# Clinical Practice Education Survey 2003

## CASN Task Force on Clinical/Practice Education

## Abstract

This report is a summary of the findings of a 2003 descriptive survey of CASN member schools of nursing. The purpose of this survey was to seek information to assess the status of undergraduate practice education across the country and to determine current practice, innovative models, and identify challenges confronting nurse educators and their students and practice partners.

While we found individual differences in nursing programs, several patterns emerged. In general, students' practice experiences progress from simple to complex, from wellness to illness, from chronic to acute, and from community to acute care to specialty settings. In most programs, the level of supervision moves from instructor-led groups to increasing student independence in preceptored experiences. Schools of nursing are responding to changes in demographics and health care delivery systems by facilitating practice experiences in a wide variety of non-traditional settings.

The responsibility of educating increasing numbers of students presents major challenges to nursing education. Some of these include ensuring sufficient, qualified educators and preceptors, expanding the opportunities for appropriate practice experiences, and securing sufficient funding and infrastructure support. Schools of nursing are creatively responding to these challenges, as reflected in this report.

The survey results and work of the Task Force will contribute to the development of a CASN position paper and national strategy for clinical/practice education.

## Introduction

Current pressures in the Canadian health care context have a significant impact on the provision of sufficient and meaningful clinical/practice education for nursing students. In view of the fundamental importance of clinical experience in nursing education, CASN Council established a Task Force on Clinical/Practice Education to explore challenges and innovative strategies relevant to practice education in Canada, and to assist in the development of national guidelines for practice education. There is some anecdotal information from education programs reflecting how they are working with health care authorities and agencies to adapt models of practice education as they strive to balance the competing demands of educating higher numbers of student nurses within environments where placement opportunities are becoming increasingly scarce.

In an attempt to capture this information in a more formal way, the CASN Task Force reviewed relevant literature on models of practice education and surveyed all member schools for information regarding the current status of undergraduate clinical practice education across Canada in May and June of 2003. For the purpose of the survey, clinical experience was defined broadly as any teaching/learning that occurs outside the physical environment of the school classrooms and clinical labs.

The report of the survey findings is intended as an internal document to inform CASN Council, although some of the content may eventually be incorporated into a more widely distributed CASN position paper and national strategy for clinical/practice education in nursing.

## Review of the Literature: Models of Clinical Practice/Education

A selected review of the literature to identify models of clinical practice education was undertaken. The review was limited to current models used in North America and Australia. It is based on a review of clinical practice education undertaken by the Faculty of Nursing at UNB. It does not include co-op programs or internships. Their respective strengths and limitations were noted, as well as the challenges, especially related to meeting student learning needs and the human and financial resources of clinical agencies and education institutions.

Five different types of clinical practice models have been identified based on who is responsible for supervision. They are:

a) direct faculty-supervised model,

b) preceptorship model,

c) clinical teaching associate model,

d) dedicated education unit model, and

e) collaborative learning unit model.

Reference is also made to two other specific models, one of which uses strategies other than direct supervision. They are the "dual assignment" model and the University of Texas "work-study scholarship" program.

Direct Faculty Supervised Model

The traditional "faculty-supervised" model is one in which a faculty member employed by the educational institution is assigned a group of eight-to-ten students in a clinical area in which he or she has current practice expertise. Student placements usually occur in health care institutions although the model can be applied to a variety of other settings, such as community agencies. The faculty member provides direct supervision of

the students for all the time the students are in the clinical area or agency and is responsible for the teaching/learning process, for patient assignment, and for student evaluation. He/she acts as facilitator, coach, role model, and evaluator.

The model allows the faculty member to work directly with students to ensure they develop the required competencies. It assumes faculty with the required practice expertise are available and that their presence on the unit makes them readily available and accessible to the students. Teacher accessibility, however, is becoming a considerable challenge, particularly in acute care areas. The increase in patient acuity levels and the quick patient turnover necessitate more attention and demands on nursing time and require diligence by the faculty supervisor, limiting his/her ability to spend time with students.

Issues have been raised as to the extent to which the model prepares students for the realities of clinical work. Faculty, given their responsibilities to the education institution, may not be as current in practice expertise as clinicians in a rapidly changing health care environment (Nehls, Rather, & Guyette, 1997). The model also limits opportunities the students have to practice nursing, given that the faculty supervisor cannot safely supervise the care of too many patients (Beeman, 2001) and be accountable for their care.

The model is also a work-intensive one from the education institution perspective and costly from both a human and financial perspective. Attempts have been made to address these issues through the use of joint appointments or clinical nurse secondments. Joint appointments are usually offered to clinical nurse specialists who then have responsibility to two employers, the education institution and the practice agency, and provide clinical teaching services to the education institution. Nurse secondment refers to

situations where nurses employed by the clinical agency are seconded to the education institution specifically to provide clinical teaching services (Edmond, 2001).

Where joint appointments or clinical nurse secondments are in effect, the nurse clinician assumes the role of a faculty member when supervising students in the practice environment. Generally, they are current in their clinical practice, well-accepted by their peers, and perceived as credible teachers. These factors reflect positively on the students (Edmond, 2001) and the clinician/teacher is seen to be in a better position than a faculty member to immerse students in the practice world. However, the fact remains that these individuals, in their capacity as teachers, essentially use a faculty-supervised model that maintains the status quo and does not offer solutions to the other issues mentioned above.

Preceptorship Model

The preceptorship model requires an experienced nurse clinician to work on a one-on-one basis in the practice agency with a senior student. The student's schedule and work/practice assignments mirror that of the nurse clinician. The model was developed in the '60s (Beattie, 1998) to provide a vehicle to assist students in their transition from the educational environment to that of a practising nurse, thus emphasizing the socialization process to the professional nursing role in the work environment (Robinson, McInervey, Sherring, and Matlow, 1999). It quickly became very popular as a teaching/ learning strategy and was embraced unequivocally by faculty, particularly for the final clinical course to satisfy graduation requirements. In recent years, the preceptorship model has been adopted by education institutions to facilitate lower-level students' (first- and second-year students') learning practice in acute-care environments (Beeman, 2001; Nordgren, Richardson, & Laurella, 1998).

The assumption is that placing lower-level students in clinical practice areas with expert clinicians will provide them with a quality learning experience, but there is little direct information to support this. There is a potential human resource challenge in the demands placed on the nurse clinician to work with too many levels of students. The possibility of preceptor "burnout" and the reluctance of nurse clinicians to offer their services for such assignments have been raised as issues.

The preceptorship model has been widely scrutinized and sufficient evidence exists to support its effectiveness in facilitating the transition from the student role to one of beginning practitioner (Ferguson, 1996). However, issues have been identified that can affect the success of a program. These are:

a) recruitment and orientation of preceptors with requisite clinical and teaching skills (Kaviani & Stillwell, 2000),

b) ensuring a good match between preceptor teaching and communication style and student learning style (Myrick & Yonge, 2005), and

c) provision of support to preceptors, particularly when a student's progress is less than satisfactory (Hrobsky & Kersbergen, 2002, Kaviani & Stillwell, 2000).

From a fiscal perspective, preceptorships have been found to be cost-effective, particularly for educational institutions.

Clinical Teaching Associate Model

The Clinical Teaching Associate (CTA) model was developed in 1987 by Philips and Kaempfer for use in hospital settings. It is based on the concepts of reciprocity and collaboration wherein staff nurses employed by the agency are directly involved in clinical instruction and faculty, who serve as 'lead teachers' (LT), provide in-kind service

to the agency by engaging in staff education and promoting research activities within the agency (Phillips & Kaempfer). The nurse "associate" closely supervises three-to-four students. Each student is assigned oneortwo patients and the total of the students' assignments constitutes the patient load for the associate.

The responsibilities of the faculty as "lead teachers" include a liaison role between institutions and nursing schools and a mentoring role for the associate. They are also directly involved in student learning in facilitating the application of knowledge to practice, monitoring student progress, and taking responsibility for the final evaluation of the student's clinical performance (DeVoogd & Salbenblatt, 1989; Phillips & Kaempfer,1987).

The Clinical Teaching Associate model was modified by Melander and Roberts to deliver upper level clinical nursing courses (Melander & Roberts, 1994). In their model, the roles and responsibilities of the student, the associate, and faculty lead teacher are similar but only one student is assigned to the associate. A major difference from the CTA model is that the patient assigned to the single student is selected from the associate's existing patient load rather than assigning several students to take over the associate's full patient load. This results in an increase in the number of associates required to deliver the clinical practice courses. The faculty lead teacher is also more actively involved in student learning through frequent visits to the unit and participation in selected learning activities such as conferences and nursing rounds (Melander & Roberts). As well, the lead teacher is available to provide ongoing support and assist in problem-solving.

It can be argued that the CTA model, as adopted by Melander and Roberts (1994), and the preceptorship model shares the same characteristics. However, on close

examination, two key aspects differentiate them. In the CTA model, the focus is on applying knowledge, developing clinical judgement and decision-making skills, as well as acquiring technical skills, rather than socialization into practice contexts (Melander & Roberts). The other aspect involves the level of faculty's participation — more direct and interactive in the CTA model than in the preceptor model (Melander & Roberts).

Two major benefits of this model are the increased availability to the student of a teacher (a CTA) who is clinically competent and well-acquainted with the clinical environment and increased opportunities for the lead teacher to influence practice through networking with expert clinicians, involvement in collaborative research, and pooling of resources for the benefit of all (Phillips & Kaempfer, 1987; DeVoogd & Salbenblatt, 1989; & Melander & Roberts, 1994). The model can also serve as a vehicle to strengthen the practice-education link. The challenges encountered have been rewarding for the associates and appropriately scheduling clinical times around the CTA work schedule.

Elements of the direct faculty-supervised model and the preceptorship model were combined by Grealish and Carroll (1998) to create a collaborative model, similar to the CTA model, for clinical practice placements of final-year undergraduate students in an Australian setting (Grealish & Carroll, 1998). In this model, the clinical teaching is shared among nurse clinicians, faculty supervisors and a program convener, with the staff nurses assuming the overall responsibility for supervising student care, fostering learning and monitoring progress. A major change is in the role of the faculty, which shifted from both instruction and facilitation/supervision to that of facilitation only (Grealish & Carroll, 1998). This is consistent with the vision of faculty's role in clinical education, as expressed by Tanner (2002), to one of designer and facilitator of clinical learning

experiences rather than as "deliverers of content and supervisors of clinical education" (p.61).

