What exposure do student nurses have to primary health care and community nursing during the New Zealand undergraduate Bachelor of Nursing programme?

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S U M M A R Y

A research project to examine the theoretical and practical exposure student nurses have to Primary Health Care (PHC) and community nursing in their undergraduate programme was undertaken in New Zealand (NZ). Providing quality clinical placements for health care students is acknowledged as a major challenge for tertiary institutions. In order to reflect the current shift in health care delivery from hospital to community settings, one such challenge is to ensure students receive appropriate theoretical programme content and clinical experience in PHC and community settings. The project consisted of a review of relevant international literature, and a questionnaire sent to all NZ tertiary institutions providing a Bachelor of Nursing (BN). Findings included a variable understanding of the concept of PHC, a lack of appropriate PHC placements across the country, competition for student placements in PHC, and professional organisation requirements for student supervision impacting on placement availability. Innovations identified to increase PHC placements comprised the establishment of Dedicated Education Units (DEUs), curriculum revision, and final year PHC placements offered only to students targeting PHC settings on registration. Study recommendations involve establishing a regional rather than a local approach to managing clinical placements, increasing professional governance support and reviewing clinical placement funding.

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Introduction and Background

The aim of this study was to examine the theoretical and practical exposure student nurses have to Primary Health Care (PHC) and community nursing in their undergraduate programme in New Zealand (NZ). International health care policy is driving the delivery of health care services from secondary care hospitals to PHC settings (Halcombe et al., 2012; Ministry of Health (MOH), 2011a; Schofield et al., 2011; Australian Government Department of Health and Ageing, 2010; World Health Organisation (WHO), 2010; MOH, 2001). As this health care delivery shift occurs (MOH, 2010; Schofield et al., 2011; Department of Health, 2010) a corresponding shift is required in the preparation of health professionals, including nurses, to ensure the future health workforce can meet service needs. Although much of the relevant literature acknowledges this move, a critical shortage in place-
what individual cultural and health beliefs mean to people in their everyday lives, and applying this knowledge, necessitates gaining “…‘real life’ experiences to underpin the academic programme content” (Baglin and Rugg, 2010 p.145). Increasing levels of long-term and often multiple health conditions, particularly in the expanding ageing population, the benefits of patient involvement in self-care and the actual cost of hospital care (Nolte and McKee, 2008) are also aspects associated with changes in health care delivery. Simultaneously, an imbalance in resources between primary and secondary care settings continues. For example, in NZ, despite over 90% of health interactions occurring in a PHC setting (MOH, 2011b), 72% of nurses continue to practise in secondary care such as hospitals and rest homes. This hinders the development of PHC services (Nursing Council of New Zealand (NCNZ), 2010).

PHC and Community Concepts

Professional nursing bodies in Western countries, including Australia and the United Kingdom (NCNZ, 2010; Nursing and Midwifery Council (NMC), 2010; Nursing and Midwifery Office, 2005) require nursing preparation programmes to provide students with clinical experience in, amongst others, ‘PHC and community settings’. Establishing the meaning of the terms PHC and community, however, is fraught. Nevertheless, a review of the international literature shows both terms are about capturing the aim of the declaring Declaration of Alma Ata (WHO, 1978) of making health care accessible, acceptable, affordable and equitable and delivered close to where people live, work and play (WHO, 2008). In NZ, the PHC strategy (MOH, 2001), launched at the turn of this century to signal the direction of health care service delivery, defines PHC as “… essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” (WHO, 1978, p.2).

Whereas the philosophy of universal access, reducing health inequities, and self-determination underpins PHC (MOH, 2001; WHO, 2008) the term primary care is often used to represent PHC. Primary care, however, relates to first level contact that families and communities have with the health care system. Like health care services in many Western countries, for example Australia, the United Kingdom and America, (American Academy of Family Physicians (AAFP) (2012); Department of Health (DH), 2012; Primary Health Care Research and Information Services (PHCRIS), 2011) New Zealand favours a primary care approach. General practice services, disease prevention, health promotion and maintenance, and long term health care, including services offered by counsellors, pharmacists and dentists are all primary care. Whereas PHC and primary care can be illustrated, what constitutes community care in NZ cannot. Therefore, in the context of this study, PHC will refer to any health care delivered in a community rather than a hospital-based setting.

