scope
Contemporary Research Topics

health & wellbeing 8:

November 2023

Original Research

https://doi.org/10.34074/scop.3008020

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Published by Otago Polytechnic Press. Otago Polytechnic Ltd is a subsidiary of Te Pūkenga – New Zealand Institute of Skills and Technology.

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MISSED OPPORTUNITIES: EXPLORING THIRD-YEAR STUDENT NURSES' CLINICAL EXPERIENCES IN AGED RESIDENTIAL CARE

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INTRODUCTION

Improving the employment and retention of registered nurses (RN) in aged residential care (ARC) has long been problematic; with the increasing demands for more facilities due to the exponential rise in life expectancy, this issue can only grow (Hughes, 2020; Ministry of Health [MOH], 2016; Nursing Council of New Zealand [NCNZ], 2019). A recent report from the New Zealand Aged Care Association [NZACA] (2022), indicates the annual turnover rate for RNs in ARC is nearing 50 per cent with an increasing reliance on internationally qualified nurses. Adding to this recruitment and retention problem, ARC has had limited success in attracting newly qualified nurses to the sector, with ARC ranked near the bottom of preferred career options (Hunt et al., 2020; MOH, 2019).

Currently, most curricula situate an ARC clinical experience in the first year of study to introduce fundamental skills and knowledge (Foster, 2019). However, studies suggest this early exposure to ARC has contributed to nursing students' negative perceptions and attitudes towards working in the sector (Abbey et al., 2006; Laugaland et al., 2021), with one study finding that 66 per cent of participants requested not to go to ARC for a clinical experience (Lea et al., 2018). Recognising how a sole ARC clinical experience occurring in Year One may influence a students' career decisions, a Bachelor of Nursing provider has introduced an additional clinical experience for third-year nursing students, emphasising exposure to the RN role and responsibilities.

Part of a wider study that examines students' third-year clinical experiences in ARC, this paper reports on 38 participant responses from four focus groups, to consider how the clinical experience can be strengthened to promote ARC as a desirable career pathway. We identify a number of missed opportunities in the roles, tasks and responsibilities that nursing students are offered. With the pending introduction of the Te Pūkenga unified nursing curricula combining 13 existing schools of nursing (Te Pūkenga, 2023), this paper argues that education providers are in a position to exert influence and engender positive change through working collaboratively with the ARC sector. Current practices are not responsive to improving the shortage of ARC nurse specialists. Results from this study can inform future options to improve nursing students' ARC clinical experience.

BACKGROUND

In New Zealand, undergraduate nurse education standards are set by the Nursing Council of New Zealand (NCNZ, 2022). To meet these standards, students must complete a minimum 1100 clinical hours in a range of healthcare settings including a "continuing care setting" (NCNZ, 2022, p.61). ARC is commonly used for this

clinical experience, and similar to international practices, this mainly occurs in the first year of education. Often working with healthcare assistants (HCA), the goal is for students to learn fundamental skills and knowledge including vital signs, therapeutic communication and activities of daily living (Fetherstonhaugh et al., 2022; Foster, 2019). The value and purpose of using ARC to learn fundamental skills and knowledge has long been debated in the literature, with concerns that the practice may negatively impact student perceptions and attitudes towards working in the sector as a graduate (Abbey et al., 2006; McAllister et al., 2020).

Negative student perceptions of working in ARC do not occur in isolation, as it is educators who set the curriculum and pedagogy that underpins student preparation and experiences (Foster et al., 2022; Negrin et al., 2020). With a desire to promote ARC as a career destination, educators used the opportunity of curriculum redesign in 2018 to introduce a second ARC clinical experience in the third year of study. Consequently, a third year 96-hour clinical experience in ARC became part of a 'complex needs' clinical course, with students being placed in a range of ARC facilities that delivered hospital-level care, including the complexities of palliative care. Using a preceptorship model for clinical supervision, the goal was for students to have an immersive experience of the RN role focusing on comprehensive assessments, care planning and delivery skills, as well as nursing leadership, including direction and delegation. The students also completed a quality improvement initiative (Toi Ohomai Institute of Technology, 2022).

