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Stocktake of placement preparation and clinical experience for Aotearoa New Zealand student nurses in aged care settings: July 2023

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Foreword

The global population is getting older. In 2019 there were 703 million people aged ≥65 years. This figure is predicted to double to 1.5 billion, or 16% of the global population, by 2050 (United Nations, 2020). By comparison, Aotearoa New Zealand is expected to see a 36% increase in people aged ≥65 years for the ten years between 2021 and 2031 (Stats NZ, 2020). Since age is the most significant predictor for the most common health conditions, and the prevalence of chronic diseases and disability is also set to increase, pressures on most healthcare services are likely to escalate (Inouye et al., 2021).

The Better Later Life (2019–2034) strategy sets out key areas of action for addressing a response to our ageing population. It recognises the importance of promoting healthy ageing and improving access to services as a fundamental part of the realisation of the strategy. A key factor underpinning this action is the education of health professionals.

Nurses are at the front line of healthcare and are ideally placed to respond to the changing demographic. As a profession, we need to analyse how well we are preparing nurses for undertaking the work that will be required. As educators, we need to anticipate curriculum developments which may be required to support a well-prepared profession.

This is the first of three reports about student nurses and their clinical learning and perceptions of working with older people. A collaboration between researchers from all Aotearoa New Zealand polytechnics, this first report reviews curriculum provision across 11 of the 13 polytechnics offering programmes leading to registered or enrolled nursing practice. As a stocktake of current provision, the findings evidence how the curriculum for student nurses in the polytechnic sector is organised and clinical experience completed. The second report addresses the findings from a study on student nurses' perceptions of aged care. Together, these findings will form the basis of the work's final phase, which will include a consultation with the nursing profession and the broader community about their views of what should be included in the education of student nurses regarding healthcare for older people.

This is our opportunity to ensure the readiness of the future nursing workforce.

Dr Samantha Heath, August 2023

Contents

Literature review

INTRODUCTION

Life expectancy in Aotearoa New Zealand is increasing (Vollset et al., 2020); by 2036 over a quarter of the population will be over 65 years (Stats NZ, 2020). This is a picture of demographic change repeated across the globe. With increasing life expectancy comes the need to provide health services tailored to supporting people living with the increasing morbidity of many diseases, chronic illnesses and disabilities (World Health Organization, 2023a). The requirement for registered and enrolled nurses to provide nursing care to a growing number of older people will increase commensurately. However, the number of nurses working in aged care is decreasing (Nursing Council of New Zealand, 2018), which may continue to decline for two reasons. Firstly, 40% of the current nursing workforce will reach retirement age in the next 15 years, and secondly, data from new graduate destination surveys in Aotearoa New Zealand shows that few newly qualified nurses chose the aged care sector on registration (Nursing Council of New Zealand, 2020a; Nursing Education in the Tertiary Sector, 2022). With the limited availability of nurse entry to practice programmes in the aged care sector (Wilkinson et al., 2016), a widespread nurse shortage, low pay, and an abundance of professional myths about the lack of career opportunities, the outlook may not be set for immediate improvement, despite evidence showing that student nurses have a positive disposition toward older adults (Fradelos et al., 2022; Neville et al., 2014). Elsewhere, the influence of curriculum experience and clinical exposure is responsible for the ongoing negative perception of aged care nursing (Neville et al., 2014; Rababa, 2020). Furthermore, it has been suggested that undergraduate nurses' professional socialisation impacts attitude development and appears to influence decision-making about later career choices (Carlson & Idvall, 2015; Parker et al., 2021). Yet, with careful consideration of content and clinical experience, nursing curricula can promote positive attitudes among students (Mohammed & DeCoito, 2023). As 75% of new nurses graduate from nursing programmes offered by Aotearoa New Zealand polytechnics, there is a need to understand how current nursing curricula are organised and how student nurses complete clinical experience in an aged care nursing context. Therefore, the purpose of this research was to review the different means adopted for teaching and learning about older people and aged care nursing across all Aotearoa New Zealand polytechnics and to use these findings to inform the development of future nursing curricula.

DEFINITIONS

Several terms are used interchangeably within the literature relating to older adults. These terms, 'aged care' and 'aged residential care', will be used consistently throughout this report and are adapted from the definition used by the Australian Government (2020):

> Aged care is the support provided to older people in their home or an aged residential care home. It can include help with everyday living,

healthcare, accommodation, and equipment such as walking frames or ramps.

Aged residential care (ARC) will mean aged care (as described above) provided within an aged residential care facility.

The definition of older people is taken from the United Nations (UN) as being people over the age of 60 years (United Nations, 2020).

THE NURSING WORKFORCE

Since this project began, there has been considerable change in the health and education sectors. In health, Te Pae Ora (Healthy Futures) Act took effect in July 2022 (Ministry of Health, 2022). It established four new entities, including Te Whatu Ora – Health New Zealand, Te Aka Whai Ora – Māori Health Authority, Whaikaha – Ministry of Disabled People and a new public health agency. Establishing these new entities aims to achieve the goals and recommendations for health delivery set out in the wide-ranging Health and Disability System Review (Ministry of Health, 2020). With a focus on population health, these significant changes brought together the opportunity to act on reducing health inequalities and improving future health outcomes by focusing greater attention on equity and the determinants of health, and commissioning services that respond to Māori health needs with commensurate investment in the health workforce. The review of vocational education (RoVE) and the establishment of Te Pūkenga as one national vocational education institution have enabled greater collaboration on the direction and achievement of the health workforce strategy, given the urgency of staff shortages, especially in nursing (Ministry of Education, 2020).

The World Health Organization (WHO) estimates the global deficiency of healthcare professionals will reach 10 million by 2030 owing to an ageing workforce, the impact of retirement and fewer younger people taking up careers as health professionals as a replacement (World Health Organization, 2023b). This is a situation with which Aotearoa New Zealand is becoming familiar. The current predicament related to nursing shortages will be exacerbated over the next 15 years as 40% of the current workforce retires or becomes eligible to do so (Nursing Council of New Zealand, 2020a; 2023). This situation will continue contributing to nursing vacancies across the health sector, particularly in aged care. Paradoxically, despite the falling numbers of staff, preparation for the notable change in Aotearoa New Zealand's demographic must continue at pace because workforce planning is implemented over lengthy periods to accommodate the completion of undergraduate and graduate entry programmes leading to registration. Here, the government has called for investment in non-traditional entry to careers and shorter courses to complete qualifications (HDSR, 2020). In the intervening period, however, the registration of internationally qualified nurses (IQNs) has more than doubled to address the national shortfall (Nursing Council of New Zealand, 2023). Such reliance on an increasing number of IQNs is not sustainable for the long term and, as Chalmers (2020) observes, does not address the ongoing necessity to increase the number of Māori nurses, which may impact the delivery of services that respond to Māori health needs. This has considerable consequences for Aotearoa New

Zealand's ageing population.

In the coming decade, a quarter of the population will be aged over 65 years (Stats NZ, 2020). Within this demographic, Māori life expectancy is increasing, meaning that more Māori and Pākehā will be living longer with disabilities and/or long-term conditions. Furthermore, age is the most significant determinant of disease, indicating that the older the population, the greater the likelihood of health service needs. At the heart of the health and disability service review was a renewed focus on population health. Given the changing demographic and the need to ensure that older adults are well served into later life, there is an urgent need to address nurses' preparation to serve this population. Thus, the aged care component of any preparatory nursing education curriculum has become a priority. Furthermore, nursing curricula need to be examined for their potential to meet the changing needs of society by considering current curriculum provision, including the organisation of theoretical content, associated clinical placements and assessments, the impact of professional socialisation, clinical supervision, and preparation for clinical placement.

THE NEW ZEALAND NURSE EDUCATION CURRICULUM

Fundamentally, a curriculum expresses shared educational ideas, values and beliefs about what students should know and how they will know it. As Prideaux (2003) outlined, curriculum exists at three levels: the planned curriculum, the delivered curriculum and the experienced curriculum. Within a curriculum, there are four essential elements that, when operationalised, will integrate to direct and shape the learning experience for the student. Prideaux (2003) indicates that these elements (content, teaching and learning strategies, assessment processes and evaluation processes) must serve the student, their communities and the broader health service. He further cautions that the curriculum is responsive and should change in tandem with contemporary values and expectations.

