



The Use of Innovative Clinical Placements in Nursing Education: A National Survey

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A National Survey**

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1. EXECUTIVE SUMMARY

Nursing programs are responding to the community and population-based foci of health care by seeking to integrate strong community components in their curricula. At the same time, recent health care restructuring and cuts to community health programs, along with increased enrolments in nursing schools, have made the allocation of clinical placements for undergraduate nursing students extremely challenging. Schools of nursing find themselves competing with other nursing and allied health care programs for limited clinical placements. Yet, clinical learning experiences continue as the backbone of nursing education where students bring theory and practice together (i.e., praxis) in a transition to professional practice. In the search for suitable clinical placements, nurse educators are turning to various non-traditional settings in a shift that is both philosophically and practically motivated. Despite the increased use of non-traditional settings, little research exists regarding the use of these innovative clinical placements.

This project examined the utilization of innovative clinical placements (ICPs) in undergraduate nursing programs from the perspectives of clinical placement coordinators (CPCs) and nurse educators (NEs). A national survey was used to collect data from 74 Canadian nursing programs in the winter of 2005/2006. The data from the survey was validated and expanded upon during a focus group with nurse educators and administrators in November 2006.

The survey results indicated remarkable consistency in perspectives from across the country:

- ❖ Innovative Clinical Placements (ICP's) are widely used - 96% the programs that responded to the survey reported using ICPs placements;
- ❖ The use of ICPs has increased over the past 5 years;
- ❖ ICPs are most commonly used for mid and upper level students (e.g., 2nd, 3rd, and 4th years of baccalaureate degree);
- ❖ ICPs are most commonly used for community health, mental health, and preceptorships or consolidated clinical courses;
- ❖ The most commonly used ICP sites include schools, community support groups, Aboriginal communities, corrections, and inner city settings;
- ❖ ICPs promote rich learning compared to traditional clinical placements, including greater initiative, engagement, creativity in decision-making, critical thinking, an appreciation for the expanded role of the nurse, insight into the social determinants of health, and professional relationships with communities;
- ❖ ICPs require more coordination and setup time than traditional clinical placements;

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- ❖ The successful use of ICPs requires negotiation of a range of possible barriers, including issues of capacity and sustainability;
- ❖ Nurse educators report that ICPs and traditional clinical placements have similar legal and ethical challenges, but safety concerns are considered greater for ICPs.

Recommendations

1. Nursing programs should continue to develop and implement the use of innovative clinical placements.
2. Strategies need to be developed to increase capacity and to facilitate sustainability in these sites.
3. The role of the nurse in non-traditional sites should be articulated. For example, easily accessible resources could be developed that communicate the role of the nurse in multidisciplinary and/or non-traditional settings.
4. Underutilized areas such as community-based gerontology, hospice care, maternal child care should be identified. Population groups targeted that are not typically served by any one clinical agency (e.g., taxi drivers) could also be developed as ICPs.
5. Student learning can be maximized in these settings by building in structure through clear course objectives, well developed learning activities, ample orientation and debriefing, and a close “fit” between the curriculum and the ICP
6. Substantive content must be included in curricula regarding concepts such as social determinants of health, health disparities, and access to health services.
7. Adequate faculty preparation should be sought to ensure adequate knowledge and skill set, and time to develop relationships with agency personnel will contribute to sustainability.
8. Agency staff, whether RNs or other field guides, must be oriented to their role and well supported by the university-based clinical instructor given the realities of heavy workloads and the risk for burnout.
9. Nursing program administrative support (such as funding, release time) should account for the extra time it takes to negotiate ICPs.
10. Partnerships between academic and host agencies should be established to facilitate the administration of ICPs and to foster student learning.
11. Research is needed to establish what factors contribute successful partnerships between agencies and educational institutions.
12. Research should be conducted with agency stakeholders to gain insight into the issues they face hosting students.
13. Further research is needed to evaluate various models of clinical supervision in ICPs.

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2. INTRODUCTION

Nursing programs are responding to the community and population-based health care needs by seeking to integrate strong community components in their curricula. At the same time, recent health care restructuring and cuts to community health programs, along with increased enrolments in nursing schools, have made the allocation of clinical placements for undergraduate nursing students extremely challenging. Schools of nursing find themselves competing with other nursing and allied health care programs for limited clinical placements. Yet, clinical learning experiences continue as the backbone of nursing education where students bring theory and practice together (i.e., praxis) in a transition to professional practice (Cloutier et. al., 2004; Tanner, 2006). In the search for suitable clinical placements needed to fulfill mandated number of clinical hours, nurse educators are turning to various innovative² settings in a shift that is both pedagogically and practically motivated. To illustrate, these settings may align with course objectives that promote community-based care; and from a practical standpoint, provide much needed clinical placements. Yet, little research exists regarding the use of innovative clinical placements.

In an earlier study, “Innovative Clinical Placements: A Descriptive Study” (2002 – 2004, Funding WRCASN), we examined student learning opportunities for population-focused nursing care in several innovative clinical sites used by one university nursing program: parish, rural, corrections, Aboriginal, and international health settings (Reimer Kirkham et. al., 2005a; Reimer Kirkham et. al., 2005b). Findings from this study revealed that these placements provide rich learning experiences for students. The study findings also suggested that innovative clinical sites may require more administrative time. The findings from this single site study needed to be compared and extended with a national sample.

With funding from WRCASN (2004 Education Research Grant competition), we designed and conducted a national survey distributed to all undergraduate baccalaureate nursing programs in Canada in November 2005 – January 2006. The purpose of the study was to describe the utilization of alternate or innovative clinical placements³ in Canadian nursing education from the perspectives of clinical placement coordinators and nurse educators and. The project complements and extends two current CASN-funded projects⁴ by eliciting the

² Innovative placements may also be referred to as “non-traditional” placements or “alternative” placements.

³ Innovative clinical placements are defined for the purposes of this study as less structured clinical environments, often multidisciplinary; typically outside or varying from the main health care delivery system (e.g., Aboriginal, rural, parish, international, correction settings, parahealth organizations).

⁴ Project 1: An inventory of strategies to delivery nursing and inter-professional clinical placements in Canada; Project 2: Costing nursing clinical placements in Canada. Both projects

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perspectives of nurse educators and clinical placement coordinators regarding pedagogical implications (e.g., the nature of learning, supervision strategies) of ICP use, and by its focus on community-based innovative placements.

3. LITERATURE REVIEW

Nurse educators are unanimously agreed upon the centrality of clinical practice in the acquisition of nursing judgment, skills, and knowledge and for professional socialization (Hartigan-Rogers et. al., 2007; Hall, 2006). The clinical learning environment is recognized as a complex entity with direct impact on learning outcomes, providing student nurses with opportunities to combine cognitive, psychomotor and affective skills, and problem-solving abilities (Chan, 2004). Gaberson and Oermann (2007) asserted that the selection of clinical sites should be based on criteria such as compatibility of school and agency philosophy, type of practice model used, availability of opportunities to meet learning objectives, degree of control by faculty, geographical location and cost, availability of role models for students, and physical resources. Gopee (2004) synthesized the classic scholarship of Fretwell and Ogier to identify the following factors that promote and hinder clinical student learning (see Table 1):

Factors that Promote Learning	Factors Hindering Learning
<ul style="list-style-type: none">- Adequate levels of qualified staff and the accessibility of mentors⁵ with appropriate educational preparation- Effective two-way communication- Effective leadership- Staff confidence and responsibility- Practical demonstration of skills- Students feeling they can take their time over performing clinical skills- Teaching on a one-on-one basis- Full explanation of procedures- Clear objectives for the placement- Students feeling valued as team members- Students being treated with respect and their supernumerary status honoured	<ul style="list-style-type: none">- Poor clinical knowledge base of mentors- Lack of enthusiasm in learners or mentors- Heavy workload of mentors- Mentors' and team leaders' attitude to the need for teaching- Low staff-student ratio- Lack of organized teaching programs- Poor leadership qualities- Mentor ill-prepared for student through insufficient communication between university tutor and mentor regarding learning outcomes- Mentors not updated on revised pre-registration curricula- Unavailability of mentor to integrate theory and practice

are being conducted at Lakehead University (Principal Investigators: Drs. Michel Morton and Patricia Smith)

⁵ Gopee's (2004) use of the term mentor is considered equivalent to the North American terminology of RN or preceptor and the term tutor is considered equivalent to nursing instructor or nurse educator.

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Table 1: Factors that Promote and Hinder Learning (Gopee, 2004)

Recent research building on this foundation in the area of clinical education is diverse and expanding, examining matters such as: the value of reflective practice; the nature of clinical supervision (Dunn, Stockhausen, Thornton & Barnard, 1995); the use of humour (Nahas, 1998); the impact of student anxiety on learning in clinical settings (Yonge et. al., 2002); the effectiveness of various preceptorship models (Brehaut, 1998); the development of critical thinking in clinical practice (Haffer, 1998); staff nurse perceptions of the contributions of students to clinical agencies (Matsumura et. al., 2004); and the outcomes of peer mentorship (Yates et. al., 1997). Core themes of role integration, confidence, and altruism were identified in a comparative study exploring students' perceptions of field experience in professional development (Dunn, Ehrich, Mylonas, & Hansford, 2000). Lofmark & Wikblad (2001) examined facilitating and obstructing factors for learning in clinical practice with students in their final placements and evidenced remarkable consistency with Gopee's (2004) summary. This Swedish study noted that responsibility and independence, practicing tasks and receiving feedback, and collaborating with and supervising other health care professionals facilitated learning. In contrast, lack of student-supervisor relationship, organizational shortcomings and lack of student initiative resulted in poor learning environments. Interpersonal relationships with health care professionals in clinical settings and autonomous learning opportunities within clearly established student roles have been identified as crucial to positive learning environments (Chan, 2004; Dunn & Hansford, 1997).

With patients increasingly being found outside of acute care settings, community-based learning opportunities have helped students to learn holistic care of individuals and families in the context of their communities and cultures, thereby identifying community health needs with the corresponding services required to meet them. Such a shift reflects the increased diversity of settings in which health care is delivered, as the focus of health care has become more global, wellness- oriented, and population-based (Gaberson & Oermann, 2007).

In a project examining clinical placement opportunities for students, barriers against placements, and factors that determine appropriate clinical placements, Canadian Nurses Association (2005) concluded that a dearth of data on the efficiency and effectiveness of different clinical education strategies exists while several factors, such as a short supply of teaching resources, stress on the system from increasing numbers of students and reduced placement opportunities, have led to reaching full capacity within traditional clinical placements. However, they also concluded that opportunities exist for clinical education in the community. Acknowledging the centrality of clinical practice within Nursing education, the Canadian Association of Schools of Nursing (CASN) "...established a task force to explore challenges and innovative strategies relevant to practice education in Canada and to assist in the development of national guidelines for practice education" (MacFarlane et. al.,

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2007, p. 18). Similarly, colleagues in the United States (Tanner, 2006) & Australia (Edwards et. al., 2004) make similar recommendations regarding the need for clinical education in a full range of community-based settings.

This acknowledgment of reaching capacity within traditional community health settings and the need to creatively embrace student learning opportunities within alternative innovative clinical placements is reinforced by the number of nurse educators reporting the use of sites such as museums, fire departments, community centers, seniors' apartment complexes, correctional institutions, churches, and zoos (Boyd, 1999; Brendtro & Leuning, 2000; Drevdahl et. al., 2001; Faller, Dowell, and Jackson, 1995; Georges, 1986; Hoshiko, 1985; Joslyn, 2000; Loden, 1989; Lough, 1999; MacFarlane et. al., 2007; Moll, Cook, & Saul, 2001; Norman, 1999). Alternative models of clinical education are being developed, as illustrated by the client-centered rather than location-centered placements described by Callaghan, Cooper, and Gray (2007). Faller et. al. (1995) observed that the move to "non-traditional learning sites resulted from both vision and events" (p. 345). Yet few research studies have formally evaluated the implications of using these settings.

In particular, the use of rural, parish, corrections, Aboriginal, and international sites have been described and evaluated to varying degrees. For example, Brendtro & Leuning (2000), Lough (1999), and Moll, Cook and Saul (2001) described the appropriateness of the parish setting as a clinical placement but did so from an anecdotal standpoint, rather than a research base. Similarly, Boyd (1999), Georges (1986), and Norman (1999) endorsed corrections settings for the purpose of nurse education. Neill and Taylor (2002) reported that rural clinical placements for undergraduate nursing provided effective learning experiences for students. Courtney et. al (2002) found rural undergraduate clinical placements to be a tool for the recruitment of nurses in rural settings. MacRae et. al. (2007) explored the required financial and educational incentives and the recruitment strategies used to draw health science students to underserved areas in South-eastern Ontario. Paliadelis and Cruickshank (2003) observed the expert role of the rural nurse practitioner in student clinical placements. Baird-Crooks, Graham, and Bushy (1998) described the process of developing a rural nursing course and establishing partnerships with rural communities to provide opportunities for a nursing practicum. We were unable to locate research related to the use of Aboriginal settings for clinical education, although nursing literature is beginning to present an appreciation of the unique cultural framing of health as viewed in Aboriginal communities against a historical background of marginalization and oppressions (Browne & Fiske, 2001; Clarke, 1997; Dickson, 2000; Hunter, Logan, Barton, & Goulet, 2004; Silverman, Goodine, Ladouceur, & Quinn, 2001).

The most widely researched and cited non-traditional clinical teaching site is international settings (Evanson & Zust, 2004; Grant & McKenna 2003; Haloburdo

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& Thompson, 1998; Harrison & Malone, 2004; Mill, Young and Cameron, 2005; Riner & Becklenberg, 2001; Walsh & DeJoseph 2003; Wright, Zerbe, & Korniewicz, 2001). A recent study by Kollar and Ailinger (2002) noted that nursing students who participated in an international clinical experience gained substantive knowledge, perceptual understanding, personal growth, and interpersonal skills that had a direct effect on how, where, and why they chose to continue their professional practice after their graduation. Mill, Young and Cameron (2005) described how international experiences provided students with a unique opportunity to gain a deepened “understanding of the influence of politics and economics on health, greater sensitivity to cultural issues, significant growth in self knowledge and improved critical thinking skills” (p. 8). Walsh and DeJoseph’s study of nursing students following an international experience described students reporting learning about being “other”, taking on the nurse role, and expanding their world view. Evanson and Zust, reporting on an international service learning experience ($n = 9$) in Guatemala, identified six themes: clarification of career path or goals; improved understanding of social justice and globalization issues; motivation to continue service work; discovering the reciprocity of relationships with others; appreciation for the whole person; and finding a way to respect the sacredness of experience.

