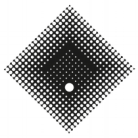
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# Evaluation of resource allocation for undergraduate nursing professional experience placements coordination in Australian Higher Education; a cross-sectional study with descriptive qualitative thematic analysis.

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## Abstract

**Aims and Objective:** To assess the implementation of standards by Australian Nursing higher education providers as set by accrediting and regulating bodies and to identify any barriers or enablers to optimizing Professional Experience Placement. To recommend strategies for safeguarding and improving any identified enablers as well as mitigating factors for any identified barriers.

**Background:** Professional Experience Placement is an essential element of all accredited Nursing Programs in Australia. The Australian Nursing and Midwifery Accreditation Council is responsible for developing accreditation standards and mandates minimum of 800 hours of Professional Experience Placement scaffolded across curriculum which some Higher Education Providers set as their exact baseline for clinical placement duration.

**Design:** Descriptive study using; questionnaire survey with qualitative thematic analysis and CROSS checklist.

**Method:** Quantitative method with descriptive qualitative thematic analysis and purposive sampling was used to target 37 higher education institutions that offer BN and BN/BM programs, 33 of these institutions were randomly selected for inclusion. Data was collected over a six-week period from 24th May to 4th July 2022 using Qualtrics online survey.

**Results:** Out of the 33 Higher Education providers who were invited to participate, 51.5% (n=17) responded. The respondent's demographics were: 94% Bachelor of Nursing only placements coordinators while one respondent reported covering both Bachelor of Nursing and Bachelor of Midwifery; Most of the respondents (65%) were in 40-55 years age group. The respondents reported to have overall responsibility across one to 6 campuses (Mean=2.2) and having support/administrative staffs ranging from 0-15 (Mean=4.11). Student population among the institutions ranged from 500-7500 with a mean of 2365.38. The number of campuses covered had statistically significant relationship with the student population ($p<0.001$; 0.392 to 0.929 confidence interval) however no statistically significant relationship with the number of administrative staff allocated ($p=0.319$; -0.297 to 0.704 confidence interval).

**Conclusions:** While great processes are in place across higher education sector in formalizing nursing professional experience placement, important challenges still exist across the nation that need to be addressed. The quantitative findings should be interpreted with caution given the low questionnaire response rate.

**Keywords.** Nursing; Nursing education; Clinical coordination; Higher Education Providers; Professional Experience Placement.

## Introduction:

Background

Professional experience placement is an essential element of all accredited Nursing Programs in Australia. The Australian Nursing and Midwifery Accreditation Council (ANMAC) is an external accrediting body established by the Nursing and Midwifery Board of Australia and are responsible for developing accreditation standards approved by the Board. Australian Nursing and Midwifery Accreditation Council assess programs of study and program providers to ensure compliance with the accreditation standards for safe provision of service to the public.

Essential to the standards is curricula that incorporates theory and simulated learning experiences to prepare students for professional experience placement (Ardern, 2022; Bridge et al., 2022). Australian Nursing and Midwifery Accreditation Council (2019) defines professional experience placement as the component of nursing and midwifery education that allows students to integrate theory and knowledge in the application of practice within the consumer care environment. These environments include a variety of settings across healthcare and are not limited to the inpatient hospital settings. Australian Nursing and Midwifery Accreditation Council mandates a minimum of 800 hours of professional experience placement (ANMAC, 2019) scaffolded across curriculum, however there is variation in exact hours set above the minimum standard hours across Higher Education Providers. The minimum hours required and reasons for the minimal hours have also been questioned by experts (Schwartz, 2019).

Purpose/Aim

The purpose and aims of this research project are to.

- Examine whether the standards set by ANMAC under the auspice of the Nursing and Midwifery Board Australia and implemented by higher education providers are well supported within the higher education providers to achieve the underlying pedagogical principles related to the learning outcomes associated with the curriculum.
- Explore the barriers and enablers to securing quality professional experience placement for undergraduate Bachelor of Nursing (BN) and Bachelor of Nursing and combined Bachelor of Nursing/Bachelor of Midwifery (BN/BM) programs in Australia. In addition, this study will examine the resources allocated to this role which is an essential component of the BN and BN/BM programs and seek variations that may

exist among Australian universities expectations on clinical coordinators of professional experience placement, clinical venues, and outcome for students.
- Examine the existence of variations across higher education providers in relation to professional experience placement models, the proportion of professional experience placement hours across curricula and outline the associated financial implications related to unsatisfactory completion of professional experience placement.
- Present the perspective of the target population on anticipated process improvements.