In another Australian study, Jackson and Mannix (2001) reported using a model of clinical teaching wherein groups of eight-to-ten students are assigned to clinical agencies and work on various wards under the direct supervision of clinical nursing staff. University-appointed facilitators "go from ward to ward facilitating, supervising, and assessing students" (Jackson & Mannix, p.272). The specific roles and responsibilities of both clinical nurses and the university facilitators are not described. This model could represent cost savings for the educational institution, as the student/ facilitator ratio is slightly higher than in the traditional faculty-supervised model, while at the same time it can serve to alleviate the staffing crisis faced by many educational institutions. On the other hand, this model would require that university faculty have expertise in many areas of nursing in order to be effective in the facilitator role — a requirement that may be difficult to meet given the accelerated pace at which changes occur in the health care environment.

Dedicated Education Unit

The dedicated education unit (DEU) is a different approach to clinical teaching and learning used in Australia (Edgecombe, Wotton, Gonda, and Mason, 1999). Both education and patient care are essential functions of the dedicated education unit which has been developed to support the teaching/learning process and to emphasize the shared responsibility of practice and education in the development of nursing students. Clinical supervision is provided by those deemed to be the most credible to practice, nurse clinicians, with faculty's involvement (Edgecombe et al.). The recognition and combination of the respective expertise of both the nurse clinician and faculty together

with the unit philosophy create a practice culture favourable to learning and professional practice.

Clinical nurses serve as teachers and provide one-to-one guidance and supervision to the students while the faculty collaborate with both the clinical nurses and students to ensure clinical experiences are relevant to the competencies required in the course curriculum and to assist in the evaluation of student performance (Gonda, Wotton, Edgecombe, & Mason, 1999). Faculty facilitators also assist in the practice unit, working directly with students and discussing teaching/learning strategies with the clinical nurses. Students at various levels are placed on the dedicated education unit, starting with the senior students then following with junior students a few weeks later. This also allows for pairing of senior and junior students with the senior student becoming a peer teacher to the junior student.

An evaluation of the dedicated education unit was conducted by Gonda, Wotton, Edgecombe, & Mason (1999) and showed positive results. The transfer of knowledge was enhanced, collegial relationships developed with the clinical nursing staff, and the sense of partnership between the health care institutions and the university was strengthened. However, the time required for nurse clinicians to integrate their teaching roles into their roles as care providers was a challenge (Gonda et al, 1999).

Collaborative Learning Unit Model

The University of Victoria, in partnership with the Vancouver Island Health Authority, adapted the Australian dedicated education unit model to introduce a pilot collaborative learning (CL) unit model in the spring of 2003. Subsequently, the model was extended to additional units and now provides six- and twelve-week practica that accommodate a significant proportion of the senior students during a term.

(Preceptorships for the remainder of the class occur in other units.) All nurses on the collaborative learning unit share responsibility for partnering with and guiding the learning of the students assigned to the unit. Students identify their goals and negotiate their patient care assignments to address their individualized learning needs, working with the graduate nurses also assigned to those patients. The faculty member arranges time on the unit to guide learning activities, consult with staff and students, and evaluate student progress.

Changing from a preceptorship model of practice education to the collaborative learning unit benefits students, staff nurses, and faculty in different ways. Students enjoy the opportunity to learn from (and compare the practice of) various partner-nurses, and to assume more responsibility for planning their practice options and learning activities. Nurses enjoy sharing their responsibility for students among the staff and having additional contact with one instructor assigned to the unit. Faculty members spend less time traveling between placements and are establishing closer relationships with nursing practice partners. Next year, the University of Victoria will place third-year students on collaborative learning units and selected other nursing schools in BC are adopting the collaborative learning model.

Other models

The literature also includes references to other strategies for clinical education. Two of note are the “dual assignment” model and the “work-study scholarship” program. The dual assignment model was used by Fugate and Rebeschi (1992) for lower-level students in a pædiatric acute care setting. Two students were assigned to work together with one patient. Each student is responsible for different aspects of care on a rotating

basis. Students were supervised by a faculty member who used the traditional supervised teaching approach.

The model assumes that working in pairs can alleviate anxiety in the student and promote learning in situations where the complexity of patient and family care is high (Fugate & Rebeschi, 1992). Students can then use each other for support and pool their own resources as they provide care, apply knowledge and learn new skills.

Campbell, Larrivee, Field, Day, & Reutter (1994) have suggested that peer support is a major factor in facilitating student learning in the clinical environment. Working together also exposes students to the co-operative/collaborative role of nursing early in the program and creates opportunities for them to develop co-operative behaviours in a safe environment. Students can then see the relevance of acquiring these behaviours for their professional role. For this model to be successful, patient care responsibilities must be clearly delineated and communicated to both students and staff. As well, student pairing must take into account student learning style and characteristics. Essentially this model is a teacher-supervised one and does not offer a 'different way of doing business' other than decreasing the total number of patients assigned to students, which in turn alleviates the faculty's workload.

The University of Texas and its affiliated hospitals have developed a "work-study scholarship" program. Students can earn academic credits while employed by the hospitals in unlicensed capacities (Kee & Ryser, 2001). Students must work a minimum of 24 hours per month and also attend seminars in order to meet the requirements for granting credit. For each semester worked, students also receive a $500.00 scholarship (Kee & Ryser). The program is co-managed by co-ordinators who are faculty members and RN facilitators who are appointed by each participating hospital. Student

performance in the clinical setting is evaluated by unit managers, whereas their academic performance is appraised by faculty (Kee & Ryser). Student employment can be terminated by the agency if agency standards are not met. Likewise, faculty retain similar rights and can withdraw students from the program if experiencing academic difficulty (Kee & Ryser, 2001).

Although program evaluation is an integral part of the overall plan**,** final study outcomes have yet to be published. However, early evaluation findings showed that students performed well in both their clinical and academic studies and that they felt positive towards the program. Agencies used the program as a recruitment strategy and were successful in hiring and retaining 60 percent of the graduates. Finally, faculty capitalized on this opportunity to engage peers in scholarly activities and to introduce changes to the curriculum to make it more reality-based (Kee & Ryser).

The selected review of the literature has shown that several models of clinical practice education have been adopted. In attempts to balance the needs to provide quality clinical practice learning experiences to students with the resource limitations, there has been a move from the traditional faculty-supervised model driven by faculty. The models reviewed have nurse clinicians more actively involved in providing and directing the student clinical practical experience. The expertise of nurse clinicians is directly recognized and valued by the nurse educators, allowing for the development of close collaboration and effective partnerships between the clinical agency and the education institution.

## Methodology

One of the proposed activities as specified in the terms of reference for the Task Force was to develop a paper identifying issues and barriers and innovative approaches to

clinical education in nursing. Recognizing a lack of recent Canadian data in the published literature, the Task Force undertook a survey of member schools of CASN during the summer, 2003. A subcommittee of three members of the Task Force drafted the questions, presenting them for discussion and revision during the Task Force teleconference, May 13, 2003. The revised questionnaire was emailed to the Chair of the CASN Education Committee and CASN national office for feedback. After final revisions, the questionnaire (Appendix E) was distributed by email to the 88 member schools of nursing, by CASN national office on May 28.

Nineteen schools responded by the due date of June 16 and a reminder was sent on June 20. Overall 39 surveys were completed (response rate: 44 percent) and the data entered into an Excel database by national office staff.

Plans for analysis were made during a teleconference meeting on August 20, 2003. Quantitative data from question one was to be summarized and the qualitative data from questions two through eleven would be analyzed thematically and by constructing tables where appropriate. The data were divided by question into four subsets; two members of the Task Force were assigned to complete the initial analysis of each data subset and distribute their analysis to the other Task Force members for discussion at the October 1 teleconference. A meeting of five members of the Task Force was held in Winnipeg, on October 24 and 25, 2003, to continue and refine the thematic analysis and begin to draft the report. Final review and revision of the report was completed at a meeting of the Task Force in Ottawa, April 26 and 27, 2004, funded by the Office of Nursing Policy.

There are limitations to this descriptive survey. Some of the questions included in the survey were non-specific and open to interpretation; other questions were too

restrictive, limiting the breadth and depth of information obtained. Some responses were difficult to interpret. The main reasons for this difficulty related to lack of clarity and duplication of answers from collaborative program partners. Also, even with a response rate of 44 percent, it cannot be assumed that we have an exhaustive list of issues, barriers and innovations. Notwithstanding the limitations of the survey, several recurring themes emerged from the data, and provide the framework for this discussion.

## Key Findings

The key findings from the survey can be categorized into four major areas of clinical practice education, a) existing processes, b) issues associated with the delivery of clinical nursing education, c) strategies for addressing the barriers to practice education, and d) directions and opportunities.

### Existing Processes

CASN member schools were asked to describe the models of clinical education they are currently using, as well as to provide a brief description of the clinical experiences in each year of the program, including experiences being provided in specialty areas such as pediatrics, obstetrics, mental health, and community health. In addition, schools were asked to describe the types of faculty engaged in clinical teaching throughout the program. Specific questions were asked regarding preceptorship, in particular orientation, evaluation, recognition and professional development.

#### Models and Description of Clinical/Practice Nursing Education

Data regarding the models of practice education were collected for each of the four years of a baccalaureate program. Interpretation of the data was somewhat difficult for a number of reasons. The data may have been clearer if they had been reported for each term in a program, rather than for each year, because with two or three terms in a

year, more than one practice course and more than one model of practice education can occur within each year. As well, there appeared to be different interpretations of the terms "instructor" and "preceptor", with some schools using them interchangeably. In addition, in response to the question of instructor-to-student ratio, where the response indicated a very high ratio (1:40), we question whether or not the respondents were referring to the theory portion of the course, or a situation where a course co-ordinator has ultimate responsibility for all students in a section and there are a number of clinical instructors who share supervision of the students.