Despite many national nursing bodies, including in New Zealand, requiring nursing students to have PHC theoretical and clinical experience (NCNZ, 2010; European Parliament the Council of the European Union, 2005), a critical shortage in placement capacity remains in all clinical areas. Competition is escalating for PHC and community care placements (Smith et al., 2010). Traditionally- utilised teams such as district nursing, practice nurses (nurses working in general practice settings) and child health care teams, are increasingly being re-configured or reduced, thus reducing their capacity to take students (Drennan et al., 2004). The monitoring of clinical placement capacity in NZ, generally done by individual health education programme providers without any regional or national oversight or coordination, adds to the concerns related to the provision of quality and effective PHC placements (Barnett et al., 2008).

Therefore the study aimed to examine the theoretical and practical exposure student nurses have to PHC and community nursing in their undergraduate programme undertaken in NZ. In doing so it aimed to identify what related issues affected NZ BN programme providers, which included universities and polytechnics, and what innovations were in place to address them. It was anticipated that the project findings would inform practice not only in NZ, but also internationally, as NZ nurse preparation programmes are remarkably similar to other areas such as Europe, Australia and North America (Fleming and Holmes, 2005).

Research Method and Design

A mixed methods approach to capture a “snapshot” of current PHC clinical and theoretical provision was utilised in the study (Denscombe, 2010, p.12), to gain a wider understanding of the range of exposure students had to PHC nursing, and the range of barriers and innovations in place (O’Cathain and Thomas, 2006). A survey of current BN programme providers was achieved through the development of a questionnaire which consisted of nine questions that included an option to make comments. The questions were designed to capture information relating to placement provision during the BN programme, the type of PHC teams BN students were placed with and the exposure BN students had to PHC theoretical principles from the tertiary institution staff. A final ‘question’ requested respondents to enter text responses to identify issues and innovations in their area.

The questionnaire, created using the Survey Monkey® web-based software, was piloted by colleagues from clinical practice and tertiary education, who would not be likely to take part in the actual survey. Minor modifications were made as suggested.

A total of 17 universities and polytechnics provide a BN programme in NZ and all were invited to complete the questionnaire. The heads of each nursing school were emailed with an explanatory letter providing background to the research project and reassurance of anonymity. They also received a hyperlink to the questionnaire, advice on how to complete it and a request to return the questionnaire within the calendar month. It was anticipated that the heads of school would forward the questionnaire to a relevant member of staff involved in delivering PHC and community aspects of the BN programme. A reminder email was sent to all providers after two weeks and again two days before the data collection period ended.

Ethics

Ethical issues were considered; in particular the role of one of the researchers as an employee of a participating institution, which had the potential for conflict of interest or reducing response rate. This researcher’s role was clearly highlighted and assurances of anonymity ensured no comparisons could be made between individual institutions. Participation was voluntary. Ethical approval was gained from the researchers’ employing institutions.

Analysis

The Survey Monkey® software provided a descriptive analysis of the quantitative data and a thematic analysis of the free text comments was undertaken by the researchers (Silverman, 2006).

Results

Definitions

‘Free text’ refers to respondents’ unsolicited comments entered throughout the questionnaire. Where the findings relate to free text responses the term ‘respondent’ is used. When discussing numbers...
or percentages of responses, the term ‘institution’ refers to the BN programme provider. The term ‘placement’ is used when referring to the overall provision of clinical experience relating to PHC. The word ‘team’ is used to identify the staff working in a specific area of the placement.

