CLINICAL TRAINING PLACEMENTS
ANALYSIS OF RESPONSES TO AHWOC

Introduction

Clinical education can be described as the component of health practitioner education that allows students to put theoretical knowledge into practice within the patient/client care environment[1].

This paper provides a map of clinical education issues, based on a survey of stakeholders undertaken in late 2004 - early 2005. It includes issues and views regarding clinical placements as an information source and to inform any future work undertaken by AHMAC's workforce subcommittees in this area. The paper collates the views of those responding to the survey, and should not be taken to represent the views of AHWOC or other AHMAC workforce subcommittees.

A range of views

Clearly, stakeholders view the issue of clinical training placements from different perspectives. Health departments and health services may view this issue from a policy perspective, focussing on how to ensure adequate training, for the right number of health professionals to ensure a workforce is available with the right skills when and where they are required and how to sustain system capacity. Health providers, who provide the training, support and supervision, may have as a priority how to reconcile service delivery and provision of training. Universities could recognise clinical training as an integral component of an academic program that requires accreditation and is therefore critical to course sustainability.

The perspective of different stakeholders influences their responses, and explains why in some cases the range of comments in the following analysis may appear somewhat contradictory.

Reasons for the issue of clinical training placements becoming a high priority for universities, health departments and health services are multifactorial, and include:

- Growth in the number of university places for health professionals has increased the requirement for clinical training places,
- This increase in university places has not necessarily been accompanied by planning for clinical placements or an increase in supervisor numbers,
- Clinical staff may be under pressure to meet higher workloads, at the same time as being asked to mentor and support students,
- Additional clinical training places are being sought for postgraduate clinical entry programs, overseas qualified pre-registration requirements for registrable professional groups and other health science courses, re-entry, refresher and certificate courses,
- Models of service delivery have changed, with length of stay and bed numbers decreasing and patient acuity increasing, particularly in teaching hospitals.

Approach

In September 2004, 63 stakeholders (Health Departments, universities; medical, allied health and nursing colleges; and training organisations) were invited to provide information in relation to clinical training placements.

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[1] Clare J. et al, *Evaluating Clinical Learning Environments – Practice Partnerships and Benchmarks for Nursing*, March 2003 , p. xiii.

Information was sought on the following:

- Work being undertaken by the organisation or Health Department to quantify the need for and/or shortage of clinical placements and the result of that work,
- Workforce groups, or specific disciplines where access to clinical placements is an issue (or is becoming an issue), and
- Developments in clinical education and/or innovative approaches to clinical placements being adopted.

Results

As at 14 January 2005, 41 responses (or 65%) were received from a possible 63 respondents. Responses primarily related to current difficulties and strategies adopted to address nursing placement issues, although responses from Health Departments did cover allied health and Deans addressed medical workforce issues. There were 31 responses from universities, 8 from Health Departments and 2 from professional associations.

The survey responses indicated where work was underway to address issues of clinical training placements. A number of institutions and jurisdictions have indicated that formal evaluation and restructuring of clinical training is underway to address growing shortfalls in clinical training placements. These vary in scope from mapping of existing clinical training capacity, education requirements for clinical training or issues identification, to radical review of clinical placement models.

The extent to which the issues identified by respondents are also shared with non-respondents is not clear.

Shortages identified by respondents:

Respondents varied in their view of the areas and extent of clinical placement shortages. Some noted there had been difficulties accessing clinical placements for several years, while others stated that only recently had access become an issue. All respondents indicated that the problem was increasing.

Specific access limitations were identified by universities and some jurisdictions in nursing clinical placements for:

- Nurses in specialty areas, such as midwifery, sexual health, mental health, psychiatric nursing, high dependency, paediatric and community health, drug and alcohol, maternal and infant care,
- First year students,
- Rural and remote places in mental health and psychiatric nursing, high dependency and acute nursing care,
- Undergraduate international students and migrant bridging students,
- Postgraduate international students places in critical, emergency and coronary care nursing,
- District and post acute care nursing.