Thus, while we have an expanding research-based knowledge about clinical nursing education in general and a growing research base regarding clinical placements in international settings, the literature features primarily anecdotal reports that highlight the benefits of using non-traditional clinical settings. Little **research** was found that examines issues pertaining to the types of settings, the level of student, perceived student learning, and the administrative challenges surrounding use of innovative clinical settings. In summary, this literature review, as others (e.g., 2005 CASN report), points to the lack of empirical data regarding clinical education and, in particular, the effective utilization of innovative clinical placements.

3.1 Introduction to Program of Research

We conducted a pilot study with students, instructors, and RNs in parish and rural settings (2001 – 2002), followed by a descriptive study examining student learning in 5 innovative clinical settings (parish, rural, international, corrections, and Aboriginal placements) in British Columbia (2002 – 2004, Funding: Western Region Canadian Association of Schools of Nursing, WRCASN). The purpose of this Phase I study (Reimer Kirkham, Van Hofwegen, & Harwood, 2005a; Reimer Kirkham, Hoe Harwood, & Van Hofwegen, 2005b; Van Hofwegen, Reimer Kirkham, & Hoe Harwood, 2005) was to examine student learning opportunities for population-focused nursing care in these innovative clinical placements. The study followed the interpretive descriptive method (Thorne, Reimer-Kirkham, & MacDonald-Emes, 1997; Thorne, Reimer-Kirkham, & O’Flynn-McGee, 2004). Using focus groups and in-depth interviews, the perspectives of 42 students, 11

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instructors, and 6 RNs regarding their experiences in innovative clinical settings were elicited and analyzed with the aim of developing a guiding framework for the use of innovative settings for nursing education. While the initial motivation to use these ICP's was predominantly one of practicality (i.e., needing clinical sites to fill the need for more community placements), the unique benefits of these placements as revealed in the reports of the participants were far-reaching. The experiences of participants across the different sites were specific to each setting but also revealed a remarkable degree of commonality. Three themes derived from the data highlight the strengths and limitations of innovative clinical settings: Envisioning Possibilities and Understanding Realities (what students learn); Engaging in Learning (how students learn); and Creating Transformative Learning Environments (how to make it happen).

The instructors and RNs described how students captured the vision of nursing in these placements with appreciation of the expanded role of nurses. Students also grew in confidence and abilities as they took on the professional role. The students observed nursing care that they described as “holistic”, and they discussed how being witness to poverty, inequities, and vulnerabilities gave them insight into the social determinants of health and heightened awareness of social justice as an important goal of nursing.

Learning was typically marked by intense engagement, and often with a level of dissonance that prompted critical reflection about their own social positioning, and the adequacies of available health care. Debriefing with and support from peers and clinical instructors were identified as important strategies in all settings. The instructors and RNs also reported that the nature of communities as pre-existing with strong social networks and infrastructure (e.g., as in the case of a parish) was integral to taking on the nursing role and learning principles of community health. The students appreciated being known by the community, and often demonstrated exceptional commitment to these communities.

Several factors were identified by instructors as particularly important in the administration of innovative clinical placements. First, although negotiating and coordinating these placements typically required more time and effort, the instructors commented that the nature of student learning offset this investment. Second, partnerships between the academic institution and the practice settings proved critical to the success of these experiences. Where strong partnerships existed, student learning was enhanced, and less time/energy was required in the set up and coordination of the learning experiences. Third, instructors and administrators needed to anticipate some of the safety issues that might arise, and plan proactively to deal with these. RNs and other collaborators in the clinical settings were vital in identifying potential safety concerns in advance (e.g., in correctional settings) and developing corresponding protocols for student safety. Fourth, while students often worked in mentorship relationships with RNs, ongoing supervision from clinical instructors was important, as was a

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balance of structured learning (e.g., specific assignments such as community assessments or community development projects to give focus to the experience) and student autonomy (e.g., setting own learning goals).

Overall, these themes pointed to the opportunity for rich learning in innovative clinical placements, and raised further questions regarding the extent to which such placements are used across the country, and the pedagogical and administrative implications may be associated with their use.

4. STUDY PURPOSE AND OBJECTIVES

This study was designed with the purpose of describing the utilization of innovative clinical placements within Canadian nursing education from the perspectives of clinical placement coordinators and nurse educators. Based on the earlier descriptive study that served as the pilot for this project, we defined innovative clinical placements and traditional clinical placements as follows:

Innovative Clinical Placements: Less structured clinical environments, often multidisciplinary; typically outside or varying from the main health care delivery system (e.g., Aboriginal, rural, parish, international, correction settings, parahealth organizations)

Traditional Clinical Placements: Structured clinical environments, typically within the main health care system (e.g., acute care settings; public health units, long-term care facilities)

The objectives of the study were to:

- a) describe the use of ICPs in Canada (type, relative prevalence in comparison to traditional clinical placements);
- b) elicit the perspectives of nurse educators regarding the nature of student learning in ICPs;
- c) explore administrative matters regarding the use of ICPs;
- d) describe strengths and weaknesses of the use of ICPs; and
- e) identify ethical, legal, and academic issues associated with the use of ICPs.

In conjunction with these exploratory objectives, the following hypotheses were examined from the perspectives of clinical placement coordinators and nurse educators:

- 1) ICPs result in relatively richer learning (course objectives met more thoroughly, increased comprehension of community nursing concepts, further

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transition to professional roles, and increased student engagement and reflection) compared to traditional community health placements;
2) ICPs require greater administrative coordination (time).

5. METHODS

5.1 Overview of the Study

We designed a national survey with the aim of describing the utilization of innovative clinical placements across Canada from the perspectives of clinical placement coordinators and nurse educators. We conducted a subsequent focus group study involving nurse administrators and nurse educators to enrich our understanding of the survey findings.

In this section we provide an overview of the strategies we used to: a) develop the survey, b) assure the functionality of the online survey (using Survey Monkey™), and c) obtain a sample of clinical placement coordinators and nurse educators in undergraduate baccalaureate nursing programs in Canada. We then provide an overview of the analytical methods that were used for the focus group study, and we conclude with a discussion of some ethical considerations.

5.2 Survey Design and Data Collection

An online survey design was chosen as the best method to address the study objectives. One of the key advantages of this design is the large number of respondents that can be surveyed in a relatively short period of time and in a cost efficient manner, even if they are widely distributed geographically (Mangione, 1998).

Survey Development

The following guidelines outlined by Gillis and Jackson (2002) were used to develop the survey:

- (1) Compile a list of variables. In our case, these variable were derived from the Phase I analytic framework, and included variables such as the frequency of ICP use, administrative issues such as safety, negotiation of sites, strategies to facilitate student learning, including clinical supervision, and the nature of the learning itself.
- (2) Anticipate data analysis techniques, including statistical procedures. Forced answers, with categorical response options as well as rating scales, and open-ended questions were utilized.
- (3) Write proposed questions, refine wording. The group of researchers met repeatedly to write and refine the questions.
- (4) Format questionnaire, including on-line development. The survey was formatted using Survey Monkey™, an online survey software program. Skip logic was used to direct the clinical placement coordinators and nurse educators to the appropriate sections of the survey.

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(5) Pre-test the survey. The survey was pre-tested for functionality and reviewed by 5 experts (i.e., clinical placement coordinators and nurse educators) for content validity. Each item was evaluated in terms of its readability, relevance, and conceptual congruence with the core concepts of the study.

In these ways, the quality of data generated by the survey was ensured

The final version of the online survey consisted of three sections and included skip logic that directed the respondents automatically to the next relevant question based on their responses to prior questions:

Section A was completed by all respondents and included demographic questions as well as questions about the role of the respondent in the nursing program

Section B was completed only by CPCs and included questions about the use of ICPs in the nursing program overall.

Section C was completed only by nurse educators who used ICPs with questions specific to pedagogical matters such as teaching strategies and student learning.

Data Collection.

The target population consisted of clinical placement coordinators and nurse educators in nursing programs in Canada. A database of all nursing programs in Canada, with names of the dean or director of the program, was developed based on information provided by the Canadian Association of Canadian Schools of Nursing about all baccalaureate nursing education programs in Canada Canadian.⁶ A particular challenge was to determine the memberships of the growing number of collaborative programs and how clinical placements were negotiated by clinical placement coordinators (CPCs) across these collaborations.

The survey distribution list included 95 Canadian generic undergraduate baccalaureate nursing programs of which 90 were eligible to participate in the study. Five nursing programs were not included for the following reasons: they participated in pilot testing of survey; they were new programs that had yet to enroll a first class; they were just within the first year of offering and presently relied upon traditional clinical settings; or no baccalaureate undergraduate nursing program was presently offered.

⁶ There is a considerable degree of national consistency in undergraduate nursing education. Undergraduate level nursing education in Canada is offered through publicly funded colleges or universities, with the only exception being the CASN accredited, privately funded, non-profit university nursing program the researchers are affiliated with. Canadian nursing graduates write what are considered equivalent nationally developed registration examinations, in either French or English, and provincial nursing bodies accept out of province registrant applications with no further examination requirements.

Distributing the survey

An email with a link to the online survey was sent to the dean or director of each nursing program with the request to forward the email to the following eligible participants:

1) Clinical placements coordinator(s) (or the equivalent person(s) arranging clinical placements) in their undergraduate baccalaureate nursing program,

or

2) Nurse educators teaching in any of the following areas:

- senior level community health course (or equivalent)
- other undergraduate courses that use innovative clinical placements
- undergraduate preceptorships in innovative clinical placements.

Data collection spanned a period of 3 months (November 2005 – January 2006). Tracking of the responses was facilitated by assigning a unique URL for each nursing program through which all respondents from that program accessed the survey. The survey was developed and distributed in English only. When the initial survey distribution yielded no responses from the francophone nursing programs a French speaking nursing student was hired to phone each program, explain the survey and request that bilingual faculty members be solicited to complete the survey on behalf of these programs.

5.3 Focus Group

A follow-up focus group was held in conjunction with a national nurse research conference to validate and extend the survey findings. The participants for the focus group were recruited through an email invitation sent to all the deans and directors, as well as to all the survey respondents who had indicated interest (via a survey question) to participate in a focus group. Included with the invitation was a summary of the interim survey findings. Further recruitment occurred at the conference presentation that immediately preceded the focus group. After obtaining consent from the volunteer sample, the focus group was audio-recorded and subsequently transcribed. The participants were invited to respond to the key findings of the survey with questions such as:

- We observed that the majority of Canadian programs use ICPs, and the use of ICPs has grown significantly in the past 5 years. What do you consider the most innovative of the clinical placements your program uses?
- What type of support from administration is needed for successful use of ICPs?
- What issues (ethical, legal, safety) have been identified regarding ICPs in your program?
- What strategies have you used for sustainability of ICPs?

5.4 Data Analysis Procedures

Descriptive statistical analyses were used to provide an overview of the types and utilization of ICP's in the nursing programs and to describe student learning and administrative considerations as reported by the nurse educators. The responses of the clinical placement coordinators and the nurse educators were aggregated to create a pooled dataset with information about each nursing program.

Chi-square analyses were used to compare differences pertaining to the use of ICPs across some types of nursing programs. We relied on Fisher's exact test procedures to determine the statistical significance for these analyses (Agresti, 2002).

Content analysis of the open-ended written survey responses and focus group transcript was conducted with the assistance of NVivo™. A codebook was established to facilitate the unitization of data and subsequent identification of shared themes. The respondents took full opportunity of the survey comment boxes, adding a depth of detail and richness to the data not characteristic of survey research. This depth of discussion was matched in the focus group.

5.4 Ethical Considerations

The project underwent ethical review by the university's research ethics board (REB). Confidentiality was protected by removing names and identifying information from all data, establishing password protected access to online survey data, storing data printouts in a secured cupboard, and only allowing access to the data by the researchers. Technology for the on-line survey was implemented in such a way so that identification of respondents was kept separate from the data itself to ensure confidentiality of the data. Informed consent was inferred through survey completion and confidentiality of respondents was preserved through anonymous completion of the on-line survey. The respondents could exit from the online survey at any point. Participation in the focus group was voluntary and written consent was obtained prior to the initiation of the group.

6. FINDINGS

In this section, we present the findings of the study based on statistical analysis of the survey data and qualitative analysis of the narrative responses provided on the survey and during the focus group. After providing a detailed description of the sample, we present an overview of how ICPs are presently being utilized in nursing programs in Canada (e.g., types of ICPs, level of students and courses that predominantly use ICPs). This is followed by a presentation of findings about student learning in these settings, including data about the nature of learning, and strategies to facilitate such learning. Finally, we present those findings that addressed the coordination of ICPs and those matters more administrative in nature.

6.1 Sample Description

One hundred and forty seven eligible respondents in 74 different nursing programs⁷ completed the survey. Of the 147 respondents, 88 were clinical placement coordinators, 36 of whom were also nurse educators who used ICPs in their teaching. Another 59 respondents were nurse educators who did not have a coordination role (See Table 1). The vast majority were female ($n = 140$) (6 were male and 1 did not respond to this question). The majority of survey respondents were masters prepared ($n = 92$) and some ($n = 12$) had completed a PhD (see Table 2). In addition, 5 of the respondents with masters' degree were enrolled in doctoral education.

⁷ In total, we had representation from 74 (or 82%) out of the 90 eligible nursing programs.

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Table 1: Role of the Participants in the Nursing Programs (*N* = 147)

	CPC	Not a CPC	Total
Not a NE	34	0	34 (23%)
NE who used ICPs	36	47	83 (57%)
NE who did not use ICPs	14	9	23 (16%)
Missing*	4	3	7 (5%)
Total	88 (60%)	59 (40%)	147

Notes: NE = nurse educator, CPC = clinical placement coordinator.

* Respondents for whom their role as NE with respect to their use of ICPs could not be inferred due to missing responses (includes 6 NEs who did not indicate whether they used ICPs).