**Questionnaire Findings**

Of the 17 providers, 14 returned completed questionnaires, giving a very good response rate of 82% (Groves, 2006). While it is acknowledged that the responses are based on the individual respondents’ perceptions, the researchers believe these were an accurate record of the tertiary education institutions’ provision of PHC theory and clinical experience for students.

**Placement Provision**

Just under half of the institutions 43% (n=6) offered two PHC placements throughout the programme, with 36% (n=5) offering one placement and 21% (n=3) offering three. Fig. 1 shows the length of placement time offered to BN students and the year of the programme when the students had this experience. Of the 13 respondents who completed this question 31% (n=4) provided information only on the length of placements offered in a particular year (i.e. Year Three). Information was not provided on the placement length for the other years nor did the respondents select the ‘no placement offered option’ [this may suggest they did not offer a placement in this year].

As seen in Fig. 1, 46% (n=6) offered a PHC placement in Year One, of one to four weeks duration. In Year Two, a three week placement was the most commonly offered. Of the 92% (n=12) institutions who offered a PHC placement in Year Three, between four to six weeks was most commonly offered, with the six weeks placement in Year Three being compulsory. Some providers offered more than one placement in Years Two and Three.

**Placement Teams**

The variety of PHC teams provided as possible answers in the questionnaire was based on the researchers’ knowledge of PHC services and placement opportunities. Respondents were able to identify any additional PHC teams they accessed. Fig. 2 clearly shows the range of teams engaged with students, the length of the placement with the teams and when in the BN programme the placement occurred. A total of 32 PHC teams were identified by the 13 respondents who answered this question. Public health nurses, district nurses, Māori health providers and practice nurses were the teams most widely involved in PHC in providing placement experience. Additional teams identified by individual respondents included correctional services, residential school for disabilities, student health centre and community mental health services. All the institutions (7) who offered a PHC placement in Year One identified that Aged Care teams were utilised.

Of the 13 respondents completing the question, relating to when in the programme PHC placements were offered, 61.5% (n=8) PHC offered placements in Year Two. Of this group of eight, 75% (n=6) utilised practice nurses and public health nurses. In Year Three, 85% (n=11) of all respondents offered PHC placements. 80% (n=9) offered placements with public health nurses, district nurses, practice nurses and Māori PHC providers.

**Exposure to PHC Principles in the Tertiary Institution within Theory Content of Course**

All 14 respondents answered questions aimed at identifying the coverage of PHC principles in the tertiary institution rather than the clinical placement. Over 86% (n=12) of institutions taught PHC-specific skills and responses in the free text entries identified community and family assessment, CPR in the community, health promotion, family planning and blood pressure monitoring as examples of the specific skills taught. Whereas the majority of institutions (n=11) embedded PHC throughout the BN programme, one institution did not deliver any PHC-specific content, and one offered specific PHC modules in Year One and Year Three. Fig. 3 clearly shows that PHC content was generally taught by academic staff with PHC experience, while Fig. 4 shows that many institutions engaged current clinicians in teaching PHC sessions, especially clinical sessions.

It is acknowledged that lecturers have a current nursing registration but for the purposes of this survey, ‘current clinicians’ referred to nursing staff currently working in a clinical practice, rather than in an academic role. In free text, one respondent highlighted that guest speakers from clinical practice support up-to-date practice. Although clinical lecturers (tertiary institution paid staff who support students on clinical placement) usually had a PHC background, several respondents raised concerns around this in the free text. Issues raised included relevance of expertise in light of current practice and that...
allocation of a lecturer to an area could be based on their proximity to the placement or their availability rather than expertise. Free text entries highlighted that academic staff may have dual roles, so are engaged for both theory and clinical teaching.