Two jurisdictions indicated student graduations were delayed to allow students to complete clinical placements. One jurisdiction indicated that disciplines where delays occurred included physiotherapy, podiatry, dietetics and clinical nutrition, pharmacy and speech pathology.

Subspecialty clinical training placement shortages were also reported in:

Occupational Therapy – mental health
Dietetics – acute inpatient clinical nutrition
Speech pathology – paediatric dysphagia, acute adult neurological rehabilitation
Physiotherapy – respiratory, amputee

Respondents noted the health system's capacity to offer a professional development year was being increasingly challenged, with greater numbers seeking placement, particularly for pharmacy, radiography and radiation therapy.

Issues identified by respondents:

Each section commences with a description of the number of responses in that category, followed by a description of the comments received. The comments may have been included in one, or a number of the responses.

General, including access

Twenty respondents, - 15 universities and 5 Health Departments provided general comments.

- Many comments related to access, with 14 Universities and 4 Health Departments indicating difficulty or extreme difficulty accessing clinical training places, compared with one university and one Health Department that reported no current difficulty.
- A number of other comments related to increased pressure on clinical placements, including:
  - The increase in university places for health professionals has increased pressure on placements and has not necessarily been accompanied by planning for clinical placements or increases in supervisor numbers.
  - Changes in the nature of service delivery, such as the reduction in bed numbers, reduced length of stay are impacting on clinical placement type, access and number.
  - Interstate universities are accessing clinical places in some health services, increasing an already high level of competition for places.
  - Additional pressure is being placed on access due to postgraduate clinical entry programs and overseas qualified pre-registration requirements for registrable professional groups eg pharmacy, physiotherapy, podiatry and psychology. In addition, students from other health science courses, re-entry, refresher, certificate courses and interstate work experience reduce the places available for undergraduate students.
  - Clinical staff under pressure to deliver services are asked to mentor and support students in addition to their normal duties. Some universities reported that clinical staff perceived students as additional work rather than a teaching opportunity.
  - The falling birth rate and reduction in the number of midwives is limiting access to midwifery student training places.
- A number of universities indicated that ongoing shortages in clinical placements would limit the number of university places being offered by that university. This is an issue for Health Departments looking to expand the number and rate of training of health professionals.
- The security of students on night duty is an issue where there is inadequate or no public transport.
- Student registration and insurance cover for students is an issue for some placements, such as community placements.
- Some responses perceived that the current model of short, varied placements does not facilitate the development of a sense of belonging by students or a sense of responsibility for the student by placements.

Accommodation and infrastructure

- Three universities and three Health Departments identified accommodation as a clinical training issue. Issues raised included:
  - Inappropriate or poorly coordinated access to accommodation.
  - Billeting or hospital accommodation is not a sustainable option for clinical placements.
  - Universities report limited funding is available to support accommodation and clinical placements.
  - Limited access to accommodation in general and concerns that preference is given to medical students.
  - Inadequate teaching facilities eg no available room for students to sit between patients, hold tutorials or write up notes.

Supervisors

- Seven respondents raised the issue of supervision and /or supervisors – five universities and two Health Departments.
- Two universities and two Health Departments reported a reduction in the clinicians that are trained and/or willing to provide supervision
- The importance of the skills base or teaching experience of the supervisors and learning outcomes was noted.
- Differing perceptions between universities and service providers about the purpose of clinical education and in some cases an increasing reluctance of supervisors to participate was raised
- Some universities report that clinical staff employed on a sessional basis may not consider themselves to be part of the university culture.
- Universities are often perceived to be seeking an ongoing commitment to learning and development from clinical staff.
- There may be differing clinical placement models and varied expectations of the supervising health professional from their employing institution and the university
- The availability of clinical places is affected by other teaching roles clinicians take on eg in-service for ambulance staff, school experience students, and enrolled nurses.
- The high service delivery workload can result in a focus on task rather than teaching by clinical supervisors.
- Considerable variation exists in the training and assessment requirements for clinical experience between universities, requiring supervisors to be conversant with a number of different systems.

