Oregon Center for NURSING

NOT WORKING WELL:
Clinical Placement for Nursing Students in an Era of Pandemic

INTRODUCTION

In the winter of 2020, the Oregon Center for Nursing (OCN) began a series of meetings designed to bring nursing leaders from both clinical and educational settings together regularly to discuss new and emerging issues during the pandemic (Inset 1). These virtual meetings have identified several ongoing themes as key concerns. High on this list is the clinical placement of nursing students in the Portland Metro area. To understand more about this problem and its impact on the nursing workforce pipeline, OCN surveyed area healthcare agencies and nursing programs.

Inset 1 | OCN Friday Morning Huddles

Attendees	On average, 30-40 leaders based in Oregon representing healthcare agencies, community colleges, workforce agencies, the board of nursing, consultants
Timing & Duration	Meets every Friday morning, from 8 am to 9 am. Huddles began in March 2020 and continue to meet weekly.
Format	Meetings take place virtually through video
Recurring Themes	COVID-19 (prevalence, guidelines, resources), nursing education curriculum changes, clinical placement modifications, employee health, racial health inequities, civil unrest, wildfire response, Nurse Practice Act

IMPORTANCE OF CLINICAL PLACEMENT

All healthcare professional education programs use some form of clinical placement to complement the didactic elements of the educational process. During a clinical placement, students observe and participate in care delivery in a wide variety of settings. In nursing, clinical education models can vary widely both across institutions and across a particular curriculum (Inset 2). Clinically-based education is mandated by accreditors and regulators, and is a strong historical norm in nursing education. For a clinical placement to be made, educational institutions must gain the permission and support of a clinical agency willing to host their students. Due to the limited clinical sites, the additional workload student presence can place on healthcare providers, and the growing number of nursing programs in the U.S., there has long been a shortage of clinical placements. This shortage is one of the most significant nationwide constraints on the growth of the nursing workforce.

Over the past two decades, nursing educators and healthcare providers have implemented several solutions to alleviate the clinical placement shortage. These innovations have included development of dedicated education units (DEU), which devote one floor of a health facility for education purposes, building online software to help track

Inset 2 | Examples of Clinical Education

A group of six nursing students early in their educational process spend 6-12 hours/week in a long-term care facility providing direct patient care while being overseen by a faculty member supplied by their educational institution.
A group of three students midway through their education participate in indigent care based out of an urban community center while being directly guided by a nurse employee of the center and remotely overseen by a faculty member.
An individual student at the end of the educational process provides direct care to a patient in a critical care setting while being directly overseen (or precepted) by a nurse who is an employee of the healthcare setting.

and coordinate clinical placements, and creating a consortium of nursing and clinical partners in the Portland Metro area to regionally manage placements.

When the pandemic struck, many healthcare agencies stopped allowing students to access their clinical sites. Concerns over personal protective equipment (PPE), risks related to the spread of COVID-19, and workforce burden, among other factors, brought a swift end to the clinical experiences of many nursing students in the Portland Metro area. Programs were forced to quickly find other solutions, and most turned to simulation. In recent decades, simulation has emerged as a trend in both supplementing and offsetting clinically-based education. While some nursing programs have replaced up to 50 percent of clinical hours with simulation, the majority of programs remain highly dependent on healthcare and community agencies to provide placements for their students. While solid evidence exists for the effectiveness of simulation, it is not known to what extent simulation can be used to offset clinical experience and still achieve learning outcomes at a comparable level.

SURVEY METHOD

In August of 2020, 30-minute phone interviews were conducted with acute care and long-term care healthcare agencies and nursing programs in the Portland Metro area. Of the 20 institutions contacted, 17 agreed to an interview. The interviews were semi-structured and guided by seven prompts. Respondents ranged in position from clinical coordinators to deans and chief nursing officers.

Due to quickly changing circumstances and the uncertainty of clinical settings disposition toward students, no attempt was made to collect quantitative data as it was at high risk of being inaccurate shortly after it was gathered. Rather, the qualitative data collected was reviewed for broad themes describing the response to clinical education difficulties during the pandemic. Themes are reported by group, that is, healthcare agencies or nursing programs. All information is aggregated and de-identified. The prompts used in the interview guide are listed in (Inset 3).