The objectives of the study are to: Identify the barriers and enablers to optimizing professional experience placement in higher education; set strategies for safeguarding and improving on identified enablers; recommend mitigating factors for any identified barriers.

## Method

Design and setting

A cross-sectional study with descriptive qualitative thematic analysis was performed using online survey questionnaires. The checklist for reporting of survey studies (Sharma et al., 2021) was used as a guideline. The settings were Australian higher education providers offering BN and BN/BM dual degrees who were invited by email to complete the online Qualtrics survey. The rationale for the methodology choice was to achieve the study aims as the required data would be best captured using a quantitative methodology, with the descriptive design gathering information from the professional experience placement staff perspective.

Developing the questionnaire

The questionnaire draft was developed by the lead researcher and reviewed by the study team members. It was independently validated by two non-study team members who were conversant with professional experience placement coordination roles and processes. The final questionnaire (Appendix A) was made up of two sections, section A which collected data on staff demographics while section B collected data on the professional experience placement coordination process, outcomes, staff ideas and thoughts on how to improve the role.

Ethics and participants

The study received institutional ethics approval from the Federation University Human Research Ethics Committee Reference No. B22-002. Targeted participants were professional experience placement coordinators across Australian higher education providers offering BN and BN/BM programs' who routinely coordinate undergraduate Nursing and Midwifery clinical placements in their respective institutions/universities.

Purposive sampling was used to target 37 higher education institutions that offer BN and BN/BM programs. Using Open epi statistical calculator with the following assumptions: 50% anticipated frequency (participation), 95% confidence interval and design effect of 1.0 and 80% statistical power, the sample size was 33. The sample was randomly selected from the target population using SPSS™ 27. The selected population were contacted through their email addresses which were obtained from the National Network of Clinical Coordinators.

Potential participants were invited through emails where a plain language information statement explaining the study processes was distributed together with an email text with a link and QR code for the questionnaire. Prior to proceeding with the survey questionnaire, participants were informed within the plain language information sheet that a consent check box would be required to be completed indicating their agreement to and being informed of the study participation. There was no significant participant commitment required beyond completing the 10-minutes questionnaire and participants had the choice to withdraw from the study any time before the data were aggregated without consequences.

Data collection and analysis

Data was collected over a six-week period from 24th May to 4th July 2022 using Qualtrics online survey. After the initial questionnaire distribution via emails on the 24th of May, follow-up email reminders were sent to the participants over 3 occasions during the data collection period.

The survey responses were exported from the Qualtrics software to SPSS™ 27 software where data analysis commenced. Numerical data were fitted into 95% Confidence Interval (CI) and presented as counts and percentages. Where there were missing values, the data were presented as n (number of cases) / N (number of instances where the value was known) with no assumptions made about missing data. Data was entered in a Microsoft Office Excel Spreadsheet and imported to SPSS™ for analysis. Numerical data were classified accordingly and presented in counts and percentages where necessary. Categorical data were analysed using chi-square tests or fisher's exact tests to compare proportions. Ordinal, interval and discrete data were analysed with Kruskal-Wallis test, bivariate correlation and linear regression tests with statistical significance indicated by a two-sided P value <0.05 and Confidence Interval (CI) range. For short answer questions, thematic analysis was undertaken where two study members arranged and coded the response into themes.

## Results

Higher education providers invited to participate were 33 out of the total 37 of which 51.5% (n=17) responded. Demographics of the respondents were as follows: 94% reported

belonging to the nursing profession while one respondent reported belonging to both nursing and midwifery; Most of the respondents (65%) were in the 40-55 years age group; The length of period the respondents reported having practiced their profession and other respondents profile data as listed in Table 1. Ninety four percent of the respondents reported having a Master or Doctoral degree qualification and the positions held ranged from Academic Level A to E with the majority holding Levels C (53%) and B (23.5%) academic positions.