Anecdotal student feedback from the ARC experience indicated that despite the educators' aspirational goals, students reported reduced capacity to maximise the learning opportunities available. To understand constraints better and the environment in general, a research evaluation of student experiences was initiated. This article reports on the results from four focus groups which formed part of the larger mixed method project reported elsewhere (Honeyfield et al., 2023). Personal accounts of the clinical experience in ARC were then fed into the key question which was: what features of this experience can be enhanced to improve perceptions and experiences of working in ARC?

METHOD

Evaluation research is intended to determine the success of an initiative (Thomas, 2006) and in this instance the aim is "to increase our understanding of third-year student nurses' perceptions and experiences of ARC and impact on career aspirations" (Honeyfield et al., 2023).

A qualitative descriptive methodology was used to explore the third-year students' accounts via a mixed methods approach incorporating a cohort survey (including a question on expected area of employment on graduation) and facilitated focus group discussions. This paper reports on the focus group data collected from 38 participants who had recently completed a 96-hour clinical placement in ARC. Four focus group sessions were held in the second semester of 2022 consisting of two groups from each of the two campuses, lasting between 45 to 60 minutes each. Focus groups enable the gathering of data through interaction and can give access to difficult-to-obtain information about experiences (Doody et al., 2013).

Following ethical consent from the Toi Ohomai Research and Human Ethics Committee (2012.021), the eligible pool of 92 third-year students was invited to participate via a message on the student learning platform. All participants read a participant information sheet before signing a consent form. The focus groups were face-to-face and conducted by a member of staff who was not involved with teaching the students. The sessions were digitally recorded and subsequently transcribed. A Māori kaiako also attended providing cultural support for students who identified as Māori and ensure values such as manaakitanga and whanaungatanga where upheld. A series of semi-structured questions guided the discussions.

Data analysis followed the general inductive approach described by Thomas (2006), beginning with multiple readings of the transcripts to gain a sense of the data. Next, themes were developed around text segments that directly related to the student experience. To assess trustworthiness of the data analysis, other members of the research team checked consistency by taking theme descriptions and finding text that belonged with that theme (Thomas, 2006). The underlying imperative was to ascertain among the text segments, examples of student experiences which might enhance the likelihood of working in the sector in the future. Researchers then drew on these experiences to suggest how improvements could be made to the clinical experience and potentially influence career choices favouring ARC.

RESULTS

Four themes emerged that capture the range of unique experiences reported by the third-year students in ARC: doing the right work, missed opportunities, building relationships and becoming a leader. These themes illustrate the authentic voice of the students who participated and are reflective of disparate experiences. Descriptions are supported by participant (P) quotations where relevant.

DOING THE RIGHT WORK

Aligned with a preceptorship model of student supervision, where the students are assigned to work with a designated RN, an immersive experience of the RN role and responsibilities was a key expected outcome of this clinical experience. Hence 'doing the right work' reflected working alongside an RN. As evidenced in the following examples, central to doing the right work was the support of the RN, thus enabling students to hone their skills:

> The nurses I worked with gave me the opportunity to do things with them. They were really good and formed good communications. Then I was actually quite lucky half way through second week lots of things were happening, lots of falls and because of that there were a lot of lacerations to dress. (P1)

> RN that gave you experience he let me do stuff, like Blood Glucose Levels. The whole time he was always teaching – do you know why we are doing this, he would wait for my answer and then maybe say not really correct. (P2)

One student reported being encouraged to show initiative, hence being given the scope to plan out their day and work somewhat independently:

> They took some time to warm up to me and they really started to recognise my skills as a third year when I took initiatives and put myself out there. I asked am I able to do this, what would you like me to do, I have made this plan today what do you think about blah, blah and they were like, "oh yeah – cool". (P3)

Emphasising the importance of the relationship between student and RN, once a relationship was established the participant was able to negotiate with the RN to work more independently. However, there were barriers to overcome before they could utilise their skills. When the student was able to engage in the 'right kind of work', work applicable to their perceived level of skill, they reported satisfaction, while others reported a range of missed opportunities.