Year 1

Models. Almost all (97 percent) of the schools that offer Year 1 nursing courses described their model of practice education during first year as faculty-supervised, i.e., a faculty member accompanies a group of students in the practice setting. Preceptored clinical experiences are relatively rare in first year. One post-diploma baccalaureate program reported using only the preceptorship model for first-year students. Three other schools indicated that they use preceptorship in addition to the faculty-supervised model. However, there was no qualitative data describing the nature of the first-year preceptored experiences. From anecdotal information, it is possible to assume that these junior-level preceptored experiences are professional role modeling or observational experiences, rather than 'hands-on' practice opportunities. Four of the responding schools do not have Year 1 students, either because their collaborative partners offer the first year of the program or because students are accepted into nursing in their second year of university.

From the survey data, faculty student ratios in practice courses generally vary between 1:6 and 1:10, with the most commonly reported ratio being 1:8, and the highest 1:24. This ratio appears to vary according to the nature of the practice experience. For

example, in high acuity clinical areas, instructors may not be able to assume responsibility for as many students as would be possible when the placement setting is extended care. As well, in practice experiences that focus on health and wellness, or those that are strictly observational, a higher ratio of students per instructor was reported.

Description of clinical experience. For the most part, Canadian nursing students spend their first-year practice experiences in community settings or in long-term/extended care settings. There is variance as to whether these experiences begin in semester one or two and in how they are operationalized. For example, some schools combine theory classes with practice each week, whereas others have two weeks in the classroom followed by three weeks in the practice setting. Only one school appears to introduce students immediately in the first semester into the acute care setting — on medical wards in the first term, and surgery in the second. Although some schools place students in acute care during the second term, most students have their first acute medical or surgical experience at the end of the first year, while still others wait until second year. Nine programs reported having, at the end of first year, a consolidated practice experience of between 90 and 120 hours in acute or long-term care settings. Only one nursing program reported introducing students to a specialty area, maternal/child health, during the first year.

Year 2

Models. All respondent schools that have second-year students reported offering faculty-supervised clinical experiences in that year, with an instructor-to-student ratio of 1:8 predominantly, with the range being from 1:6 to 1:11. Three schools also reported offering preceptored experiences in Year 2, with one or more preceptors assigned to one student. Two of the three schools reporting the preceptorship model described the type of

clinical experience as a consolidated medical or surgical practicum of 144 to 244 hours. No other models were reported in Year 2.

Description of clinical experience. Wide variation in the specific type of practice experiences was evident in the Year 2 survey data. However, the majority of schools reported having an emphasis in second year on the learning and application of more complex skills in acute care medical and surgical settings, with patients experiencing episodic health challenges. Approximately half the schools indicated they also place students in specialty areas of nursing practice, in addition to medical and surgical settings. The specialty areas reported were primarily maternal-child and mental health, but also included pediatrics, community health, and rehabilitation. Again, there was a great deal of variance in the reported length of time in these areas, ranging from 84 to 196 hours. The practice experiences occurred from 6.5 hours to 12 hours in a day. Most schools reported offering one or two days of clinical experience per week in the first two terms of Year 2, and 11 schools described a consolidated practicum of at least 90 hours offered during intersession. Another type of practice experience, described by three schools, was of students independently engaged in health or family assessments in clients' homes, unaccompanied by an instructor.

Year 3

Models. The pattern of faculty-supervised clinical experiences continues in Year 3, with 84 percent (27/32) of schools reporting the predominant use of this model, while four schools indicated they offer only preceptored experiences in Year 3. One school does not have clinical experience in third year. As well, consistent with ratios reported for Years 1 and 2, at least half of the schools had instructor to student ratios of 1:8, with all reported ratios ranging from 1:5 to 1:16.

Twenty-two schools use the preceptorship model as well, with a wide variation in instructor to student ratio ranging from 1:3 to 1:40. One explanation of the variation could be that there are different levels of faculty involvement in preceptored experiences, depending on the course and program. In some cases, one faculty person is responsible for co-ordination of the course, with several teachers directly responsible for a smaller group of students.

Description of clinical experience. From the descriptions provided by the respondents, it is evident that the clinical focus in third year is on caring for increasingly complex patients in acute care. However, almost all schools also offer specialty experiences, predominantly in mental health and community/public health, with some providing pediatrics and maternal health experiences. Several schools reported practice courses in community development and prevention/health promotion, with students placed in appropriate community agencies. The preceptorship model becomes more prominent in third year, particularly for those schools with degree completion, and during consolidated experiences in intersession. In response to the question asking for a description of the clinical experiences offered, several schools also described a variety of employment opportunities offered by health service organizations for undergraduate student nurses. While there is wide variation in how these experiences are designed and implemented, there seems to be a growing trend for educational programs to recognize the educational value of these work experiences (for example, by having the work experience reflected on the student's transcript as a non-credit course with specified hours of clinical experience).

Year 4

Models. The predominant practice education model in Year 4 is preceptorship, with 100 percent (24) of respondent schools (with fourth-year clinical courses) indicating they use preceptors in the final year of the program. Not unexpectedly, there were fewer faculty-supervised clinical experiences reported in Year 4 as compared with the first three years, with only 75 percent (18 out of the 24) of schools using this model. Six programs use only the preceptorship model in fourth year, and have no faculty-supervised experiences.

For the faculty-supervised practica, instructor-to-student ratios ranged from 1: 5 to 1: 20, with approximately half being 1:9 or fewer. In the preceptored practica, the instructor-to-student ratio is more variable, from 1:3 up to 1:40, with a mode of 1:20. Presumably at this senior level, students are able to be more independent than earlier in the program.

Description of clinical experiences. The generally reported focus during the final year of the baccalaureate programs is on developing leadership skills, attaining competencies required of a newly graduated nurse, and preparing students for independent practice. Many schools try to incorporate some exposure to unique settings within acute care, such as emergency, ICU, CCU, palliative care, and recovery room. Some programs, having had a focus on acute care in the earlier years, offer prevention and community placements during the last year. There is a trend toward giving students the opportunity to choose the setting for their final practicum(s) according to their career aspirations, where possible. Final preceptorship experiences vary in length (120 to 450 hours over four to 16 weeks), with a significant number lasting ten weeks or more.

It is clear from the data that the traditional faculty supervised model is widely used across the country to deliver clinical education in the lower years of nursing programs. For the more advanced students, particularly those in their final term, the preceptorship model is favored.

In summary, it is striking that, with regard to practice education, so many different routes are followed to achieve a common goal. Nurse educators across the country are producing generalist nurses who can meet the national entry-level competencies, pass the registration examination, and practice in a variety of health care settings. While the sequence of practice experiences varies from program to program, all schools offer a broad range of practice experiences, mostly over four years, and, in general, seem to achieve quite similar outcomes.

Practice Experience in Specialty Areas

Respondents were asked to indicate whether students usually have practica in seven common specialty areas of practice, namely: pediatrics, obstetrics, mental health, community health, home care, public health, and palliative care. As depicted in Table 1A below, most schools built into their programs clinical learning activities in all of these areas except for home care and palliative care. Twenty schools offered home care as a required experience. The number of schools requiring an experience in palliative care is considerably lower (seven). However, students can request to have a practicum in those two areas should they so choose.

**Table 1A Practica in Selected Areas (Both Colleges & Universities)**

| | Paeds | Obs | Mental Health | Community Health | Home Care | Public Health | Palliative Care |
|---|---|---|---|---|---|---|---|
| N | 36 | 36 | 34 | 36 | 35 | 35 | 34 |
| Yes | 29 | 33 | 32 | 35 | 20 | 23 | 7 |
| No | 3 | 0 | 0 | 0 | 4 | 3 | 7 |
| If requested | 4 | 3 | 2 | 1 | 11 | 9 | 20 |

Data were grouped into two categories: colleges/institutes and universities/university colleges (see Tables 1 B & 1C). A cursory examination of the data breakdown showed the pattern of clinical placement was approximately the same for both groups. The two areas where there might be slight differences are in community health and palliative care. A more in-depth analysis of this data could prove to be a futile exercise given the small numbers of responses in each category.

**Table 1B Practica in Selected Areas by Colleges**

| | Paeds | Obs | Mental Health | Community Health | Home Care | Public Health | Palliative Care |
|---|---|---|---|---|---|---|---|
| N | 15 | 15 | 14 | 15 | 14 | 14 | 15 |
| Yes | 12 | 14 | 13 | 14 | 8 | 9 | 3 |
| No | 2 | 0 | 0 | 0 | 2 | 1 | 5 |
| If requested | 1 | 1 | 1 | 1 | 4 | 4 | 7 |

**Table 1C Practica in Selected Areas by Universities & University Colleges**

| | Paeds | Obs | Mental Health | Community Health | Home Care | Public Health | Palliative Care |
|---|---|---|---|---|---|---|---|
| N | 21 | 21 | 20 | 21 | 21 | 21 | 19 |
| Yes | 17 | 19 | 19 | 21 | 12 | 14 | 3 |
| No | 1 | 0 | 0 | 0 | 2 | 2 | 3 |
| If requested | 3 | 2 | 1 | 0 | 7 | 5 | 13 |

Other specialty areas that were reported include NICU, OR, ER, ICU, CCU, long-term care, rehabilitation, and geriatrics/gerontological care. Experiences in specialty areas occurred primarily during the preceptorship component of programs.

Types of Faculty Engaged in Clinical Teaching

Schools were asked to identify the types of faculty that are engaged in the teaching of the clinical practice component of each year of the program. Most university schools of nursing report that tenured or tenure-track faculty teach in every year of the program with the highest concentration in the third and fourth year. Collaborative partners and/or community colleges do not report tenure or tenure-track positions as such. In the latter instances, permanent and/or renewable full and part-time contracts are common among faculty types cited. Other types listed from both universities and colleges include clinical instructors, clinical associates[1], or faculty assistants working in full-time, limited term, permanent and/or temporary part-time sessional or casual positions. Schools report that staff members may also be seconded from health care institutions for yearly,

[1] Clinical associate: Some universities have two classifications of nursing staff : 1)a faculty stream (PhD or pending, and 2) a clinical nursing practice category (master's level or pending). Clinical associates are expert in a particular area of clinical practice, and work with nursing students in clinical practice and laboratory settings. Normally they partner with designated nursing faculty members.

part-time, or sessional contracts. All educational institutions report engaging preceptors in clinical supervision, mostly in the senior year of the programs. However, the use of preceptors in other years was reported in a few instances (see discussion on "Models of Teaching"). Tables depicting the actual number and types of faculty used for universities and for colleges are included in Appendix A.