The respondents reported to have overall responsibility across one to 6 campuses, with administrative staff support ranging from 0-15 (Mean=4.11, SD=3.763) with 15 being an outlier (Figure 1). As detailed in table 3, the respondents provided feedback under broader themes of '*subordinance of practice'* and the roles being *'disconnected, disempowered and devalued'* with comments such as requiring - "*"More administration staff, more training support for clinical coordinators, more clinical coordinators"*.

Student population among the institutions ranged from 500-7500 and had a statistically significant relationship ($p<0.001$; CI, 0.392 to 0.929) with the campuses covered. However, the number of campuses covered had no statistically significant relationship with the number of administrative staff allocated ($p=0.319$; CI, -0.297 to 0.704). Administrative staff numbers were also found to have no statistically significant relationship with the student population ($p=0.887$; CI, -0.521 to 0.580). Reported proportion of PEP time in the total programme duration ranged from 4%-95% with a mean of 37%. Table 2 shows further breakdown of resources allocated and outcomes with staff classifications as the dependent variable.

Staff response on required resources to match the clinical placement proportion in a free text entry captured the following main themes with related quotes as detailed in Table 3 with key quotes on resources requirement being, "*"Internally, better admin support to manage complex contractual arrangements that see fines implemented for late name changes, students withdrawing from prac late etc. Enrolment of students to placement availability rather than mass enrolment without consultation and then trying to find placements that don't exist"*

In relation to professional experience placement models embedded across health settings, respondents generally reported the use of mixed clinical placement models using block, flexible and integrated higher education providers/clinical placement providers and/or clinical school-based models. ANMAC do not stipulate the models of professional experience placement, this is directed by the clinical placement providers and the individual organisations capacity to support students with higher education providers being at the peril of the clinical placement providers.

Among the respondents (n=14), 28% reported utilizing external preceptors with one respondent reporting the use of employed clinical lecturers as facilitators. Many respondents were unsure on facilitator arrangements stipulated by the clinical placement providers. Frequency of visitation to the clinical areas by the respondents is shown in Table 4. The frequency of visits to clinical venues had no statistically significant relationship with proportion of clinical placement time p=0.016. The themes listed in Table 3 emerged when respondents were asked about the reason for the frequency of their visits to clinical venues. When respondents (n=14) were asked whether extra allocation of resources was required to improve the quality, satisfaction, and engagement of students during placements, 93% responded “Yes” and in a free text response, the participants gave the feedback as shown in Table 3 with emphasis on coordinated approach, “*“A central placement system may be useful, standardisation helpful”.*

In relation to the proportion of students with unsuccessful professional experience placements, 93% of the respondents reported ≤10% of their students failing their placements whilst the remaining respondents reported the proportion to be >10% but ≤25% (n=14). Acute (30%) or mixed specialties (30%) represented the largest areas where the students were not successful, followed by sub-acute at 12% and then aged care (6%). The annual cost related to unsuccessful professional experience placements were quantified by 9 respondents with a range of $0 to $1.2 million, mean of $160,000.00 The remainder of the respondents reported unsuccessful professional experience placement to be very expensive (n=1) or were unsure (n=4) of the cost. The loss resulting from unsuccessful completion was found to be statistically associated with the number of support/administrative staff working in the role with the professional experience placement (p=0.014, CI 19947.993 to 110678.109) but not statistically associated with the population of students across higher education provider (p=0.572, CI, -130.847 to 215.315), the number of campuses the professional experience placement coordinator was responsible for (p=0.136, CI, -33940.675 to 185614.328), or the proportion of clinical placement duration (p=0.510, CI, -6548.923 to 11535.045).

When respondents were invited to suggest future key process improvements to PEP roles, they anticipated over the next 12 months period, the themes, and related quotes in Table 3 emerged. When respondents were asked whether they had any further information they wished to share on the role, the common theme that emerged were; A Broken System or the Work is Never Done as captured by the following respondents shared feedback regarding their professional experience placement Role.

*“I burnt out from this job. I had to be the main point of contact for private and public organisations and each organisation has something different in regard to pre-requisites to having”*.

*“I also had to manage complaints between staff and students and also visit sites. I was on-call at night and on the weekends and I did not get paid for this. I got burnt out”*.