Inset 3 | Interview Guide

	Healthcare Agencies	Nursing Programs
1	What is your plan for students this fall? What do you anticipate being the disposition toward students after fall if the pandemic continues? If it does not continue?	Do you have sufficient clinical placements in number and type for your students this fall? If not, what are your greatest areas of need? What steps are you taking to deal with the shortage of placements in the short and long-term?
2	With regard to student placement, what are your tentative decision-making criteria? What spoken or unspoken forces are shaping decision-making?	With regard to student placement, what are your tentative decision-making criteria? What spoken or unspoken forces are shaping decision-making? Do you have concerns over the long-term impact of alternate scenarios?
3	What is your current workforce plan? Are there concerns over stress in the workplace, retirements, and new hires?	Are nursing faculty being negatively impacted by the current challenges? Are there concerns over stress in the workplace, retirements, or exacerbations of shortages?
4	What is the current status of your new nurse residency program? What is your disposition toward this program in the future? How can educators help?	How are you talking with your new grads and current seniors about changes they may encounter in the workplace as a new nurse?
5	How does your agency, your personnel, feel about new nursing grads who have exchanged significant amounts of clinical practice time for simulation time? Can you imagine a scenario in which clinical training is greatly reduced? What would it look like?	How does your program, your faculty, feel about new nursing grads who have exchanged significant amounts of clinical practice time for simulation time? Can you imagine a scenario in which clinical training is greatly reduced? What would it look like?
6	How valuable do you feel the NCLEX® is in indicating a new grad's clinical readiness?	How valuable do you feel the NCLEX® is in indicating a new grad's clinical readiness?
7	In our current season of challenge, are there ways you would like to see clinical agencies and nursing programs working together differently?	In our current season of challenge, are there ways you would like to see clinical agencies and nursing programs working together differently?

SURVEY FINDINGS

Plans for Students This Fall and Beyond

Healthcare Agencies. Generally, healthcare agencies are accepting student placements in the Fall of 2020. However, all agencies accepting student placements have modified their approach (see question 2). Approximately half of the respondents indicated the intent to continue accepting placements in 2021. Others were either uncertain or believed that student placements were unlikely.

Nursing Programs. In August of 2020, just as most programs were preparing to begin the fall term, respondents reported a quickly changing and unpredictable scene concerning clinical placements. Excepting one program, all reported insufficiencies in either the number of placements or the type of placements and in most cases, both. One respondent stated, "For heaven's sakes, no… it's hideous now." Shortages tended to be in long-term care and community sites though some struggled to identify acute care placements as well. All programs reported making significant changes in their approach to clinicals and the use of simulation.

Criteria, Modifications, and Influences on Student Placement

Healthcare Agencies. The majority of agencies described an approach to student placements that observed several "bright lines" while maintaining fluidity with other more subjective parameters. For example, most agencies indicated that students would not be allowed to take care of positive COVID patients. In some cases, this extended to entire units where patients with COVID or suspected COVID were present. The most prominent rationale for this modification concerned preserving PPE supplies. Less frequently, concerns over patient risk, student risk, and virus spread were voiced. Another example involved denying student placements with certain populations or in certain settings, though examples given varied widely from the aged to home care to urgent care to critical care.

Other measures such as smaller clinical groups, shorter rotations, and mandatory COVID testing, were occasionally described as modifications. Some noted, however, that measures such as smaller clinical groups and shorter rotations only contributed to the number of different people working with patients exacerbating the risk of COVID transmission. Influences on decision making included guidelines or rules issued by state and national level regulatory agencies, centralized corporate structures, and staff burden. In several cases, innovation transpired secondary to clinical limitations including pipeline programs with students in their final year of education, placements in agency-owned simulation settings, and increased placements in telehealth.

Nursing Programs. The nursing programs interviewed did not report any clear criteria related to the pandemic in place for determining whether or not students would be placed in certain settings. Most expressed that going along with the parameters set by healthcare agencies was the operational default. However, some respondents identified external forces, such as centralized administration at academic institutions and state regulators, as impacting decisions about student placement. For example, one program shared that the President of the academic institution had instituted a strict "no face-to-face" policy, which posed significant problems for the nursing program.

The list of modifications programs are making to accommodate the reduction in available clinical placements is long. Almost every program reported reducing the size of clinical groups and reducing the length of clinical experiences. These steps were taken to accommodate the need to move more students through sites that were still accepting students and to comply with some clinical sites' requirements that fewer students be allowed into settings. To offset the reduction in clinical hours, all schools turned to significant increases in skills labs, simulation labs, and screen-based simulation as well as alternate clinical activities involving community care (e.g. volunteering at the YWCA) and indirect patient care activities (e.g. chart review). Concern was frequently expressed over the rapid increase in simulation and the impact it might have on students' outcome achievement. Several programs mentioned removing students from sites that either did not have clear COVID guidelines in place or were not stable enough to ensure that students would have the opportunity to meet their learning objectives.