Schools were asked about what arrangements are made for paying clinical teachers. Twenty-four out of 29 respondents report the teaching institution is responsible for salaries. Thirteen out of 29 respondents report the teaching institute reimburses the agency for seconded staff. No differences exist according to year of the program. Twenty-two out of 29 respondents reported paying hourly rates for part-time and casual staff. Another arrangement cited was the educational institution directly paying the collaborative partner. In some instances, where university salaries do not match the seconded person's income, a supplemental stipend is paid by the educational institution. Tables depicting the actual arrangement for making payment are included in appendices B and C.

Schools were invited to identify issues regarding the recruitment of clinical teachers. The results can be found in appendix D and are presented as a unit and not by year of program. Sixty percent (21/35) of all respondents chose the lack of master's- and PhD-prepared faculty as the most common problem. Twenty-six percent (9/35) respondents indicated that lack of experienced faculty was an issue. Twenty percent (7/35) indicated salary and benefits at the university or college level were not competitive in the workplace, and that downsizing in the health care sector made it more difficult to recruit experienced instructors. Other issues cited include: lack of individuals willing to

precept students, reputation of heavy faculty-related workload, and lack of availability of BN nurses willing to instruct or precept students.

Preceptorship

In light of the growing use of the preceptorship model in nursing programs, and increasing difficulty in recruiting experienced preceptors, CASN member schools were surveyed regarding several key areas relating to preceptors, including orientation, evaluation, recognition, and professional development.

Orientation

Thirty-three participants responded to this question with the majority (27) reporting they provide preceptor orientation. Six indicated that they do not. However, when considering these responses within the context of the open comments, it is clear that four of them have in place some type of orientation activity for their preceptors. In such instances, the preceptors' employers conduct the orientation activities. This leaves two educational institutions with no reported orientation program for their preceptors.

As shown in Table 2A, most preceptor orientation programs are delivered by the educational institutions in the form of a one-day workshop. In some cases, the orientation is done on a one-on-one basis between the course instructor/professor and the preceptor. Local health authorities/ regions also offer preceptor courses for their employees. A preceptor handbook supplements orientation activities, except in two situations where the manual constitutes the orientation. Phone or e-mail discussions, as well as follow-up visits, are also used as a means to augment orientation sessions and to maintain contact with preceptors throughout the preceptorship experience. One school reported using WebCT (an electronic learning system) as a medium for preceptors to "connect, problem-solve, and provide support." Finally, one respondent mentioned that annual conferences

on preceptorship are held by a professional association thus providing a means for the discussion of issues associated with preceptoring students.

**Table 2A Orientation Activities ( n = 31 )**

| Activities | Area of Responsibility | | |
|---|---|---|---|
| | ***Schools*** | ***Health Agency*** | ***Collaborative Efforts*** |
| Workshop /Inservices | 9 | 5 | 1 |
| Manual | 2 | | |
| One-on-one Meeting | 1 | | |
| Workshop & Manual | 2 | | 1 |
| Manual & One-on-one Mtg | 5 | | |
| Workshop, Manual, & One-on-one Meeting | 3 | | |
| Unspecified | 3 | | |

Note: Some participants gave more than one response

Only three participants provided some information about the content of their orientation programs. Areas common to all three programs consist of: overview of program, program objectives, roles of players, and the teaching/learning process. One respondent indicated covering information about the theoretical underpinnings of the curriculum as well as the major concepts within the curriculum, including its structure.

Recognition

Appreciation. The majority (25) of the 32 respondents reported implementing measures to formally recognize the preceptors (See Table 2B). Seven indicated they did

not do anything although the open comments suggested at least two of them engaged in appreciative gestures. Recognition/appreciation is expressed primarily in the form of token gifts, a recognition certificate, and/or letters of thanks. Letters usually come from the dean and assigned faculty course facilitator and often are copied to the employer to be added to the preceptor's file. In one instance, it was mentioned that students also sent thank-you letters to their preceptors.

Nine respondents indicated holding receptions (i.e., teas or luncheon) for their preceptors. These social activities were described as providing the opportunity for students and preceptors to share their stories and recognize the learning that has taken place.

At one educational institution, a document is given to preceptors that can be used to fulfill continuing competency requirements of the provincial nurses association. At another, the preceptor is offered up to $600.00 worth of tuition fees towards courses offered by the institution. At another, an award, which carries a prize of $200.00 and a day off with pay, is presented to the best preceptors as nominated by the students. The other nominees receive a token gift or flowers.

**Table 2B Preceptor Recognition (n = 25)**

| *Rewards* | *Descriptions* | *# of Institutions* |
|---|---|---|
| Token gift/ gift certificate | Lapel pins, engraved items, books, fruit baskets | 15 |
| Preceptor monetary awards | $200.00 & 1 day-off with pay | 1 |
| Letter of thanks: Dean & Faculty<br>: Students | Some letters are placed on employees' file and/or copied to employer | 17<br>1 |
| Certification of merit/recognition | | 12 |
| Receptions | Teas, wine & cheese, luncheons | 9 |
| Honorarium | For new preceptors only | 1 |
| Access to library | Access to library card x 1year | 1 |
| Contribution towards course tuition fees | Up to $600.00 for one course taken at the educational institution | 1 |

Note: Some participants reported offering a combination of rewards.

Financial Reward. Of the 34 responses obtained, 25 participants responded that they do not provide financial rewards to their preceptors while 9 indicated that they do. The nature and the source of the financial rewards vary considerably as is shown in Table 2C. They range from an hourly rate of $.65 per hour which is paid by the preceptors' employers as per the provincial Nurses Collective Agreement to gift certificates offered by educational institutions.

**Table 2C Financial Rewards ( n = 9)**

| **Reward** | ***# of Responses*** | **Contributing Agency** |
|---|---|---|
| Rate of $ .65/hr | 4 | Regional Health Authority or hospital |
| Honorarium (range: $ 50 – $300) | 5 (1 to new preceptors only) | Primarily educational institution |
| Gift certificate | 1 | Educational institution |
| Extra time off , i.e., 1 day or get a full day's pay for preceptor orientation | 1 | Educational institution |
| As per union agreement | 1 | Regional Health Authority |

Note: Some participants gave more than one response.

Evaluation

Of the 33 respondents, nine answered in the affirmative. However, the explanatory comments (21) did not always correspond with the yes/no answers. In fact, in some instances, the answer given was a no but the nature of the accompanying comment implied that informal evaluation took place.

The written comments offered by the respondents who answered in the affirmative showed that primarily the students evaluated preceptors as part of course evaluation. Observations and dialogue of teachers with preceptors were identified as informal means through which preceptors are evaluated. Interestingly, no one reported conducting formal evaluations other than the written feedback from the students. At one institution, it is possible for preceptors to request to be evaluated by their respective students.

Professional Development

There were 33 responses to this question. Of these, seven respondents reported having professional development programs for the preceptors. However, closer examination of the open comments revealed that at least five of the seven respondents interpreted professional development program to be the same as orientation program, thus providing the same or similar answers to this question and the previous one. This suggests that the question lacks clarity and specificity.

At one institution, preceptors are eligible to participate in continuing education activities of the Health Sciences faculty and to apply for a clinical teaching fellowship providing them with a one-year training in teaching. At another institution, measures are being taken to develop a program of support for preceptors that will include professional development opportunities in addition to recognition.

## Issues Associated with the Delivery of Clinical Nursing Education

Respondents were asked in the questionnaire to identify barriers to providing clinical experiences and key issues associated with the delivery of clinical nursing education. Themes that emerged from the reported barriers and issues are 1) decreasing quantity and quality of available placements (including preceptored experiences), 2) shortage of qualified teachers, 3) difficulties in funding clinical education, and 4) increasing competition for placements. Factors identified in the responses which contribute to clinical education issues are health care restructuring, stress in the workplace, and increasing enrolment in nursing programs due to the growing nursing shortage.

Quantity and Quality of Placements

The majority of responding schools reported difficulties in providing a sufficient number of appropriate practice placements for their students. Overall, the scarcity was more pronounced in acute care settings than in extended or intermediate care. Thus, while approximately half of the schools reported having sufficient numbers of placements for first-year students, by fourth year, only five schools noted having no difficulty placing their students. This is in spite of the fact that several schools noted the tendency for agencies to welcome senior students because new staff members are often recruited for employment in their final practicum setting. The shift to community care is being echoed in a shift to more community placements, where securing enough suitable placements is also beginning to pose problems.

Changes in the delivery of health care have reduced the availability of placements in acute care (and some community) settings. As hospitals downsized, fewer units and fewer inpatients are now available for clinical education. At the same time, the size of individual units has decreased and fewer students can be accommodated per unit. Thus, many hospital sites are requesting smaller group placements and instructors are often required to cover several units at a time, making it difficult to provide appropriate supervision, particularly for the less experienced students. Some schools are aware that "agencies are tired of students." As well, with the shorter length of stay in hospitals, the inpatient population tends to be more acutely ill, making care for many patients too complex for inexperienced nursing students.

As students become more experienced and progress through specialty areas, the shortage of placements becomes even more noticeable throughout the country. Respondents noted the shortage of placement opportunities in obstetrics, pediatrics,

psychiatry, and palliative care, to the point that increasingly students finish their program with limited exposure to these areas. This shortage is as a result of amalgamation of services and the shift from acute to community-based services. In many instances, this shift has not resulted in an increase in community placement opportunities. As well, one respondent indicated that while the program is trying to "teach for the future" there is limited health care system support for primary health care initiatives.