In Aotearoa New Zealand, curriculum models and their underpinning philosophies in nursing education are not prescribed. Instead, each provider adopts those most suited for their use, provided that the Education Programme Standards laid out by the regulator, the Nursing Council of New Zealand, are met by students during and on completion of their programme (Nursing Council of New Zealand, 2008; 2010; 2022). The tertiary institution awards the relevant degree, diploma or certificate, and entry to the register is by completion of the appropriate final state examination for registered or enrolled nursing, administered by the Nursing Council. A graduate entry-to-practice programme is also available in some tertiary institutions for students wishing to enter nursing who already have a degree. Competency assessment programmes (CAPs) for internationally qualified nurses and nurses retuning to practice after a break of more than five years are also available. The Nursing Council works with the New Zealand Qualifications Authority (NZQA) and the Committee on University Academic Programmes (CUAP) on quality assurance to support their role as regulator of nursing practice and mandate to protect public safety. There is regular programme monitoring against the prescribed education standards outlined in the accreditation documentation (Nursing

Council of New Zealand, 2008; 2010; 2022). The articulation of standards rather than a prescribed curriculum has allowed Aotearoa New Zealand nurse educators to recognise an Indigenous perspective of nursing. Notably, Te Ao Māori-informed programmes have been developed at two polytechnics. Further, to support upholding Te Tiriti obligations more widely, the Nursing Council education standards ensure that all approved programmes have systems and processes embedded that will serve Māori interests. Specific programmes have also been developed that reflect Pacific-informed world views.

With a standards-led approach, the responsibility for curriculum coherence is left to institutions to design and implement. Choices about curriculum direction and organisation are essential to student achievement, and Rata (2020) clarifies this task's centrality. Arguing for a curriculum that is knowledge rich, Rata (2019) notes that there is a need for it to address both conceptual and procedural knowledge, but that it is in the connection of these the result is 'know-how-to'. Her curriculum design coherence (CDC) model is arguably a blueprint for thoughtful practice in nurse education, especially considering the commentary on the burgeoning content of undergraduate programmes, and conceptual requirements (Epp et al., 2021). However, constructivist perspectives are also upheld in views on nursing curricula. For example, Bruner's (1966) spiral curriculum explores the same concept or topic in increasingly complex iterations, building on students' previous learning (Coombs, 2018). Furthermore, educators cannot dismiss consideration of the impact of social learning (Bandura, 1969) on students through observation, imitation and modelling in a profession like nursing. The institutional policies, resource allocation and institutional slang to which students are exposed reflect what Hafferty terms the 'hidden curriculum' (Raso et al., 2019), and are also seen in tertiary institutions where lecture content, socialisation with other students, and resource materials provided can covertly influence professional development (MacMillan, 2016). The phenomenon of the hidden curriculum can also be specifically related to developing student attitudes towards caring for older people and working in the ARC sector (Carlson & Idvall, 2015; Dahlke et al., 2019; Mohammed & DeCoito, 2023).

CULTURE AND THE CURRICULUM

Cultural diversity within nursing curricula was addressed more than two decades ago when Australia's Nurses' Board of Victoria (Nay, 2002) assessed the aged care nursing components of undergraduate nursing programmes. The Board concluded that, while all nurses were required to be competent in caring for older people upon graduation, there was still a need to improve the current educational practices and opportunities offered. Specifically, the review highlighted the need to adopt more cultural and Indigenous perspectives within aged care nursing course content. Given the persistent health disparities experienced by Indigenous people globally, professional and accreditation bodies worldwide now require that health professionals can effectively deliver culturally specific healthcare (Francis-Cracknell et al., 2022; Hikaka & Kerse, 2021; Nursing Council of New Zealand, 2022). In Aotearoa New Zealand, competencies for registered and enrolled nurses require the

application of the principles of the Treaty of Waitangi to their practice, and that they practice in a manner that the health consumer determines as being culturally safe (Nursing Council of New Zealand, 2012; 2016). Outcomes of other work have recommended that content delivery be moved from simply imparting cultural awareness or literacy of Indigenous health issues towards that of cognisance and adaptability. Nursing graduates must respond appropriately to varying situations and circumstances related to Indigenous peoples' healthcare needs (Coffin, 2007; Nakata, 2006; Williamson & Harrison, 2010). Further, as the Aotearoa New Zealand population ages and our Indigenous population's life expectancy increases, still greater significance will be attached to the need for an appropriate cultural response to reflect the health needs of older people.

Identifying the need for greater emphasis on cultural aspects of aged care has pre-empted a call for a shift in the focus of teaching and learning. Teaching and learning strategies that promote the necessary change in culturally appropriate content delivery have been identified and reported by Francis-Cracknell et al. (2022). Promoting positive reactions to learning about Indigenous health were those teaching methods that encouraged honesty, and included placement preparation, story-sharing by Indigenous individuals, practical patient care, reflective journaling, blended learning, activity-based learning, and learning programmes that ran across undergraduate degrees (Francis-Cracknell et al., 2022). Additionally, the chance to have placements within an Indigenous health service was also well received by learners. While aged care has long been synonymous with learning foundational nursing skills, the current debate suggests that the knowledge and practical skills required by students for aged care clinical experience have moved significantly beyond a basic, acultural threshold.

THE AGEING POPULATION AND THE CURRICULUM

McCloskey et al. (2020) articulate that educators are responsible for ensuring nursing students are work ready and prepared to deliver nursing services to an increasing number of older people. Indeed, including curriculum content related to older people must be a primary focus of modern, responsive nurse education curricula given current population predictions (Boscart et al., 2017; Canadian Gerontological Nurses Association, 2010; World Health Organization, 2023a). The curricular organisation plays an integral part in developing skills and knowledge through exposure to valuable theoretical *and* practical experience. However, given the level of unpredictability that can be associated with both the delivered curriculum and experienced curriculum, issues can arise, especially in the light of work that addresses the sometimes-covert impact and outcomes of the hidden curriculum and the need for adequate student support during clinical experience (MacMillan, 2016; Raso et al., 2019).

Curriculum links to developing perceptions of different specialities are not a new consideration. Previous nursing research identified that curriculum content related to older people has influenced how nursing students have developed their perceptions of the speciality (Carlson & Idvall, 2015; Dahlke et al., 2019; Foster et al., 2022; Hsu et al., 2019; Mohammed & DeCoito, 2023). Furthermore, over the past two decades, researchers have continued

to demonstrate the importance of content related to older people within the undergraduate curriculum (Boscart et al., 2017; Dahlke et al., 2019; 2020; Deschodt et al, 2010; Moyles, 2003; Nay, 2002; Pearson et al., 2001). Recently, Garbrah et al. (2017) echoed the need to ensure that students receive adequate practical and theoretical knowledge for future employment in the aged residential care sector. Curriculum content relevant to practice and care delivery standards with increased and improved coverage of specific topics and sharing of experiences relating to older people is required. Given that older adults will use almost all health specialist services, future nurses must be cognisant of the changing health needs and human development across the senior years. However, as Neville et al. (2014) point out, undergraduate nursing curricula have continued to incorporate little specific theoretical content despite these warnings.

In the USA and Canada, the landscape is different. Both the American Association of Colleges of Nursing (2010) and the Canadian Association of Schools of Nursing (2017) have developed and implemented gerontology competencies suitable for entry to practice programmes. Moody et al. (2020) report on an evaluation using curriculum mapping and identify how students' knowledge and skills developed throughout the programme. Hsieh & Chen (2018) conclude that the change to a more focused and comprehensive curriculum had much to offer nurses' gerontology nursing capability on entry to practice. However, reflecting the North American position back to Australasia requires contemplation on the differences in both programme structure and the length of study required to achieve the respective initial qualification. In what is already a packed three-year undergraduate curriculum in Aotearoa New Zealand, there may need to be careful assessment of how such a proposal would be managed and, further, how it would be maintained in the shorter graduate entry to practice programmes. Notwithstanding these considerations, evidence for the need to address current curricula is available in findings from local research.

In a recent Foucauldian discourse analysis by Foster et al. (2022), nursing curricula were found to perpetuate stereotypical assumptions about older people. These researchers found that aged residential care was viewed by senior academic staff either as a convenient alternative learning space for developing foundation nursing skills or as a learning space only to be considered when other, more desirable, clinical placements were unavailable. The widespread practice of using aged care as a default placement option in the case of a shortage of acute or primary healthcare placements further amplifies the limited importance ascribed to aged care nursing (Foster et al., 2022). Deschodt et al. (2010) indicate that such practices could leave students without the required preparatory knowledge for an aged care clinical placement, given that the theoretical underpinnings of an acute care or primary healthcare module may be focused on other topics, thereby contributing to students' dissatisfaction with their clinical experience. Equally, placing students without appropriate knowledge of aged care nursing in settings centred on caring for older people also increases the chance of experiencing uncertainty and anxiety, which can produce long-lasting negative perceptions (Fowles & Kennell, 2007; Robinson & Cubit, 2007). There is an awareness of the importance of providing students with well-considered aged

care learning opportunities, although caution is expressed by Berman et al. (2005), who were among the first to signal that when integrating aged care content there remains the possibility of obscuring the relevance of the ageing process. De Guzman et al. (2013) and, later, Yan et al. (2022) concluded the most appropriate way to integrate content into the curriculum remains unclear because of the inconsistencies in curriculum approach and the types of evaluation methodologies used.