Table 2: Profile of Survey Participants by Highest Level of Education

	CPC and NE Groups		
	CPCs but not NEs	CPCs and NEs	NEs but not CPCs
	(<i>n</i> = 33)	(<i>n</i> = 54)	(<i>n</i> = 58)
Diploma (<i>n</i> = 3)	3 (9%)	0 (0.0%)	0 (0.0%)
Baccalaureate. (<i>n</i> = 38)	14 (42%)	14 (26%)	10 (17%)
Masters (<i>n</i> = 92)	16 (49%)	39 (72%)	37 (64%)
Doctoral (<i>n</i> = 12)	0 (0.0%)	1 (2%)	11 (19%)

Notes: *N* = 145 (2 missing).

Description of nursing programs

Of the 74 programs that yielded survey responses, 40 were represented by 2 or more respondents (a combination of clinical placement coordinators and nurse educators). The nursing programs varied by student enrolment, average age of student and type of degrees offered (see Table 3). Many of the nursing programs offering generic baccalaureate degrees also offered a post-RN baccalaureate degree (41%). In addition, several offered other types of certificates and degrees (*n* = 28) including licensed practical nursing education (*n* = 10) and nurse

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practitioner education ($n = 9$). Almost all of the nursing programs that participated in this survey utilized ICPs.

Table 3: Description of programs included in the survey

Variable	<i>n</i> (%)
Student enrolment	
100 or less	11 (15%)
Between 101 and 300	26 (35%)
Between 301 and 400	13 (18%)
More than 400	19 (26%)
Don't know or missing	5 (7%)
Average age of students	
21 to 25 years	26 (35%)
26 to 30 years	20 (27%)
Don't know or missing	28 (38%)
Type of degree offered	
Diploma	10 (14%)
Generic baccalaureate	67 (91%)
Post-RN baccalaureate	30 (41%)
Masters degree	18 (24%)
Doctorate	10 (14%)
Other	28 (38%)
Don't know or missing	5 (7%)
Used ICPs	
Yes	71 (96%)
No	3 (4%)

Notes: $N = 74$ nursing programs.

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Description of focus group participants

In total, ten participants contributed in the focus group (see Table 4 for breakdown of roles), with representation from across the country (2 from the maritime provinces, 2 from Ontario, 2 from the prairie provinces, and 4 from British Columbia). Given our interest in nurse educator perspectives and a reported nursing program Administrator “survey fatigue” (CASN, 2004), our survey did not seek the views of Administrators such as Deans and Directors. To fill this gap, Deans and Directors were invited to the focus group. Nursing education Administrators’ perspectives gleaned in this format were important in expanding our understanding of administrative challenges specific to the utilization of ICPs.

Table 4: Profile of Focus Group Participants by Role

Role in the program	<i>n</i> (%)
Administrators	3 (30%)
Nurse educators	4 (40%)
Clinical placement coordinators	1 (10%)
Joint role (more than one of the above roles)	2 (20%)

6.2 Survey and Focus Group Findings

The responses to the survey questions were relatively consistent across the different nursing programs, indicating strong shared experience in how ICPs were utilized and the type of issues that arose with their use. Moreover, the interest in the study as indicated by the number of responses to the survey and the detailed narrative comments speaks to the timeliness of the study. Comments such as “*Good timing for this survey as more placements are needed and the traditional areas are over crowded. ICPs...are the wave of the future*”, and “*This is an important survey as clinical placements for community are becoming more difficult to obtain*” reinforce the relevance of the study.

Use of ICPs in the Nursing Programs

ICPs were **widely used**. Seventy-one (96%) of the 74 undergraduate nursing programs utilized ICPs in their clinical education. Of the 71 nursing programs that used ICPs, 45 (63%) reported that their use of ICPs increased over the past five years (14 (20%) reported no increase and 12 (17%) didn't know or did not provide a response to this question) (See Table 5). Twenty-nine (41%) of the nursing programs used ICPs for most of their community clinical placements and 27 (38%) used ICPs for less than half of their community clinical placements (this data was not available for 15 (21%) of the nursing programs that used ICPs). A majority of programs ($n = 39$ (55%)) used ICPs for more than 50 hours of clinical learning experiences throughout the undergraduate curriculum (see Table 5).

The ICPs in nursing programs were most commonly used in community health courses (60 nursing programs (87%)), preceptorships or consolidated learning experiences (42 nursing programs (61%)), and mental health courses (39 nursing programs (57%)). Least common courses to use ICPs were palliative (12 nursing programs (17%)) and medical or surgical nursing courses (14 nursing programs (20%)) (see Figure 1).

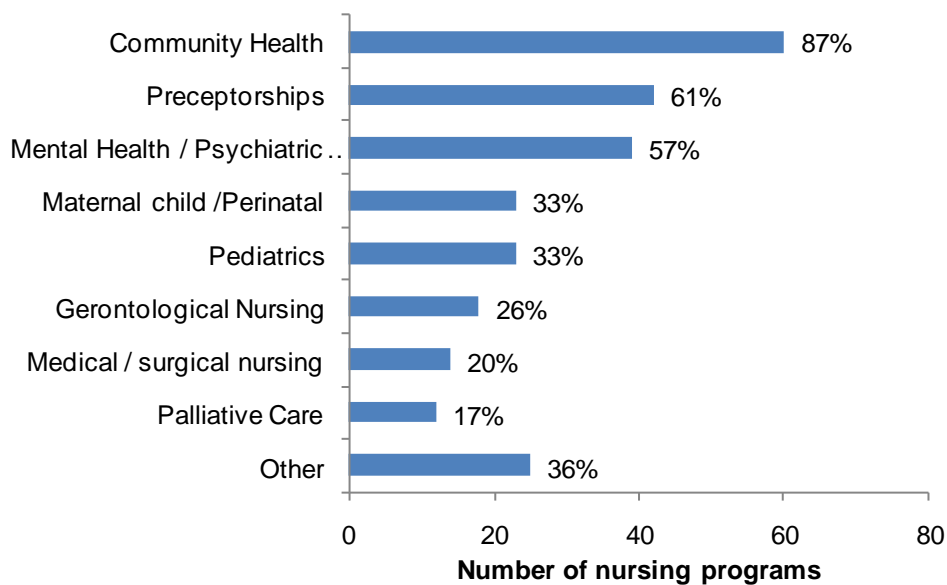
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Table 5: Use of ICPs in the Nursing Programs

Variable	<i>n</i> (%)
During the past 5 years, the use of ICPs has:	
Has increased	45 (63%)
Has not changed	14 (20%)
Don't know or missing	12 (17%)
Hours that students spend in ICPs in the undergraduate nursing program:	
More than 200 hrs.	11 (15%)
151 to 200 hrs.	8 (11%)
101 to 150 hrs.	13 (18%)
51 to 100 hrs	7 (10%)
Less than 51 hrs.	6 (8%)
Don't know or missing	26 (37%)

Notes: *n* = 71 programs that used ICPs. Information based on data provided by the CPCs.

Figure 1: Use of ICPs for clinical courses in nursing programs*

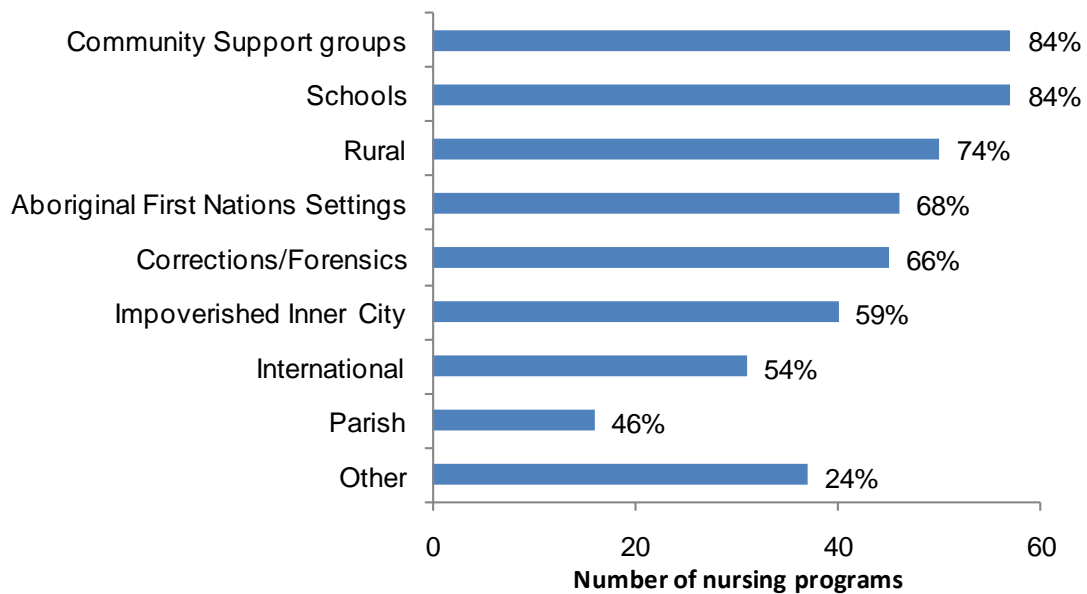


* *n* = 69 nursing programs that used ICPs (data about the use of ICP sites was not available for two additional nursing programs).

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The most common ICP sites included community support groups, schools, rural settings, Aboriginal communities, corrections, and inner city settings (see Figure 2). International placements were used in almost half of the nursing programs and Parish nursing settings were used in only 16 nursing programs. Other sites included places of religious gathering (e.g., Sikh temple), occupational health sites (e.g., Canada Post, industrial settings), fitness groups, summer camps, daycares, community housing coalitions, university residences, and community aggregates such as bus drivers, taxi drivers, and hotel staff. (See Appendix C for a list of ICPs collated from focus group data and narrative responses.)

Figure 2: ICP sites used in nursing programs*



* *N* = 68 nursing programs that used ICPs (data about the use of ICP sites was not available for 3 additional nursing programs).

The data was analyzed to see whether the extent to which ICPs were used varied by types of nursing baccalaureate programs offered by the institution (Post RN degree compared to generic degree), size of program (i.e., student enrolment), existing partnerships (i.e., programs with established partnerships with agencies for ICPs) or context (i.e., were graduate nursing program(s) offered by the institution).

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Partnerships: Out of the 71 nursing programs that used ICPs, 28 (39%) reported invited partnerships with community agencies and 32 (45%) indicated having no partnerships (this information was not provided for 11 (16%) of the 71 nursing programs). When we compared the number of ICP hours in nursing programs that had partnerships with community agencies with those that did not have partnerships, we observed that students in programs with partnerships spent relatively more hours in ICPs (see Table 6). This difference, however, was not statistically significant (two-tailed p Fisher's exact > 0.05 for any of the partitions of the chi-square table).

Table 6: Comparison of hours spent in ICPs for programs with and without partnerships.

Hours that students spent in ICPs	Partnerships ¹	
	Programs with partnerships ($n = 28$)	Programs without partnerships ($n = 32$)
> 200 hrs	7 (25%)	4 (13%)
150 to 200 hrs	5 (18%)	3 (9%)
101 to 150 hrs	6 (21%)	7 (22%)
51 to 100 hrs	1 (4%)	6 (19%)
≤ 50 hrs	2 (7%)	4 (13%)
Don't know / missing	7 (25%)	8 (25%)

¹ $N = 60$. Information about partnerships was not available for 11 of the 71 nursing programs that used ICPs.

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Context of Graduate Programs: We also examined whether the nursing programs with both graduate and undergraduate programs used ICPs more extensively than those programs that did not have graduate programs. Of the 71 nursing programs that used ICPs, 18 offered a masters or doctoral program and 48 did not offer a graduate program (this information was not obtained for 5 nursing programs). We did not observe any significant differences with respect to the number of hours that undergraduate students spent in ICPs.

Table 7: Comparison ICP use in nursing programs with and without graduate programs.

	Degree offered ¹	
	No graduate degree (n = 48)	Graduate degree (n = 18)
ICP hours per student		
> 100 hrs	23 (48%)	9 (50%)
≤ 100 hrs	11 (23%)	2 (11%)
Don't know / missing	14 (29%)	7 (39%)
ICPs used for beginning level students*		
Yes	18 (38%)	2 (11%)
No	26 (54%)	15 (83%)
Missing	4 (8%)	1 (6%)
ICPs used for intermediate level students		
Yes	38 (79%)	15 (83%)
No	6 (13%)	2 (11%)
Missing	4 (8%)	1 (6%)
ICPs used for senior level students		
Yes	33 (69%)	14 (78%)
No	11 (23%)	3 (17%)
Missing	4 (8%)	1 (6%)

¹ n = 66 nursing programs (this information was not provided for 5 nursing programs).

* Two-tailed Fisher's exact $p < 0.05$ (ignoring missing data).

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CPCs were asked to indicate the various levels of the program in which ICPs were used by selecting on or more of the following categories: beginning level nursing students (first year of the nursing program), intermediate level students (not in the first year and not in the last two semesters of the nursing program), or senior level students (last two semesters of the nursing program). ICPs were used for intermediate or senior level nursing students in 59 of the 61 nursing programs for which these data were obtained, and ICPs were used for beginning level students in only 20 of the 61 of the nursing programs. When comparing nursing programs that offered graduate degrees to those that did not, only 2 (12%) of those with graduate programs used ICPs for beginning students, whereas 18 (41%) of the nursing programs that did not offer graduate degrees used ICPs for beginning level students ($\chi^2_{(1, 61)} = 4.73$, two-tailed Fisher's exact $p = 0.04$, ignoring missing data for 10 nursing programs) (see Table 7). A possible explanation for this difference is that nursing schools with graduate programs presumably are in larger universities that may not offer any clinical experiences to first year students.

Overall, the study findings speak to the broad range of clinical placements being widely used in Canadian nursing education, extending far beyond traditional hospital and public health unit placements.

Teaching and Learning in ICPs

The NEs who used ICPs were asked to respond to a series of questions pertaining to their experiences in using ICPs (section C of the survey)⁸. Findings indicate that rich learning occurs in these settings. There was general agreement among nurse educators that ICPs promoted student initiative, engagement, creativity in decision-making, critical thinking, and professional relationships with communities. One of the respondents commented: "ICPs have a huge effect on students, often opening their eyes to a part of society unknown to them". A clinical placement coordinator wrote:

ICPs are excellent for the depth, diversity and complexity they allow our students to encounter. It also allows them to see how health care is not just for formalized systems. They tend to promote independency for our students and open up experiences that change life views.