Recurrent and persistent reorganization in health care settings coupled with the high levels of acuity has resulted in high levels of stress for staff in institutional settings. The survey respondents frequently referred to this theme in their description of clinical education issues. Some respondents used the terms "burnout" when referring to staff nurses and "chaos" when referring to the health care environment. High staff turnover means that many clinical areas have a high proportion of new graduates who lack the experience to be able to mentor and/or support students. Several respondents indicated that there seems to be a shift, in some agencies, from providing educational opportunities for students to viewing students as essential for provision of service. As well, there appears to be increased expectation for new graduates to be 'work-ready', and questions about whether or not nursing education programs are adequately preparing students to begin work in the current health care context. All of these factors contribute to a deteriorating learning environment with increased workload for clinical teachers, as they have less and less assistance from staff nurses in supervision of students.

The shortage of preceptors is also a function of staffing patterns. Increasingly, there are fewer registered nurses and a proliferation of other levels of staff providing nursing care in inpatient units. There also tends to be high staff turnover among nurses, further reducing the numbers of experienced preceptors available. Some centres highlighted the

insufficiency of experienced nurses as particularly problematic in tertiary care and for placing senior students who require more challenging placements. The high proportion of registered nurses working part-time is another impacting factor. One respondent observed that a single student might have several preceptors during a single course. On another level, not everyone views teaching students as a primary function of the staff nurse's job description. For example, one respondent said that collective agreements present a problem for accessing preceptors and another observed that managers may refuse to take students on inpatient units, in order to protect their overworked staff. Preceptors in community placements are also in short supply. Many community agencies employ no registered nurses or the registered nurses occupy managerial positions and have limited direct involvement with clients. In summary, throughout Canada, the demand for practice experience outweighs the supply of qualified teachers. Nursing programs are being forced to come up with innovative strategies to address this imbalance and the other problems they encounter in providing practice education.

Another factor contributing to the issues in providing sufficient clinical experiences is the increased enrolment in nursing programs in response to the RN shortage and an aging workforce. This has led to an increased demand for clinical placements in an environment that has fewer clinical opportunities.

Shortage of Qualified Teachers

Another major problem is that of the supply and demand for clinical teachers. That is, there is an imbalance between the number of nursing students requiring practice experience and the availability of qualified people to supervise that experience. Nursing programs throughout the country are expanding their cohort sizes to counteract the nursing shortage. At the same time (as is true for preceptors), the aging of the workforce

and growing rates of retirement leave a smaller proportion of experienced nurses to fulfill the roles of clinical teacher. Most schools of nursing rely on hiring sessional or contract instructors to teach in the practice settings and several noted that finding such teachers is becoming more difficult. Hiring of clinical teachers often occurs at the last minute due to changes in tenured faculty workload. In many instances, educational institutions are unable to meet nursing union wages, resulting in an unstable and often inadequately prepared sessional workforce. Several schools cited the lack of MN or PhD prepared clinical faculty as a barrier to providing adequate practice experiences for nursing students. Many factors impinging on the availability of clinical teachers have been highlighted in appendix D as issues associated with recruitment. Unless these issues are resolved, the shortage of qualified teachers will continue to be of concern and become even more serious.

Funding for Clinical Education

Almost half of the respondents noted that one of the key issues in clinical education for their institution is lack of appropriate funding. Costs of clinical education are increasing due to stresses on systems but, in general, funding for nursing education programs is not keeping up to the demands. Along with the effect of the changing health care and unstable learning environment, with a resultant need to decrease size of clinical groups, respondents identified the move to baccalaureate as entry-to-practice as a contributing factor. In many instances, funding formulas for university programs do not appropriately reflect costs of clinical education. In addition, community placements that are essential in a degree program are more costly to supervise than traditional acute care placements. Another factor, which was reported as contributing to funding difficulties, is

the high turnover of sessional clinical teachers and the cost of orientation and mentoring of new teachers.

Competition for Placements

Several respondents indicated that they are in competition for placements with other nursing programs. As well, several responded that there is competition with other health science programs, including competition in clinical areas that do not hire graduates from the other programs. All types of caring occupations require that learners spend time in the "real world" with "real care recipients" to attain competence in applying their theoretical and "hands-on" knowledge. Consequently, there is keen competition for practice placements across the country in virtually all types of health care settings.

Nursing school representatives reported that the majority of health care agencies were being used to capacity, at least during the daytime, by an expanding number and type of programs requiring practical experience. Nursing students are competing with learners from other educational agencies that train nursing care providers, allied health professions, and other associated human service professions.

In fact, one respondent noted that there is "competition from everyone." Registered nurses are not the only occupational category providing nursing care and programs for other levels of care providers are expanding, including the expansion of private colleges. In any geographical area, the need may be for student practica to educate practical nurses, various levels of care aides and home support workers, and registered psychiatric nurses. In many areas, multiple programs within "mainstream" nursing also compete for placements; for example, diploma programs, baccalaureate programs, post-basic specialty certifications, graduate programs including nurse practitioners, and

nursing refresher courses. One university program observed that it competes for placements with its own collaborative partner.

Similarly, programs for allied health professionals continue to expand and require accommodation in health care settings. Student physicians, paramedics and other emergency medicine technicians, child-care workers, social workers, physiotherapists, occupational therapists, recreational therapists, speech pathologists can all be found in the health care settings along with student nurses. Occasional respondents even identified fitness students, education students, unit clerk students, and high school students from career development programs or Big Sisters as part of the mix.

In summary, the overall theme reflected throughout the completed surveys is that co-ordination of placements is becoming very complex. The respondents highlighted the importance of developing new models of practice education and clinical supervision of students.

## Strategies for Addressing the Barriers to Practice Education

A number of strategies are being tried or at least proposed for alleviating the problems encountered in practice education. While concrete suggestions were proposed, the respondents highlighted the importance of developing new models of practice education and for the clinical supervision of students. As well, schools of nursing are searching for meaningful ways to recognize the contribution of nurses in the practice setting. Specific strategies for addressing barriers were extrapolated from the data and consist of: a) use community agencies more fully, b) expand clinical placement locations beyond the school's boundaries, c) maximize the utilization of the work week, d) create practicum co-ordinator positions, e) enhance relationships with practice partners, e)

engage in timely planning and negotiation, f) provide rewards and incentives, g) modify programs and/or courses, and g) use creative educational strategies.

Use Community Agencies More Fully

More and more, practice experiences are taking place in community agencies. One Ontario school noted that due to the SARS outbreak, all of their 2003 final preceptorships occurred in community settings. Many students now receive their maternal/child, pediatric, and mental health experience in community settings, a trend that may only increase the difficulties in recruiting for these specialty areas in hospitals. In the last decade, health clinics have opened up across the country. As well, parish nursing is flourishing in some areas while in others, resource centers such as children's resources centers have been created. These areas were recommended as settings wherein practice experiences can occur. The use of a senior apartment complex for the study of healthy aging is another resource respondents indicated using for clinical placement.

Increasingly in the community, students are paired with non-nurse preceptors or field guides. Presumably, these staff members with diverse backgrounds and qualifications are involved in some capacity in students' learning, however, the degree and level of involvement have not been provided. This can spread clinical instructors rather thinly, as they try to supervise increased numbers of students in multiple sites.

Expand Clinical Placement Locations Beyond the School's Boundaries

Another option is for programs to look further afield for practice placements, outside their normal geographical area. For example, one respondent from a large city suggested extending clinical placements beyond the metro area of the city while another, from a more rural province, recommended placing students and instructors in practice locations across the province. This can be an option particularly for strong students in

their final preceptorship. Thus, an instructor may be overseeing students throughout the province or even in other provinces, with or without the opportunity of visiting the student in the practice setting. Although this strategy may relieve the scarcity of finding placements in the immediate area of a particular program, it may increase the problem for other nursing schools located in the areas where those off-site students are placed.

Maximize the Utilization of the Work Week

Scheduling practica is becoming increasingly complex and some creative innovations are being tried across the country. Some respondents have suggested that it helps ensure clinical placements if the work week schedule is flexible. Students (and their instructors) are increasingly working evenings and nights, seven days a week and expanded times on certain days to reduce the overcrowding of acute care units during days. Schools which have traditionally only had one level of students on a particular unit at any time may now have a mixture of students simultaneously at the same placement. Where consolidated practice experiences have generally taken place during intersession (April/May/June), programs are beginning to consider scheduling them at other "non-peak" times during the year.

While nursing programs are testing out new ways of placing students, some practice settings are attempting to alleviate the crowded practice settings by imposing rules of their own. Where multiple levels of students have traditionally been placed, some practice settings are restricting the students assigned to a particular unit to only one level. Thus, for example, one unit will only accept senior students and another will only have students in their second year. Others have designated different units for different schools or occupational categories of students, or different days for different schools. As one respondent said, "We get Thursday and Friday; they get Monday to Wednesday."

Create Practicum Co-ordinator Positions

What has emerged is an increasingly complex constellation of tasks for those staff whose job it is to arrange student practica, and several schools reported high levels of stress and overwork for these people. To address this problem, some practice settings have appointed a practicum co-ordinator to work with nursing and other professional programs; some educational institutions have appointed a co-ordinator to arrange the placements for all of their professional programs. This co-ordinator position may entail a wide variety of activities some of which are: actively exploring alternative areas for learning, chairing committee meetings, co-ordinating placement requests, and also functioning as a liaison person between the university and placement agency. Across the country, improved co-ordination of practicum placements between and among educational institutions and practice settings is becoming a priority.

Enhance Relationships with Practice Partners

Respondents have indicated that it is necessary to actively maintain excellent relationships among faculty, placement contacts, and other clinical liaisons. Maintaining relationships may take many forms, such as regularly planned meetings, ongoing discussions, and conducting regular follow-ups with clinical placement supervisors. This type of maintenance should be seen as an investment as it helps ensure that communication links are maintained; the need to match learning needs with level of learning opportunity is addressed; concerns or suggestions are openly discussed; and agencies feel supported and heard by faculty. Some of the ways to build on long-established relationships with staff and agencies include such activities as: a) faculty keeping in touch with clinical agencies through thank-yous and seasonal greetings, b)

having the students extend personal thank-yous, and c) meeting regularly with other educational institutions in the area.

Collaborating with both internal and external departments/agencies is also another means to strengthen relationships among all stakeholders. This, in turn, would go a long way to secure sufficient numbers of clinical placements for students. In fact, some respondents have indicated that several clinical placements were developed by collaborating with nursing faculty, both full-time and sessional. Some respondents seem to make such collaboration a priority, stating that this is a mutual and very personal investment of time and respect.