Similar to modifications, many influences were identified by respondents. Some programs discussed the financial implications of exigencies experienced by their host institutions and the increase in the raw number of clinical groups to be overseen by faculty with no additional fiscal or human resources. Others shared how clinical groups of students were formed according to a student's risk level and anticipated exposure to COVID in the clinical setting.

Impact on Staff and Faculty

Healthcare Agencies. Most employers described difficulty recruiting nurses, especially for specialty areas. Fewer shared that increases in resignations or retirements had occurred. In addition to hiring, staffing was frequently identified as a challenge, described by one respondent as a game of "Whack-a-mole" requiring the shifting of staff RNs to unfamiliar environments. All respondents identified increased stress as a factor negatively impacting the nursing workforce. Clinical sources of stress included "layers" of requirements such as changes in PPE requirements; staffing changes, concerns over patient and provider safety, and the experience of ongoing uncertainty. Other sources of stress included childcare, working from home, and concerns over the safety of family members secondary to being exposed to COVID by a provider-family member. Many institutions have responded to these concerns by stepping up employee assistance programs, providing additional stress management resources, and offering additional pay.

The tension between building the pipeline of future nursing professionals and the practical burden of student placements was identified by several respondents. Concerns over the limited and potentially shrinking capacity to host student placements in contrast with the growing number of nursing students being educated in the Portland Metro area figured prominently. Nursing students, while valued, place an additional burden on staff who are concerned to ensure that students are given quality clinical education and kept safe from COVID exposure, all while delivering safe, effective, and efficient care to patients.

Nursing Programs. One word, more than any other, was mentioned by respondents, stress; in the words of one interviewee, "Incredibly stressed." Many factors contributed. For most programs, faculty headcount has been reduced due to resignations or retirements. Several eluded to the possibility of furloughs. In many programs, the reality of very heavy workloads without additional compensation or even less compensation (pay cuts) contributed to low morale. Quickly learning new teaching approaches and attempting to compensate for the loss of substantive clinical hours also contributed to stress levels. Some faculty were reported to be concerned about their personal exposure to COVID due to age or other health risks. Some faculty opted out of taking students to clinicals to avoid exposure. Several programs reported faculty constraints due to changes in schooling and childcare.

Scene for New Grads

Healthcare Agencies. Most agencies have a transition to practice, nurse residency, or extensive orientation program in place for new graduates. While several agencies have temporarily canceled these programs, the majority made modifications to adjust to the new norms of the pandemic. Changes included extending the length of the program, incorporating social distancing, supplementing technical skills potentially missed during the final terms of the student's clinical experience, and utilizing alternatives to direct patient care hours.

Nursing Programs. Programs uniformly reported student conversations about the decrease in opportunities they would experience in the job market. Of particular concern to students was the possibility of not landing a residency. Programs generally encouraged students to be flexible in their expectations. Faculty prepared students to explore opportunities in settings other than acute care and outside of the Portland Metro area. Some programs reported conversations with students designed to help them advocate for themselves with employers by explaining the strengths that may be associated with increased simulation time and other curricular changes.

Clinical vs. Simulation Experience

Healthcare Agencies. Respondents shared a wide diversity of opinions on the sharp increase in the substitution of simulation experiences for clinical time. Almost all acknowledged concern that new gaps in readiness may appear and that attention should be given to mitigating these gaps in new grad hires. Most discussed increasing the length and adjusting the focus of orientation and residency programs. Importantly, many agencies noted that they have

yet to work extensively with new grads from fall and winter terms and are uncertain about what deficiencies they may see. Only a few respondents expressed a positive view of the benefits that increased simulation might have on students' readiness to practice, noting improved critical thinking and reflective practice skills observed in students graduating from programs with substantial simulation. They also noted the importance of simulation being standardized and well-resourced to be effective.

Respondents shared various specific concerns. Several noted the uncertainty around how much simulation is too much, or conversely, how little clinically-based education is too little. Others implied that increased simulation greatens the burden placed on employers when students come to them with a lack in the strong technical skills increasingly needed in acute care settings. One interviewee noted that students are missing out on the learning that could be taking place from one of the largest healthcare crises in modern history, suggesting that the reduction in clinical exposure was unfortunate.

Nursing Programs. Programs reported a significant amount of variance in their perceptions of simulation. Some stated they were not "believers" and didn't agree that students could achieve desired outcomes by replacing 50% of clinical time with simulation. Others lauded the impact of simulation and felt strongly that simulation was enriching students' education by allowing increased focus on clinical judgment, the ability to guarantee that every student experiences certain scenarios, and the standardization of student experiences.