Administration

Eight respondents raised administration issues, six universities and two Health Departments.

Responses included:

- The capacity to improve the administration, consistency and coordination of clinical placement arrangements to prevent issues such as double booking.
- The importance of positive relationships between clinical and academic educators to good outcomes for students.
- The potential for better alignment between university and Health Department communication and planning processes eg in some cases, forward booking of places must be completed before student numbers are known or confirmed.
- Differences in the formal documentation of clinical placement arrangements eg some

universities are seeking comprehensive legal service contracts where previously simple service agreements existed, which is an additional time and resource requirement.

- The different levels at which decisions may be made to participate in clinical placements. For example, while Health authorities and health services may be committed to clinical training, decisions to participate in clinical training are often taken at ward or individual practitioner level in public facilities. Factors in deciding to take no or a limited number of students include: staff shortages, skill mix, casualisation of the workforce, acuity of patients, stresses and pressure on nursing staff who will provide training / supervision.

Timing

- Three universities raised timing issues.
- Timing of placements results in increasing competition for places (ie during semester) within and between professional groups.
- Weekly placement of students fluctuates, with peaks and troughs.
- Peaks often coincide with graduate intakes and staff change over periods in facilities.

Cost of Clinical Training

- Seven respondents raised the issue of cost, six were universities, one a Health Department.
- Universities report the costs of clinical placements and supervision are escalating and are likely to be difficult for universities to sustain.
- Costs include fee or subsidy to health services for clinical training.

Rural Training Placements

- Thirteen respondents raised the issue of rural training placements, seven universities and six Health Departments.
- Small rural and regional facilities with staff shortages, either lack preceptors or the additional workload of preceptors prevents them from taking additional undergraduate students.
- Rural and regional health services report increasing pressure on placements in rural and regional centres.
- In rural and regional areas there may be an inability of many service areas to accommodate the specified staff/student ratio for clinical education.
- The growing need to travel to placements in rural and remote locations is resulting in an additional time and cost burden on students that may already be facing high education fees.
- Access to specialty placements is more limited in rural areas eg psychiatric nursing, high dependency training.

Strategies identified by respondents:

Partnerships

Nine respondents (six universities and three Health Departments) recommended the establishment of clinical education partnerships. The partnerships varied considerably and may include:

- Ward staff

- Health service– public and private, aged care
- Universities operating across the same geographical regions
- TAFE – providing health related courses and seeking clinical placements in the same geographical regions
- State / Territory Health Department
- Industry partners.

Respondents described these generally as formal arrangements, aimed at:

- Coordinating timing and understanding of the requirements of each institution
- Negotiating agreements for provision of clinical education and funding of agreements between academic institutions and service providers.
- Addressing governance issues related to the roles, responsibilities and accountabilities for clinical training placements.
- Developing clinical plans in collaboration with hospital educators.
- Bringing together state clinical coordinators to share clinical plans.
- Establishing relationships and maintaining close contact for example with ward staff providing supervision.
- Mapping current clinical placements for students, identifying possible additional places and determining the gap between demand and supply.
- Allowing coordination of clinical placements in a student's local area for students undertaking distance education.
- Increasing university community profile.
- Increasing flexibility and allowing for the piloting of new clinical placement models.
- Through relationships, developing recruitment strategies for health professionals.
- Considering the shortcomings of the current clinical placement model to meet increasing demand and alternatives.