In Fig. 5, response from all 14 respondents to the statement, “The BN Programme delivered at this institution adequately prepares students for working in a PHC setting on registration”, shows that most respondents, (79% [n = 11]), either ‘agreed’ or ‘strongly agreed’ to this statement. The remaining 14% (n = 2) were undecided. The free text response from one institution highlighted that a student could have over 12 weeks in PHC throughout the three years, in which case the respondent ‘strongly agreed’ that students were well prepared to work in a PHC setting. Cross-referencing this question to the answers provided throughout the questionnaire could not conclusively identify the specific features of a programme that led to the perception that some students were being better prepared than others for working in PHC settings.

Issues and Innovations

The final question invited respondents to identify issues affecting their institution’s ability to provide appropriate PHC theoretical and clinical experience for student nurses. Respondents were also invited to highlight innovations in their area, aimed at addressing these issues. A full list of the comments, with modifications made to maintain anonymity, is available by contacting the authors.

Issues Raised

Thirty two separate points were made in thirteen free text responses related to placement provision. Lack of placement availability was most commonly highlighted, mainly due to increased student numbers, and student requests for PHC clinical experience outnumbering the availability of placements. Competition between providers was also identified. Placements in medical/health centres were highlighted as an issue as medical students were seen to be given preference over nursing students. Payment for placements was identified as an issue, especially regarding placements in medical/health centres. However, a NZ institution paying for placements is not uncommon so why this is deemed a barrier was not clarified.

Requirements for Registered Nurse (RN) supervision of students restricted the use of non-nursing services, such as addiction and community support centres, which one respondent felt could provide students with appropriate exposure to PHC experience. The impact on clinical staff taking a student was identified on several occasions. Reluctance of staff to take on extra responsibility was cited, as was the impact on workloads, number of clients and frequent staff changes, all of which can make student placements challenging for staff. One respondent believe the perceived value of the placement by the students and clinical staff was of concern. Points raised were that medical students took priority; nursing students did not see the relevance or value of the PHC placement to their practice; and students were hospital focussed. Additionally, nursing staff did not recognise the value of their role in PHC and therefore what their team had to offer students.

Innovations

The free text entries identified the following initiatives in place for managing PHC placements.

• A revised curriculum embedded PHC concepts of health promotion and education throughout the programme.

• Rest homes were incorporated in Year Three PHC placements to increase placement capacity.

• A district nursing service had, through the development of a Dedicated Education Unit (DEU) increased placement capacity, enabling students to feel well supported, while staff felt less pressured when students were on placement. A DEU, (Betony and Yarwood, 2010; Edgecombe et al., 1999) model of clinical teaching differs from the well-established preceptor model, which is dependent upon a RN working closely with a student throughout a placement in that all staff, including academics, offer supportive learning opportunities for nursing students (Jamieson et al., 2008)

• Only 3rd year students who identified an interest in working in a PHC setting on qualifying were offered a second PHC placement for their final clinical placement, ensuring appropriate use of placements and supporting transition into a new role.

• Whanau Ora, the wellbeing of whanau/family, a NZ government initiative providing inclusive services to NZ families in need, focuses on enabling and empowering families as a whole rather than working with individual members. The involvement of whanau, hapu and iwi, (tribal and political Maori family groups), is seen as critical to ensure family well-being, whatever their circumstances (Ministry of Social Development, 2012; Te Puni Kokiri, 2012). One respondent felt the advent of Whanau Ora may well lead to opportunities for integrating this programme into PHC placements, enabling students to work with families.

• A hospital admission reduction pilot project team is also being considered as a possible PHC placement in one area.

Discussion

The aim of the study was to examine the theoretical and practical exposure that student nurses have to PHC and community nursing in their undergraduate programme in NZ. Similar to findings from a UK study (Betony, 2011) the range of PHC teams providing undergraduate nursing students with PHC experience is wide. Although the use of PHC teams varies between institutions, mostly traditional community health teams such as public health nurses, district nurses and practice nurses are used. Moreover, one respondent believed these
placements were not ‘pure PHC’, a comment illustrating the ongoing debate about the underpinnings of PHC versus those of primary care. While the secondary care nature and growing acuity of district nurses’ and other community nurses’ roles takes the focus away from addressing health inequities, people do have accessible and affordable health care where they live.