*“It is a great job but it is very constant. Eg never lets up - commences Jan 1 and goes to Dec 24th! More staff would support this. Very difficult to get any research done so well done to you!”*.

*“This portfolio is the busiest in any nursing school. It should be awarded a respectful workload”*.

## Discussion

Preparing students safely for professional experience placement which is scaffolded across the curriculum is integral to the registered nurse accreditation Standards (ANMAC, 2019), Professional experience placement is also a mandatory component of the undergraduate BN and BN/BM curriculum that prepares students for transition to practice and to the registered nurse health workforce. Despite the importance of professional experience placement and the roles associated with its implementation to support undergraduate BN and BN/BM students there are ongoing challenges across professional experience placements related to mentoring, monitoring and evaluation of students and support for academic roles that support Professional Placements which are yet to be addressed both locally and internationally (Jansen et al., 2021; Rosina et al., 2022; Strandell-Laine et al., 2022).

This study highlighted important process issues and variations amongst Australian higher education providers in relation to professional experience placement implementation. Important to note is the inconsistency related to minimum hours set by higher education providers with some providers working to meet the minimum 800 hours of professional experience placement set by ANMAC (2019) and other providers having additional hours. Despite the minimum hours there is consistent feedback on this duration not being sufficient to equip the students with the required knowledge and skill set when transitioning to the role of a professional registered nurse (Schwartz, 2019).

Qualifications of professional experience placement/clinical facilitators particularly the preceptors were also raised to be a factor (McCarthy & Murphy, 2010). In this study, the results portray clinical coordinators at an academic level were well experienced but there was a lack of information on preceptorship or clinical educator’s roles, qualifications and institutional position descriptions differences. The role of the preceptor is said to be critical to the transition of student to the professional experience placement environment and to the newly registered graduate nurse however there seems to be lack of uniformity in the

definition of a preceptor or those guiding principles to assist professional registered nurses in their role as preceptors.

This could raise some concern related to current workforce shortages and perceived inexperienced workforce currently supporting a new and increasingly higher volume of registered nurses given the requirements for the future and the pressure on government to recruit into health. The study participants raised concerns on how much higher education providers or even clinical venues undervalue the role of the professional experience placement/clinical coordinators and clinical facilitators within the clinical placement providers as this study states, *"This study identified the importance that a CF needs to be a respected clinical leader with emotional intelligence, a critical thinker and resilient"* (Rosina et al., 2022, p. 388). It is evident from the study that greater onus is placed on academic support for the delivery of curriculum theory despite professional practice being a substantial part of the course. Many participants in the Professional Practice role stated they worked in isolation with little support and decreased resources in comparison to their counterpart's delivering theory. These staff were often on call, worked increased hours, particularly through COVID-19 pandemic conditions to support students with lack of workload or acknowledgement of the huge role. This can also lead to less robust processes through lack of resources which may see the integrity of the curriculum compromised.

Concrete evidence lacks on clinical placement costs and benefits (Bowles et al., 2014). However, findings on wasted funding for unsatisfactory completion of clinical placements strain institutional financial resources as students are required to repeat the clinical placement hours at a cost to the higher education providers. This exerts further financial burdens in an economic climate which is already under pressure (Jessup et al., 2022; Roos et al., 2016; Usher et al., 2022) and one in which higher education providers have been required to make fiscal constraints across the board. In addition, demands on the university to source extra clinical placement hours places further stress to the clinical environment which is already at capacity.

The clinical placement attracts a larger than usual workload demand for higher education staff (Bilgin et al., 2017) which impedes the staff's capability in identifying students' needs and ensuring inclusivity for students with special circumstances/needs (Wenham et al., 2020). Some institutions allocate multiple clinical coordinators and/or administrative staff in comparison to others. There are multiple clinical placement models used by higher education providers and their professional experience/clinical placement providers (Birks et al., 2017; van der Riet et al., 2018). Visits to clinical/health care venues form part of the ANMAC requirements to ensure that health facilities/venues are risk assessed to guarantee

safe and supported student learning, to safeguard best practice clinical learning environments and to ensure that Registered Nurses are suitably qualified to support and assess undergraduate students during professional experience placement curricula requirements (ANMAC, 2019). This may have been affected over the last two years due to the impacts of COVID-19 and limitations on visitation to venues particularly across jurisdictions which prevented higher education providers staff from attending professional experience placement. In addition, new venues which assisted in facilitating student experience placements as a mitigation to COVID-19 and to ensure the Health Workforce supply remained uninterrupted may not have been assessed for quality clinical learning environments. Further investigation into the individual demands of these models and the impact on associated professional experience placement coordinators roles and workload demands with consideration of COVID-19 impact is essential.