Innovative Approaches to Clinical Placement

Most respondents provided some explanation of their approach to clinical placements. A wide range of strategies has been adopted (or are planned) to address the growing shortfall in clinical places. These include:

University based initiatives:

Clinical Placement Structure

- Curriculum with extended academic year, so clinical placements are not restricted to university semesters, including summer school options.
- Arrangements to withhold university results to allow clinical placements to be completed over longer periods.
- Staggering of clinical placements in order to place all students.
- Limiting or removing the need for clinical placement in year one of courses.
- Reality based nursing clinical placements, with students being rostered shifts as members of the nursing team.
- Clinical placements of sufficient duration for students to become useful and valued members of the health care team.
- Early, frequent and substantial clinical exposure to ensure graduates are aware of demands of the profession, allowing a smooth transition into practice and a reduction in the attrition rate after the first year of practice.
- Various clinical placement types operating at once ie block release – a number of

weeks at a time, day release – one or more days per week over a semester, shared placements - 5 day fortnight with one placement shared between 2 or more students, preceptor model – student practicing 1:1 alongside a preceptor or clinical nurse, student fellowship placement – training across a network of sites.

- Use of training networks where students rotate around a number of facilities, including regional centres as part of their placement.
- Students undertaking all clinical education in one institution to reduce the need for orientation at the commencement of each clinical block.
- A practice-focused curriculum with an emphasis on students developing excellence in core clinical skills.
- Integration of theoretical and clinical components of the program to ensure effective preparation of students for their clinical placements.
- Development of university run and staffed clinical units for professional disciplines operating within the University eg particularly for health groups that offer rehabilitation services such as for audiology, occupational therapy, physiotherapy, speech pathology.

Funding

- Negotiation with industry for remuneration for students during their clinical placements so extended clinical placements could be sustained.
- Payment of a nominal fee to facilities taking students particularly in the private sector or difficult to access specialty areas eg midwifery.
- Universities becoming a self insurer for medical and other students particularly in community settings.

Supervision

- Planning for effective clinical supervision of students with a clinical lecturer student ratio of 1:5 in years 1 and 2 and 1:10 in year 3.
- Establishing clear criteria for the employment of clinical lecturers to supervise students.
- 'Student Initiated Practicum Placement' offered to students in distance education programs to allow placement in their local area and reduce their personal and financial costs.
- Academic appointment of clinical practitioners and access to a range of benefits eg university email account and website access, IT support, training, library access and research opportunities and support, membership of clubs and societies.
- Including clinical supervisors in University professional development, email circulation and consultative and advisory group activities.

Alternative Training Sites

- Expanding the use of non traditional training placements, including outpatients, dialysis units, emergency, coronary and intensive care, operating theatre, dental hospital, day surgery, medical centres, community health agencies, prisons and schools.
- Private hospitals are increasingly being seen as potential training grounds for students.
- Developing semester practical training as part of a multidisciplinary based team to undertake a community assessment in a rural location.

Infrastructure and systems

- Use of a computerised data management system for clinical placements, which is integrated with other university system such as enrolment and timetabling. This

allows the placement grid to be viewed via a web site, with clinical venues invited to update relevant information annually or as omissions are identified.

- Piloting a database model that allows the hospital to identify patients who are willing to participate in teaching and assessment as an outpatient or following discharge from an acute ward.

Relationship building

- Establishing 'Clinical Development Units' to build closer relationships in those institutions that have a primary relationship with one training institution.
- Working with agencies to plan one year in advance, in particular with clinical coordinators to develop and share information in clinical plans

Health Department based initiatives:

- Providing clinical placements for professional groups for which there are no courses operating in that state. For example, Tasmania offers places in orthotics and prosthetics, podiatry, physiotherapy, speech pathology.
- Establishing clinical schools in rural areas to support and coordinate clinical training in those areas.
- Identified funding to develop and implement a placement scheme to build a workforce entry link between the tertiary education sector, non government organisations and health services.
- Funding chairs of health professional disciplines, particularly in rural areas that have responsibility for coordination of clinical training.