CLINICAL LEARNING EXPERIENCES

Clinical learning experiences for nurses involve a range of clinical and professional skills learned in various workplace or simulated settings (Bowen-Withington et al., 2020; Chipchase et al., 2004; Lekkas et al., 2007). Simulated clinical learning is also permitted within current Aotearoa New Zealand education programme standards as an opportunity for demonstration and safe practice. Citing Jeffries (2005, p. 97), the Nursing Council of New Zealand (2010) defines simulation as:

> activities that mimic the reality of a clinical environment and are designed to demonstrate procedures, decision-making and critical thinking through techniques such as role-playing and the use of devices such as interactive videos or mannequins. A simulation may be incredibly detailed and closely simulate reality, or it can be a grouping of components that are combined to provide some semblance of reality. (p. 3)

In an integrative literature review of high-fidelity simulation in undergraduate nursing education in Aotearoa New Zealand, Bowen-Withington et al. (2020) found that, although students were receptive to high-fidelity and low-fidelity scenarios, skill transfer to the clinical learning situation did not always occur. For this reason, the number of simulated hours allocated to programme completion is limited for both the registered and enrolled nurse scopes of practice (Nursing Council of New Zealand, 2010; 2022).

By contrast, clinical placements provide the opportunity to attain 'hands-on' practice-based experience vital to developing professionalism, problem-solving, clinical management and psychomotor skills (Hande et al., 2017; Jahanpour et al., 2010). Clinical placements can often stimulate interest in speciality-related sectors such as gerontological nursing, although the reverse is also true (McCleary et al., 2011; Nunnelee et al., 2015; Potter et al., 2013). Clinical experiences are usually within local community health services, often near a particular academic institution, and are prescribed by the Nursing Council of New Zealand for both the registered and enrolled nurse scopes of practice. Registered nurses must complete 1100 hours of clinical learning over the three years of their programme. The Nursing Council further mandates that 150 hours are completed in the first year and that the transition to practice in the final semester is 360 hours (Nursing Council of New Zealand, 2022). Enrolled nurses must undertake 900 hours in their four modules. Clinical learning hours are mandated in sectors like mental health and long-term/disability specialities (Nursing Council of New Zealand, 2010). A principal component of becoming a nurse, clinical learning is where students integrate

theory and practice through direct and indirect supervision and assessment by registered nurses and faculty.

SECURING AND SUSTAINING CLINICAL PLACEMENTS

There is a great deal of complexity associated with clinical placements, from their acquisition to assessing their suitability, maintenance, and role in the socialisation of future health professionals (Abbey et al., 2006; Andrews et al., 2005). The teaching and learning activities available require the preparation of both students and their supervisors to ensure maximum benefit and professional development.

A recent study by Taylor et al. (2017) outlines the breadth of tertiary education providers' challenges in acquiring clinical placements. Among them is the need to initiate and maintain dialogue with placement providers in what could be a time-consuming negotiation process. Autonomous practitioners or placements not affiliated with a larger organisation require more time and effort to recruit. They rely heavily on tertiary education providers continuing to follow up, supporting them, and encouraging their engagement (Taylor et al., 2017). Where tertiary education providers met a perceived lack of interest in hosting students for placements, it added further difficulty in maintaining relationships. Reasons cited for the lack of interest in accepting students for placement were numerous and often intricately related to the clinical environment context. McInnes et al. (2015) also note that registered nurses acting as supervisors in primary healthcare practices highlighted the lack of financial compensation and insufficient physical space as issues impeding their ability to assist with student placement. However, solutions have been innovative and are well documented.

Besides reimbursing the provider or offering financial incentives, Taylor et al. (2017) recommend in-kind support, such as sharing educational resources or providing free professional development programmes for placement provider staff. Another popular support strategy reported throughout the literature is the availability of mentoring for healthcare provider staff as a payment in kind (Peters et al., 2013; Smith et al., 2015; Taylor et al., 2017). Regulatory bodies have previously endorsed such strategies and noted that mentoring provided advantages in the support available for student learning and assessment (English National Board for Nursing, Midwifery and Health Visiting, 2001). A different strategy was to forge and strengthen ties between educational providers and alumni. Here, alumni helped secure new placements by advocating for students, increasing awareness of the programme's value, and directly supporting students on placement (Taylor et al., 2017).

To address the issues of placement negotiation, management, and facilitation of student support while on clinical placements, Taylor et al. (2017) suggest that a 'placement manager' role could be more effective than an academic staff member. However, they concede that educational providers might be more efficient in identifying willing healthcare providers and targeting these in the first instance (Taylor et al., 2017). O'Keefe et al. (2016) were also concerned with improving the management of student clinical placements. These authors conclude that successful placements were developed in areas with positive workplace culture, shared goals and mutually understood

expectations. However, successful placements also rely on the commitment, enthusiasm and preparation of the student allocated to the clinical area.

TIMING OF AND EXPOSURE TO CLINICAL PLACEMENTS

It has been well established that clinical placements for aged care nursing education can occur in diverse settings, possess numerous aims, and be implemented at all phases of nursing programmes (Storey & Adams, 2002). However, the local consensus concerning aged care among senior academics in Aotearoa New Zealand is that aged care clinical experience is synonymous with a suitable first-year placement (Foster et al., 2022). This consensus exists despite there being no regulatory requirement for using aged care to develop foundational skills, nor any mandatory period in which such skills are to be acquired (Nursing Council of New Zealand, 2020b).

In a Canadian-based study conducted by McCloskey et al. (2020), integrating a clinical placement involving caring for older people towards the end rather than at the beginning of a nursing education programme generated interest among students, resulting in aged care becoming a preferred career choice. McCloskey et al.'s (2020) finding is reinforced by that of Foster et al. (2022), where clinical placements implemented at the beginning of nursing education programmes to support learning foundation nursing skills have unintentionally undervalued the depth of knowledge and skills required for aged care nursing and have, subsequently, dissuaded students from careers in aged care. Given these consistent findings, it is difficult to dismiss that both the visible and hidden curricula associated with clinical placements directly affect students' future carer plans (McCloskey et al. 2020). These findings also make sense of the perspective offered by Grealish et al. (2010) and McKenna et al. (2010), who have argued for implementing initiatives that improve the quality of learning during clinical placements and positively influence students' experience.

EDUCATIONAL ACTIVITIES TO ENHANCE CLINICAL LEARNING

An evaluation study conducted by Brynildsen et al. (2014) explored students' perceptions of clinical placements in aged residential care homes following implementation of measures to improve learning in clinical settings. These measures included an introductory programme on the first day of the clinical placement; regular follow-up actions from clinical preceptors (i.e., mainly registered nurses); mutual guidelines for teaching and learning; utilisation of a tool for reflection; regularly scheduled meetings with preceptors and faculty; and co-ordination of supervision to first- and third-year students which explored the potential for peer collaboration (Brynildsen et al., 2014). Of all the measures implemented, students were most satisfied with peer learning that heightened their awareness of their prospective nursing role and increased the variety of learning opportunities (Brynildsen et al., 2014). Measures more concerned with preceptor supervision, preparation of the practice area, and organisation of placements received lower satisfaction ratings, mainly because of contextual issues such as staffing, which caused conflict with models of supervision (Brynildsen et al., 2014). However, the overall positive reaction of students in the study indicated that helpful learning experiences in aged

care placements could indeed be constructed, on the condition that students were adequately prepared and supervised, and encouraged for their stage of learning.

Aotearoa New Zealand researchers have generated an understanding of sustainability in supervising students and enhancing their clinical learning. Dedicated education units (DEUs) allow the whole team to be involved in students' teaching and learning, rather than the more problematic one-on-one situation reflective of the preceptor–preceptee arrangement. Crawford et al. (2018) undertook a mixed-method inquiry following the implementation of a DEU. Overall, the student nurses and staff involved in the study reported positively about their participation. In Canterbury, Aotearoa New Zealand, DEUs are well established, and have effected strong partnerships between health and education (Borren & Harding, 2020). There is also evidence that increased numbers of students can be supported during their placement in clinical areas that are DEUs. Furthermore, as Borren and Harding (2020) observe, there have been reported improvements in staff knowledge and skills from supervising students, and motivation to engage in higher education.

A recent study by Parker et al. (2021) highlights other educational activities that enhanced the clinical learning experience. Nursing students were encouraged to utilise a workbook that included learning activities related to the major features of aged care nursing. Parker et al.'s (2021) findings uphold that integrating focused learning activities dissipates negative attitudes and derogatory or stereotypical labels about older people, and helps students recognise the value embedded within an aged care clinical environment.

PREPARATION FOR STUDENTS' CLINICAL LEARNING

Leonardsen et al. (2021) explored the views of clinical supervisors on student preparedness before clinical placements. Findings from their study indicate that supervisors deemed student preparedness to be the responsibility of both students and their tertiary institution. Further, clinical supervisors had expectations regarding the students' initiative to ensure their preparedness for clinical placements. Preparedness was considered as students' cognisance of the required learning outcomes and opportunities related to their specific course and the allocated clinical area. It was noted that this entailed sourcing relevant material on medical conditions or visiting placement areas beforehand (Leonardsen et al., 2021). Reinforced by other researchers such as Chipchase et al. (2012), supervisors wanted students to have assumed responsibility for their own preparation for placement and to be well prepared theoretically (Webb & Shakespeare, 2008).