Whilst the RN accreditation standards set by ANMAC are written to be implemented by higher education providers, the higher education providers and clinical placement providers are often not aligned and do not work synchronously. In addition, higher education providers have individual pedagogical learning outcomes for units of study that have been accredited , however these are often not specifically aligned to the assessment tools that are used in the clinical environment instead are related to the Registered Nurse Standards of Practice that students need to achieve by course end (ANMAC, 2019).

While ANMAC (2019) is taking positive steps in relation to enhancing the quality of clinical placements in Australia through the development of the National Placement Evaluation Tool under the National Placement Evaluation Centre (NPEC, 2022) and Health Education Services Australia (HESA), an important finding in this study was the lack of standardization across the professional experience placement/clinical coordination roles and activities across higher education providers and similar trends have been reported internationally (Jansen et al., 2021). Given that, undergraduate BN and BN/BM students will be deployed in varying healthcare settings across the country or even internationally, it would be prudent of higher education providers to equip them with the same level and quality of skill set and knowledge to ensure that, they are well rounded graduates and safe practitioners.

This study has important limitations, particularly with the low survey response rate which has the potential to introduce selection bias and implications on the generalizability and significance of this study to wider audience. The lack of pre-validated survey tool is also a limitation as this resulted in our development of this individual questionnaire tool for a single point in time use.

## Conclusion

While great progress has been made in the formalization of nursing in higher education, there still exists important challenges across the nation that needs to be addressed. Structured support for academic staff in professional experience placement Roles, Standardization of the roles positions and terms of references across institutions Nationally, involving professional experience placement staff in role related financial planning and resource allocation processes and better recognition of the important role the staff play in enabling higher education providers meet their curriculum accreditation can be the starting point in streamlining the role, minimizing related loss, and improving student skills and outcome. The quantitative findings should be interpreted with caution given the low questionnaire response rate.

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**Tables**

Table 1. Demographics and profile (n=17)

| Variable | Minimum | Maximum | Mean | SD |
|---|---|---|---|---|
| **Age group range (Years)** | 25-39 | ≥56 | | |
| **Total practice period (Years)** | 11 | 40 | 29 | 8.581 |

| | | | | |
|---|---|---|---|---|
| **Practice period in other HEP** | 1 | 15 | 7.5 | 6.245 |
| **Current role practice period (Year)** | 2 | 21 | 8.84 | 5.131 |

Table 2. Resources allocated and outcomes (n=17)

| | **Academic Level** (Dependent Variable) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Variables** | **A (2)** | **B (4)** | **C (9)** | **D (1)** | **E (1)** | **Mean** | **SD** | **CI** | **P Value** |
| **Total number of BN students (n=13)** | 500-550 | 1500-3500 | 1000-7500 | 1000 | 3000 | 2365.38 | 1881.199 | -0.278-0.758 | 0.258 |
| **Campuses responsible for (n=14)** | 1-2 | 1-5 | 1-6 | 1 | 2 | 2.21 | 1.578 | -0.597-0.484 | 0.789 |
| **No. of Admin/support staff (n=14)** | 1-2 | 4-15 | 1-8 | 3 | 6 | 4.11 | 3.763 | -0.427-0.641 | 0.606 |
| **Clinical Placement proportion (%) n=14** | 29-95 | 4-33 | 27-58 | 40 | 25 | 36.61 | 20.534 | -0.569-0.515 | 0.897 |
| **Annual ≤10% Unsuccessful placement reported by %(n) n=14** | 15.4(2) | 23.1(3) | 46.2(6) | 7.7(1) | 7.7(1) | 1.07 | 0.267 | -0.460-0.617 | 0.706 |
| **Unsuccessful completion related cost ($) n=9** | 0-8000 | 1200000 | 2000-82500 | 42000 | 17500 | 160000 | 390806.938 | -0.524-0.788 | 0.539 |