There were several strategies suggested to enhance collaboration. Faculty were encouraged to develop direct working relationships with nurses in the health care agencies and to promote working with students. Faculty were also asked to participate on professional committees, boards, and nursing councils. Adjunct faculty were also used to secure unique practicum placements which they could directly supervise.

In addition to internal collaboration, a number of respondents have indicated that they also collaborate with external agencies. Some of these external agencies include health authorities at provincial and local levels, health authorities at other educational facilities (e.g., other universities), and hospitals. Specific examples of such external agencies include the NECBC and a nurse leaders' group in British Columbia, as mentioned by Camosun College, and the direct liaison of Sault College with the Sault Area Hospital in Ontario to identify hospital staff members that would be willing to take students. Collaboration also occurred on a broader basis through creating a regional committee to address nurse education issues and, at a provincial level, to develop

ongoing liaison with key nurse leaders to promote nurse education and seek potential placements.

Engage in Timely Planning and Negotiation

Several respondents have indicated that timely planning and negotiating have enabled them to secure a sufficient number of clinical placements. Timely negotiations with clinical collaborators or employers regarding placements should be a priority. However, negotiations may also be required with other educational institutions, as well as faculty.

Provide Incentives

Respondents have indicated that offering incentives to staff at clinical placements can also be used to increase the likelihood that there are enough clinical placements. The incentive could be directed towards the placement agency and/or hospital staff or toward the student. There were many different examples of incentives cited. They ranged from facilitating access and connection between clinical agency staff and faculty and providing teaching workshops for the staff of the placement agency. More tangible recognition is giving university appointments to clinical nurses to formally recognize their contribution to the education program. Such an appointment provides the clinical nurse with access to ongoing teaching and learning support, to the library, and to web-based course materials from the university. Another incentive is the introduction of a "Graduating Award for Exceptional Practice Units." This has been found to be successful in encouraging clinical nurses to volunteer to act as preceptors.

Clinical placements outside the province have also been tried. To address the issue of the reluctance of students to move to clinical agencies outside the province, one

university has offered $500 directly to students to assist in their expenses. The student provides 40 hours of work to the Faculty of Nursing in return.

To support the costs of such incentives, some institutions have proposed negotiation with the province to provide funding for the clinical component of the program. This would also point out to provincial authorities the additional costs incurred in delivering clinical programs.

Modify Program and/or Course

Respondents have indicated that they have made changes or adapted their nursing program with regard to curriculum and/or program structure in attempts to help students receive a clinical placement. Adaptation of the curriculum may involve developing the program around nursing concepts such as management of chronic illness, allowing increased versatility in clinical placements. Adaptation of the program structure may involve changing the placement of courses or changing the length of the practicum placement.

Generally, program structure adaptations have allowed for an increase in the ability to provide clinical experiences through expanding the time available for scheduling. Respondents indicated that clinical courses were scheduled throughout the calendar year rather than the institution's calendar. Another example cited was to double-teach the second year of the program so that clinical areas could be used in both semesters.

One institution has staggered the delivery of intersession courses in Year 3 so that some students start two weeks ahead of others. This allowed the scheduling of clinical placements over a six-week period rather than four weeks.

In a community health nursing practicum, a preceptored six-week block was changed to a two-days-a-week format over a thirteen-week semester with field guides. This decreased the pressure on the clinical preceptor to supervise for a continuous six-week period.

In another instance, a four-week consolidated practicum has been scheduled for students completing the second year of the program. Students work directly with the nursing team on particular wards and work blocks of three twelve-hour shifts per week. Faculty make the rounds periodically and also carry "beepers" to be on call.

The implementation of accelerated programs for students who have prior learning experience has also allowed for greater flexibility in accessing clinical practicum resources. One institution has instituted a "fast-track" option for the BN program through which the student can meet graduation requirements in a shorter period of time. Because semester start-dates can vary and the entire calendar year is used to deliver the program, there is more flexibility in scheduling clinical practica. Co-ordination takes place so that clinical rotations are scheduled at different times for students in the regular (generic) program.

Creative Educational Strategies

For the majority of the schools, finding sufficient meaningful clinical placements can be a challenge. To overcome this, many respondents emphasized the need to use a variety of non-traditional settings for clinical placements. Some schools have introduced the concept of students rotating through multiple sites, inpatient and community, during a specialty experience. A variation of this are specialty experiences in which students follow individual patients in and out of the hospital over the course of their treatment.

Six respondents reported having some form of inter-professional/inter-disciplinary practica as a means of alleviating the shortage of clinical placements and to keep abreast of changes in health care delivery. The majority of these practica are project-focused and were described as constituting course assignments in a theory course or community-based placements in clinical courses. In these practica, nursing students work collaboratively with students from other health disciplines such as health and human services, social work, and physiotherapy. The Interprofessional Rural Placement in BC was cited as an example of a program involving members from different disciplines. Another example of interprofessional team placements was offered where student teams supervised by on-site professional teams take on several patients for a period of five weeks. It is unclear if these placements are community- or institution-based. Specific details about these practica were not provided.

Finally, it was mentioned by one school that, in some instances, students were exposed to or worked with ward clerks, respiratory technicians, physiotherapists and other similar groups during hospital rotations. The nature of learning activity was not described.

Respondents were also asked to indicate whether they were negotiating offering a new or different model of clinical/ practice education in an attempt to capture innovations in practice education. Of the thirty-seven participants who answered this question, 20 indicated not being involved in exploring new models while 17 specified that they were either in the process of exploring new or different models or implementing recently developed strategies as shown in Table 3.

Of particular interest are the Collaborative Learning Unit Model developed and implemented by the University of Victoria, for which an evaluation report will soon be

**Table 3 Innovations in Practice Education (n = 17)**

| Strategy | Phase of Development | Number of Institutions |
|---|---|---|
| Extension of preceptorship | Planning | 1 |
| Use of field guides in collaboration with instructors | Planning | 1 |
| Nurse internship program | Under discussion | 1 |
| Establishment of bilingual program (↑ placement opportunities) | Waiting for final approval | 1 |
| Dual intakes & 'trisemester' | Implementation<br>Exploration | 2<br>1 |
| Use of evening/night shifts & weekends | Implementation | 1 |
| One instructor with different levels of students on one unit | Exploration | 1 |
| CLU model | Implementation | 1 |
| Accelerated option | Implementation | 1 |
| Use of PLAR | Implementation | 1 |
| International Practicum | Implementation | 1 |
| Proposal for Government to fund clinical education with a faculty-student ratio of 1:8. University based faculty responsible for course coordination & orientation | Under review | 1 |
| Use of specialty areas for final practicum | Implementation | 1 |
| Participation in HSP net (Health Sciences Placement BC Network) | Exploration | 1 |

Note: Some participants gave more than one response.

available, and the proposal by McGill University requesting that the government fund the clinical education component of its program. This proposal calls for an instructor-student ratio of 1:8. In addition, it was proposed that university-based faculty function in the role of course co-ordinator and provide orientation programs while part-time faculty would be encouraged to take part in teaching-learning sessions.

The analysis of the open comments revealed that educators across the country recognize the need to innovate and think 'outside the box' to meet the challenges associated with clinical placements. Some have already moved beyond the traditional settings to adopt alternative clinical experiences. It is believed, however, that the nature of the survey questions might have been too restrictive and, as a result, did not capture the extent of innovations in clinical education. In fact, there was no mention by respondents of the use of clinical simulations or computer-supported programs as strategies complementary to clinical practice when it is known that some programs make use of such strategies.

## Directions and Opportunities

The CASN taskforce recognizes that many schools of nursing are currently involved in delivering innovative and creative practice opportunities. The following statements are not prescriptive and it is understood that each school of nursing will provide opportunities for students in locations that work for that community.

- Practice opportunities can include activities within the educational institution, such as standardized patients, labs, case studies, as well as traditional clinical/practice settings.

- Learning opportunities to meet core competencies can be met in a variety of settings (include hospital care, community, schools, workplace — wherever there are people).
- Nursing clinical/practice education continues to heavily rely on acute care medical/surgical institutional settings. Consider investigating opportunities outside of the institution for "traditional" experiences, such as acute/complex and post-natal care in the home.
- Explore community settings from a broad perspective.
- Rather than focus on "settings," continue to seek out practice opportunities that develop core competencies such as critical thinking, diagnostic reasoning, assessment skills, such as teaching/learning skills — first-year nursing students developing an interactive program based on a Grade 5 science curriculum.
- Explore relationships with other agencies and groups such as school boards, industry, workplace, seniors activity centre. Faculty time to create and maintain these relationships is growing and needs to be recognized in order to allow these relationships to develop.
- Reconsider level of faculty supervision required for nursing students. Various practice settings may not call for the same type of direct supervision that has been traditionally assumed.

## Next Steps

The above report of the 2003 Clinical / Practice Education Survey of CASN member schools of nursing, conducted by the Task Force on Clinical / Practice Education, is a summary of current nursing education programs across the country. In the report are many challenges confronting schools of nursing, as well as strategies being

used by nurse educators to overcome them. Faculties of nursing across the country are responding to the current health care context and the nursing shortage by modifying their delivery of practice education and by moving into non-traditional settings.

Analysis of the data raised two unanswered concerns. Although the survey reveals a number of innovative changes being introduced by selected faculties, the Task Force observed that these changes are not being communicated suitably to other schools across Canada. In addition, we suspect that there may be additional modifications that, because they were not identified as "innovations," were, therefore, not reported by the survey respondents. To address these concerns the Task Force is hosting a national forum on clinical / practice education in nursing November 16 & 17, 2004, titled *Practice Education: Building Capacity Through Partnership and Innovation.*

The preceding report constitutes a major step toward fulfilling the terms of reference for the CASN Task Force on Clinical / Practice Education – to produce a CASN position paper and a CASN national strategy for clinical / practice education. By combining the survey report with what we will learn from the national forum, the Task Force intends to produce the above two documents, thus completing its mandate by the November 2005 CASN annual meeting.