Almost all programs reported mixed feelings among the faculty. Fewer reported that the forced transition to simulation had accelerated faculty adoption and support of simulation. Several programs shared the belief that the changes in clinical experiences would be permanent and that smaller clinical groups were not sustainable because of the financial impact on faculty costs. These same programs expressed dissatisfaction with acute care clinical experiences in general as the pace and rate of change in clinical settings have reduced the quality of student experiences. Interestingly, several schools stated that faculty who were more closely connected to clinical practice had greater difficulty in accepting simulation as a substitute to clinicals.

NCLEX® & Clinical Readiness

During the spring of 2020, the mechanism for administering the qualifying exam for RN licensure experienced difficulty. Like most institutions, the organization responsible for administering the NCLEX® was not prepared to handle the challenges of a pandemic. In some areas in the United States, this led to delayed testing. From this disruption, several discussions concerning the value of the NCLEX® emerged including a conversation over how to best deal with pass rates as a measure of program success.

Healthcare Agencies. While the majority of respondents acknowledged the NCLEX® as a kind of baseline, there was widespread ambiguity about its helpfulness as an indicator of clinical readiness. The inadequacies identified included the lack of attitudinal measures, lack of competency measures, and the high pass rates. One respondent commented, "Even a driver's license test has a competence component…" Another stated, "I never see the students who don't pass, so I can't really tell how the nurses who do pass compare." This is not an unusual phenomenon, and is known as range restriction. The range of scores in one variable is restricted (only those who pass become nurses) compared to the other variable (clinical readiness).

Nursing Programs. A single respondent felt that the NCLEX® was an adequate measure of clinical readiness. Several programs supported the use of the NCLEX® as a measure of basic safety or minimal competency but not as a strong indicator of a student's readiness for practice. Like healthcare agencies, ambiguity characterized the majority of responses. Opinions about the use of first-time versus total pass rates were divergent. Some saw first-time pass rates as "useless" while others viewed them as an important distinguishing metric for programs. Concern was also voiced that if the focus is shifted to total pass rates, students would be subjected to unnecessary stress due to the possibility that programs would not be as attentive to preparing students to be successful on the first attempt.

Improving Collaboration

Healthcare Agencies. The strongest theme emerging from healthcare agency respondents' comments was the need to find "new ways" of partnering to accomplish clinical placement, clinical education, and new grad transition to practice. Many diverse concerns were shared about the

current model. Most prominent was the unsustainability of continued nursing program growth in the Portland Metro area with limited clinical placements and the stress this places on healthcare agencies. Other concerns included the lack of understanding between the clinicians and educators, the absence of perceived reciprocity between healthcare agencies and nursing programs, the limitations imposed by regulatory bodies, and the need for agencies to support extensive training programs for new grads despite four years of academic education. A few respondents shared concerns about education programs "padding" or requesting more placements than needed to adjust for changing schedules, failure to comply with agency protocols for clinical placement, and not realizing the full potential of the regional consortium. All of these factors lead to inefficiency for healthcare agencies that result in a waste of time, money, and energy.

Nursing Programs. Respondents frequently noted the need to find new ways to incorporate students into the clinical setting beyond the traditional placements and traditional sites. Some shared the desire for stronger partnerships that created value for not only the clinical setting, but the community as well. More negatively, programs felt clinical agencies exerted too much control over clinical education, were too slow to reply to requests for placements, and simultaneously "over-honored" and "under-honored" historical placements. Regarding the consortium, most were grateful for its existence, but felt that it did too little to facilitate change and improvement, failed to follow some rules, and engendered transactional versus collaborative or transformational relationships. Concern was also expressed that many residency programs are being put on hold at the same time students' clinical experiences are being reduced.

CONCLUSION

This report reveals that the pandemic has not so much created new problems in clinical education, but exposed and exacerbated old ones. For decades, these issues have created barriers to the expansion of nursing programs, tensions between and among nursing programs and healthcare agencies, and questions about the appropriate preparation for clinical readiness. Despite the advent of consortiums, advanced clinical placement databases, and alternative models such as the dedicated education unit (DEU), the deep partnerships, mutual benefit, and full acceptance of nursing students as functional members of the healthcare team have yet to fully emerge. The fallout of the pandemic has brought the robustness, resiliency, and redundancy of the current system into question.

We have been sharply reminded of the need to both incrementally and disruptively innovate our way toward better approaches for clinical education in nursing. It has been established that a communal sense of urgency is a key component in any large-scale change effort. Our current challenges have brought with them an authentic and, some would say, visceral, sense of urgency. Consequently, all members of the nursing workforce pipeline have an opportunity to leverage the motivation for rapid and, potentially, paradigmatic change. All that is needed now is a clear vision for the future and nurses who are willing to lead the way.

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Report Authors

Devon M. Berry, PhD, RN
Jana R. Bitton, MPA