Indeed, the study objective to identify strengths of ICPs was well addressed in the articulation of the nature of learning that occurs in ICPs. Various strategies were used to promote learning in ICPs. Student supervision featured predominantly within these strategies.

⁸ CPCs who were not NEs did not complete Section C of the survey. Of the 83 survey respondents who indicated they were nurse educators that used ICPs, 71 completed this section of the survey. The 12 nurse educators who did not complete this section are not included in our analyses.

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Nature of Learning

The nurse educators were asked to indicate their extent of agreement with a series of statements comparing student learning of particular concepts in traditional placements with student learning in ICPs. These concepts included: community development, social determinants of health, social justice and equity, poverty, culture and diversity in ICPs. For each of these concepts, the majority of nurse educators agreed strongly that ICPs were more effective than traditional clinical placements for learning the concepts, with just a small contingent (ranging from 3 - 7% depending on the concept) indicating that ICPs were not more effective for promoting learning of these concepts (see Table 8).

Table 8: Degree of NE Agreement regarding Effectiveness of ICPs compared to TCPs for Student Learning of Nursing Concepts

In comparison to traditional clinical placements, ICPs are more effective for promoting student learning:	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly	Don't know
Community Development	49 (69%)	17 (24%)	3 (4%)	0 (0%)	2 (3%)
Social Determinants of Health	46 (65%)	19 (27%)	2 (3%)	1 (1%)	3 (4%)
Social Justice and Equity	42 (59%)	21 (30%)	4 (6%)	2 (3%)	2 (3%)
Poverty	44 (62%)	19 (27%)	4 (6%)	1 (1%)	3 (4%)
Culture & Diversity	40 (56%)	20 (28%)	6 (8%)	1 (1%)	4 (6%)

Notes: $n = 71$ nurse educators that used ICPs. Percentages may not add to 100% due to rounding.

The strength of ICPs in fostering the desired learning outcomes of population health and community concepts was echoed in the written responses:

- Learn health promotion and community development rather than reaction to client illness”;
- “ICPs sensitize students to the health needs of marginalized populations with whom they otherwise would have no contact”
- “As they [students] move out from under the medical model as dominant ideology they see how social determinants work
- “Students usually have the greatest personal and professional growth in these sites”
- “ICP’s on the whole provide students with amazing learning opportunities, particularly in areas of interprofessional collaboration and community development”

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- “Promotes a more global way of thinking...students gain an appreciation for the diverse factors that affect the health of a population”
- “Makes students more aware of the many roles assumed by nurses”
- “Life altering experiences for students”
- “Allow students to learn critical thinking... develop excellent communication skills, to become more reflective in their practice”

Participants took full advantage of written comments to emphasize the many strengths and benefits of using ICPs.

Further dimensions of ascribed student learning related to initiative and critical thinking. Although the agreement was not as strong for this cluster of statements as the agreement around community development and social justice concepts, the majority of nurse educators agreed (strongly or somewhat) that students in ICPs demonstrated more initiative toward engaging in clinical learning opportunities (70%), more creativity in clinical decision-making (77%), and more critical thinking by identifying appropriate nursing assessments and interventions (63%) (see Table 9). Interestingly, narrative responses also indicate that those students who do well are those who are creative, take initiative, are self-directed. So some care must be taken here in claiming that these qualities result FROM the ICP experience. A majority agreed strongly (34%) or somewhat (48%) that students in ICPs develop stronger professional relationships with the communities in which the ICPs are located. The agreement as to whether ICPs are more effective in promoting student integration of theory and clinical learning was not as strong; only 45% of the nurse educators indicated that they agreed strongly or somewhat with the statement that students in ICPs more effectively integrate theory and clinical learning.

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Table 9: Degree of NE Agreement regarding Effectiveness of ICPs compared to TCPs for Fostering Student Development of Professional Attributes

In comparison to traditional clinical placements students in ICPs:	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly	Don't know
Demonstrate more initiative toward engaging in clinical learning opportunities	22 (31%)	28 (39%)	19 (27%)	1 (1%)	1 (1%)
Demonstrate more creativity in clinical decision-making.	23 (32%)	32 (45%)	9 (13%)	2 (3%)	5 (7%)
Demonstrate more critical thinking by identifying appropriate nursing assessments and interventions.	17 (24%)	28 (39%)	17 (24%)	3 (4%)	6 (8%)
Develop stronger professional relationships.	24 (34%)	34 (48%)	10 (14%)	1 (1%)	2 (3%)
More effectively integrate theory and clinical learning	7 (10%)	25 (35%)	28 (39%)	1 (1%)	10 (14%)

Notes: $n = 71$ nurse educators that used ICPs.

Factors that Promote Learning

The survey gleaned information regarding several factors deemed important in promoting learning in ICPs, including student initiative and independence, structure of the experience, and supervision of students in the placement settings (see Table 10).

Student initiative. Student initiative and independence was rated as an important factor in facilitating learning. Thirty four percent of nurse educator respondents indicated this factor as “could not be more important”, another 62% as “very important”, and 3% as “somewhat important” (1% indicated “don’t know”).

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Table 10: Factors Facilitating Learning in ICPs

How important are the following factors in facilitating learning in ICPs?	Could not be more important	Very important	Somewhat important	Slightly important	Not important at all	Don't know
Well established partnership	30 (42%)	30 (42%)	8 (11%)	0 (0%)	1 (1%)	2 (3%)
Ongoing clinical instructor presence	14 (20%)	32 (45%)	17 (24%)	6 (8%)	1 (1%)	1 (1%)
Role modeling and mentoring by RNs	24 (34%)	30 (42%)	8 (11%)	5 (7%)	2 (3%)	2 (3%)
Student initiative	24 (34%)	44 (62%)	2 (3%)	0 (0%)	0 (0%)	1 (1%)
Clarity of course & placement objectives	27 (38%)	40 (56%)	2 (3%)	0 (0%)	0 (0%)	2 (3%)
"Fit" between curricular themes and clinical placement	26 (37%)	35 (49%)	8 (11%)	1 (1%)	0 (0%)	1 (1%)
Presence of other students	4 (6%)	19 (27%)	20 (28%)	12 (17%)	13 (18%)	3 (4%)
Orientation to the setting	19 (27%)	44 (63%)	4 (6%)	2 (3%)	0 (0%)	2 (3%)
School assisting logistics	10 (14%)	19 (27%)	15 (21%)	13 (18%)	7 (10%)	7 (10%)

Notes: $n = 71$ nurse educators.

Structure. Along with recognizing the importance of student initiative was the NE agreement that learning activities must be very structured to ensure course learning objectives are met (24% agree strongly; 44% agree somewhat) (see Table 11). Clarity of course and clinical placement objectives specific to ICP settings was very important (39% say this could not be more important, another 57% rated this is very important) (see Table 10). Likewise the "fit" between curricular themes and clinical placements was viewed as "could not be more important" by 37% of NEs and as "very important" by 49%, as "somewhat important" by 11% and "slightly important" by 1% (see Table 10). In addition, most nurse educators strongly agreed (28%) or agreed (38%) with the statement that students in ICPs require much more support during entry and exit to clinical

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sites in comparison to students in traditional sites, (see Table 11). Orientation to the setting was rated very highly by 90% of nurse educators.

Table 11: Structuring ICPs

Statement	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly	Don't know or missing
Learning activities (e.g., assignments) in ICPs must be very structured to ensure course learning objectives are met.	17 (24%)	31 (44%)	14 (20%)	7 (10%)	2 (3%)
Time required for coordination and setup for ICPs is greatly increased compared to traditional clinical placements.	39 (55%)	15 (21%)	11 (15%)	3 (4%)	3 (4%)
Students in ICPs require much more support during entry and exit to clinical sites compared to students in traditional sites.	18 (25%)	28 (39%)	17 (24%)	6 (9%)	2 (3%)

Notes: $n = 71$ nurse educators.

Once again, written responses reinforced the importance of structuring the learning experiences, with clear learning objectives for both students and the agencies. Several dimensions related to structuring the learning experiences were itemized, such as strengthening links to curriculum. A nurse educator wrote: *“part of a planned continuum and not just a place to dump students that do not have traditional placements due to lack of placements”*. Another noted that *“students must have a good theory base”*. Clarity regarding course objectives was raised. Along these lines, one nurse educator wrote: *“It is important to have very clear course objectives and structured learning activities. Otherwise the students just wander around being bored or having inappropriate conversations with clients and wasting time. They need strong direction”*. Another nurse educator offered this perspective:

Care must be taken to ensure that the placement meets the course requirement and that staff are able to supervise students effectively. Close discussion with the agency and the instructor throughout the placement ensure that students are directed appropriately.

Supervision

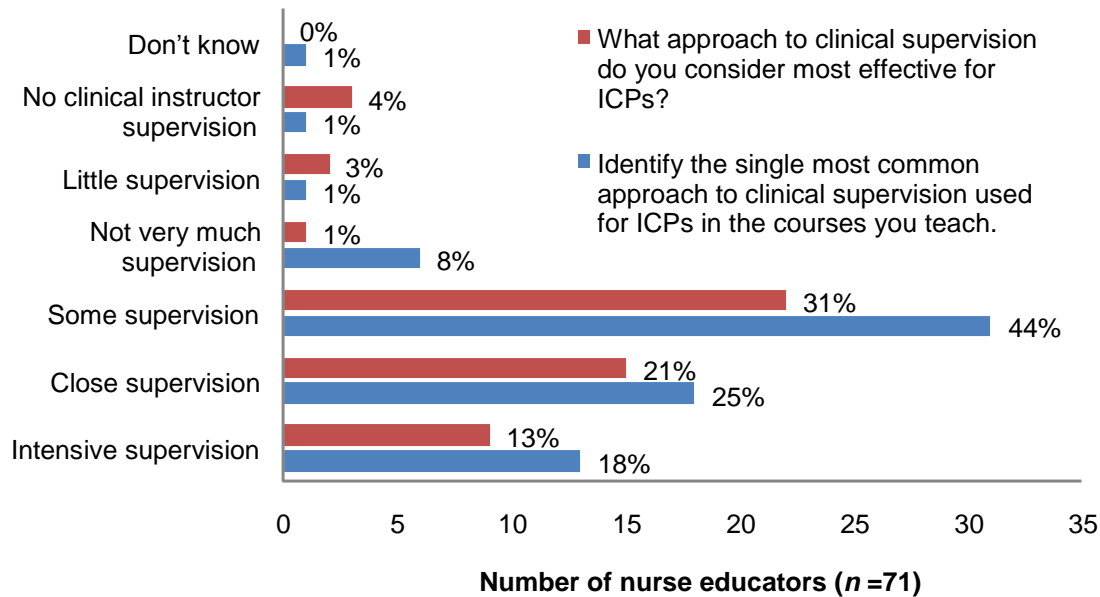
Supervision of students was emphasized as an important factor when using ICPs. Models of clinical supervision varied widely, depending on a range of factors such as level of student, the course, type of setting, and whether RN

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mentors were available in the sites to mentor or oversee student learning. The nurse educators that used ICPs were asked to indicate the level of clinical supervision that they used for ICPs in their courses. Of the 71 nurse educators who completed this section of the survey, 13 (18%) reported using intensive supervision (clinical instructor on site most of the time), 18 (25%) reported using close supervision with clinical instructor visiting the site every 2 – 3 clinical days) and 31 (44%) indicated using some supervision where contact was every 2 – 3 days but more likely to be via email, telephone, or on-campus contact rather than directly in the clinical setting. The remaining nurse educators indicated that they did not provide very much supervision ($n = 6$), little supervision, ($n = 1$), or no supervision ($n = 1$) (1 additional nurse educator indicated “don’t know”) (see Figure 3). Along with site visits, faculty had contact with students via telephone, email, web based communication systems (e.g., online forums), and during seminars back on campus. A strong message in the narrative data was that clinical instructors served as catalysts to ensure optimum learning. For example, clinical instructors framed the learning in ICPs in a way that reassured students of their legitimacy, even though not a traditional site, through an emphasis on the values and beliefs of a community and by foregrounding health promotion activities. As articulated by one respondent, a clinical instructor would offer: “*An initial discussion with students to assist in understanding that clinical experience is not limited to traditional settings*”.

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Figure 3: Use and perceived effectiveness of the level of clinical supervision.



To further explore whether the most common models of clinical supervision were by preference or perhaps dictated by factors such as resources (e.g., lack of funds to increase faculty to student ratio) a second question was asked regarding what approach to clinical supervision was considered most effective for ICPs (see Figure 3). Surprisingly, only 24 (34%) of the nurse educators that used ICPs recommended close or intensive supervision, and most nurse educators offered more clinical supervision than the level of clinical supervision that they considered to be most effective. In the written comments for these questions, the nurse educators indicated that the degree of supervision was dependent upon the student factors such as the level of the student (first year vs. senior consolidation), initiative and strengths of the students; and whether students were alone or in a student group. The nature of the relationships between the student and the agency personnel were noted as important factors in determining the amount of clinical supervision, as was the proximity of the clinical sites. Distance to the site was reported in the narrative data as influencing the type of contact and supervision established.

The intensity of clinical supervision was also reported by the nurse educators to be dependent in large part upon whether the student had a RN in practice (e.g., a preceptor) who provided close support, as reflected in the following excerpts from the written responses:

“Because many of the settings used for ICPs do not employ nurses, close supervision by a nursing instructor helps students in identifying and participating in a nursing role in these settings”.