References

Beattie, H. (1998). Clinical teaching models: A review of the role of preceptor in the undergraduate nursing program. *Australian Journal of Advanced Nursing, 15*(4), 14-19.

Beeman, R. Y. (2001). New partnerships between education and practice: Precepting junior students in the acute care setting. *Journal of Nursing Education, 40*(3), 132-34.

Campbell, I. E., Larrivee, L., Fields, P.A., Day, R. A., & Reutter, L. (1994). Learning to nurse in the clinical setting. *Journal of Advanced Nursing, 20,* 1125-1131.

DeVoogd, R., & Salbenblatt, C. (1989). The clinical teaching associate model: Advantages and disadvantages in practice. *Journal of Nursing Education, 28* (6), 276-78.

Edmond, C.B. (2001). A new paradigm for practice education. *Nurse Education Today, 21,* 251-259.

Fugate, T., & Rebeschi, L. (1992). Dual assignment: An alternative clinical teaching strategy. *Nurse Educator, 17*(6), 14-16.

Ferguson, L.M. (1996). Preceptors' needs for faculty support. *Journal of Nursing Staff Development, 12*(2), 73-80.

Grealish, L., & Carroll, G. (1998). Beyond preceptorship and supervision: A third clinical model emerges for Australian nursing education. A*ustralian Journal of Advanced Nursing, 15*(2), 3-11.

Hrobsky, P.E. , & Kersbergen, A.L. (2002). Preceptors' perceptions of clinical performance failure. *Journal of Nursing Education, 41*(12), 550-553.

Kaviana, N., & Stillwell, Y. (2000). An evaluative study of clinical preceptorship. *Nurse Education Today, 20*, 218-226.

Kee, G., & Ryser, F. (2001). Work study scholarship program for undergraduate nursing students: A win-win service education partnership. *Nursing Scholarship Quarterly, 26*(1), 29-34.

Melander, S., & Roberts, C. (1994). Clinical teaching associate model: Creating effective BSN student/faculty/staff nurse triads. *Journal of Nursing Education, 33*(9), 422-25.

Myrick, F. (2002). Preceptorship and critical thinking in nursing education. *Journal of Nursing Education, 41*(4), 154-164.

Nehls, N., Rather, M., & Guyette,M. (1999). The preceptor model of clinical instruction: The lived experiences of students, preceptors, and faculty-of-record. *Journal of Nursing Education, 36*(5),220-27.

Nordgren, J., Richardson, S., & Brown Laurella, V. (1998). A collaborative preceptor model for clinical teaching of beginning nursing students. *Nurse Educator, 23*(3), 27-32.

Phillips, S.J.,& Kaempfer, S. H. (1987). Clinical teaching associate model: Implementation in a community hospital setting. *Journal of Professional Nursing, 3*(3), 165-175.

Robinson, A., McInerney, F., Sherring, M., & Matlow, A. (1999). Developing a collaborative preceptor program involving registered nurses, student nurses and faculty. *Australian Journal of Advanced Nursing, 17*(1), 13-21.

Tanner, C. A., (202). Clinical education circa 2010. *Journal of Nursing Education, 41*(2), 51-52.

Appendix A

**Types of faculty engaged in teaching and clinical practice component- Universities & University Colleges (n=22):**

. FT= full time, PT= part time, LT= Limited term, Ren= Renewable contract

| Tenured & Tenure track | Number of Institutions | Year 1 | Year 2 | Year 3 | Year 4 | Total |
|---|---|---|---|---|---|---|
| Faculty: Tenured & Tenure track FT | 11 (50%) | 7 | 7 | 10 | 9 | 33 |
| Faculty: Permanent FT | 10 (45%) | 7 | 8 | 9 | 6 | 30 |
| Clinical associate/instructor/ sessional/term instructional assistant, Casual, PT hourly | 9 (40%) | 7 | 7 | 8 | 7 | 29 |
| Preceptors | 10 (45%) | 5 | 5 | 7 | 10 | 27 |
| Faculty: FT, LT | 6 (27%) | 3 | 6 | 6 | 5 | 20 |
| Seconded from HCI for FT, LT | 6 (27%) | 5 | 6 | 3 | 3 | 17 |
| Clinical associate/instructor, permanent FT | 5 (23%) | 4 | 4 | 5 | 3 | 16 |
| Faculty: Permanent PT | 3 (22%) | 3 | 3 | 2 | 1 | 9 |
| Clinical associate/instructor/ instructional assistant, FT,LT, Ren | 3 (22%) | 2 | 3 | 2 | 2 | 9 |
| Seconded from HCI for PT, LT | 2 (9%) | 0 | 2 | 2 | 2 | 6 |
| Clinical associate/instructor, permanent FT academic year | 2 (9%) | 2 | 1 | 2 | 0 | 5 |

**Colleges & Institutes (n=15)**

| Tenured & Tenure track | Number of Institutions | Year 1 | Year 2 | Year 3 | Year 4 | Total responses |
|---|---|---|---|---|---|---|
| **Type of faculty/staff reported** | | | | | | |
| | | | | | | |
| Faculty: Tenured & Tenure track FT | | | | | | |
| Faculty: Permanent FT | 2 (13%) | 2 | 2 | 2 | 1 | 7 |
| Faculty: Permanent PT | 3 (20%) | 3 | 3 | 1 | 1 | 8 |
| Faculty: FT, LT | 2 (13%) | 2 | 3 | 1 | 1 | 7 |
| Clinical associate/instructor, permanent FT | 2 (13%) | 2 | 2 | 1 | 4 | 9 |
| Clinical associate/instructor, permanent FT academic year | 1 (6%) | 1 | 1 | 1 | 1 | 4 |
| Clinical associate/instructor/ instructional assistant, FT,LT, Ren | | | | | | |
| | | | | | | |
| | | | | | | |
| Seconded from HCI for FT, LT | 1 (6%) | 1 | 1 | | | 2 |
| Seconded from HCI for PT, LT | | | | | | |
| Preceptors | 2(13%) ?? | 1 | 1 | 2 | 3 | 7 |

Appendix B

**Arrangements made for paying clinical instructors: Universities & University Colleges (n=19)**

FT= full time, PT= part time, LT= Limited term, Ren= Renewable contract

| | Number Institutions | Year 1 | Year 2 | Year 3 | Year 4 | Total |
|---|---|---|---|---|---|---|
| **Staff Category** | | | | | | |
| Paid salary by teaching institution full time employment | 17 (89%) | 15 | 14 | 17 | 14 | 62 |
| Teaching institution reimburses agency for seconded full time or part time staff | 8 (42%) | 5 | 5 | 7 | 6 | 24 |
| Teaching institution reimburses agency for seconded part time staff, paying additional educational stipend | 1 (5%) | 1 | 1 | 1 | 1 | 4 |
| Employed for limited time periods by educational institute and paid hourly rate for hours worked | 17 (89%) | 16 | 16 | 16 | 13 | 61 |
| Employed by teaching institution for session & paid by educational institution for session with benefits | 4 (21%) | 4 | 4 | 4 | 3 | 15 |
| Pays affiliating educational institution for work contracted | 0 | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| concerning the teaching of their students | | | | | | |
| Leave of absence from agency; salary paid by teaching institution during contract | 2 (11%) | 1 | 2 | 1 | | 4 |
| Teaching agency receives payment from another educational institution for work contracted concerning the teaching of their students | 0 | | | | | |
| First two years paid for by teaching institution & 3& 4th year paid by affiliating university | 0 | | | | | |
| Preceptors paid honarium | 1 (5%) | 1 | 1 | 1 | 1 | 4 |
| Preceptors not paid honarium by school | 5 (26%) | 3 | 3 | 5 | 5 | 16 |
| Additional stipend paid sesconded staff | 0 | | | | | |

Appendix C

**Arrangements made for paying clinical instructors: Colleges (n=13):**

FT= full time, PT= part time, LT= Limited term, Ren= Renewable contract n=13

| | Number of Institutions | Year 1 | Year 2 | Year 3 | Year 4 | Total |
|---|---|---|---|---|---|---|
| **Staff Category** | | | | | | |
| Paid salary by teaching institution full time employment | 12 (92%) | 12 | 12 | 7 | 4 | 35 |
| Teaching institution reimburses agency for seconded full or part time staff | 5 (38%) | 5 | 5 | 3 | 1 | 14 |
| Teaching institution reimburses agency for seconded part time staff paying additionl educational stipend | | | | | | |
| Employed for limited time periods by educational institute and paid hourly rate for hours worked | 5 (38%) | 5 | 5 | 3 | 1 | 14 |
| Employed by teaching institution for session & paid by educational institution for session with benefits | 3 (23%) | 3 | 3 | 2 | 2 | 10 |
| Pays affiliating educational institution for work contracted concerning the teaching of their | 1 (8%) | 1 | 1 | | | 2 |

| | | | | | | |
|---|---|---|---|---|---|---|
| students | | | | | | |
| Teaching agency receives payment from another educational institution for work contracted concerning the teaching of their students | 1 (8%) | | | | 1 | 1 |
| First two years paid for by teaching institution & 3& 4th year paid by affiliating university | 1 (8%) | 1 | 1 | | | 2 |
| Leave of absence from hospital/agency & salary paid by teaching institution during contract | 1 (8%) | 1 | 1 | 1 | | 3 |
| Preceptors paid honarium | 1 (8%) | | | 2 | 1 | 3 |
| Preceptors not paid honarium by school | 1 (8%) | | | 1 | | 1 |
| Additional stipend paid sesconded staff | | | | | | |

