What ‘makes’ a placement

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Introduction
Remote and rural health workforce shortages are an international phenomenon that Australian governments are working to improve.1,2 A myriad of strategies have been trialled and implemented, without absolutely determining ways of ensuring a consistent rural workforce.3,4 Numerous studies have been conducted, again without confirming the factors that ensure the uptake of rural and remote health career placements.5,6 Even when students are surveyed outright the results are often complex and contradictory.7 Many studies take place in either one school or faculty or with a single discipline of health students. This study proposed to garner the opinions of a national cohort of students from across the health disciplines on the topic of what makes a really good clinical placement. This paper presents an overview of the findings with discussion of the preliminary qualitative results.

Methods
In 2010 the National Rural Health Student Network (NHRSN), with a student membership of approximately 9000, established a national database. Permission was requested and received8 to conduct an online survey utilising the new database. A questionnaire was developed for students who had undertaken at least one clinical placement with questions based on issues raised in the literature.1,2 Participation was anonymous and voluntary and the survey opened for a six week period in April/May 2011. Students were encouraged to complete the survey with the opportunity to win an iPad. The survey contained 16 forced answer questions which asked respondents to either select answer options or to value rate using a Likert scale. There were three open ended questions included and the survey was organised in three sections which included:

- demographic questions
- questions relevant to the course of study
- questions specific to type, quality and satisfaction ratings of clinical placements.

Ethics clearance
Ethic approval was obtained from the University of NSW Human Research Ethics Committee (HREC 10275 (S). Participant consent was confirmed on entry to the online survey.

Data analysis
Quantitative data were entered in IMB SPSS (version 19) and analysed for frequency statistics. Qualitative data were reviewed for consistent themes among responses.

Results
From over 4,000 surveys that were distributed 1,046 completed surveys were received giving a 26% response rate. This participation rate may have been effected by students self-selecting out of the study if they had not participated in any clinical placements.

Eight hundred and thirty five female and 211 male students completed the survey. Ages ranged between 18 and 61 years with a mean age of 27.4 years. These demographics indicate a small increase in numbers of mature-age students undertaking courses when compared to 1990s data.9 Two hundred and fifty three (24%) were living with a partner and 130 (12.5%) were supporting between one and seven children.
Respondents included nine (0.9%) Aboriginal or Torres Strait Islander students and 430 (41%) students with rural or remote backgrounds. Only 4% attended regional universities. Two hundred and seventy one (26%) students held some kind of scholarship of which 87 (8.3%) were bonded scholarships.

A total of 321 students were studying medicine. From this cohort 220 were female and 101 male, however this represented 47.9% of the male respondents compared to only 26.3% of the female respondents, therefore amongst the male respondents more medical students than students from other disciplines completed the survey. A total of 285 students reported studying nursing, midwifery or a combination of both courses and of these 23 (11%) were male.

Allied Health courses provided 375 (35.8%) of student respondents and a further 47 (4.5%) students were undertaking management, community or public health programs.
The survey data stated that 148 (14%) students reported that their university did not actively encourage them to consider rural or remote practice. This could however be due to the students’ not noticing or hearing information rather than no information being given. However 976 (93.3%) stated that their course required them to complete compulsory clinical placements, although the survey did not ask specifically about rural placements. Forty per cent of the clinical placements were of five weeks or longer.

**Figure 4 University and placements**

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Figure shows numbers of students reporting compulsory placements (green). Number of placements longer than 5 weeks (Red). Students stating they were not actively encouraged to undertake rural placements (blue).

**Survey results:** Survey questions focused on important clinical and social aspects of placements that provided an experience that would attract students to return as graduates. Data analysis identified seven strong themes that most students utilised to measure the value and positivity of their clinical placements.

Overwhelmingly dominant among the issues identified regarding the value of a placement was how welcomed the students felt. Again and again respondents reported that preparedness of the staff at a placement to welcome them and admit them to the team environment was paramount. The understanding of welcoming encompassed student-focused staff and competent clinicians who were supportive of having students in their workplace, enthusiastic and willing to share knowledge and to teach students. Eighty seven per cent of students indicated this as an issue in placements.

Student’s comments included: “Staff who go out of their way to engage you in things” and “Supervisors ideally should be engaging, motivating, enthusiastic and keen to teach students and enhance students’ knowledge, skill, competence, confidence and experience”.

Unfortunately the reports of negative placement experiences, which primarily came from nursing and paramedic students, were equally unanimous regarding staff attitude and preparedness to deal with students. There was a multitude of accounts of students feeling ostracised, unwelcome or in the way and these were identified as the primary reason for a placement being negative. A respondent commented:

“...on what makes a good placement ... the main one is that your supervisor basically wants you there, or at least doesn’t not want you there.”

Over 75% of nursing students reported at least one instance of having a less than satisfactory placement because of staff attitude. “... just being used to do the jobs that the staff don’t want to do”. Several students warned that more care needs to be taken with
negative workplace culture and perceptions being aired in a way that can influence job uptake by graduating students:

“After listening to views and opinions of [the staff] ... I made the decision to not be part of that kind of culture”.