Additionally, Banneheke et al. (2017) reveal that professionalism and willingness to learn were traits that supervisors regarded highly, and Leonardsen et al. (2021) comment that supervisors preferred that students had practised a range of different practical skills (i.e., hygiene principles and aseptic procedures) at least once within a simulated setting. However, Parker & Grech (2018) observe that educators have been nudged to rethink pedagogical practices supporting student preparation for clinical placements. This is due mainly to an ongoing lack of placement areas, coupled with the intricacies of contemporary nursing and workforce shortages that restrict

the availability of clinical staff for student supervision. Consequently, there have been calls for the redevelopment of strategies and practices to prepare placement providers and their staff to manage students' clinical supervision (Barnett et al., 2008; Rodger et al., 2008).

PREPARATION FOR SUPERVISORS AND PLACEMENT FACILITIES

A recent review by Splitgerber et al. (2021) underscored that effective clinical learning environments are built on the comprehensive preparation of the clinical staff who will undertake student supervision. Students' development relies on enhanced partnerships between nursing education and providers such as residential aged care facilities, a mutual understanding of aims and constraints, and sharing of resources (Splitgerber et al., 2021). It has been argued that such partnerships benefit students and generate positive impacts for healthcare facilities through improved recruitment and funding directly from collaboration with academic organisations (Loffler et al., 2018). Vitally, however, a favourable clinical placement in aged care also relies heavily on knowledgeable staff who can engage students and deepen their understanding of the depth and breadth of aged care (Eccleston et al., 2015). Knowledgeable practitioners with expertise in aged care nursing promote and nurture positive attitudes among students and can accurately assess the quality of care being delivered, and role model how to initiate evidence-based, holistic care (Ferrario et al., 2007). These studies suggest that the only placement in which students could have such positive experiences might be in aged residential care. However, it is also important to recognise that student nurses can achieve learning outcomes concerning healthcare for older people without a complete focus on this sector. Indeed, the WHO (2015) advise that residential care is only part of the broader picture of healthcare for older people.

Hospital and community settings can add tremendous value to clinical learning opportunities, especially when education and support programmes are available for clinical educators (Hsieh & Chen, 2018; van Iersel et al., 2016; Nay, 2002). Support programmes are most valuable when they address the building blocks for successful placements, described by both Taylor et al. (2017) and O'Keefe et al. (2016). Further, nurse education programmes that make use of clinical placements in a range of clinical settings with older patients, or deliver care for older people with chronic illnesses or for those who are well, also appear to attract students to look at aged care as a future career option (Dahlke et al., 2020; Garbrah et al., 2020). The benefits of positive role modelling and affirming professional socialisation can be far reaching.

PROFESSIONAL SOCIALISATION

Professional socialisation refers to the process in which individuals learn to become part of a group through internalising the associated characteristics (Blais et al., 2002). A consequence of this 'hidden curriculum' is that the socialisation process shapes student attitudes and career preferences (Garbrah et al., 2017; 2020; Hebditch et al., 2020). It involves appropriate values, conduct and skills related to the nursing profession being assimilated

and adopted by students and has been described as a cornerstone of developing professional identity (Din Mohammadi et al., 2013; Hunter & Cook, 2018; Melrose et al., 2012;). It is a process that begins at programme entry and continues through student advancement into the workforce (Black, 2019; Wolf, 2007; Young et al., 2008). Professional socialisation is crucial to nursing students' progress as they transition through clinical settings and, eventually, registered practice (Black, 2016; Wolf, 2016). It is necessary in order to cement professional commitment and strengthen skills such as problem-solving and critical thinking (Nesler et al., 2001).

Notably, all nurses have a crucial role in the socialisation of student nurses and their attitude to aged care employment (Moradi et al., 2017; Strouse & Nickerson 2016; Tahmasbi et al. 2017). Newhouse et al. (2007) conclude that positive engagement with facility staff improved professional socialisation, encouraged interest in the clinical area, and reduced the number of those who wanted to leave. Educators with expertise in aged care were also determined to be essential to student socialisation; their teaching of aged care content increased interest in the speciality (McCloskey et al., 2022; Queensland University of Technology, 2004). In contrast, faculty and facility staff with little to no specialisation or interest in caring for older people adversely affected levels of interest in aged care nursing among the students working alongside them (McCloskey et al., 2022). The literature supports the view that staff influence on students may permeate on both conscious and unconscious levels, directly affecting perspectives on future career opportunities (Jack et al., 2017). Staff who view themselves as good role models for students have a greater tendency towards role modelling professionalism and quality care to students (Passi & Johnson, 2016). Similarly, clinical supervisors with expert knowledge of aged care are pivotal in fostering positive attitudes towards older people (Parker et al., 2021).

A stocktake of clinical placements in Aotearoa New Zealand

The issues raised in this literature review indicate the contemporary issues facing nurses in the current healthcare climate. Moreover, curricula are expected to evolve with changing values and community expectations. The forthcoming change in Aotearoa New Zealand's demographic and the likely impact that will have on nurses at the forefront of healthcare, the dominance of Pākehā models of healthcare and the expected increased life expectancy for Māori, together with the current unification of Aotearoa New Zealand polytechnics and their nursing programmes, make this an ideal time to take stock of what is currently in place, and to reflect on the action required to adopt a nursing curriculum fit to educate the future nursing workforce. Understanding and appreciating the range and diversity of operational nursing curricula related to aged care in Aotearoa New Zealand is not an activity that has ever been completed. Therefore, this study intends to address this gap.

Aim and research questions

The study aimed to replicate research conducted at the University of Queensland (Neville et al., 2008) to review placement preparation and clinical experience for Aotearoa New Zealand student nurses in aged care settings.

The research questions were as follows:

- At what stage of pre-registration programmes are aged care clinical placements undertaken?
- How do polytechnics define aged care clinical placements?
- Which health services are used for aged care clinical placements?
- What educational activities and experiences are offered by the health services?
- In what ways are students prepared for undertaking aged care clinical placements?
- What preparation arrangements are made for staff and clinical teachers to support and supervise students?

Ethical approval

Unitec Research Ethics Committee (UREC) granted ethical approval in December 2021 (2021-1044). Access was applied for and granted by each polytechnic to access staff respondents.

Research method

This study replicated a cross-sectional descriptive survey by Neville et al. (2008). Queensland University of Technology (2004) developed the survey used in the original research in response to the Aged Care Core Component in Undergraduate Nursing Curricula Principles paper commissioned by the Australian Government Department of Health and Ageing (Queensland University of Technology, 2004). Twenty Australian Universities validated the survey's suitability before its use in Neville et al.'s. (2008) research. The current study included a minor adaptation to include the Bachelor of Nursing (BN), Bachelor of Nursing (Māori), Bachelor of Nursing (Pacific), Diploma of Enrolled Nursing (DEN) and Return to Nursing (RTN)/Internationally Qualified Nursing (IQN) competence programmes, as these are also taught in the Aotearoa New Zealand polytechnic sector and were judged to be highly relevant because of their contribution to and impact on the local context.

Australian and Aotearoa New Zealand undergraduate nursing curricula are similar in that both are three-year full-time degrees leading to a Bachelor of Nursing qualification. Each country uses a theory/practice model and has

requirements for completing a set number of clinical hours, meeting objectives for the respective graduate profiles, and demonstrating clinical competencies before students are eligible to register with their respective regulating bodies. Aged care theory and clinical placements are a feature of each curriculum. The programme similarities indicated that the survey could potentially inform a stocktake of existing aged care clinical placements for nursing students in Aotearoa New Zealand.

Representatives from nursing schools at eight polytechnics, who were also research team members, reviewed the Neville et al. (2008) survey. Their initial review was to determine the questions' suitability for the Aotearoa New Zealand context, and whether any language or terminology adjustments were required. The research team shared findings and agreed on alternatives for inclusion before testing. Six nursing lecturers piloted the survey. They had sufficiently detailed programme knowledge to provide commentary on the questions posed. In response to the feedback, three minor adjustments were made.

The survey was available for six weeks in May–June 2022. All nursing programme managers in the Aotearoa New Zealand polytechnic sector were invited to participate via an email from the principal investigator. The email contained project information with a hyperlink to complete the study online. As polytechnics were still recovering from the impacts of Covid-19, programme managers were advised that they could share the link with a colleague who they judged would be able to complete the survey instead, if necessary. Consent was implied by submission of the completed digital survey. The data were confidential and shared only with the project team as needed to conduct the analysis. Responding polytechnics were anonymous to the research team.