Alternatives to Clinical Training

Four respondents identified alternatives to clinical training in a health care environment– two universities and two Health Departments. These include:

- Simulated practical sessions that incorporate planning, facilitation, role play, student feedback and evaluation of management of patients.

  Victoria is undertaking a clinical skills education requirement study to identify core clinical skills requirements, the contribution to be make by simulation based education, availability of existing simulated education and the optimum level of access to this skills development.

  The high cost of equipment has to date limited the widespread use of simulation laboratories.

- Expanded use of telehealth as a mechanism for providing education and teaching.
- Overseas placements eg some students are undertaking primary health care and midwifery placements in Thailand and other Asian countries.

Funding for Clinical Training

Nine respondents raised the issue of funding and three respondents indicated that they are now required or provide payment to health services as an incentive to accept students on clinical placement.

- Commencing in 2005, Queensland Health is charging universities $39.51 per student in a preceptor relationship where there is an assessment component. This is currently the arrangement for all nursing students.

  Some Universities have expressed concern about the rising cost of nursing and the

potential flow on effects should other institutions start charging fees to access clinical or work based placements. The response of universities to the imposition of this fee has been to review the nursing course, and instead of blocks of clinical, students will attend clinical two days per week for the term.

The implications of this arrangement are that universities and certain organisations may become linked via a payment and income stream, which could potentially result in a reduction in the breadth of placement types but an increase in the depth of training in any one location.

- In some NSW centres, universities are meeting the salary and on costs of clinical staff providing supervision.
- Victoria and a number of other states are funding rural placement support and academic chairs to ensure high quality (allied) health placements in rural areas.
- NSW has provided funding to establish a training course, clinical placement coordinator and clinical tutors in radiation oncology medical physicists.
- Some states have indicated they have funded infrastructure, such as accommodation and teaching facilities in rural areas to facilitate the placement of students.
- Queensland Health has an agreement entitled the *Professional and Technical Stream Employees and Dental Officers (Queensland Health) Certified Agreement 2005 which is out for ballot and includes*
    - A payment of $50 per week whilst supervising students will be paid to appropriately trained staff who meets specified criteria.
    - allocate funding of $75 per student per placement week to departments within Queensland Health facilities for undergraduate and graduate entry university students.

Support for Supervisors

It was recognised that specific strategies were required to support supervisors. Those referred to in responses included:

- Training and accreditation of preceptors providing clinical supervision.
- Workshops of clinical educators to ensure consistency of clinical experience funded by universities.
- Access to teaching programs run by university for clinical supervisors to expand their teaching skills.
- Assistance via the university for clinical supervisors to complete formal qualifications.
- Transition programs to adapt to the university environment, clinical programs.
- Continuing professional development workshops offered by the academic staff developed for supervisors.
- Appointment of clinical lecturers to academic positions.
- Queensland has introduced a state wide training program for nursing preceptors.

Changes in Assessment

Some responses indicated that the clinical learning model, which emphasises assessment of total performance, is evolving through initiatives such as:

- Formative assessment – formal weekly assessment of performance.
- Core clinical skills assessment – assessment of core competencies.
- Student self assessment of competency through reflective practice.

- Final semester assessment – university funded competency assessors.
- Clinical Liaison nurses.
- Mentor program – university funded support program for Registered Nurses that will provide mentoring to students.
- Secondment of Clinical Staff – to provide on and off campus clinical teaching.

Suggestions made by respondents:

- Better planning and coordination, including multidisciplinary coordination of placements and accommodation; and early identification of placements to allow for course development and guarantee student intakes.
- Recognition by all stakeholders that the **need for** and **shortage of** clinical placements are separate issues and need to be addressed in that way.
- Collaboration between State and Commonwealth health and education sectors is required.
- Mechanisms need to be identified to facilitate the establishment of effective clinical education partnerships.
- Review of clinical training placements, that includes consideration of need for placement of students early in their course, length of clinical blocks or placements, clear learning objectives for students and supervisors and alternatives to clinical training.

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