“The staff were really lazy and there was a systematic hate for the workplace by the employees, therefore either students go elsewhere for work or become of the same cynical views and poor standards as those already there”.

Both nursing and medical students reported that they believed nurses often treated the medical students much better than nursing students. Nursing students complained of being ignored in favour of medical students being invited to participate in clinical activities and teaching and that nurses were more likely to be rude or aggressive towards nursing students. There were numerous instances of medical students reporting they liked learning from nurses especially in the early phases of their course. It was suggested by some that this lead to a “... big expectation and load on the nurses, which left them time poor and unwilling to teach nursing students.”

There was intense emphasis on students wanting health professionals to be great teachers accompanied by some intolerance for those who fell short of the expectation.

“The best teachers are those that love what they do and can also convey that love in multiple forms of communication. Often they are only good at one aspect”.

“Staff need to be able to support your learning and teach you; if you put students with clinicians who want to teach then you will produce better practitioners”.

A common suggestion to deal with this was that staff with placement supervision responsibilities could be formally evaluated by the students on issues such as attitude to having students in the workplace and their willingness and capacity to teach or facilitate student learning. Students believed that this measure might help improve some of the negative experiences they have encountered and to address student perceptions of poor professional safety.

The second most frequently cited aspect of positive placement experience was involvement of university appointed preceptors, facilitators and/or administration staff whose responsibilities included ensuring the placement was well prepared, that learning outcomes of the placement were known and in-tune with the clinical capacity of the placement and that there was either structure, for example a timetable, or that staff understood that the student would be responsible for creating the structure required for the placement. Access to these people was seen as providing someone for students to “… discuss issues including learning needs and debrief with”.

The third most cited issue that aided the attractiveness of clinical placements was variety. This included variety in clinical presentations, patients, diagnoses, different hospital wards and health services. Students complained bitterly if they had to undertake numerous placements in the same institutions or areas.

“I had three aged care placements as a senior student even though I had worked in aged care for 20 years prior to study, this was a waste of time.”

“Nursing Homes are ill equipped and understaffed and RNs are out of touch with current evidenced based practice—they are not much good for any placement other than teaching basic personal care.”

“Nursing homes are ok for 1st years but not beyond that level”.

Medical students wanted more flexibility to utilise time and effort in accordance with what clinical presentations were occurring however on the whole they were of the opinion that more clinically variety could be experienced in larger centres.
Hands-on experience remains one of the top interests for students undertaking placements and was the fourth most common theme identified in this study. Clinical placements by their nature are a proven pedagogical strategy for converting theory to practice and therefore placements must enable students to take active roles and not just observe.\textsuperscript{10,11,12}

**Figure 5** The percentage of students who referenced these issues impacting on placements

![Bar chart showing the percentage of students who referenced different issues impacting on placements.]

Respondents reported that being able to actively participate in the everyday roles and responsibilities of the staff they are working with makes them feel included as part of the team and involved in direct patient care. It also provides real-life experience and builds confidence and competence. Students also stated that this needs to be accompanied by supervision which ensures safety for both patient and students and critical feedback which is essential for learning. Many students lamented the absences of one or more of these aspects of hands-on experience.

“There is nothing worse than sitting in a clinic all day with nothing to do”.

“Sometimes the supervisor’s patient allocation was huge and they had little time to allow you to practice ... when this happened or the preceptor was uncommunicative, the 8 hour day of learning was lost and so to was confidence and desire for the profession or career.”

The fifth most common theme to emerge was the need to be productively engaged. Although this may appear similar to hands-on work, it was expressed as the need for the workplace to have enough flexibility so that during quiet periods or when there was a lack of opportunity to be involved in activities that would involve learning or consolidating, students would be able to leave the workplace and engage in private study, work on assignments or explore another area of the service. Students were very scathing of being used as “…a pair of hands” or the oft-cited “…slave labour”.

Unfortunately the data does not enable this theme to be explored further at this stage as it would be interesting to examine what specific tasks students were rejecting as unnecessary, so this is an area that lends itself to further investigation. Students stated that the best placements occurred in “…busy places with lots of interesting things happening” and also when there was “…flexibility to organise you own study/learning activities which incorporate time to devote to study and doing assignments when there is little happening on the wards”. Medical students in particular held that; “...It’s a waste of my time standing around waiting for something to happen”. Students often saw that this down time offered the ability for them to visit organisations outside the realm of their placement e.g. the hospital, community health or Aboriginal Medical Services or to take advantage of other opportunities for extra-curricular activities outside the core placement.
Another well acknowledged factor, affordability, shared a ranking of sixth place with equitability. Complaints about cost of accommodation and transport to placements and the expectations that students can travel long distances and pay for accommodation on top of their home costs came predominantly from nursing and allied health students.

“I work but got given 7 days straight for a placement—so I lost my income but got no financial assistance from anywhere to undertake the placement. I had to fund travel, accommodation and expenses on top of my normal ones (sic).”

There were also many comments about the inequitable nature of assistance that is available for medical students and other health science or nursing students.