Table 3. Staff responses to open ended questions (n=17)

| **Question** | **Themes** | **Related quotes** |
|---|---|---|
| What resources do you think the university should allocate to this role? | The subordinance of practice | "*1 person to manage the role with no other responsibilities. Admin support"*.<br><br>*"Admin staff to manage the allocation of placements, Admin staff to manage the mandatory requirements to attend placement, Academic and Technical staff to source and support placement providers"*.<br><br>*"More admin support and more support in managing pre-clinical prep (mandatory requirements for prac)"*.<br><br>*"More administration staff, more training support for clinical coordinators, more clinical coordinators"*.<br><br>*"More professional staff support More time in my working day"*. |

| | | |
|---|---|---|
| | Role Recognition – Disconnected, Disempowered and Devalued | *"Myself + 2 permanent support officer roles. Please note, that although for the question regarding academic level, as i had to put in an answer, I nominated Level A. However, I am a professional staff member, HEO 7*"*.<br><br>*"I chose "Level A", however, my role is classified under the Profession staff award. Resources for partner relationship building are preferred also*"*. |
| Reason for the frequency of your visit to clinical venues | The Power of Presence | *"Building partnerships"*.<br><br>*"Maintain connection with the university, support relationships with industry"*.<br><br>*"To maintain relationships"*. |
| | Maintaining Requirements | *"ANMAC regulation to maintain relationships and complete mandatory forms such as risk assessments etc"*.<br><br>*"Another role is responsible for students once they are in placement. My role relates to ensuring students are compliant and allocated appropriately"*.<br><br>*"A large number of facilities that span across and large Geographical area, plus COVID. Insufficient workload allocated to visit facilities"*. |
| Extra resource allocation's requirement to clinical placement to improve the quality, satisfaction, and engagement of students during their placement | Personnel related | *"Due to the shortage of staff, innovative advancements are often put to the side".*<br><br>*"More personnel will support improved capability to monitor the quality of clinical placement and implement improvement initiative in collaboration with industry"*. |
| | Coordinated approach | *"A central placement system may be useful, standardisation helpful".*<br><br>*"Both students and facilities feel more supported with regular contact".*<br><br>*"Everything is too rushed and not as supported as it should be"*.<br><br>*"Often there is delay in student placement allocations, or responses to emails etc"*. |
| | Simplification of processes | *"There is now so many pre-placement requirements for the students, some of it very complex, that to ensure this is completed correctly needs time".*<br><br>*"The role of the clinical coordinator is complex and resource allocation is definitely required"*. |
| Key process improvements you foresee over the next 12 months | Resources | *"Additional staffing, reduction in admin and support tasks due to covid"*.<br><br>*"Lessen staff burnout rate. the turnover is remarkable and often novice academics are allocated the role"*. |
| | Engagement and enrolment | *"Additional compliance, increasing enrolments"*<br><br>*"Internally, better admin support to manage complex contractual arrangements that see fines implemented for late name changes, students withdrawing from prac late etc. Enrolment of students to placement availability rather than mass enrolment without consultation and then trying to find placements that don't exist".* |

| | |
|---|---|
| | *"More improved preparation of students to understand the importance of clinical placements".* |
| Quality improvement | *"Improved goal setting and Clinical learning plans have been implemented. and remediation".*<br><br>*"Communication between CPP and EP".*<br><br>*"Improving preplacement mandatory requirement compliance. Improving clinical facilitation processes to improve student experience".*<br><br>*"Increased placement information to stakeholders should be earlier and concise".*<br><br>*"National Placement Evaluation Centre implementation".* |

*The Qualtrics survey contained academic staff classifications and did not consider professional staff roles(hew/o).

Table 4. clinical coordinators frequency of visits to clinical venues (n=14)

| Visit Frequency | Occurrence | Percent | Mean | SD |
|---|---|---|---|---|
| **Random days in a Week** | 1 | 7.1 | | |
| **Weekly** | 2 | 14.3 | | |
| **Monthly** | 1 | 7.1 | 6.50 | 1.653 |
| **Once every few Months** | 6 | 42.9 | | |
| **Never** | 4 | 28.6 | | |