MISSED OPPORTUNITIES

Participants identified a number of barriers to carrying out clinical skills which they had previously undertaken in an acute care environment, often independently. One of the major obstacles was constraints around the administration of medications. In acute care settings, students are able to administer a range of medications under the direct supervision of the RN. As part of the requirement to administer medication safely the student must be able to sign the prescription form as the administrator (New Zealand Nurses Organisation, 2014). This proved problematic as most ARCs now use an electronic medication administration system such as Medi-Map (Garratt et al., 2020) that requires the person who administers the medication to have a unique login. In some ARCs, students were not issued with a login, hence unable to administer medication to residents, causing significant frustration for students:

> The rest home use a computerised system and we don't have a log on so cannot contribute. I think that was a major hassle. You can do a lot of stuff during the med round but you can't do things and can't do the cycle. (P4)

> I would try and do things but I can't do medication rounds, they are all on-line and they don't have student access. We can't handle medications as they in blister packs, so sitting around a lot unfortunately. (P5)

This inability to complete the medication administration process because of system constraints was not an isolated event. Students also reported the supervising RN not allowing them complete other episodes of care:

> There was so many opportunities with different treatments yet we were not allowed to do any. I took the wound trolley to one lady for the RN and the manager to do the dressing, the lady wanted me to do it. I just had to sit there. (P6)

Reporting a similar situation, some students offered a rationale as to why they believed they were not permitted to undertake certain skills they had previously mastered. These included a range of possibilities, from lack of understanding of the student's capabilities, to a lack of trust. For example:

> They [RNs] did not know what we could do. I printed out our clinical companion showing what we could do, but they weren't interested. They were predominantly international nurses and I felt they did not trust we could work under their registration, even though we were year three and RN next year, just that barrier. (P7)

One student clearly communicated their ability to complete certain episodes of care but was still not allowed to, reporting the RN wanted to keep safe:

> I said I have done plenty of these in the ward [dressings] and I am allowed to and she said we were not allowed to do these, just to be safe. (P8)

As evidenced above, most participants' comments describe barriers to advancing clinical skills. However, in the final example, the student concedes that while there are constraints around what they could do, there are numerous learning opportunities available:

> We are so restricted in what we can and cannot do in ARC. I feel like there are way more opportunities we could focus on like, leadership, we could do so much more of care planning, critical thinking, set goals. (P9)

Ironically, the student offers a solution to improving the experience by alluding to one of the purposes of the clinical experience, developing leadership skills. This comment captures how a mismatch between the clinical staff's understanding of student capability, the curriculum and course expectations contribute to a less than optimal learning experience for the student.

BUILDING RELATIONSHIPS

The ability or contrarily, inability to build relationships with residents is an important factor reported by some participants:

> The biggest thing from year one to three was the approach you get with your residents. It is more hands on, more interpersonal. You learn a lot more and engage with a lot more emotions as a year three. (P10)

> I wanted to go into aged care and areas I could see myself working in and the reason being is I love working with older people. Many have dementia and I don't know they just are a special group of people to me. (P11)

In contrast, it was a limited capacity to build relationships with residents that left one student disillusioned with the reality of the practice environment:

> I am basically open to anything but after that placement and seeing the role and I love interacting with patients and doing extra things to try and make them feel like humans and that someone cares about them not just like here is your medication see you later – that was not me. (P12)

Relationship building again highlighted a mixed response with both negative and positive examples evident, yet all comments foreground the ability to build relationships with residents as central to positive perceptions of ARC.

BECOMING A LEADER

A key finding from participants who spoke of a positive experience in ARC was being cognisant of what was happening beyond developing clinical skills. Students appreciated the advanced skills required to work in ARC, including the uniqueness of caring for residents rather than patients.

In the first example, the student is aware of the range of responsibility and leadership required of an RN in comparison to an acute care setting, and how pivotal RNs are to managing the environment, including other staff. They appreciated the fact residents were a relatively stable demographic as there was not the high turn-over experienced in acute care settings:

> I always thought med surg [as a workplace] above ARC but now having been there and seeing what the nurses are allowed to do, their span of control, directing HCA [health care assistant] far more beneficial and healthier environment than a [hospital] ward where you don't get that. You have 4-6 patients and then they change. (P13)

Another student, while describing clinical skills, highlighted their appreciation in being able initiate episodes of care based on their experience:

> I would work in aged care – I like continuity and after I had worked there for the first week, I knew what wound cares needed to be done and I could go and take initiative to go and do it and set it up, I was able to show autonomous decision making and rapport. (P14)

These comments indicate positive experiences. What appears to have made the difference is being able to take the lead in planning care and the potential to make a difference in resident outcomes through leadership.