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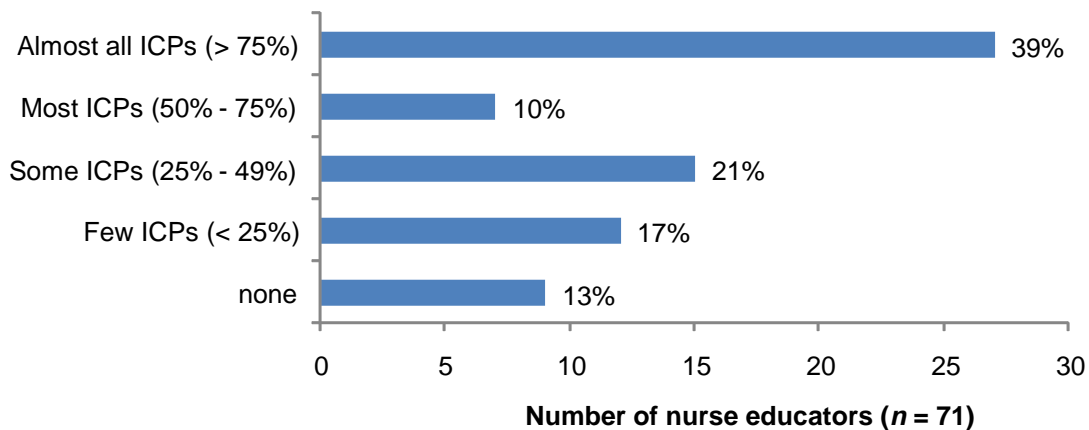
“As each of these students currently are placed with a nurse preceptor the student has that resource on a near constant basis”.

“It is more than every two or three days. We see the students in class and keep in touch via office visits, journals, emails, and the odd visit. It’s really all about the relationship”.

Even when a preceptor model was used, supervision by a clinical instructor was identified as important. One respondent wrote: *“Intensive supervision is necessary, otherwise having student placements becomes a burden on staff which will burn them out over time”.*

The nurse educators were asked to indicate how much they relied on health care providers for clinical supervision. As shown in Figure 4, the nurse educators relied extensively on health care providers, such as RN preceptors, to provide direct clinical supervision. In addition, role modeling and mentoring by RNs in the practice settings was rated as “could not be more important” or “very important” by most of the nurse educators (see third row in Table 10). Yet, contact with such agency personnel who were supervising students also varied, and the nurse educators reported that maintaining this contact was challenging at times given the number of students they might be overseeing at multiple sites.

Figure 4: Percentage of ICPs that rely on health care providers for clinical supervision.



Visibility, Understanding, and Valuing the Role of the RNs. According to survey findings, an issue currently being debated within nursing programs is whether the host agency must employ RNs, and, further, whether preceptors must be RNs. Many written responses raised this issue regarding the visibility of the role of the nurse in the agency. One respondent reported: *“the school has the fixed idea that RNs only may preceptor students”*, and another noted that students themselves prefer placements *“where RNs are visible in the daily work”*. Similarly, another reported that *“Some students don’t value and / or want these types of placements - they ‘just want to be real nurses in the hospital’*. One nurse

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educator cited the lack of RN role models in clinical settings as a challenge. Another mentioned *“gleaning the role of the nurse within agencies that do not have a nursing presence”* as a challenge. There was variation in the written responses regarding how important the visibility of the RN role is; one respondent commented that *“the most important aspect seems to be appropriate supervision and role modeling by nursing professionals”*.

Along with concern regarding visibility of the RN role was the more fundamental concern regarding misperceptions or lack of knowledge regarding the RN role and student abilities. *“Challenges reflect the agencies’ understanding of what skills and abilities nursing students bring with them to the placement. I believe this reflects the overall lack of public understanding of registered nurses’ abilities; many believe that nurses work in hospitals only!”*

In response to such concerns and misconceptions, the nurse educators indicated that clarifying perceptions on the part of all stakeholders was important. One nurse educator wrote: *“Since many of the innovative community placements don’t have nurses, I spend a great deal of time explaining the role of the nurse and the purpose of the student engaging in the practicum”*. Another observed that one of the challenges was to assist agencies to learn that *“students are there to learn, not work as additional staff members”*.

The Negotiation and Coordination of ICPs

Despite the widespread use of ICPs and the rich learning reported, there were challenges reported related to the use of ICPs, many of which related to the negotiation and coordination of the placements. Interestingly, when respondents were asked to speak to strengths and weaknesses/challenges in the use of ICPs, they had as much to say about the strengths as the weaknesses/challenges, suggesting that these challenges likely do not overwhelm the strengths. Indeed, one respondent noted that *“on occasion we have had difficulties—but generally much fewer challenges than dealing with the usual health care system”*.

Methods of Negotiation.

Information about negotiating access to ICPs was provided by the clinical placement coordinators in 60 of nursing program that used ICPs (this information was not provided for 11 nursing programs). ICPs in 58 of the nursing programs were negotiated by clinical placement coordinators (45 nursing programs or 75%) or nursing faculty (34 nursing programs or 60%). Notably, the point was made in the focus group that each institution must discern whether a CPC position is the best model for negotiating placements, particularly in smaller programs.

With respect to student involvement in the negotiation of ICPs, we observed that 9 (15%) of the 60 nursing programs expected students to negotiate their own

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ICPs, whereas 17 (28%) of the nursing programs did not allow students to negotiate their own ICPs. Student involvement in the negotiation of ICPs did not differ for nursing programs that offered a graduate degree in comparison to those that did not offer a graduate degree, nor was there a significant difference of student involvement in relation to the size of the student population.

Partnerships were identified as one way to sustain ICPs, with one participant asserting: “*Without collaborative relationships, these projects don't work.*” Another respondent wrote of how the profiling of existing partnerships in the Faculty of Nursing’s newsletter resulted in queries from other agencies interested in being involved in student placements.

Challenges and Barriers to the Use of ICPs

The CPCs and NEs were asked whether they had encountered any barriers in negotiating or utilizing ICPs. Of the 81 CPCs in nursing programs that used ICPs, 50 (62%) answered “yes” and 23 (28%) answered “no” (the remaining 8 (10%) CPCs did not respond to this question). Similarly, 41 (58%) of the 71 nurse educators that used ICPs and completed this section of the survey indicated encountering barriers; 30 (42%) did not encounter any barriers. The data of the CPCs and NEs were aggregated so as to determine whether the reported barriers differed by size of nursing programs, for nursing programs that had community partnerships versus those that did not have community partnerships, and for nursing programs that offered graduate degrees versus those that did not. Statistical analyses revealed no significant differences for these comparisons.

Specific survey items addressed the study objective to identify ethical, legal, and academic issues associated with the utilization of these settings (See Table 12). While a majority (36 (51%)) of nurse educators agreed either strongly or somewhat that safety concerns are much greater for ICPs compared to TCPs, their counterparts (33 (47%)) disagreed somewhat or strongly with this assertion. Written comments made little mention of safety concerns in ICPs, other than one observation that extra review to ensure student safety was undertaken before placing students in placements such as “compassion clubs”, and a comment by a second respondent regarding resistance by some faculty members on the account of concerns for student “safety” (quotation marks used by respondent). Ethical concerns were not explicitly raised in the written comments, although concerns voiced regarding workload for faculty, the impact of restructuring, and unstable allocation of resources (e.g., funding) can be understood as ethical issues, particularly as they impact practice environments and moral agency. The nurse educators did not, however, overtly frame these as ethical concerns specific to ICPs. Furthermore, of the many written responses, only three comments were made regarding legal issues, having to do with liability coverage in these settings. So while the nurse educators placed some weight on safety,

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ethical, and legal concerns in the survey items, these matters were not emphasized in the written responses as barriers, weaknesses, or challenges to the use of ICPs.

Table 12: Safety, ethical, and legal concerns, according to NEs

	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly	Don't know
Safety concerns for students are much greater for ICPs compared to TCPs.	12 (17%)	24 (34%)	21 (30%)	12 (17%)	2 (3%)
Ethical concerns are much greater for ICPs compared to TCPs.	6 (8%)	19 (27%)	28 (39%)	14 (20%)	4 (6%)
Legal concerns are much greater for ICPs compared to TCPs.	8 (11%)	13 (18%)	32 (45%)	12 (17%)	6 (8%)

Notes: $n = 71$ nurse educators that used ICPs.

The respondents did take the opportunity presented by the open-ended questions to speak to several other challenges that they encountered in the negotiation and utilization of ICPs, ranging from the strong consensus that ICPs are labour intensive to negotiate and coordinate to other agency-related, college/university-related, faculty-related, and student-related factors.

ICPs as Labour Intensive. There was strong consensus that ICPs require increased coordination; 54 (72%) of the nurse educators reported that they strongly agree or agree with the statement that the time required for coordination and setting up ICPs is greatly increased compared to traditional clinical placements. One respondent wrote:

The numbers of agencies and individual students can be overwhelming to the clinical placement coordinator when we are looking at the numbers of agencies, students, preceptors and faculty persons involved. Each one involves different players, policies, procedures and communication factors. A challenge indeed!

Coordinating logistics—of tracking numbers of students, agencies, and clinical instructors—thus posed a significant challenge. The increased labour intensiveness represented by ICPs occurred at several points or levels.

Finding them! The first level of extra time and coordination for ICPs arises in the process of identifying the placements—what one respondent referred to as the “ongoing search for placements”. When responding to the written question regarding barriers to using ICPs, one clinical placement coordinator simply wrote “finding them!” Cited as barrier was the discrepancy between “the number of students in class versus the number of placements available in the community

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agencies". Several further factors were identified as contributing to the difficulty in locating placements:

- competition for sites from other nursing programs and other disciplines such as social work, addictions counseling, occupational therapy, and so forth.
- finding the appropriate level of ICP's in light of faculty/student ratios, faculty expertise, increased acuity of clients, and heavy workloads of staff. The workloads of agency staff were identified repeatedly in the written responses as a challenge to finding sufficient numbers of placements. As one respondent put it: "*There are not enough agencies willing and able to take students due to their space limitations or their own personal workload being so heavy.*" Rural placements were identified as particularly difficult to find because of staff shortages.
- getting "buy in" from all stakeholders (as discussed above).
- finding the right point person in the agency to negotiate with.

One nurse educator reported that when the program shifted its focus from "place" to the nature of learning they desired in students, a new creativity emerged that promoted the development of innovative clinical sites:

Rather than look at the place, look at learning needs, look at what learning needs to happen and where can that learning happen. We've tried to determine that so we've had to experiment a little bit ...you can probably have learning almost anywhere!

Once placements were identified, another layer of negotiation added to the overall work; namely that of meeting specific agency requirements such as an agency-specific criminal record check, doctor's certificate, liability coverage, and, of course, the service agreement between the agency and the educational institution. Larger organizations might have several bureaucratic layers to navigate, such that "*approval processes are slowed down and [thereby] impact whether a willing individual within the agency can get permission to proceed.*" The observation that agencies often differed in their requirements added to the complexity of negotiating placements.

Sustaining Placements. Respondents drew our attention to the ongoing challenge of developing and maintaining ICPs even once they were being utilized. As one respondent wrote: "*development and maintenance of ICP's is very faculty resource-intensive, and difficult to sustain*". Several respondents mentioned preceptor and/or agency "burnout" on account of too many students and/or high workloads. Another respondent observed:

I think an ongoing consideration is the impact on some of these sites over time if they are seen as relief valves for the formal system and don't see enough benefits related to having students return as full fledged practitioners (in some sites).

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Relationship between clinical instructors and the agency was identified as an important factor. One respondent wrote: *“ICPs require release time and investment of time/energy from clinical instructors to go and get to know the staff. Need agency leaders to support the project and get buy-in from staff.”*

A further way of organizing the data related to the overarching theme of labour intensiveness associated with ICPs is by grouping the identified challenges and/or barriers according to where they originate and/or carry most impact—that is, whether faculty, educational institution, student, or agency-related.

Faculty-related Challenges

Faculty-related factors cited as barriers or challenges to the use of ICPs spanned several issues. One concern raised was that of faculty skill level, specifically that the assignment of faculty members who were not experienced in community-based nursing could lead to losing placements. In one situation, this was framed as a lack of understanding on the part of administration as to the skills required to teach in this type of setting: *“one of the frustrations is the impression by some administrators that a nurse is a nurse is a nurse ...and as long as this instructor is upright, breathing and moving ...she can teach community because it’s nothing anyway.”* Another respondent pointed out that inexperienced faculty might not be familiar with or support teaching objectives for ICPs.

Another challenge was that of faculty shortages, which were described as common within Canadian nursing programs. Faculty workload was also referenced as a concern on a number of accounts: respondents called for a recognition that scattered placements with a few number of students in multiple agencies was accompanied by the need for “PR” work in each setting including orientation, and increased travel time. Another concern was raised in regard to resistance from other colleagues not teaching in ICPs who may not support the learning that students gain or who see ICPs as a lesser placement.

Educational Institution-related Factors

From the perspective of the educational institution, challenges and barriers pertained generally to securing, sustaining, and coordinating placements. In this domain, the role of the clinical placement coordinator was pointed out as an important factor in working through the logistics of utilization of ICPs. For instance, one focus group respondent described their CPC as a “go-getter” who was always looking for new placement sites, although another respondent cautioned against a blanket endorsement of the CPC as the best model for negotiating clinical placements. Competition with other disciplines and even other nursing programs for limited spaces was raised by several respondents, particularly as agencies become known for taking students. Increased costs

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needed to be accounted for as employee salary, travel and time costs for clinical supervision may be significant as there may be smaller student/faculty ratios. From an administrative perspective, the concern was raised regarding how to calculate reasonable workload for clinical instructors in ICPs: *“my biggest issue is what’s sensible? How many groups can this one instructor look after?”*

Some respondents from collaborative programs described geographic factors as a barrier. Lower/junior students and students transferring to the university settings are not as well known to faculty and so NE express need to supervise their practice more closely and such students are not as likely to be assigned to ICPs

Student-related Factors

The third group of factors was student related, with students often directly impacted by the challenges or barriers. For instance, respondents made the observation that geographically remote placements, such as international or rural placements, typically come with more challenges. These were reported as including additional costs (e.g., for travel or accommodation), scheduling challenges (e.g., juggling on-campus courses with clinical placements), and impact on family or work commitments. Access to technology in rural or international settings was also noted as a potential challenge as was lack of public transportation.

Agency-related Factors

The final group of factors reported related to issues arising in the agencies themselves. These included staffing shortages and change over, seasonal fluctuations in the programming, space and equipment limitations, and general familiarity with the student learning experience, as observed by one respondent: *“many agencies do not have a culture that assumes student presence and participation in student learning”*. Finding sufficient field guides or RN preceptors was repeatedly identified as a challenge. As articulated by one respondent, *“The greatest challenge in recent years has been finding a RN who is willing to preceptor or mentor the student. RNs indicate this is because they ‘always have a student’ and need a break, or they find it is more work which adds to their workload.”*

A refusal by agencies to have junior students was raised as a barrier in the written responses. Additionally, reference was made to *“complex political procedures”* for First Nations placements. International placements could reportedly be complicated by communication (e.g., language), lack of technology, establishing the credentials of possible preceptors, and understanding differences in roles and health care delivery systems. Another factor identified as a barrier was an agency’s protectiveness of its’ clients or their confidentiality.