Findings

The principal investigator emailed the survey link to programme managers at all 13 Te Pūkenga subsidiaries offering nursing qualifications in May 2022. When the survey closed seven weeks later, there were 12 responses. After data were cleaned and blanks removed, 11 responses were usable. The programmes reported in this research are Bachelor of Nursing (BN), Bachelor of Nursing (Māori), Bachelor of Nursing (Pacific), Diploma of Enrolled Nursing (EN) and Return to Nursing (RTN)/Internationally Qualified Nursing (IQN) competence programmes.

STAGE OF PRE-REGISTRATION PROGRAMME FOR AGED CARE PLACEMENT

Placements in aged care were reported as taking place in all years of the programme. Decisions about placements timing was related to the type of curriculum model used at the educational institution. The most frequently reported curriculum model was an integrated approach (n = 5) whereby different courses within the RN programme included content relevant to older people. Related studies included pharmacology, mental health, continuing

and complex care, lifespan and development, and age-related changes. Polytechnics offering EN programmes concurred with the integrated approach (n = 2). Two other curriculum approaches were identified. The first of these (n = 1) was an integrated approach with a 'deep dive' into the principles of aged care nursing as a specific course. The remaining model was a one-off specific course in Year One (n = 1). For CAP students, related material was reported as being delivered during the theory weeks (n = 1).

DEFINING AGED CARE PLACEMENTS IN THE CURRICULUM

Respondents (n = 9) shared a perspective of aged care placements within the curriculum, with all nominating ARC facilities or any other healthcare provider with an aged care focus as the defining placement for this clinical experience. Other respondents (n = 2) reported a broader view, defining aged care placements as those that could be used to meet relevant learning objectives, for example, from Polytechnic 2 (P2):

> *"Year One [is] a 96-hour placement to learn foundational skills including therapeutic communication. Year Three [is] a 96-hour placement. Leadership, RN practice, chronic care, quality assurance."*

Further, from a different respondent (n = 1):

> *"Aged care clinical placements are used in Semester One Year One for students to build on the newly acquired skills." (P1)*

A further polytechnic (n = 1) formally defined aged care placements in the curriculum as being "any placement that cared for patients over 65 years of age" (P11).

HEALTH SERVICES USED TO PROVIDE AGED CARE CLINICAL PLACEMENTS

Clinical experience providers

While all polytechnics used ARC facilities, it was clear these were not the only option available for clinical experience in aged care. Table 1 shows student nurses' allocation across health services. The private and public sectors were both represented, together with mental health and hospital-based services. Polytechnics least used community nursing agencies and Māori and Pacific healthcare providers for aged care clinical experience.

TABLE 1. RANGE OF HEALTH SERVICES USED TO PROVIDE AGED CARE CLINICAL PLACEMENTS.

Placement type	**No. of respondents (n = 11)**
Aged residential care facility	11
Acute medicine – hospital	6
Rehabilitation unit – hospital	6
Private nursing home services	6
Mental health facilities	4
Acute surgery – hospital	4
Community nursing	3
Māori and Pacific providers	1

Location of aged care clinical experience providers

Placement provision was usually within the same town (73%, n = 8), with only 27% (n = 3) reporting the use of out-of-town but within-island placements. No student had an aged care clinical placement outside of the island in which they were completing their studies.

Planning, organising and paying for placements

Across the country, the number of placements required by a single polytechnic might be as many as 150 per semester. Students rotated to accommodate 30 at the same facility up to four times per year to achieve the number of placements needed. Respondents indicated other options where students being organised in groups of ten at a time for one facility. The size of the facility also impacted the number of students allocated to the clinical area, with a smaller number of students assigned where necessary.

Despite the volume of student placements required, all respondents (n = 11) reported that they were "always" or "often" able to provide clinical experience in aged care for their students. However, 82% (n = 9) also reported that they had experienced placement refusal from their providers.

Asked why refusal occurred, 56% (n = 5) indicated facilities had been closed during the Aotearoa New Zealand response to the Covid-19 global pandemic. Pre-pandemic closure issues were also considered by respondents, with 33% (n = 3) noting that facilities experienced outbreaks of infectious diseases such as norovirus. The availability of clinical support from facility staff was a further consideration for 56% (n = 5), where the number of preceptors limited the number of students allocated. The expressed need for a break in taking students to mitigate placement fatigue for facility staff had also impacted placement availability for one polytechnic. So, too, did local policies that addressed the seniority of students allocated; for example, one ARC facility would only accept Year Three Bachelor of Nursing students. As an ongoing problem, nursing workforce concerns were raised by 56% (n = 5) as a reason for declined placement access.

Seventy-three percent (n = 8) of respondents indicated that they paid a cost per student per day as remuneration for placement provision. Respondents did not reveal the actual charges, and none reported whether payment in kind opportunities, for example, provision of professional development or preceptor courses, were considered by the 27% (n = 3) who did not pay for student clinical experience.

Timing of clinical placements

Respondents (n = 11) highlighted issues with clashes of placement requirements. Polytechnics experienced such difficulties with respect to their programme or another programme provider. Competition for placements was encountered by 55% (n = 6) of respondents. One respondent provided an example of how this might occur in general comments:

> *"[It can] be a challenge to secure dementia placements for aged care course[s] as mental health also access these at the same time." (P3)*

Further complexity occurred with multiple programme intakes each year and in larger urban centres; and with the competing needs of university

providers of BN and other healthcare professional preparation programmes such as medicine, which also required access to the same pool of aged care placement experiences for their students. For RTN/IQN programmes, all polytechnics indicated they provided aged care clinical placements in the clinical phase (eight weeks). Polytechnics can deliver three or more of these programmes in a single year.

The difficulties encountered with placement requirement clashes can be more easily quantified with an overview of each polytechnic's courses (see Table 2) and by viewing the location of aged care clinical experience across the respective programmes (Table 3).

TABLE 2. NURSING PROGRAMMES OFFERED BY POLYTECHNICS.

Respondent number	BN	EN	IQN/RTN
1	X		X
2	X		X
3	X	X	X
4	X	X	X
5	X		X
6	X		X
7	X		X
8	X		X
9	X	X	X
10	X	X	X
11	X		X

TABLE 3. YEAR IN WHICH AGED CARE CLINICAL PLACEMENTS OCCUR FOR BN/EN PROGRAMMES.

Year	BN	EN
1	6*	4
2	4*	4
3	3*	N/A

**Polytechnics offer aged care placements at one or more places in their curricula; hence n does not equal 11.*

Selecting a facility to provide an aged care placement

When asked about the processes used to select aged care clinical placements for student nurses, 64% (n = 7) of respondents volunteered that one or more formal or informal methods were in place to assess the adequacy of a facility. Table 4 summarises the processes used in selection arrangements. Notably, 36% (n = 4) of respondents had no procedures to support selection.

TABLE 4. STRATEGIES USED TO SELECT AGED CARE CLINICAL PLACEMENTS.

Selection processes	No. of respondents (n = 7)
Memorandum of understanding	3
Site visit	2
Anecdotal evidence	2
ARC audit	1

It was also apparent in the responses provided that aside from audit, site visit and memorandum of understanding (MOU), potential placements were also assessed for the adequacy of clinical support that students could expect during their placement, for example: facility staff had completed preceptor training (n = 2); registered nurses were available to work alongside students (n = 3), and had sufficient post-registration experience in Aotearoa New Zealand to be able to sign off on Nursing Council-required documents (n = 1). Answers here also determined the number of students who may be allocated to one facility. One respondent summarised their goal as being to select facilities that

> *… demonstrate best practice, safe and professional behaviours and those who welcome the opportunity to educate student nurses. (P11)*

EDUCATIONAL AND CLINICAL ACTIVITIES AVAILABLE

The selection of a facility to provide clinical experience is strongly linked to the aims and objectives of the course and programme. These are, in broad terms, to integrate theory and practice. At the outset, respondents (n = 2) indicated that placements in ARC were linked to learning specific skills. These differed for junior and senior students. When asked about the educational activities and experiences offered by clinical placement providers, respondents (n = 11) also identified other learning experiences. Table 5 shows the range of opportunities and the general agreement on expectations.

Respondents had an opportunity to provide additional information. One respondent used this category to give a more detailed explanation of the foundation skills available in the clinical placement. The skills identified included developing skills in communication, health assessment, time management, documentation, meeting daily living needs like washing and dressing, experiencing diverse cultural practices, and learning about health and safety concepts within the clinical work environment.

TABLE 5. EDUCATIONAL EXPERIENCES AVAILABLE IN CLINICAL PLACEMENT.

Activity/experience	No. of respondents (n = 11)
Palliative care	10
Dementia care	10
Wound management	9
Infection control	9
Community care	6
Other	5

Polytechnics identified one or more activities/experience; hence, n does not equal 11.

Tailored clinical experience and student need

Despite the challenges of placement availability and the need to match theoretical learning with practical experience, 91% (n = 10) of respondents still considered that clinical opportunities were tailored to meet students' educational levels. They provided descriptions of how this occurred.

