decision making, and problem solving by students. Furthermore, student engagement in emergency situations in practice is usually in an observer role unless they are first responders. It appears that there is an important place for simulation-based education as practice, in order to limit some of these known difficulties and deficits.

The notion of the non-work ready graduate may, therefore, be a construct of the lack of evidence underpinning the current system of clinical education. It may also be that the terminology being used is incorrect and we should be referring to the work-safe graduate. There is a need to revisit this.

Placement hours and modes

Many jurisdictions mandate minimum clinical placement hours that students are required to complete prior to graduation. These are widely variable depending on the country from 800 h in Australia to 2300 in the United Kingdom. Furthermore, in some countries, such as Singapore and Hong Kong, required hours are attributed to specific specialty areas (Table 1) whereas in others there is no such requirement. It has been suggested that these models have largely evolved from the historical apprenticeship education system, where training was provided in hospitals, and they continue to be driven by local factors (Levett-Jones et al., 2008-2009; McKenna et al., 2009). However, considering the global nature of the contemporary nursing workforce, this seems counterproductive. If registered nurses are moving between countries, the expectation would be that there is some similarity in the ways in which they are being prepared for practice. There is clearly a need for new evidence to inform curriculum policy makers and developers.

Clinical placements can be delivered in block mode or in integrated or continuous mode, whereby students return to the same placement for a few days each week. Anecdotally, block placements are more common because they suit health providers or curriculum models or placement planning rather than whether they are the most educationally robust mode. Placement structure has been allowed to evolve, often without sound rationale, with clinical education exposures being pragmatic rather than pedagogically-based. There is little available evidence around such placement modes, and much of what is available is dated

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Table 1
Mandated clinical hours in sample countries.

Country	Total minimum hours	Specific details, if any	Source guidelines
Australia	800	No specific requirements, but does not include simulation	Australian Nursing and Midwifery Accreditation Council (2012) Registered Nurse Accreditation Standards 2012 https://www.anmac.org.au/sites/default/files/documents/ANMAC_RN_Accreditation_Standards_2012.pdf
Hong Kong	1400	Medical surgical - 440 h Surgical nursing - 330 h Paediatric and adolescent nursing - 60 h Obstetric nursing - 60 h Gerontological nursing - 60 h Mental health nursing - 60 h Community nursing - 60 h Primary Health Care - 60 h Accident and Emergency Nursing - 60 h Any clinical area(s) in any of above - 210 h	Nursing Council of Hong Kong (2017) Handbook for Accreditation of Training Institutions for Pre-Enrolment/Pre-Registration Nursing Education. https://www.nchk.org.hk/filemanager/en/pdf/Accreditation_Handbook.pdf
Singapore	1280	General Medical (Acute or Community Hospitals with minimum of 4 weeks in acute hospital) – 240 h Elder care/Intermediate and long term care (Community Hospitals, Nursing Homes, Elder Care Centres) – 80 h Paediatrics – 80 h Community health (Primary care, school health, community health care/ rehabilitation centres, home nursing & eldercare centres) – 80 h Mental health (Institute of Mental Health) – 40 h Obstetrics and gynaecology – 80 h Emergency – 40 h General surgical (Operating theatre, surgical, orthopaedics & day surgical wards) – 280 h Consolidated clinical practice (medical-surgical) – 320 h	Singapore Nursing Board (2018) Guidelines for Curriculum Accreditation/*Re*-Accreditation of Pre-Registration Nursing Programs http://www.healthprofessionals.gov.sg/docs/librariesprovider4/guidelines/guidelines-for-curriculum-accreditation-of-pre-registration-programme.pdf
New Zealand	1100 -1500	The clinical experiences occur in a range of settings with health consumers across the lifespan a An extended clinical experience of 360 h minimum is included in the final semester of the programme t. Simulation hours cannot be included in clinical experience hours	Nursing Council of New Zealand (2019) Education programme standards for the registered nurse scope of practice. https://www.nursingcouncil.org.nz/Public/Education/Approving_and_monitoring_programmes/NCNZ/Education-section/Approving_and_monitoring_programmes.aspx?hkey=262d7d05-8ac5-428a-9209-68cd0275edd2
South Africa	1830	Can be work-based, clinical skills laboratory or other clinical experiences	South African Nursing Council http://www.sanc.co.za/pdf/Qualifications/bachelor's%20degree%20in%20nursing%20and%20midwifery%202014-07-23.pdf (Course is nursing/midwifery double degree)
United Kingdom	2300	None	Nursing and Midwifery Council (2018) Realising professionalism: Standards for education and training Part 3: Standards for pre-registration nursing programmes https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/programme-standards-nursing.pdf

(Adams, 2002; Levett-Jones et al., 2008-2009) or only focused on student experience (Birks et al., 2017; McKenna et al., 2009; Rohatinsky et al., 2017). Similarly, there is little evidence to inform education providers about what is best practice. We need to revisit expectations of learning outcomes when sending students into the clinical workplace and understand exactly what clinical learning experiences students need in order that we can reliably generate and predict these learning outcomes.

Thus, little is known about the optimal clinical learning environment and how exposure is best structured to achieve competence as a registered nurse. There is a need for large-scale robust research into best practice clinical education modes for developing the clinical competence required of nurses on graduation. Furthermore, it appears that there is a need for development of sound underpinning pedagogy, and serious consideration of the place of simulation in addressing some of the deficits in graduate preparation. If we are committed to producing high quality, work-ready (work-safe) graduates through sustainable education processes, we need evidence to direct us to the most educationally sound clinical education approaches. We need to work with health providers and policy makers to implement cost-effective, best-practice clinical education. Currently, it appears there is inadequate evidence to support existing clinical placement strategies, which suggests that we are largely just leaving appropriate clinical education 'all to chance'.

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