7. DISCUSSION

Based upon the national representation of survey respondents, the survey response rate, and plentiful and detailed respondent comments, it is clear that the use of ICPs for clinical nursing education is a topic that resonates with clinical placement coordinators and nurse educators, and is a nursing education matter that requires further development and study. Indeed, we were surprised by the widespread prevalence or “mainstreaming” of ICPs, such that the term ICPs might indeed be questioned as not entirely accurate! Yet, as descriptor, “innovative” certainly reflects the type of learning strategies employed, and the flexibility and creativity required in these settings. By far most Canadian nursing programs were using these types of settings. The additional commentary provided by respondents included a mix of enthusiastic endorsement (“...excellent for the depth, diversity and complexity it allows our students to encounter...change life views”; to the extent that after a long list of strengths, one respondent wrote “*I can’t think of any limitations! It’s all good*”) and realistic accounting of the challenges and barriers encountered.

We frame the discussion here around those findings we consider particularly salient to the development and utilization of ICPs along the themes of building capacity, maximizing learning, ensuring sustainability, and fostering partnerships.

7.1 Building Capacity

The widespread prevalence and innovation in establishing non-traditional clinical placements revealed in this study can be understood as testament to the current pressure on finding clinical placements. The survey findings provide insight into several avenues for increasing clinical placement capacity. First, findings point to what may be underutilized sites with the possibility for expanded use. The finding that non-traditional sites are not used as widely for pediatric, obstetrics/maternity, gerontology, and medical/surgical courses suggests that the community or non-acute settings that serve these population groups may hold capacity for more clinical placements. A second salient finding of the study related to building clinical placement capacity derives from programs that establish clinical placements on the basis of curricular themes that provide an avenue to target particular population groups not typically served as a “group” by health care services. For example, one program worked from a focus on advocacy for healthy public policy to target elementary and high school students regarding snowmobile safety in conjunction with campaigning policy makers. Similarly, the theme of health promotion prompted another program to target taxi drivers in a testicular cancer education campaign. Third, identifying and overcoming barriers to the use of ICPs clearly serve as another approach to building capacity for clinical placements. Although some barriers to using non-traditional community agencies are beyond the purview or influence of nursing

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programs (e.g., lack of funding for an agency, or high staff turnover in the agency), other barriers are more amenable to effective address. The frequently mentioned lack of understanding of the expanded role of the nurse, or the related nursing program or provincial nursing licensing body's policy of placing students only with RNs, are two such barriers that could be strategically addressed for improved clinical placement capacity. Education (campaign) regarding the expanded scope of nursing practice for students, faculty, and agency personnel might serve to legitimate alternate sites as clinical placements. Where nursing programs lack skilled faculty, focused faculty development could address this barrier. Likewise, the finding that identified competition between programs and disciplines for clinical placements draws attention to possibility to further develop interprofessional health education programming.

7.2 Maximizing Learning

The strong agreement regarding the rich learning in non-traditional clinical settings suggests the importance of educational support for this type of learning, particularly in leading students to reflective action. The nature of learning derived in these types of placements—higher level learning of concepts related to social justice, social determinants of health, and increased creativity and independence—translate well into all arenas of nursing practice, and arguably characterize the type of practitioner required for today's complex and high demand health care environments. It follows then that nursing programs should embrace these pedagogical strengths of ICPs, and intentionally seek to maximize them. Substantive content regarding concepts related to social justice, health disparities, and social determinants of health including poverty should be well represented in nursing curricula.

The emphasis on curricular consistency and structure such as clear objectives and careful orientation can be taken forward as wise counsel for nursing programs utilizing non-traditional clinical placements.

The range in models of supervision used across the country suggest that various models can be used, depending on what fits best with each program and level of student. Given that the type of concepts learnt in these placements require critical engagement by students, supervision should be structured enough to guide students in this type of learning. Well-prepared faculty within clearly articulated models of supervision and well structured course objectives and learning activities will be vital in those situations where RN mentors may not be available. Concern regarding faculty preparedness to supervise students in ICPs highlights the need for careful assignment of faculty with theoretical and practical knowledge regarding the populations served by healthcare agencies, as well as orientation to the nature and purposes of innovative community-based clinical placements. Dickson et. al. (2006) in their study of clinical facilitators, identified

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the importance of clinical faculty knowing their own limitations, and this type of self-awareness seems particularly important for faculty supervising ICPs.

The unexpected finding that most nurse educators offered more clinical supervision than the level of clinical supervision that they considered to be most effective raises some interesting questions. Are agencies providing adequate supervision, resulting in less required supervision from faculty? Are there unidentified agency factors impacting clinical supervision practices? Are enhanced student learning outcomes regarding critical thinking and substantive knowledge more a result of the level of faculty supervision than a result of student learning opportunities within ICP settings? Is the type of learning that results in these settings such that students can engage in with less supervision? Alternatively, perhaps the upper level students typically assigned to ICPs need less supervision due to fewer psychomotor clinical skills required in these community-based agencies.

7.3 Ensuring Sustainability

Despite all their benefits, continued student placements in innovative clinical sites may not be sustainable given the increased labour demands associated with them, and the multiple pressures already experienced by some host agencies. The burn-out factor posited by some respondents must be carefully monitored, and where strain on agency personnel is apparent a break from student placements for the agency might need to be negotiated. On the other hand, sustainability may be enhanced at some agencies where continuity can be ensured. A consistent flow of students may assist agencies in planning their delivery of services. Undoubtedly, ongoing open communication between agency and nursing program personnel is necessary to ensure mutual understanding of each party's capacity and ability to meet negotiated mutual expectations.

The observation by several respondents that a weak student could result in "losing the placement" raises the question of how students are assigned to placements, and whether some screening mechanisms should be instituted. Respondent comments regarding "*the importance of developing relationships between the agency, instructor and student*", assigning only "*students who have good communication skills and are very motivated*", and ensuring "*the right fit*", support the premise of implementation of student screening mechanisms. Such a suggestion, however, is tempered in part by the observation that many times placements may be assigned 6 – 12 months in advance, making this type of selection more difficult. Concern over "the right fit" extended also to the clinical instructor, as the instructor was described as the "*catalyst to the student experience for optimum learning*." A weak clinical instructor was seen to be an impetus to losing a placement, again pointing to the importance of assigning faculty with theoretical and practical experience and then providing adequate

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faculty orientation (e.g., time and training) to ICPs. As asserted by one participant: *“One bad experience can set you back quite far”*.

Establishing partnerships between community agencies and educational institutions may be one way of ensuring this type of continuity, and hence, sustainability.

7.4 Fostering Partnerships

The data suggests that some nursing programs are establishing formalized partnerships with community agencies to facilitate clinical placements. From the comments offered by participants, it appears that mutuality is an important dimension, with a tangible benefit to both parties. While the benefit to the nursing program may be clear in providing clinical placements, benefits for the host agency also need to be “tangible to them” as one respondent put it. One of the routes for reciprocity is through projects conducted by students for the agencies. *“The community partners are very pleased with the products that the students produce and it becomes a win-win situation for all involved.”* The survey did not elicit information specific to the nature of partnerships, nor how partnerships were established, and this matter is recommended for more careful study.

There is a growing literature, predominantly non-data based, that speaks to the importance of partnerships in the broader context of nursing education (Lamb, 2003), and innovative clinical placements specifically (Brown, et. al., 2006; Matteson & Zungolo, 2000). For example, Williams-Barnard et. al. (2004) emphasized the importance of partnerships between students, faculty, and consumers in non-traditional community-based education. Dickson et. al. (2006) in a qualitative study with clinical facilitators in Australia found that developing alliances with clinical agencies was a significant dimension of the clinical facilitator’s role, a finding that speaks to the importance of relationship between the university and the clinical agency. In order to build such alliances, fostering continuity through the same faculty member(s) returning to the same agency was recommended. Similarly, Reifsnider and colleagues (2004) described a partnership between 3 types of public health agencies and a nursing program in south Texas that contributed to students’ learning of public health principles. In Connecticut, Novotny and colleagues (2004) developed a partnership, as strategic alliance, between a school of nursing and a hospital. While the hospital represents a traditional placement, the principles and process of establishing a formal partnership are informative. The guiding principles that drove this were a joint commitment to the partnership being valued for the education of students, as the source for future nurses, and, most importantly, the care of patients. The partnership was a strategic alliance that fulfilled the mutual interests and shared goals of both organizations. A partnership of this nature differs from the common

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view of students as guests in a hospital, and in the example described by Novontny et. al., followed the principles of:

1. Agreed-upon missions, values, goals, and measurable outcomes.
2. Mutual trust, respect, genuineness, and commitment.
3. Identified strengths and assets, including areas that need improvement.
4. Balancing the power and sharing resources.
5. Clear, open, and accessible communication.
6. Roles, norms, and processes are agreed on with input from everyone.
7. Feedback comes from all stakeholders and is based on continuous quality improvement.
8. Credits for accomplishments are shared. (p. 218).

National benchmarks from Australia for university-healthcare organization partnerships include

- Partners will develop a shared formal agreement between a university and a health service regarding clinical education of undergraduate nurses.
- There is effective and timely communication between partners.
- The rights, roles and responsibilities of persons at every level of the clinical learning partnerships are clearly defined.
- Scholarly teaching by both partners occurs in the clinical learning environment.
- The partnership elements that promote high quality learning for students are provided within the clinical learning environment.
- There is regular monitoring of agreed partnership elements that affect learning, teaching and progress of students.

(Clare et al. 2003, pp. 57-65)

Service-learning, a development promoted throughout higher education in the 1980s and 1990s, is also promoted within nursing literature and carries partnership as a core value. The four characteristics of service learning include: experiential learning, students' address of community needs while learning, reflective practice, and reciprocity between the service learner and those being served (CASN, 2005).

From these three models for partnerships, we see intentionality, mutuality, clear communication, and evaluation as key components to partnerships.

7.5 Study Limitations

As with any convenience sample, this study is limited by the possibility of partial representation in its sample. Potential bias lies in the possibility that those with strong opinions are those who respond. Due to financial constraints, the survey was not translated into French. In order to increase the response from French language programs, a bilingual Research Assistant phoned representatives at each of these programs to introduce the survey and invite their participation, a

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strategy that was limited in effectiveness, as responses were received from only 4 of the identified 11 predominantly French language programs within Canada. The study did not pursue the perspectives of agency stakeholders who would add an invaluable dimension regarding the use of ICPs, particularly in regard to increasing capacity and fostering sustainability. While limitations of online surveys have been reported in the literature, few technical difficulties were encountered in this project that were not able to be remedied. Finally, study hypotheses were tested based on the perceptions of nurse educators, not based on measured student performance indicators.

8. CONCLUSIONS

Prevalence—ICPs are widely used, a move both *necessitated* by a pressing need for clinical placements and *motivated* by curricular foci such as primary health care and health promotion. ICPs were most commonly used in community health courses, preceptorships/consolidated learning experiences, and mental health courses. Most commonly used sites were community support groups (84%), schools (84%), rural/remote (74%), First Nations (68%), corrections/forensic (68%), impoverished inner city (59%), and international (54%). ICPs were used most commonly for intermediate and/or senior level nursing students. Nursing schools without graduate programs were more likely to use ICPs for beginning level students.

Partnerships—Nursing programs that reported partnerships with clinical agencies indicated a higher use of ICPs.

Capacity—While ICPs are widely used, more capacity may be generated by: a) accessing under-utilized sites; b) developing population-based placements; and c) intentionally addressing barriers to ICPs such as perceptions regarding the nurse's role.

Sustainability—Overloading community agencies may result in burn-out and loss of placements. Adequate faculty preparation to ensure adequate knowledge and skill set, and time to develop relationships with agency personnel will contribute to sustainability.

Learning Opportunities—ICPs are particularly suited to facilitate learning in regard to concepts of social justice, social determinants of health, and poverty. ICPs are also more effective than traditional placements for the development of stronger professional relationships, creativity in clinical decision-making, initiative, and critical thinking.

Factors Facilitating Learning—While much about ICPs represents a relatively unstructured environment, building structure into the learning process through clear and specific expectations and objectives, ample orientation, and supportive supervision will enrich the learning experience. Other factors deemed very important in facilitating learning in ICPs were student initiative, well-established partnerships, and the “fit” between curricular themes and the clinical placement. Visibility and valuing of the RN role by agency and university personnel were raised as important factors. In contrast, the presence of other students and the school assisting with the logistics of ICPs (e.g., travel, housing) were less important.

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Clinical supervision—Clinical supervision was rated as an important factor when using ICPs but nursing programs vary in their approach to clinical supervision. The most common approach was using some supervision where contact was every 2 – 3 days but more likely via email, telephone, or on-campus follow-up rather than direct supervision in the clinical setting. The majority of NEs indicated they relied heavily on agency personnel for supervision of students, and role modeling and mentoring by RNs in the practice setting was rated as very important in facilitating student learning. Programs varied as to whether they assigned students to settings that did not have a nurse employed and/or to preceptors who were not nurses.

Negotiation—ICPs are most commonly negotiated by clinical placement coordinators in a centralized role, although nurse educators are also active in identifying and negotiating sites. Less common is the expectation that students negotiate their own ICPs. The negotiation of ICPs was described as labour intensive, with multiple unique logistics.

Challenges—Although widely used and endorsed, ICPs do present certain challenges. A majority of CPCs and NEs reported encountering barriers in negotiating and/or using ICPs. Reported barriers did not differ significantly by size of nursing program or presence of partnerships.