One respondent indicated that recognition of prior learning was made for RTN/IQN students, as these students would necessarily have completed a nursing course leading to registration in Aotearoa New Zealand or abroad. More than one registered nurse (RN) was assigned to work alongside an RTN/IQN student (n = 2) for varied experience and, in addition for the IQNs, to understand the role and context of nursing in Aotearoa New Zealand (n = 1). One polytechnic (n = 1) advised preceptors about the differences between students in the IQN/RTN and BN/EN programmes (n = 1).

The tailored experience for an undergraduate student contained different elements. One polytechnic pointed out that Year One students might work alongside healthcare assistants (HCAs) with an RN from the facility supervising in a ratio of 1:6 or 1:10 (n = 1). RN supervision was fundamental to clinical experience in another polytechnic, as Year One and Year Three students were assigned to work alongside them (n = 1). As student placement exposure increased, a different polytechnic included students spending a day with an RN building on clinical skills learned in simulation (n = 1).

Four respondents highlighted preparation pre-placement. Data showed this preparation was conducted as part of theoretical courses (n = 3) or developing skills in simulation labs (n = 2) directly preceding the clinical placement. One polytechnic used an annual placement assessment, with each clinical placement undergoing review to ensure student learning needs were met and tailored to reflect the programme requirements.

STUDENT PREPARATION FOR AGED CARE CLINICAL EXPERIENCE

All polytechnics (n = 11) responded that students completed pre-clinical experience preparation. In qualitative responses, two themes identified the parallel strategies used. Academic preparation (n = 9) included the range of theoretical material to be covered, while simulation lab experience developed practical skills in preparation for the clinical environment (n = 5).

Respondents reported the range of theoretical topics for undergraduate and RTN/IQN students. One respondent outlined the topics covered by Year One students:

> *"Communication principles, cultural safety, and awareness, assessment of body systems noting the changes throughout the lifespan, changes in body systems, i.e., skin changes, immunity, etc., polypharmacy, supporting mobility and nursing an immobile person, experiences of grief and loss, nursing people experiencing dementia, delirium and depression, communication: de-escalation, etc." (P1)*

Respondents reported clinical skill preparation was conducted in the simulation lab (n = 5). Activities in the lab included learning to use a hoist, washing patients, undertaking observations and infection control. An alternate learning framework was offered by one respondent, who identified using a

more integrated model where academic and clinical classes were held before, during and after the clinical experience.

PREPARING FACILITY STAFF TO SUPPORT STUDENTS

Most respondents (64%, n = 7) completed some staff preparation to supervise students in the clinical area. This preparation involved face-to-face meetings with facility staff (30%, n = 4) or in-service education sessions (n = 1) to clarify roles and expectations. Additionally, pre-placement in-person visits allowed polytechnic staff to orientate to the clinical area (n = 1) and check in on student progress during the placement (n = 1). Further to communication in person, emails or MOUs were used to capture written information that detailed the pre-placement preparation undertaken by students; the support that the polytechnic would provide; the assessment documentation to be completed onsite; contact addresses and phone numbers. Learning objectives for the placement were shared with placement providers and included expectations of students at each year level (n = 2). One polytechnic indicated that weekly visits by academic staff were a feature of their support for facility staff.

Participants were asked about the skill mix of the staff who supported students during aged care placements. Table 6 identifies this mix among supervisors across the country. Notably, of the three respondents who indicated enrolled nurses adopted a supervisory role for students on placement, only two delivered a Diploma of Enrolled Nursing programme. One respondent indicated students were allocated to work with HCAs, and another included staff in this role as part of the supervision team.

TABLE 6. SKILL MIX OF STAFF SUPPORTING AND SUPERVISING STUDENTS DURING AGED CARE CLINICAL PLACEMENTS.

Skill mix of staff supporting and supervising students	No. of respondents (n = 11)
Registered nurse employed by the aged care facility	9
Clinical facilitator employed by the polytechnic	9
Academic staff member employed by the polytechnic	8
Nurse educator employed by the aged care facility	8
Enrolled nurse employed by the aged care facility	3
Other: Healthcare assistants/support workers	2
Preceptor employed by the polytechnic	0

Arrangements for direct clinical supervision of students

In polytechnics with no direct supervision arrangements, responses indicated that students were in Year Two or Three of their BN programme or in either year of their DEN programme when their aged care clinical placement occurred. Where arrangements were in place for the direct supervision of students (73%, n = 8), polytechnics had expectations about the skills and qualifications required (see Table 7).

TABLE 7. SKILLS AND QUALIFICATIONS REQUIRED FOR CLINICAL SUPERVISORS PROVIDING DIRECT SUPERVISION.

Skills and qualifications required for clinical supervisors	No. of respondents (n = 8)
Minimum two years' experience as a registered nurse	7
Experience in aged care with no tertiary qualifications	2
Tertiary qualifications but only general nursing experience	2
Tertiary qualifications with experience in aged care	1

Polytechnics identified one or more options; hence, n does not equal 8.

Responses also identified the different models employed to deliver direct supervision for Year One students, and the relevant polytechnics provided outlines. The supervision models highlighted the additional support needs of Year One and other students in nursing programmes. For Year Two and Three students, a weekly visit from an academic staff member was organised (n = 3), and this frequency could be increased if required (n = 1). For Year One students, supervision was described as small groups of 4–8 students with one academic staff member onsite for the whole placement (n = 2). Where an academic staff member did not supervise, registered nurses undertook the task of student supervision (n = 5). Registered nurses were provided by the aged care facility (n = 5) or the polytechnic (n = 1). Where registered nurses were undertaking supervision, one polytechnic reported a ratio of 1:6–1:10. Registered nurses were supported by HCAs who worked alongside students to 'get to know' the residents and routines (n = 1). Registered nurses also assisted student nurses in accessing information required for their academic assessments. They held daily tutorials to reflect on learning and promote professional clinical behaviours, including handover (n = 1). However, where a clinical assessment was needed for course requirements, the academic staff made time for its completion (n = 1). One polytechnic reported covering their arrangements formally in an MOU.

Discussion

AT WHAT STAGE OF PRE-REGISTRATION PROGRAMMES ARE AGED CARE CLINICAL PLACEMENTS UNDERTAKEN?

There was no consensus about the stage at which aged care placements should occur. Our data indicated that half of all BN nursing students experienced an ARC placement in Year One, with all DEN students being similarly allocated. For these students, there was a consistent pattern of preparation and placement to integrate theory and practice, which, as a curricular device, is in keeping with established education practices. There was evidence for the use of a spiral curriculum, where material related to older people's health was explored early in the programme and later with respect to greater complexity in Year Three. This is in keeping with the

work of Bruner (1966) and the nature of the 'spiral curriculum'. The lack of consistency found in the timing of placements within the data is unsurprising given the current debate about the most appropriate curriculum location for aged care placements and the suitability of ARC for Year One students' clinical experience (Dahlke et al., 2020; de Guzman et al., 2013; Deschodt et al., 2010; Foster et al., 2022; Neville et al., 2008).

HOW ARE AGED CARE CLINICAL PLACEMENTS DEFINED?

Aged care placements were defined in the data by the clinical placements used to support theoretical content. Describing placement by type seems to have ensured that ARC facility placements have become the 'gold standard' definition of an aged care clinical experience across nurse education providers. However, although now outdated, one polytechnic defined their placement parameters in keeping with the WHO's definition of older people being those over 65 years (World Health Organization, 2015). Viewing placements using a WHO definition of older people supported using a wider variety of placement venues, such as those available within Te Whatu Ora in-patient services or at non-government organisations (NGOs). This practice sets a benchmark that underscores the need for a shared definition of older people because it influences broader consideration of the placement possibilities and planning for students' clinical experience. This will be imperative for the unified Te Pūkenga nursing curriculum. More troubling, however, is the convergence of a curriculum model with a single exposure to aged care course content and clinical placement.

The work presented here validates the view of Foster et al. (2022), who articulate that an ARC placement is often a convenient alternative to finding a wider variety of placements for the required clinical experience. Furthermore, increased use of a spiral curriculum to reiterate older people's health needs with increasing complexity may be more helpful in preparing the nursing workforce for the demographic situation they will increasingly encounter. As Atella et al. (2019) highlight, when the age of the population rises, so too does the prevalence of chronic disease. This means that older people will become higher users of specialist health services in communities and hospitals, and that future registered nurses will need to be able to provide appropriate health services in almost all areas where they will seek work. Instead of a single, once-and-for-all placement introducing aged care nursing to students, the focus should be on developing the most appropriate methods for integrating understanding of an ageing population whose health needs are likely to use much of the available health resource.

WHICH HEALTH SERVICES ARE USED FOR AGED CARE CLINICAL PLACEMENTS?

All polytechnics identified that they provided exposure to ARC placements. This position aligns with the WHO (2016) recommendation that nursing curricula allow students to develop professional identities within nursing homes and hospitals. However, heavy reliance on them as examples of health services for older people appears to deny some students the perspective that in-patient or community specialities might additionally provide. Further, as a

placement selection, ARC also favours exposure to Pākehā models of care because of this population's high usage of these facilities (Hikaka & Kerse, 2021).