NCNZ’s stipulation that a BN student must have direct RN supervision is identified as limiting creativity regarding PHC provision, as teams such as women’s refuges and church-based organisations addressing poverty in their local community remain excluded. This is despite such organisations offering what could be described as the epitome of PHC care that is accessible, acceptable, affordable and equitable (WHO, 1978). To mitigate this barrier in the UK, the most recent standards for pre-registration education (NMC, 2010) appear slightly less rigid. A requirement that assessments are completed by a mentor, who may be a registered nurse, allows supervision by “other suitably prepared registered professionals” (NMC, 2010 Standard R4.2.2).

As highlighted in the UK study (Betony, 2011), adopting a ‘team approach’ to student learning could alliviate some of the issues impacting on PHC staff and limited placement capacity. A ‘cluster’ of PHC staff or teams including, for example, nurse specialists, podiatrists, GPs and non-nursing services, could contribute to a student placement. Increased inter-professional collaboration could reduce competition for placements and provide opportunities for inter-professional placements, such as student nurses with physiotherapists and medical students with nurses. This in turn could lead to an increased awareness of the value of nurses to PHC services, while providing the student with a broader view of PHC and allowing the involvement of non-nursing organisations as long as a RN retains overall responsibility for supervising and assessing the student. Dedicated Education Units, identified by one respondent, provide a clear example of how a team approach to student learning in the clinical area together with increased collaboration between the academic institution and health care provider has increased placement capacity.

Students’ exposure to PHC principles and PHC-specific clinical skills, while in tertiary institutions, was generally provided by staff with PHC experience and currency of knowledge, as is recommended best practice (NCNZ, 2010). However, in some areas, staff, including those supporting students while on placement, with little or no PHC experience, were involved. Limited PHC experience not only impacts on student learning, but also on the placement team, whose PHC focus may well differ from a secondary care, disease treatment approach. Identifying social determinants of health is an example of a key approach to PHC, but one frequently neglected in secondary care. A crucial component of a positive student clinical experience is a supportive, knowledgeable lecturer who works in collaboration with the clinical placement team.

As NCNZ (2010) does not stipulate how many hours any PHC clinical placement should be, the length and frequency of placements varied among the institutions. As most offered two placements, almost always with one being available in the third year of the programme, it does appear that students are gaining exposure to a wide range of PHC clinical practice settings.

The final placement in the BN programme must be substantive to allow students to consolidate their learning before qualifying (NCNZ, 2010). It is traditional and understandable that students prefer to be placed in a practice setting they wish to pursue on qualifying. Increasingly, requests are being made for a placement in PHC settings, suggesting a growing interest in working in PHC once registered. This increase does, however, place pressure on placement availability.

Although placement lengths vary considerably between the UK and NZ, both countries appear to favour Year Two as a time for offering a PHC placement. The difference in placement length between countries is understandable when the UK requirement is for at least 2300 h in practice learning (NMC, 2010), an average of 14 weeks a year, compared to a maximum of 1500 clinical hours over three years in NZ (NCNZ, 2010).

Many respondents highlighted difficulties in sourcing PHC placements, yet others had the potential to allow students several weeks of working with a PHC placement team over the three years, including the final transition placement. One strategy identified was the ‘targeted’ PHC placements given only to students who expressed an intention to work in PHC on qualifying. In an environment where competition for PHC placements continues to grow, sharing such strategies between providers can assist individual institutions to manage their clinical placements. For example, PHC placements with practice nurses were among the most commonly sought - a finding similar to Betony’s (2011). Yet many barriers were identified, including funding issues, competition from medical students and the increased busyness of general practice. Gathering information about the number of individual PHC teams each institution used would have provided greater understanding of this issue.