- Safety, ethical, and legal concerns were not perceived by the majority of nurse educators as greater in ICPs compared to traditional placements.
- The time required for the set up and coordination of ICPs is greatly increased compared to traditional clinical placements
- Locating ICPs was identified as a challenge, including competition for sites from other nursing programs or other disciplines.
- The large number of nursing students made finding a sufficient number of placements difficult.
- Meeting agency requirements added another layer of negotiation to the overall work of using ICPs.
- Sustaining placements given the reality of heavy workloads at agencies and agency “burnout” was identified as a challenge.
- Finding appropriate field guides was presented as a challenge.
- Faculty skill level or experience in ICPs was identified as an important factor, with the risk of losing placements due to inexperienced faculty.
- Faculty workload, particularly with students scattered across many sites, was raised as a concern.
- The additional costs, scheduling challenges, and impact on family and/or work commitments represent possible challenges for students in ICPs.

Despite these challenges, ICPs were generally enthusiastically endorsed by CPCs and NEs.

9. RECOMMENDATIONS

1. Nursing programs should continue to develop and implement the use of innovative clinical placements.
2. Strategies need to be developed to increase capacity and to facilitate sustainability in these sites.
3. The role of the nurse in non-traditional sites should be articulated. For example, easily accessible resources could be developed that communicate the role of the nurse in multidisciplinary and/or non-traditional settings.
4. Underutilized areas such as community-based gerontology, hospice care, maternal child care should be identified. Population groups targeted that are not typically served by any one clinical agency (e.g., taxi drivers) could also be developed as ICPs.
5. Student learning can be maximized in these settings by building in structure through clear course objectives, well developed learning activities, ample orientation and debriefing, and a close “fit” between the curriculum and the ICP.
6. Substantive content must be included in curricula regarding concepts such as social determinants of health, health disparities, and access to health services.
7. Adequate faculty preparation should be sought to ensure adequate knowledge and skill set, and time to develop relationships with agency personnel will contribute to sustainability.
8. Agency staff, whether RNs or other field guides, must be oriented to their role and well supported by the university-based clinical instructor given the realities of heavy workloads and the risk for burnout.
9. Nursing program administrative support (such as funding, release time) should account for the extra time it takes to negotiate ICPs.
10. Partnerships between academic and host agencies should be established to facilitate the administration of ICPs and to foster student learning.
11. Research is needed to establish what factors contribute successful partnerships between agencies and educational institutions.
12. Research should be conducted with agency stakeholders to gain insight into the issues they face hosting students.
13. Further research is needed to evaluate various models of clinical supervision in ICPs.

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Appendix A

FOCUS GROUP GUIDE

I. Use, Prevalence

- We've heard that the majority of Canadian programs use ICPs, and the use of ICPs has grown significantly in the past 5 years. What do you consider the most innovative of the clinical placements your program uses?
- The survey results indicate ICPs are used extensively for community health courses (80% of CPC respondents) and mental health (58%) but much less for med/surg, palliative, gerontological, and maternal-child/perinatal courses (between 10.5-25%). Do you perceive opportunities for ICP development in these courses, and if so, in what courses/settings?

II. Student Learning

- Findings indicate that rich student learning occurred in ICP settings. What concepts do students gain from ICPs that stand out as significant or unique from your perspective? Are there learning gaps or deficits that show up consistently for students who have been in ICPs (compared to those in traditional settings)?
- Clarity of course and clinical placement objectives in the ICP are vital, according to survey respondents (93%). From your perspective, is it important to be prescriptive regarding specific student learning activities, or instead focus more broadly on learning outcomes, allowing flexibility/creativity in **how** students meet these objectives?

III. Administrative

- What type of support from administration is needed for successful use of ICPs?
- What issues (ethical, legal, safety) have been identified regarding ICPs in your program?

**Innovative Clinical Placements:
A National Survey**

IV. Capacity & Sustainability

From the survey, we gather that concerns regarding capacity and/or sustainability are issues with either school or agency. The next questions speak to these matters.

- What strategies might we use to increase ICP capacity?
- Programs with agency partnerships used ICPs more extensively. What makes for a successful partnership?
- What strategies have you used for sustainability of ICPs?
- Survey respondents addressed that faculty colleagues sometimes viewed ICPs as “lesser” placements. How might we promote the value of ICPs with faculty colleagues?
- Agency personnel sometimes query the role of the nurse or nursing student in their particular agency? How might we better articulate the role of nursing in non-nursing based placements? (i.e., where nursing is not the primary professional designation, eg., MADD)

Do you have any other comments?

Appendix B

A National Survey: The Use of Innovative Clinical Placements



TRINITY WESTERN UNIVERSITY

NATIONAL SURVEY

Use of Innovative Clinical Placements in Undergraduate Nursing Education: A National Survey

We are conducting a national survey of nurse educators regarding the utilization of innovative clinical placements in undergraduate nursing education. We are interested in the prevalence and types of clinical placements used that vary from the main health care delivery system. This study is important in contributing to our understanding of the nature of student learning and effective strategies for innovative clinical placements.

The survey will require approximately 15 - 20 minutes to complete. Informed consent is inferred by completing the survey questions, and all identifying information will be removed from the data.

Your participation is very much appreciated!

Research Team:

Sheryl Reimer Kirkham, PhD, TWU, Principal Investigator

Catherine Hoe Harwood, MScN, TWU, Co-Principal Investigator

Landa Terblanche, PhD, TWU, Co-investigator

Lynn Van Hofwegen, MSN, TWU, Co-investigator

Rick Sawatzky, MSN, TWU, Collaborator

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TRINITY WESTERN UNIVERSITY

NATIONAL SURVEY

Use of Innovative Clinical Placements in Undergraduate Nursing Education: A National Survey

There is no time limit to the survey, and you can change your responses to previous questions as long as you have not left the survey. Your responses will be submitted as soon as you close this window.

Please click Next to complete the survey now.

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Use of Innovative Clinical Placements in Undergraduate Nursing Education: A National Survey

Demographic Information

1. Indicate your role in the nursing program (select all that apply)

- I teach one or more courses.
- I teach or supervise students in clinical settings.
- I coordinate clinical placements.

2. Indicate your educational preparation (select all that apply):

- Diploma
- Baccalaureate
- Masters
- Doctoral
- Other (please specify)

3. Indicate male or female

- Female
- Male

*** 4. Are you a clinical placement coordinator or equivalent person arranging clinical placements for your nursing program?**

- Yes (Note: respondents were redirected to question 5).
- No (Note: respondents were redirected to question 26).

Please click Next to continue.

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TRINITY WESTERN UNIVERSITY

Use of Innovative Clinical Placements in Undergraduate Nursing Education: A National Survey

 Program Information

5. How long have you held a position as clinical placements coordinator in your nursing program?

- Less than 1 year
- 1 - 4 years
- 5 - 9 years
- 10 - 14 years
- 15 - 19 years
- 20 or more years

6. What nursing programs does your educational institution offer (select all that apply)?

- Diploma
- Generic baccalaureate
- Post-RN baccalaureate
- Masters
- Doctoral
- Other (please specify)

*** 7. How many students attended your undergraduate nursing programs last year?**

- 0 - 100
- 101 - 200
- 201 - 300
- 301 - 400
- 401 - 500
- More than 500

8. Estimated average age of undergraduate baccalaureate students when they graduate from the nursing program:

- 21 – 25 years of age
- 26 – 30 years of age
- 31 years or older
- Don't know

Innovative Clinical Placements (ICPs):

Less structured clinical environments, often more multidisciplinary; typically outside or varying from the main health care delivery system (e.g., Aboriginal, rural, parish, international, corrections settings, Para-health organizations, etc.)

Traditional Clinical Placements (TCPs):

Structured clinical environments, typically within the main health care delivery system (e.g., acute care settings; public health units; home care services; long-term care facilities).

* 9. Does your undergraduate nursing program utilize innovative clinical placements (ICP) for any portion of clinical nursing education according to the above definitions?

No (Note: respondents were redirected to question 26).

Yes (Note: respondents were redirected to question 10).

Please click Next to continue.

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TRINITY WESTERN UNIVERSITY

Use of Innovative Clinical Placements in Undergraduate Nursing Education: A National Survey

Program Information (cont'd)

* **10. Compared to 5 years ago, the use of ICPs in your nursing programs has:**

- Increased greatly
- Increased somewhat
- Stayed about the same
- Decreased slightly
- Decreased greatly
- Don't know

* **11. What courses in your undergraduate program(s) use ICPs for any portion of clinical nursing education? (select all that apply)**

- Community Health
- Pediatrics
- Maternal-Child/Perinatal
- Mental Health/Psychiatric Nursing
- Gerontological Nursing
- Palliative Care
- Medical/Surgical Nursing (general nursing courses)
- Preceptorship (or consolidated practice experiences)
- Other nursing courses that use ICPs (please specify)

12. Please provide the titles of courses in which innovative clinical placements are used in your undergraduate program(s):

13. In what types of program does your school of nursing use ICPs? (select all that apply)

- RN diploma
- Baccalaureate (generic)
- Baccalaureate (post-RN)
- Graduate
- RN refresher program
- Other (please specify)

*** 14. What types of innovative clinical settings has your undergraduate nursing program(s) used in the past year? (select all that apply)**

- Parish
- Corrections/Forensics
- International
- Rural
- Aboriginal First Nations settings
- Impoverished Inner City
- Schools
- Community Support groups
- Other
- Please comment on your responses to this question

*** 15. Do you use ICPs for (select all that apply):**

- Beginning level nursing students (E.g., students within the first year of entering your program)?
- Intermediate level nursing students (i.e., students who are not at the beginning or senior levels)?
- Senior level nursing students (E.g., students within the last two semesters prior to graduation)?

16. Does your program use ICPs that involve four or more visits per student to the same location?

- Yes
- No
- Don't know

* **17. Approximately what percentage of community clinical placements in your program are in ICP settings (compared to traditional settings such as public health units, outpatient clinics)**

- Almost all our community placements are in ICP settings (More than 90%)
- More than 3 out of 4 of our community placements are in ICP settings (75% – 89%)
- More than half of our community placements are in ICP settings (50% – 74%)
- Less than half of our community placements are in ICP settings (25% – 49%)
- Less than 1 out of 4 community placements are in ICP settings (10% - 24%)
- Hardly any placements are in ICP settings (Less than 10%)
- Our program does not offer any clinical placements in ICP settings
- Don't know

* **18. Approximately how many hours on average do generic undergraduate students in your nursing program spend in ICPs throughout their entire program?**

- More than 200 hours
- 151 – 200 hours
- 101 - 150 hours
- 51 – 100 hours
- 26 – 50 hours
- 10 – 25 hours
- Less than 10 hours
- Don't know

* **19. What approach(es) to clinical supervision are used for ICPs in your program? (select all that apply).**

- Intensive supervision (clinical instructor on site most of the time)
- Close supervision (clinical instructor visits student on site every 2 or 3 clinical days)
- Some supervision (clinical instructor does not visit student at site regularly but has contact every 2 or 3 clinical days via email, telephone, or on-campus contact)
- Not very much supervision (clinical instructor visits or contacts student infrequently over term)
- Little supervision (clinical instructor visits or contacts student once or twice/placement)
- No clinical instructor supervision
- Varies across placements (please comment)

20. Identify the single most common approach to clinical supervision used for ICPs in your nursing program.

- Intensive supervision (clinical instructor on site most of the time)
- Close supervision (clinical instructor visits student on site every 2 or 3 clinical days)
- Some supervision (clinical instructor does not visit student at site regularly but has contact every 2 or 3 clinical days via email, telephone, or on-campus contact)
- Not very much supervision (clinical instructor visits or contacts student infrequently over term)
- Little supervision (clinical instructor visits or contacts student once or twice/placement)
- No clinical instructor supervision
- Don't know

21. What percentage of ICPs in your program rely heavily on other health care providers (e.g., RN preceptors) to provide clinical supervision?

- Almost all our ICPs (More than 75%)
- Most of our ICPs (about 50 - 75%)
- Some of our ICPs (about 25 - 49%)
- Few of our ICPs (less than 25%)
- None

22. Please comment on how clinical supervision is provided for ICPs in your nursing program

*** 23. How are ICPs negotiated for your nursing program? (select all that apply).**

- Clinical placement coordinator negotiates placement
- Nursing faculty approach ICPs for potential opportunities
- Students are expected to negotiate ICPs
- Students are not allowed to directly approach ICPs
- Community agencies have invited partnerships with nursing program
- Other
- Please provide any responses to this question

* **24. Have you encountered any barriers in negotiating or utilizing community ICPs?**

No

Yes: please describe any barriers encountered

25. Please comment on strengths, limitations, or challenges associated with the use of ICPs.

Please click Next to continue

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TRINITY WESTERN UNIVERSITY

Use of Innovative Clinical Placements in Undergraduate Nursing Education: A National Survey

Nurse Educator Perspectives

The following definitions are used in this survey:

Innovative Clinical Placements (ICPs):

Less structured clinical environments, often more multidisciplinary; typically outside or varying from the main health care delivery system (e.g., Aboriginal, rural, parish, international, corrections settings, Para-health organizations, etc.)

Traditional Clinical Placements (TCPs):

Structured clinical environments, typically within the main health care delivery system (e.g., acute care settings; public health units; home care services; long-term care facilities).

* 26. Do you have a role in:

- 1) Teaching a course that uses innovative clinical placements
- 2) Supervising preceptorship students in innovative clinical placements
- 3) Clinical teaching in innovative clinical placements

- No, I do **not** fulfill any of the above roles (Note: respondents were redirected to verification page).
- Yes, I do fulfill one of the above roles (Note: respondents were redirected to question 27).

Please click Next to continue.

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TRINITY WESTERN UNIVERSITY

Use of Innovative Clinical Placements in Undergraduate Nursing Education: A National Survey

Verification

You have indicated that you do not currently teach in undergraduate nursing courses that utilize innovative clinical placements. In this case, we ask that you kindly forward the email introducing the survey to someone in your department who meets the inclusion criteria of:

a) clinical placements coordinator (or equivalent) OR

b) nurse educator who teaches in any of the following areas: - senior level community health course (or equivalent) - other courses that use innovative clinical placements - preceptorships in innovative clinical placements

If you have any comments about the use of innovative clinical placements please provide them on the next page.

Thank-you.

Please click Next to continue.