Notably, this study showed less frequent use of Māori and Pacific health services as clinical placements, which could potentially emphasise the absence of older Māori and Pacific people. Given that the population of Māori over 65 years will increase more rapidly than that of non-Māori in the coming years, educators must consider adjusting the clinical experience available to reflect the change (Hikaka & Kerse, 2021; Stats NZ, 2021). Furthermore, respondents did not present a strong inclination towards addressing Indigenous health needs or culture in the indicative content for the placement preparation they outlined. Considering the updated education programme standards (Nursing Council of New Zealand, 2021), the recent wide-ranging Health and Disability System Review (Ministry of Health, 2020), and the recent establishment of four new entities, including Te Whatu Ora – Health New Zealand, Te Aka Whai Ora – Māori Health Authority, and Whaikaha – Ministry of Disabled People, there is an opportunity to develop and strengthen this aspect of a unified Aotearoa New Zealand nursing curriculum (Coffin, 2007; Nakata 2006; Ministry of Health, 2020; 2022; Williamson & Harrison, 2010). Furthermore, any commentary or account about the healthcare needs of older people living with disability, chronic or life-changing illnesses, or mental illness was also absent. Increasing life expectancy and the continued improvement in medical treatment and supportive care will increase the prevalence of older people living with disability, chronic diseases and mental illnesses.

Hospital services provided students with further clinical opportunities within medical/surgical, rehabilitation or mental health services. This is a purposeful development framing general hospital services within the broader context of care for older people and making use of the tremendous learning opportunities identified by van Iersel et al. (2016) and others, and one that could be more widely adopted (Hsieh & Chen, 2018; Nay, 2002). While recognising hospital services as aged care placements is a positive observation, it is essential to consider that polytechnics provide nursing programmes in urban centres. Consequently, there is the further possibility that using additional acute care placements could contribute to preferentialism of hospital over acute and rural health service placements.

In this study, there was little evidence to suggest that rural placements were a feature of aged care clinical experiences provided. In the future, an increasing number of older people are likely to live rurally, which should signal the need for more significant placement development to accommodate more opportunities for clinical experiences of this type. The plight of rural healthcare is recognised in the Health and Disability Services Review (2020). The intention to lift service levels to these communities will allow nurses to explore pathways to becoming nurse practitioners and nurse prescribers, and develop community partnerships that could offer some solutions to meet the health needs of older people who live rurally. Given the broad reach of professional socialisation and the impact of well-organised placements, it is also possible to suggest that widening the scope of placements associated with aged care theoretical content could have a positive effect on hard-to-staff areas (Garbrah et al., 2017; 2020; Hebditch et al., 2020).

Planning and organising placements

Planning clinical experience to coincide with and support theoretical content delivery appears challenging. In this study, the issues reported were twofold. The first issue was the volume of placements required with specific curriculum timing across programmes; second was competition for placements because of curriculum overlap within the same nursing school or other legitimate claims on the clinical opportunity, for example, from medical schools. These problems are not unique and have previously been illuminated in Australia by Neville et al. (2008), and are worthy of further consideration in the current healthcare climate, as each has consequences.

Myriad authors have recognised the global nursing shortage impacting nursing care delivery. Indeed, the associated problems of understaffing have magnified existing stereotypes about the nature and type of work in aged residential care in particular. Many already consider it a less attractive career option due in part to lower remuneration and resourcing issues (Rababa, 2020). This creates a context in which it would be appropriate to suggest that the volume of students allocated to such a clinical experience could impede the quality of the learning experience that might be otherwise available. Furthermore, over-allocating students could be counterproductive in the long term because clinical exposure as a student markedly influences the perception of the speciality and, for the aged residential care sector, goes some way to deterring potential employees (Baumbusch, 2012; Jack et al., 2017; McCleary et al., 2011; Nunnelee et al., 2015; Parker et al., 2021; Potter et al., 2013). Yet, despite favourable consideration in the literature, the value of DEUs was not articulated in this data (Crawford, 2018; Borren & Harding, 2020). More comprehensive implementation of these innovative clinical teaching and learning support systems may assist the sector in transforming its external perception.

In this study, respondents identified that providers had already refused placement access because of over-use and the need for facility staff to have a break from constant student presence. Re-examining the necessity to use ARC facilities as the 'gold standard' for clinical experience in aged care might provide a solution and reduce loading. Given that older people will use almost all medical specialities, there is a need to see healthcare for this population as service wide rather than a specialist service for the most frail and vulnerable. Any reconsideration of placement use would be well framed by including learning outcomes that reflect the care of older people in each course and at the level expected for students across the academic years of their respective programmes. While the literature remains equivocal on whether aged care placements are the most helpful in providing an experience for learning foundational or complex nursing skills, it should by now be apparent that the integration of aged care content would best serve contemporary nursing education practice to support understanding an ageing population from both a health maintenance and a health speciality perspective.

Considering these research findings and including the advancement of Te Pūkenga's unified nursing curriculum across the sector together with the reality that 75% of nurses are educated within this institution, there is an urgent need to consider the redefinition of aged care placements both in and across each year of each programme, as well as understanding the implications

for placement providers. In deference to colleagues in aged care who are currently stretched because of broader health service issues, any increase in placement demand could impact the ambition for the more comprehensive benefits of a unified curriculum to be felt.

Selection and remuneration for the provision of an aged care placement

The data indicated little consistency in the requirements polytechnics use to determine the suitability of placements for students. While some good practices were adopted, an opportunity remains to improve the standardisation of requirements and, thus, expectations of the quality of service required. O'Keefe et al. (2016) identified that successful placements relied on shared goals and mutually understood expectations. Although not recently debated in the literature, a pre-selection placement audit might provide a helpful tool to assess the potential quality of the learning environment, and engage with clinical areas about the mutual benefits of having students on placement and underlining expectations. It could also identify clinical areas where there have been changes in staffing issues, or other resourcing or unexpected events that could detract from the educational purpose of the placement. Furthermore, an annual re-audit and renegotiation of expectations would support an ongoing opportunity to share expertise; for example, mentoring or provision of professional development may, in turn, impact the quality of support available for students (English National Board for Nursing, Midwifery and Health Visiting, 2001; Smith et al., 2010; Peter et al., 2013; Taylor et al., 2017).

Remuneration for placement was also inconsistently applied in the reported data, whether financial or in kind. Few insights in the literature assist with perspectives on fees for service. It would be worth exploring the impact of fee-for-service models on the quality of education provided in the future. However, one lens provided in the literature was by McInnes et al. (2015), who identified that registered nurses who supervised students were not financially compensated. While remuneration is a matter for the employer, it could be a legitimate option for some placement providers in conjunction with any fee-for-service model that might be used in future.

WHAT EDUCATIONAL ACTIVITIES AND EXPERIENCES ARE OFFERED BY THE HEALTH SERVICES?

The data showed that individual polytechnics had considered a range of educational activities and experiences that could be acquired during an 'aged care' clinical placement. Yet the site most frequently reported for clinical placement was ARC, meaning that there is the potential for students' clinical experience to be limited by placement variety. Furthermore, data indicated that almost all students are exposed to palliative and dementia care, wound management and infection control. These can be challenging and complex areas of practice for most qualified nurses. As such, the observation that half of BN students and all DEN students have an aged care clinical placement in Year One suggests that there may be a level of incongruence between the desire to introduce students to clinical practice and teach 'foundational nursing skills', and placement allocations that include some of the frailest members of society. As Foster et al. (2022) and McCloskey et al. (2020b)

articulate, the interaction between the curriculum and placement allocation may unintentionally devalue the depth of knowledge and skill required for this practice speciality.

There is an opportunity to review both the timing and purpose of clinical exposure in aged care for student nurses. A broader view of suitable placements and an appreciation of the imminent shift in Aotearoa New Zealand's population of over 65s between 2021 and 2031 indicates an opportunity to match the stage of learning with the type of clinical exposure. In doing so, learning and exposure to aged care could be more effectively scaffolded and potentially dispel some unnecessary, prevailing professional myths (Moyles, 2003).

IN WHAT WAYS ARE STUDENTS PREPARED FOR UNDERTAKING AGED CARE CLINICAL PLACEMENTS?

Pre-clinical preparation was reported as being provided by all respondents and consisted of academic or simulated content. Decisions about what should be included in the required content for clinical experience preparation appeared to be the domain of the tertiary institution, and this responsibility is reflected in the literature (Leonardsen et al., 2021; Webb et al., 2000). This raises some interesting observations, not least relating to whether placement areas agree that the topics identified are relevant and appropriate. Furthermore, respondents demonstrated that the purpose of placements was not necessarily focused on learning gerontological content, but rather the placement met opportunities to acquire 'foundational' skills. Such a view is at odds with the literature, which provides a view of aged care nursing being a complex and challenging speciality, and a regulator that stipulates the need for students to achieve competency standards across well-articulated domains of practice (Foster et al., 2022; Nursing Council of New Zealand, 2021; McCloskey et al., 2020b). Endorsing that a more extensive view of aged care content is required settles comfortably with the indication from both this data and the context in which it was gathered that integration of content throughout the nursing curriculum related to older people is now an obligation if the health needs of the population are to be met by the future nursing workforce.