The high response rate to the questionnaire has enabled the researchers to compile a comprehensive overview of the range of PHC and community settings used in offering clinical experience to Bachelor of Nursing students in NZ tertiary institutions. Barriers and innovations impacting on the provision of PHC placements in BN programmes have also been identified.

**Recommendations**

**Regional Management of Clinical Placements**

Regional clinical placement allocation groups should be established in order to pool resources regarding placement availability, and allow a share of ideas, as some respondents appeared to have greater placement capacity than others. Groups including tertiary education institutions and health care provider representatives would allow a more structured and cooperative approach to managing and addressing the shortage of clinical placement capacity highlighted in the survey. Regional Postgraduate Training Hubs (Health Work Force NZ, 2011) are currently being established in NZ. While the focus is on postgraduate education and medical staff, representatives from all health professions are included. Thus the presence of tertiary and health providers presents an ideal platform for a sub-group to share ideas focussing on clinical placements for health professional undergraduates.

**Review of Clinical Placement Funding**

As in Betony’s (2011) UK study, the cost of payment for placements was identified in the questionnaire responses as having the potential to reduce the range of available placements. Clinical placement funding for BN students that tertiary institutions receive should be reviewed in order to ensure that a lack of placement funding is not a barrier to placement provision. Again, the Regional Postgraduate Training Hub appears to be a logical vehicle to manage this issue.

**Support from Health Professional Governing Bodies**

Confusion over the role of health professional governing bodies in PHC was identified as a reason for some clinical areas not offering PHC experience for BN students. Clarity of the professional governing bodies’ expectations in regard to student nurses’ exposure to and experience of PHC must be considered. Without this, tertiary institutions and health care providers may be missing opportunities to provide appropriate PHC experience to healthcare students.

The governing bodies should also recognise a need for flexibility relating to student supervision during clinical placements and consider a range of models that would meet both student and regulatory needs.

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Future Research

Future research, exploring students’ perceptions of their experiences and employers’ perceptions of how well BN students are prepared for work in PHC and community settings, would be of value. A closer review of placement provision to identify the actual number of placements available in different PHC and community teams could also be considered.

Limitations of the Study

Certain limitations of this study are noted. Firstly, the desire for brevity of the questionnaire impacted on the clarity of some of the responses, especially regarding placement length and time with specific PHC and community teams. It would also have been useful to note what percentage of placements offered were with certain groups, e.g. how many health/medical centres provided placements. Secondly, time constraints prevented the conducting of post-questionnaire semi-structured telephone interviews which would have allowed clarification of these issues and a deeper understanding of the exposure that student nurses have to PHC settings. Thirdly, although the healthcare system and nursing preparation programmes in NZ are similar to other countries such as the UK and Australia, regional implementation and strategic structures differ, making the applicability of some recommendations beyond NZ, somewhat limited.

Conclusion

This study examined the theoretical and practical exposure student nurses have to Primary Health Care (PHC) and community nursing in their undergraduate programme in New Zealand (NZ). Clinical practice experience is an essential component of any undergraduate health professional education programme. Yet there appears to be a range of barriers, both in NZ and internationally, impacting on tertiary education institutions’ abilities to provide quality clinical placements. This issue is particularly noticeable in the area of PHC, which, with the policy move to focus health care delivery in PHC rather than secondary care settings, is developing rapidly. In nurse education the challenges providing PHC placements are similar to all clinical placements, but with a set of very specific issues such as a variable understanding of what PHC is, a lack of clarity about a team’s role in PHC delivery, and limited capacity to accommodate students. However, despite identified issues, some institutions appear to have found innovative ways of ensuring students gain appropriate PHC experience. Sharing this information between institutions, collaboration between institutions on placement provision, and increased awareness among health care and tertiary institutions on what is PHC and community nursing, could lead to increased placement capacity. Supporting PHC teams to provide student placements will not only enhance the likelihood of a positive experience of PHC for the student, but also encourage and enable qualified staff to provide effective learning experiences.

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