(Note: Respondents continued with question 42)

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TRINITY WESTERN UNIVERSITY

Use of Innovative Clinical Placements in Undergraduate Nursing Education: A National Survey

Nurse Educator Perspectives

* **27. Please indicate which of the following roles apply to you (select all that apply):**

- teaching a course that uses innovative clinical placements
- supervising preceptorship students in innovative clinical placements
- clinical teaching in innovative clinical placements

28. How long have you held a position as nurse educator (in any nursing program)?

- Less than 1 year
- 1 - 4 years
- 5 - 9 years
- 10 - 14 years
- 15 - 19 years
- 20 or more years

* **29. What courses do you teach that utilize ICPs? (select all that apply)**

- Community Health
- Pediatrics
- Maternal-Child/Perinatal
- Mental Health-Psychiatric Nursing
- Gerontological Nursing
- Palliative Care
- Medical/Surgical Nursing (general nursing courses)
- Preceptorship (or consolidated practice experiences)
- Other (please specify)

* **30. What type of ICP settings have you utilized in courses that you teach in this program? (select all that apply)**

- Parish
- Corrections/Forensics
- International
- Rural
- Aboriginal First Nations settings
- Impoverished Inner City
- Schools
- Community Support groups (please specify below)

- Other (please specify below)
- Please comment on your responses to this question

31. What proportion of ICPs in your courses rely primarily on other health care providers (e.g., RN preceptors) to provide direct clinical supervision?

- Almost all our ICPs (More than 75%)
- Most of our ICPs (about 50 - 75%)
- Some of our ICPs (about 25 - 49%)
- Few of our ICPs (less than 25%)
- None

*** 32. What approach(es) to clinical supervision are used for ICPs in the courses you teach? (select all that apply)**

- Intensive supervision (clinical instructor on site most of the time)
- Close supervision (clinical instructor visits student on site every 2 or 3 clinical days)
- Some supervision (clinical instructor does not visit student at site regularly but has contact every 2 or 3 clinical days via email, telephone, or on-campus contact)
- Not very much supervision (clinical instructor visits or contacts student infrequently over term)
- Little supervision (clinical instructor visits or contacts student once or twice/placement)
- No clinical instructor supervision
- Varies across placements
- Please comment on your responses to this question

33. Identify the single most common approach to clinical supervision used for ICPs in the courses you teach.

- Intensive supervision (clinical instructor on site most of the time)
- Close supervision (clinical instructor visits student on site every 2 or 3 clinical days)
- Some supervision (clinical instructor does not visit student at site regularly but has contact every 2 or 3 clinical days via email, telephone, or on-campus contact)
- Not very much supervision (clinical instructor visits or contacts student infrequently over term)
- Little supervision (clinical instructor visits or contacts student once or twice/placement)
- No clinical instructor supervision
- Don't know

34. What approach to clinical supervision do you consider most effective for ICPs?

- Intensive supervision (clinical instructor on site most of the time)
- Close supervision (clinical instructor visits student on site every 2 or 3 clinical days)
- Some supervision (clinical instructor does not visit student at site regularly but has contact every 2 or 3 clinical days via email, telephone, or on-campus contact)
- Not very much supervision (clinical instructor visits or contacts student infrequently over term)
- Little supervision (clinical instructor visits or contacts student once or twice/placement)
- No clinical instructor supervision
- Don't know
- Please comment on your responses to this question

35. Please answer the following questions

	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly	Don't Know
Learning activities (e.g., assignments) in ICPs must be very structured to ensure course learning objectives are met	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Safety concerns for students are much greater for ICPs compared to TCPs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Safety concerns do not arise in either ICPs or TCPs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Safety concerns for instructors are much greater for ICPs compared to TCPs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ethical concerns are much greater for ICPs compared to TCPs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Legal concerns are much greater for ICPs compared to TCPs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Time required for coordination and set-up for ICPs is greatly increased compared to traditional clinical placements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Students in ICPs require much more support during entry and exit to clinical sites compared to students in traditional sites	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In comparison to TCPs, ICPs are more effective for promoting student integration of theory and clinical learning.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

36. In comparison to traditional clinical placements, ICPs are more effective for promoting student learning of nursing concepts such as:

	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly	Don't know
community development	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
social determinants of health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
social justice and equity (access to health care services)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
poverty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
culture and diversity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

37. In comparison to traditional clinical placements, students in ICPs:

	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly	Don't know
Demonstrate more initiative toward engaging in clinical learning opportunities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Demonstrate more creativity in clinical decision-making	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Demonstrate more critical thinking by identifying appropriate nursing assessments and interventions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Develop stronger professional relationships (e.g., loyalty, interpersonal relationships with community members) with the communities in which the ICPs are situated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

38. How important are the following factors in facilitating learning in ICPs? [If significant differences among settings – please comment below]

	Could not be more important	Very important	Somewhat important	Slightly important	Not important at all	Don't Know
A well-established partnership between practice agency and university/school of nursing.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ongoing clinical instructor presence.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Role modeling and mentoring by RNs in practice settings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Student initiative and independence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clarity of course & clinical placement objectives (specific to ICP settings).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
“Fit” between curricular themes and clinical placement.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Presence of other students (e.g., cohort of students in the same setting).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Orientation to the setting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
School assisting logistics (Eg. facilitating accommodation, travel, etc)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Timing/scheduling (Eg. not conflicting with traditional school term)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*** 39. Have you encountered any barriers in negotiating or utilizing ICPs?**

- No
- Yes: please comment on any barriers encountered

Please click Next to continue.

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TRINITY WESTERN UNIVERSITY

Use of Innovative Clinical Placements in Undergraduate Nursing Education: A National Survey

 **Comments**

40. Please comment on other factors that you consider important to facilitate learning in ICPs

41. Please comment on strengths and limitations of ICPs

Please click Next to continue.

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TRINITY WESTERN UNIVERSITY

Use of Innovative Clinical Placements in Undergraduate Nursing Education: A National Survey

General Comments (Note: this page was only for those who answered "no" to question 26).

42. Please comment on the reason(s) why your program does not use ICPs

Please click Next to continue.

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TRINITY WESTERN UNIVERSITY

Use of Innovative Clinical Placements in Undergraduate Nursing Education: A National Survey

 **General Comments**

43. Please use this space to provide any additional comments about this survey.

Please click Next to continue.

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TRINITY WESTERN UNIVERSITY

Use of Innovative Clinical Placements in Undergraduate Nursing Education: A National Survey

 Future Participation

44. A second phase of this study involves a focus group held at an upcoming national nursing education conference. If you are interested in participating in a focus group, please provide your contact information below or email us directly at Sheryl.Kirkham@twu.ca

All identifying information is kept separate from the survey data to ensure anonymity of your responses.

- No, please do not contact me
- Yes, contact me at (name and email address):

Please click Next to continue.

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TRINITY WESTERN UNIVERSITY

NATIONAL SURVEY

Use of Innovative Clinical Placements in Undergraduate Nursing Education: A National Survey

Your participation is very much appreciated!

Research Team:

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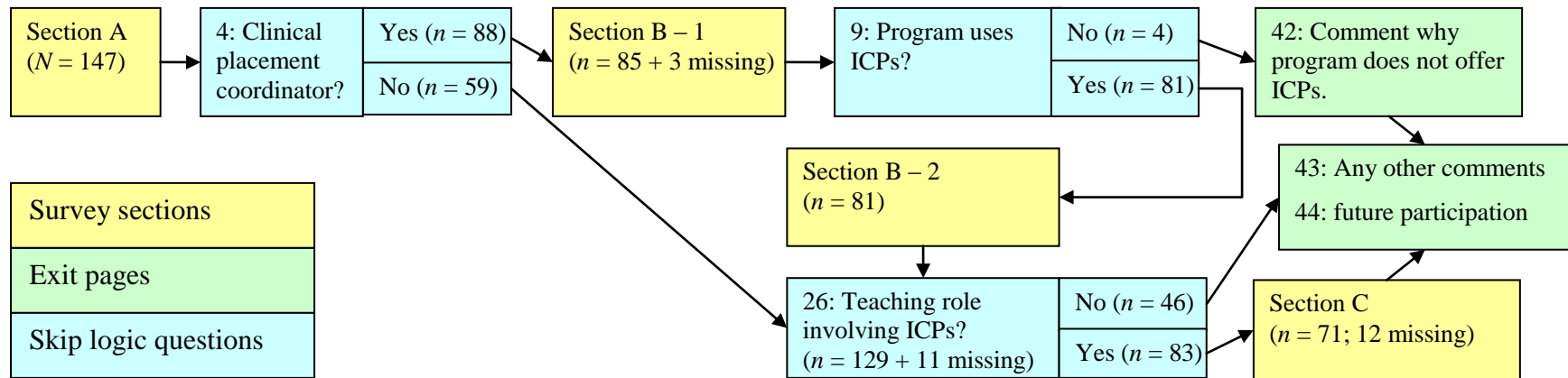
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**Appendix C
Skip Logic Chart**



Survey sections:

Section A (items 1 to 4): To be completed by everyone.

Section B-1 (items 5 to 9): To be completed by all clinical coordinators.

Section B-2 (items 10 to 25): To be completed by clinical coordinators nursing programs that use ICPs.

Section C (items 27 to 41): Only to be completed by educators involved in teaching courses with ICPs (items 27 to 41).

* item 26 was to be completed by all educators and clinical coordinators in programs that used ICPs.

Exit pages:

Program does not offer ICPs: only completed by clinical coordinators in nursing programs that do not offer ICPs.

Any other comments: completed by everyone.

Future participation: completed by everyone.

Appendix D

List of ICP Sites and Partnerships Reported in Survey Narrative and Focus Group Responses.

Aboriginal programs - Diabetes initiative program, Native friendship centers
Aboriginal Community Health Centers (on reserves)
Addictions programs and centers – (E.g. Government sponsored alcohol & drug prevention programs), Tobacco reduction initiatives
Agency based experiences within traditional health care settings. E.g. Non-acute care experiences within acute care facilities – partner with or placed in settings such as: Infection control nurse, nurse educator, float nurse, day surgery, diabetic education center, research programs, float nurse, occupational health ns in hospital, assigned with Nurse Educators in setting – E.g. OR, ICU
Correctional and Forensic settings – including multiple level security settings and transition programs, John Howard Association
Community based support programs - E.g. for seniors living in the community, neighbourhood houses, family resource center, Family Caregivers' Association; grief support groups
Community-based sports and leisure programs - recreation programs, Scouts/Girlguide programs, community garden program, Mom and Tot based programs, Y swimming program, established play programs, music programs
Community Intersectoral committees/groups
E.g. Pandemic Preparedness planning – subcommittee of the emergency planning committee. Involved developing preparation /information packages & delivering to community settings such as schools, daycares. Also interacting with Media.
Community housing coalitions, low-income housing settings and housing co-ops
Day Care programs – for children, for seniors
Diagnosis or Illness based Organizations E.g., Asthma Association, Alzheimer's Society, CP parent support group, HIV programs, Post-polio syndrome support group, Eating Disorder Association and support groups; Canadian Cancer Society; Post-partum Depression outreach centers and support groups
English as a Second Language classes and similar Multi-cultural and new immigrant outreach settings, Intercultural Associations
Fitness groups – targeted for specific rehabilitation post injury or illness or general programs
Food banks, Soup kitchens, Homeless shelters – accessing broader issues of poverty, homelessness, impact of nutrition on health, mobile clinic activities

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Health Care & community safety providers – partner with E.g. RCMP, social workers to develop resources

Health Care providers in private practice – Midwives, Physicians, Nurse practitioners

Health promotion agencies

Horseback Riding for the Disabled

Hospice

Industry based occupational health and safety departments, Workplace safety program development. Types of companies/industry mentioned include: Canada Post, Industrial settings, Oil & Gas industry, manufacturing companies, mining sites

Inner City area community based clinics, some established by nursing faculty, Street clinics, mobile clinics

Inner City community support programming – boys and girls clubs, various programs dependent upon local setting

International settings and partnerships – group and individual placements

Legal aid clinics, victim services

Linkages with federal, provincial and local government programs/departments – E.g. Federal government disability assessment nursing, Ministry of Children and Families, Multi-cultural associations, sheltered workshops, Government programs such as “BC Housing” – partner with housing societies

Mental Health community based promotion and transition programs, senior mental health outreach

Military facilities/settings/health settings

Municipality based programs E.g. Anti-smoking bylaw education

Nursing research settings – partner with ns researcher

Parish nursing settings – Involvement with parish nurses, partnering with established church programming such as: senior’s groups, youth groups

PARTY program (Prevention of Alcohol Related Trauma in Youth)

Prenatal/postnatal classes – also prenatal nutrition programs

Pre-school age child preparation program for admission to the hospital setting (simulated)

Preschools/daycare settings

Population health programs –E.g. immunization clinics (public & private agency run), health promotion displays, programs targeting various ethnic groups.

Religious gathering sites E.g. Sikh temple,

Rural Community health centers

Rural outreach programs E.g. snowmobile safety program – including writing to Government advocating for public policy re: snowmobile safety

Salvation Army based service programs – E.g., Safe house, addictions programs

Schools – Health promotion activities including teaching in classes, breakfast clubs, before and after school care programs, targeted programs for special needs children in school settings

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Partner with recreational therapists for special needs children in schools
Summer Camps – including targeted camps for children have a diagnosis or disability, preceptorships with Camp ns at camps for pediatric populations with special needs
Travel clinics – public health based or private
United Way – partner with various programs
University health clinics, also take programs to university student residences
University based community aggregates such as foreign language speaking students
Vulnerable populations services: EG Domestic Violence services such as safe houses, transition houses
Walk in clinics
Workplace or type of work based community aggregates such as bus drivers and hotel staff, taxi drivers – mentioned targeted educational program re; promoting testicular examinations among taxi driver population
Sex trade workers

Creative Assignments described in Survey Narrative Comments

Advocacy assignment – termed “Becoming Influential Exercise”. Students have to explore and complete application exercises for certain population. Then have to write a letter to an editor and discuss what they think about issue and advocate for a strategic change to better the situation for population.

Community based projects for nursing students partnered with other health care professions students – E.g Nursing student partnered with pharmacy student to understand the reality of why low income persons might be challenged to maintain consistency with diabetes medications.

Technology support program for Community health nurses – set up of PDAs or computers. E.g. Students do needs assessments for educators, public health nurses and long term care nurses and then create power point presentations for nurses to take into homes on their lap tops. Create teaching resources based upon client teaching /support needs.