WHAT PREPARATION ARRANGEMENTS ARE MADE FOR STAFF AND CLINICAL TEACHERS TO SUPPORT AND SUPERVISE STUDENTS?

A range of strategies was reported to assist academic staff in preparing facility/staff to support students during their ARC clinical placement. The chosen methods had been developed locally in response to educational/health provider relationships, and in some cases, the details were formalised in an MOU. Learning objectives were also reported as being shared by some. Once placements began, support was sometimes reported as being enhanced by regular visits from an academic staff member. Across the polytechnics surveyed, no dominant method of preparation for facility staff prevailed. As Splitgerber et al. (2021) note, comprehensive preparation of clinical staff, strong partnerships and sharing resources are the cornerstones of preparation for staff supervising students. The unification of the nursing curriculum with the advent of Te Pūkenga may provide an opportunity to agree to a single

process and strengthen partnership models for supervisor preparation and sharing of resources. An outcome of a single approach to preparation and a unified curriculum may also support staff who move to take up vacancies in other provinces.

Student supervision

The data demonstrated a range of models of supervision for students, including those eligible to carry out this function. Faculty and facility staff were engaged in the process, and there was a wide range of expectations about the experience and/or qualifications they would possess. Some polytechnics required tertiary qualifications and post-registration experience, yet experience in the sector was sufficient for others. Given the emphasis placed on supervisors in promoting positive placements and nurturing positive attitudes toward aged care nursing within the available literature, who supervises students must be carefully considered (Eccleston et al., 2015; Ferrario et al., 2007). As several commentators have pointed out, educators with expert knowledge of aged care are essential to positive student supervision (Jack et al., 2017; McCloskey et al., 2022; Parker et al., 2021).

The question of 'who supervises' is critically important when reflecting on data that indicated HCAs had been used in this role. There is a clear need for emerging registered nurses to be supervised by professional peers, especially regarding the role-modelling of their professional identity (Bandura, 1969; Black, 2016; Din Mohammadi et al., 2013; Melrose et al., 2012; Wolf, 2016; Young et al., 2008). Furthermore, there are clear expectations about supervision in the education standards for programme regulation stipulated by the Nursing Council of New Zealand (2022).

Reflection on the current context of staff shortages in clinical facilities and the ongoing need for high-quality supervision offers a backdrop for considering whether adequate supervision might be done more effectively and consistently. Options could include using a clinical teacher role to avoid additional supervision responsibilities for already stretched registered nurses and the add-on supervision for academic staff. Joint appointments have also promoted successful student supervision (Beitz & Heinzer, 2020), meeting the levels of best practice for supervisors to be clinically excellent and role models for providing care (Queensland University of Technology, 2004).

Although not reported in this study as part of student supervision in aged care placements, the development of DEUs in aged care might be a solution where an increasing number of students are allocated, to address staffing and supervisory issues (Crawford et al., 2018; Borren & Harding, 2020).

Limitations

The research occurred as the country stepped down from the emergency response to Covid-19. Questionnaires were sent out in what transpired to be a busier than usual time for programme leaders as teaching and learning returned to campus and hours of lost clinical experience had to be

reorganised. This may have impacted the time available to complete the survey and, consequently, the quality of the answers provided.

The data collection instrument used in this survey was a previously validated questionnaire from a major study undertaken in Australia. While the process used to assess its suitability was robust, extensive tool validation did not occur beyond the pilot study. This leaves open the possibility that there are weaknesses in the questionnaire, which may influence the trustworthiness of the data.

While efforts were made to ensure that the vocabulary used in the questionnaire could be applied across the country, it became apparent that there was some variable nomenclature. Every effort was made to double-check these instances across the research team to ensure appropriate interpretation.

Conclusion

The purpose of this study was to review placement preparation and clinical experience for Aotearoa New Zealand student nurses in aged care settings. Undertaken in the polytechnic sector at the threshold of unification into a single organisation, Te Pūkenga, this report seeks to inform the development of a unified nursing curriculum.

CURRICULUM, CONTENT AND ORGANISATION

The view of aged care in a future nursing curriculum as a once-and-for-all curriculum topic and placement is no longer valid. In reflecting on contemporary health service provision, nurses will need to recognise the needs of older people throughout the system. Curriculum objectives must be adapted where necessary to reflect that change. The balance between curriculum content and supporting clinical exposure must also evolve. At a minimum, curriculum content must reflect the human condition in detail commensurate with current life expectancy. Supporting placements in ARC facilities is often associated with providing complex and challenging care. These facilities are not an ideal situation in which the future nursing workforce should be expected to learn foundational nursing skills. Integrating aged care content themes throughout the nursing curriculum will diminish ‘othering’ of older people and encourage a more inclusive view of this population. Learning objectives that reflect the health needs of older people should be included in each course of the revised curriculum, with placements appropriately targeting the students’ skill levels. The undergraduate competency approaches to care of the older adult seen in both Canada and the USA could well be useful options to bring agreement between the clinical and education sectors about the knowledge, skills and attitudes it is desirable for graduating nurses to possess.

SUITABILITY, ACQUISITION AND MAINTENANCE OF CLINICAL PLACEMENTS

The challenges associated with placement provision were reflected in internal and local competition for availability, and clinical facilities also reported placement over-use. A unified curriculum could place more pressure on an already over-stretched sector, and it is timely to reconsider the types of placements to be used across the curriculum. Widening the scope of aged care placements to include community, hospital, outpatient and other services, in general, is likely to be beneficial in reducing pressure and alerting students to the legitimate consideration that older people are not confined to ARC facilities alone. Exposure to placements reflective of various stages of learning through well selected and supported placement venues is also desirable.

The opportunities to streamline processes associated with acquiring and maintaining clinical placements were evident. Pre-acquisition and subsequent regular auditing of placement provision is essential to maintaining high-quality placement venues. Audit needs to be coupled with MOUs and fees for service to provide the benefits of clear expectations and accountability for both parties to uphold the agreement to ensure the best possible experience for students, given the impact of professional socialisation on role identity and poor placements on future career choices. Adding a clinical placement manager where one does not exist would be an advantage to developing placement suitability, acquisition and maintenance.

SUFFICIENCY OF PLACEMENTS

The data made clear that there is a need to address the sufficiency of placement type to reflect the ageing population accurately. Te Ao Māori (Māori worldview) and the health needs of older Māori need to be more substantially addressed in both curriculum content and placement options. Other cultural groups are also under-represented. Furthermore, disability and mental illness in old age also need to be reflected in careful consideration of curriculum content for healthcare for older people, as few specialities will avoid the necessity to adapt services.

MODELS OF CLINICAL SUPERVISION

Unification of the nursing curriculum within Te Pūkenga will provide an excellent opportunity to streamline documentation, curriculum objectives and consequent management of clinical supervision. DEUs have much to offer in this context. They could be helpful to support colleagues in ARC to deliver a placement experience they might otherwise struggle to provide. It should also present the opportunity to determine clear expectations about the qualifications and clinical orientation of those supporting this essential placement activity component. In the current healthcare context, there is an opportunity to consider who is likely to be the most appropriate clinical supervisor and whether this is the responsibility of the placement provider or, indeed, if this should be Te Pūkenga, to guarantee consistency, quality, achievement of curriculum outcomes and regulatory requirements.

Recommendations

The following recommendations are made:

1. The scope and definition of clinical placements to address learning objectives related to the care of older people should be widened to present students with an understanding of the health needs of this population across health specialities.
2. Te Ao Māori must be better reflected as part of considering the health needs of older people in both curriculum content and placement provision, and supporting the implementation of the Health and Disability System Review intentions.
3. A placement audit for evaluating the quality of clinical experience available for student nurses should be developed and used. When placements are selected, an MOU and fees-for-service should be documented to clarify the mutual expectations and respective accountabilities in placement provision.
4. Curriculum content related to aged care is integrated throughout each programme rather than delivered once as a separate course.
5. Consideration is given to the merits of specific competencies related to the care of older adults to be achieved on completion of a nursing qualification.
6. Aged residential care facilities should no longer be used to provide 'foundational skills' as an objective for placements designed to support learning about older adult healthcare.
7. Models of clinical supervision should be evaluated in the current healthcare context to explore possibilities that will reduce the impact of supervisory roles on care delivery in placement areas and provide consistency for students.
8. The addition of a placement manager to oversee the suitability, acquisition and quality of all clinical placements.
9. A standardised national preparation for academic staff who supervise students in aged care placements.
10. Professional development is delivered for all academic nursing staff to ensure they are cognisant of current practices and develop an awareness of how they might inadvertently undermine aged care nursing as a speciality.

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