**Fact Sheet: The Impact of Health Care Reform on Nursing Student Clinical Placements**

Why are clinical placements necessary for learning?
Clinical placements provide students with the opportunity to develop confidence in their skills, allow them to apply their theoretical background to practice, and increase their feelings of responsibility for their patients. Students have the opportunity to assess, diagnose, and manage multiple clients in a short period of time under the direct supervision of a faculty member in the hospital setting. Community sites encourage independent decision making reinforcing professional practice and provide increased opportunity to address the goals of health maintenance and disease prevention.

What does the research say about current clinical placement issues?
A survey of institutions (Nicklin, 1997) across Canada found that changes in the hospital and university setting had an impact on the availability of student placements. These changes included fewer beds, less clinical areas available, movement of staff due to layoffs and redeployment, increasing acuity of patients, 5-6 different types of students in the patient environment, a shift to shortened length of stay and ambulatory care, fiscal constraints leading to fewer faculty, clinical competence of faculty, curriculums not seeming to adapt at the same pace as hospital restructuring, and universities/colleges not always aware of hospital changes.

(a) Fewer beds
- Hospitals are treating fewer inpatients and discharging them earlier, thus decreasing the number of students that hospitals can accept. Previously, hospitals could afford to have 10 students and one staff on a unit, but now only four students and one staff member are allowed due to decreased numbers of patients on units (Mezibov, 1997).

(b) Less clinical areas available
- A survey of nursing schools found that the “single most significant factor” affecting a program’s ability to expand is the availability of hospitals, primary care clinics, and other facilities as sites for clinical instruction. The supply of clinical sites dictates whether educational programs can expand or cut back. Many nursing schools have found it increasingly more difficult to secure enough clinical slots for students at both the bachelor and graduate-degree levels. As more hospitals consolidate or merge, such specialty units as pediatrics, psychiatry, and obstetrics/gynecology are closed or concentrated at one facility only, further diminishing an already limited supply of clinical sites (Mezibov, 1997).

- Community sites that nursing schools have used for years are being approached by other disciplines. “Medical schools are interested in sites they would not touch in the past - homeless shelters, community health centres, inner-city clinics - sites where nurses...have committed themselves for decades” (Mezibov, 1997).

(c) Movement of staff due to layoffs and redeployment
- Surveys indicate that hospitals are employing more unlicensed aides, thus decreasing the number of registered nurses per floor and permitting fewer students per shift (Mezibov, 1997).
(d) Increasing acuity of patients

- Anecdotal evidence states that the problems of clients in acute care settings are too complex for student nurses. Clinical education in these settings are not compatible with teaching basic concepts, principles and skills fundamental to nursing. The acuity level of patients in hospitals and long-term care facilities challenges the skills of beginning level students, threatening their self-esteem and the safety of patients. Instruction and nursing management for perioperative, perinatal, and convalescent clients once handled in hospitals have moved to the home, long-term care facilities, and other community-based practice sites. Many community health agencies are prepared to support the needs of more advanced students but may not be prepared to provide more than observational experiences for students learning communication, teaching, health assessment, screening and hygiene skills (Faller, Dowell & Jackson, 1995).

- Patient acuity in home care situations is increasing also, making clinical placements in this setting more difficult to arrange. Smaller agencies may not have adequate numbers of nurses to pair with students and if they do, it is a labour intensive option. The nurse’s schedule may not coincide with that of the student (Andresen, 1995). Higher caseloads, drive for higher productivity and reimbursement issues mean the loss of clinicians who have long acted as on-site “preceptors.” “Cash consideration may be the only way to retain some preceptors” (Mezibov, 1997).

(e) Shift to shortened length of stay and ambulatory care

- Acute care institutions are encountering problems such as shorter lengths of stay, increased patient acuity, and added technical expectations. In the ambulatory setting, students are faced with sicker patients, the need for high-level independent judgement, and strict charting requirements necessary for reimbursement (Tompkins, 1996).

Possible solutions

- Students may be moved to 12-hour clinical shifts in programs such as obstetric/gynecologic nursing to meet the limitations set by clinical sites. Evening experiences may be utilized because the daytime is becoming too hectic to accommodate students. Limiting the number of students in a group will ensure better supervision, as well as ensuring joint appointments with clinical agencies (Mezibov, 1997). Another possible solution is to assign students to a program or specific patient populations as opposed to a ‘unit’ (Nicklin, 1997).

- Changes in the health care delivery system indicate that baccalaureate nursing programs increase clinical experiences in primary care settings. Focus on acute care areas would be reduced and increased focus and access placed on ambulatory and day care areas. University nurse educators will be challenged to look further into the community for opportunities to meet educational needs. Collaboration and new partnerships with community and home health agencies, businesses/on-site occupational health centres, respite centres, wellness sites, student health centres, homeless shelters and churches will enhance community relationships, education and the quality of life. Wellness sites such as day care centres; preschools; well-baby and immunization clinics; and elementary, secondary and special education facilities offer valuable learning experiences in prevention and promotion. The services provided by a student may not be reimbursable, but can give the agency increased visibility in the community (McNamee, 1997; Faller, Dowell and Jackson, 1995).

- Expand the role of preceptors to include facilitating student learning. Many agencies promote the facilitation of student learning by staff and encourage their participation as preceptors (McNamee, 1997). Educational institutions must provide support for orienting and developing staff to act as preceptors (Nicklin, 1997). Preceptors and clinical facilities need to be given incentives to take on additional students. Funds used for nursing education could also be used for clinical training at community care access centres, home care agencies and other settings that deliver outpatient care. This would help reimburse preceptors and practice sites for student training and allow for hiring of additional faculty (Mezibov, 1997).

- Clinical practice with patients could be placed at the end of the program. The total number of clinical hours need not be changed, but summed and consolidated at the end of the program. No change in the credit requirement for the program is necessary. Students become eligible for clinical practice after successfully completing all other portions of the program (Tompkins, 1996).