Appendix D

**Issues associated with the recruitment of clinical teachers and/or preceptors (n=?)**

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| | **Colleges/Institutes**<br><br>**n=15** | **University/**<br>**University College**<br>**n=20** | **Total**<br><br>**n=35** |
|---|---|---|---|
| Lack of MN or PhD | 9 (60%) | 12 (60%) | 21 (60%) |
| Lack of experience | 4 (26%) | 5 (25%) | 9 (26%) |
| Salary and or benefits not competitive with health care agencies | 2 (13%) | 5 (25%) | 7 (20%) |
| Downsizing and short staff situations in settings where nurses are normally recruited from seconded | 3 (20%) | 4 (20%) | 7 (20%) |
| Lack of individuals willing to precept /mentor students in clinical preceptor burn out | 2 (13%) | 4 (20%) | 6 (17%) |
| Lack of baccalaureate<br>Degree nurses to instruct | 2 (13%) | 3 (15%) | 5 (14%) |
| Reputation of heavy workload and large faculty to student ratios | 1 (6%) | 3 (15%) | 4 (11%) |
| Lack of experienced nurses to instruct in specialty areas (ICU, Emerg, etc) | 3 (20%) | | 3 (9%) |
| Retirements | | 3 (15%) | 3 (9%) |
| Lack of suitable placement settings for students/ competitive with other users | 1 (6%) | 2 (10%) | 3 (9%) |
| Completive with other learners<br>Placement diff | 1 (6%) | 2 (10%) | 3 (9%) |

| | | | |
|---|---|---|---|
| Lack of job security in non tenured, part time , and renewable positions | 1 (6%) | 1 (5%) | 2 (5%) |
| Difficulty filling part time /casual positions | | 2 (10%) | 2 (5%) |
| Difficulty recruiting qualified staff because of isolated setting, high cost of housing etc | 1 (6%) | 1 (5%) | 2 (5%) |
| Lack of funds to hire enough clinical instructors | | 2 (10%) | 2 (5%) |
| Difficulty filling fulltime clinical positions | | 1 (5%) | 1 (3%) |
| Poor orientation for part time and casual staff | | 1 (5%) | 1 (3%) |

Appendix E

**Clinical / Practice Education Survey**

Introduction: Current pressures in the Canadian health care context impact on the options available to nursing programs for providing their students with sufficient and meaningful practice education. In beginning to develop national guidelines for practice education, the CASN Task Force on Clinical / Practice Education is seeking information from all member schools to help us assess the status of undergraduate practice education across the country. From informal conversations we know that schools are working with their health care authorities and agencies to develop models of practice education, as they strive to balance the competing demands of educating higher numbers of student nurses within health care environments where (for a number of reasons) placement opportunities are becoming increasingly scarce, and persons are less willing/able to preceptor/supervise students.

Please forward this questionnaire to the person in your school who is best able to provide this information. We request that the questionnaire be completed in the next two weeks and returned to the CASN National Office by fax (613) 235-4476 **before June 16, 2003.**

Name of School _____

Location _____

Number of Students this year (academic year 2002-03): Year 1_____ Year 2_____ Year 3_____ Year 4_____

Number of continuing faculty – full-time_____part-time_____

(Continuing faculty include all regular, on-going faculty appointments. These may be tenured, tenure-track, senior instructor, limited-term appointments of at least two years, who are hired by the school/faculty of nursing. This does not include faculty who are hired on a contract basis to teach a specific course, even if the same person is hired to teach the same course more than once.)

**To the person providing this information:**

Should the CASN Task Force wish to contact you for further elaboration or clarification, please provide us with contact information:

Name _____

Phone number at work _____

Email address _____

FAX number _____

**Glossary**

Clinical experience – In this questionnaire, we use this term broadly to indicate any teaching/learning that occurs outside the physical environment of the school classrooms and clinical labs. (hospital, nursing homes, clinic, community, private

dwelling, schools, industry, etc.). We tend to use the terms clinical experience interchangeably with practice experience or practice education.

Faculty supervised model – This refers to the traditional model of student supervision in practice settings, whereby an instructor or clinical teacher accompanies a group of students in the clinical setting. Generally, this faculty member is responsible for negotiating the students' assignments, supervising their patient/client care, and evaluating their practice.

Preceptored or Preceptorship model – In this model of practice education, students are paired with an experienced clinical/agency staff member, who is responsible for directly teaching and supervising the student in practice. Faculty members often have students in multiple settings, visiting each setting periodically to meet with the student/preceptor pairs, thus assessing the student's practice more indirectly.

Funds / Funding – The costs of providing clinical/practice education (primarily including payment of instructors) vary. Costs may be covered by the institution where the practice occurs, by the university or college, through a partnership/shared agreement by the two, and/or subsidized by the provincial government (departments of health / education).

**Part A: Models of Clinical Placement**. The answers to questions in this section are divided according to the year of the program within which the practice experience occurs. Please fill in the information for all years that are appropriate for your program. If you do not offer a clinical experience in a particular year, please note that. If you offer a post-diploma BSN (or equivalent degree), those two years would normally be considered years 3 & 4 of the baccalaureate. Similarly, we are defining a two-year nursing degree following another university degree as years 3 and 4, i.e. students would enter the program at the equivalent of year 3.

1. What model(s) of clinical education do you currently use?

**Year One:**

Faculty supervised ☐ Ratio: 1 instructor to ___ students

Preceptorship ☐ Ratio: 1 instructor to ___ students

1 preceptor to ___ students

___ preceptors to 1 student

Other ☐ Type: (e.g. co-op)_____

No practicum ☐

**Year Two:**

Faculty supervised ☐ Ratio: 1 instructor to ___ students

Preceptorship ☐ Ratio: 1 instructor to ___ students

1 preceptor to ___ students

___ preceptors to 1 student

Other ڤ Type: (e.g. co-op)_____

No practicum □

**Year Three:**

Faculty supervised ڤ Ratio: 1 instructor to ___ students

Preceptorship ڤ Ratio: 1 instructor to ___ students

1 preceptor to ___ students

___ preceptors to 1 student

Other ڤ Type: (e.g. co-op)_____

No practicum □

**Year Four:**

Faculty supervised ڤ Ratio: 1 instructor to ___ students

Preceptorship ڤ Ratio: 1 instructor to ___ students

1 preceptor to ___ students

___ preceptors to 1 student

Other ڤ Type: (e.g. co-op)_____

No practicum □

2. Under each year of your program, please indicate the type of teaching staff engaged in clinical/practice teaching. Then, describe the clinical experiences

noted in question one. Include, for example, the nature and type of clinical experience being offered, the kind of facilities environment within which it occurs, and the length of time that students spend in the practice setting.

---

**Year One**

Number of continuing faculty doing clinical teaching _____

Number of sessional (contract) faculty doing clinical teaching _____

Practicum description for year one:

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**Year Two**

Number of continuing faculty doing clinical teaching _____

Number of sessional (contract) faculty doing clinical teaching _____

Practicum description:

---

**Year Three**

Number of continuing faculty doing clinical teaching _____

Number of sessional (contract) faculty doing clinical teaching _____

Practicum description:

---

**Year Four**

Number of continuing faculty doing clinical teaching _____

Number of sessional (contract) faculty doing clinical teaching _____

Practicum description:

**3.** Are you experiencing any problems/barriers in providing these clinical placements?

**Year One** Yes ☐ No ☐ If yes, please elaborate. If no, why not?

_____**Year Two**

Yes □ No □ If yes, please elaborate. If no, why not?

_____

**Year Three** Yes □ No □ If yes, please elaborate. If no, why not?

_____

**Year Four** Yes □ No □ If yes, please elaborate. If no, why not?

4. Who else is using these clinical areas for student placements (e.g., medicine, other allied health professions, other schools of nursing)? Are these facilities being fully used or are there any barriers to the maximum usage of the facilities? If there are barriers, can you envision any strategies for overcoming those barriers?

**Year One**

_____**Year Two**

_____

**Year Three**

**Year Four**

5. This question has to do with funding arrangements, i.e. how are your clinical teaching staff paid?

a) Please describe the types of faculty engaged in teaching the clinical/practice components of your program? Various schools use various terms, so it may be helpful for you to define any titles that you are using. For example: tenured or tenure-track faculty, senior instructors, sessional faculty, clinical staff (RNs as preceptors, clinical resource nurses, clinical instructors from the practice setting).

**Year One**

**Year Two**

**Year Three**

**Year Four**

b) Also indicate the arrangements made for paying these instructors. Some examples: tenured or tenure-track faculty fully paid by the university or college, sessional instructors hired by the university or college to teach individual practice courses, clinical staff with an LOA from their employer and salary paid by the educational institution, various other types of partnership arrangements between the school of nursing and practice settings). Please

comment on the sustainability of these funding arrangements.

**Year One**

_____**Year Two**

_____

**Year Three**

_____**Year Four**

c) Please comment on any issues that you are experiencing regarding recruiting people to teach and/or preceptor students in practice settings.

**Year One**

_____**Year Two**

**Year Three**

**Year Four**

**Part B: General Questions**

6. What do you see as a key issue (or key issues) of concern regarding the nursing practice component of nursing education?

7. What strategies have you used to ensure sufficient clinical placements for your students?

8. Are practice experiences in “specialty areas” considered to be part of the core clinical learning activities that students in your school are expected to have? For example, do students in your program generally have a practicum in:

| | | | |
|---|---|---|---|
| paediatrics/ child health | Yes □ | No □ | Only if requested □ |
| obstetrics/maternal health | Yes □ | No □ | Only if requested □ |
| mental health | Yes □ | No □ | Only if requested □ |
| community health | Yes □ | No □ | Only if requested □ |
| home care | Yes □ | No □ | Only if requested □ |
| public health | Yes □ | No □ | Only if requested □ |
| palliative care | Yes □ | No □ | Only if requested □ |

others? Please list _____

How well are you able to provide these experiences?

9. If you are presently using a preceptored model:

   a. Do preceptors receive any financial reward for their work?

      Yes ف No ف

      If yes, who pays them? What amount?

   b. Do you provide preceptor orientation?

      Yes ف No ف

      If yes, please describe your orientation program.

   c. Do you provide a professional development program for preceptors?

      Yes ف No ف

      If yes, please describe.

d. Do you have any other recognition program for preceptors?

Yes ڤ No ڤ

If yes, please describe:

e. Do you evaluate your preceptors?

Yes ڤ No ڤ

If yes, please describe how you do this:

10. Do you offer any inter-professional or inter-disciplinary practicums?

Yes ڤ No ڤ

If yes, please describe these placements and how they are funded and administered.

11. If your school is presently negotiating offering a new or different model of clinical / practice education, please describe what you plan to do. If necessary, attach another page.

*Thank you for your time in completing the questionnaire and the information you have provided. Please fax the completed survey to*

**CASN National Office at (613) 235-4476 by June 16, 2003.**