DISCUSSION

Drawing on the authentic experiences of third-year students provided a unique opportunity to critique our current practices and from there, consider feasible changes for the future. Although the broader research survey results reported overall satisfaction with participants' ability to apply skills and knowledge (Honeyfield et al.,

2023), data from the focus groups illustrates some areas that contradict these findings. Throughout the data, the theme of missed opportunities resonated, with a number of participants reporting a lack of recognition of their skills and procedural barriers to administering medications. The comments also reflect the subtle influence of curricula that privileges development of acute care technical skills; this reinforces the notion that there is little to be learnt in ARC beyond fundamental skills (Abbey et al., 2006; Algoso et al., 2016). In reality, working in ARC as an RN is complex with high levels of responsibility and accountability (Amaduro et al., 2018), while also offering pathways to nurse practitioner roles (Adams, 2021). Unfortunately, the reported limitations around planning and completing episodes of care, coupled with constraints on furthering decision-making and leadership skills, may not encourage students to positively envisage an RN or nurse practitioner role in ARC.

Confirming earlier research, a supportive relationship with the RN and an enriched learning environment are pivotal to students' reporting positive learning experiences in ARC (Brown et al., 2008; Hunt et al., 2020; Lea et al., 2018). The challenge then is how to foster a more consistent, enriched learning environment and limit the missed opportunities for students in a sector struggling with a high turnover of nursing staff (NZACA, 2022). In our current model for student supervision, reflecting the RN preceptorship model (Billay & Myrick, 2008), students shadow the RN, observing and assisting with delegated and some self-directed episodes of care and also, independently complete a comprehensive nursing assessment on one resident. As evidenced in participant comments, working alongside a RN does not consistently meet the learning needs of all students.

Based on our findings, we recommend that alternative clinical experience models reporting more positive outcomes for student learning be explored and trialled. Ryan et al. (2018) piloted a model where third-year students, once orientated to the facility, assume responsibility for providing care for up to eight residents under the indirect supervision of the RN. Dedicated Education Units (DEUs), that promote a collaborative learning environment where a clinical liaison nurse is employed to support both clinicians and students, have also reported positive outcomes (Dimino et al., 2022; Grealish et al., 2010). Both models encourage students to progress decision-making skills incorporating assessment and planning of residents' care, and should be considered as viable options to the current preceptorship model. The models do however require a greater level of support from both the education and the ARC providers than current practices.

Findings from this research suggest ARC has the potential to be an enriched learning environment for students but there remain many barriers to fully realising learning opportunities (Foster et al., 2022). Some barriers, for example the ability to sign for medications, could be quickly resolved with co-operative dialogue between interested parties. Other barriers are more entrenched and require a more collaborative relationship between nurse education providers and the ARC sectors. The introduction of a new unified nursing curriculum (Te Pūkenga, 2023) offers the opportunity for nurse education providers to work with the ARC sector to produce graduate RNs who are better equipped to meet the needs of an ageing population.

CONCLUSION

The aim of this study was to increase our understanding of third-year student nurses' perceptions and experiences within the ARC sector, and how these factors may impact later career choices. Through evaluating the student experiences in ARC, this report has provided not only a better understanding of the challenges students encounter in ARC but also practices that contribute to a positive learning environment. Despite a number of affirming comments from participants, current third year clinical experiences in ARC continue to fall short of student expectations, reinforcing a discourse that devalues ARC as a career option. Future curricula changes to improve the career aspirations for ARC could, for example, include the implementation of DEUs in the third year, however, more research is required. If nurse education is to be an effective force in advocating for a long-term commitment to improving ARC as a graduate destination, it is imperative we work closely with the sector and consider new models of supervision to improve the third-year student clinical experience.

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