“We had to pay $150 per week for a cell in an old nurses home while the medical students had 5-star accommodation across the road for free”.

“A lot of rural clinical school accommodation is supposed to be multidisciplinary but that is just not happening, if there is no medical student, the place is empty”.

There was also evidence of growing animosity between disciplines because of the inequitable level of support; “...medical students got everything for free, just everything...”

The seventh issue that was raised was relevance of the placement to the subject and level of study of the student. Students found that some placements were not able to provide the clinical experience commensurate with their level of study. This was a frequent lament of nursing students in particular who repeatedly stated that nursing homes were not providing the clinical instruction required for senior year students. Also some medical students reported not being able to access some clinical experiences from rural placements because “...those cases were shipped out to the city hospitals”. Some students stated that some placements were completely out of step with either what they were learning via their course work or their own clinical interests. While the first of these is a topic educators and clinicians may need to consider the second seemed to be more about students not getting their prioritised placement selections. A commonly repeated theme was a plea from students undertaking their final year practicums who “...want clinical experience and practice to build confidence and competence not just doing basics again.”

An interesting sub-theme to emerge was the different expectations students had of different placement types. This was especially so for allied health students who often had different terms for different placement types, “...a community placement is community and clinical is clinical and a rural experience is about the social community”. There was a marked difference in expectation between allied health and medical students with regard to community placements. Allied health students viewed these predominantly as working in private practice and the different types of patients and clinical cases one saw, while medical students commented from the broader perspective which was based on the whole community as a social realm. Nursing students were interested in what communities could offer them in the form of social activities and “things to do” as were medical students, while allied health students generally appeared to rate the community based on the clinical capacity the placement offered.

Discussion

Students are forthright in describing their likes and dislikes with regard to clinical placements and this research shows that the commonly identified themes remain largely unchanged. Requiring a variety of and interesting clinical case exposure, a hands-on rather than an observational role, university facilitation to ensure the placement runs smoothly and meets the requirements of the placements, affordability, accessibility and relevance are well-documented requirements for a successful clinical practicum.\(^6, 13, 14, 15\)

What was different from other studies was the emphasis on students being welcomed, wanted and treated well by staff, preceptors and clinicians in the workplace. There is ample literature that examines
examples of less than optimal conditions in relation to student nurse placements.\textsuperscript{16,17,18} The authors could find no such records relevant to any other discipline and yet there were repeated complaints of similar conduct from ambulance placements as well as a number from medical students. Unfortunately these complaints came almost uniformly from students who had encountered poor staff behaviour and attitudes towards them in rural settings. Obviously issues such as these are going to impact negatively on the experience students have of a placement and by default the broader setting and community. There were comments which linked negative staff attitude with a declaration of not returning to the community.

“I found the prac hard … there are nurses who enjoy making you feel dumb and putting you down. It did have an influence on my experience, I wouldn’t like to live there”.

Juxtaposed with this unfortunate finding were another group of statements in which students claimed that they themselves could influence the attitudes of staff. By being positive, inquisitive and polite students found they positively influenced staff attitudes towards them and the amount and quality of clinical education opportunities.

“I have found … that by showing an interest and having a go at all tasks I’m able to undertake ... staff seek me out when they had procedures which I could do”.

This attitude is verified in the literature.\textsuperscript{11,16}

A question that does arise is; Are the poor attitudes depicted by staff reactions to having students constantly in the workplace a sign of stress?

**Recommendations**

These early findings have highlighted a number of matters that are likely to be common to a range of clinical placement settings. They include clear communication between the university and the service provider for the practicum, collaboration, and the integration of students into clinical departments while re-examining the role of clinical staff as educators. From these preliminary findings several recommendations have been postulated and will form the core of a set of recommendations for placement providers in rural and remote areas.

1. Communication and collaboration between universities and health providers is essential and needs to be constant and vigilant. This must include establishing policies and procedures to detect, report and deal with incidences of bullying, harassment and prejudice.

2. Universities and workplaces need to work together to promote quality clinical learning departments and workplaces in which learning opportunities are maximised and professional discussion encouraged for the benefit of staff and students.

3. Universities and service providers need to be mindful of how clinical placements are managed in order to ensure clinical staff are coping with the additional burden of students and are able to provide effective learning environments.

4. Integrations of students into the clinical setting is required to promote involvement and the acquisition of team skills and a positive professional identity. There needs to be a focus on the right place for the student’s level of training.

5. Levels of supervision within the clinical workplace should be monitored to ensure students are supernumerary and not used to carry a workload.

6. Significant effort is required to develop the facilitation skills of clinical staff. The role of educator could be explicit in job descriptions and increased emphasis placed on the value of teaching within the clinician’s everyday activities. Professional development focused on enhancing the educational skills of clinicians is required.
More research is needed to ascertain the underlying reasons that so many students are reporting less than satisfactory welcomes in the workplace. This could commence with an investigation of stress levels of staff balancing clinical work load and student supervision.

References
8. Rural Health Workforce Australia—Correspondence with Executive Manager (RHWA) and Co-Chairs of the National Rural Health Student Network NRHSN. May 2010.