Enhancing Student Nurses’ Clinical Education in Aged Care Homes: A Qualitative Study of Challenges Perceived by Faculty Staff

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Abstract

**Background:** The ageing population is increasing the demand for geriatric care services. As nursing schools respond to this demand, more clinical placements are required, and aged care homes are suitable placement sites. Although an aged care experience for students is beneficial, the basis for effective implementation of these placements is yet to be fully established. The aim of this study was to explore faculty staff perspectives on the challenges associated with providing clinical education in aged care homes to first-year student nurses.

**Methods:** An exploratory qualitative study was conducted using in-depth interviews (n=15) with program leaders of nurse bachelor programs (n=4), course leaders (n=6) and practice coordinators (n=5) in three Norwegian universities. Data were analyzed using thematic analysis. The standards for Reporting of Qualitative Research (SRQR) checklist were used to report the findings.

**Results:** Five themes describe the perceived challenges to implementing clinical education in aged care homes: (1) the staffing model limits capacity to host students; (2) prevalence of part-time teachers can compromise the quality of students’ learning experiences; (3) tension about required qualifications and competence exist; (4) variation in learning assessments; and (5) lack of quality assurance.

**Conclusions:** These challenges signal key areas for attention in quality assurance for aged care placements. Further research into the minimum levels of staffing required to support student learning in the aged care setting is required. Methods for developing shared practices around facilitation of learning in aged care homes is required to address the preference for part-time teaching appointments. Further research into the levels of qualification and competence required to support student learning can assist with setting standards for this sector. Finally, academic-practice institutions must engage with bureaucrats and national nursing bodies to develop national standards for clinical education in aged care homes.

**Background**

The population is ageing, with one in six people in the world expected to be over 65 years of age by 2050. In 2018, for the first time in history, people aged 65 years and older outnumbered children under five years of age [1] Further, the number of people aged 80 years and older is expected to triple by 2050 [1], making the ageing of the population a significant demographic transformation in the 21st century.

Nurses constitute a significant percentage of the health workforce, so university nursing programs are essential in preparing a workforce to meet future healthcare needs, especially those associated with an ageing population [2]. However, a scoping review found little evidence of geriatric or gerontologic theory components in nursing education [3]. There is emerging evidence that nursing students learn about ageing and aged care through placements in aged care homes [4].
Aged care homes provide support for older people who can no longer live independently. While the homes promote a homelike environment, residents have limited control over decisions about their daily routine [5]. A review of nurse staffing standards in aged care homes in six countries found a reliance on personal care workers, rather than professional nursing staff [6]. In Norway, immigrant nurses, often unfamiliar with the native country’s culture and history, can comprise up to 43% of the staff [7].

The renewed interest in aged care homes as clinical placement settings for nursing students has been prompted by the growing health care needs of an ageing population, saturated clinical placements in health services, and regulatory requirements in countries such as Norway [4]. Aged care home placements are often provided for first-year students to foster learning about the essence of nursing [8] and instill positive attitudes about older people [9].

A review of nursing students’ experience of aged care home placements found that students valued the chance to build relationships with older people and to improve their skills in communication and assisting the elderly with their activities of daily living but note that students had to overcome several challenges to achieve learning [2]. For example, when assigned to aged care homes for clinical placement, nursing students do not value working with personal care assistants and often report that the practice sites were unprepared for them [2].

Indeed, a survey of Norwegian nursing students on placement in nursing homes assessed the clinical learning environment more negatively than hospital placements on nearly all dimensions [10]. In an exploratory study of Norwegian nursing students’ perceptions of a good learning experience, students highlighted their own and their mentors’ attitudes and competencies as important and student learning potentially being limited by lack of access to registered nurses (RNs) in aged care homes [11].

The predominant clinical placement model in aged care homes involves students working with staff, being mentored by a RN and followed up by a nurse teacher [12]. Within this model the teacher focuses on the co-operating between the RN mentor and the student, supporting the integrating of theory with practical learning. The teacher is responsible for coordinating the students learning, performing a liaison role rather than getting involved with hands on patient care [12]. Hence, contact with and support from the teacher is important for first-year students. This gives opportunities for critical reflection with peers supporting deeper learning about practice [13, 14]. For successful student placements, a carefully prepared academic service partnership, encouraging mentors and teachers, and high-quality nursing care is required [15].

For clinical placements, the qualities of the nurse teacher should enhance student learning [16]. Nurse teachers should therefore be able to form positive relationships with students [11] meet regularly with them [12] and be well-versed in the nursing care in the placement setting [17]. In one study, differences in learning in an aged care home were attributed to the facilitation styles of nurse teachers [18].

In aged care homes, access to experienced gerontology nurse teachers is often limited. Nurse teachers with backgrounds in acute care may be less interested in the care of older people and can bring negative
attitudes into the aged care home setting [16]. Training first-year students is often relegated to the most junior, novice educational staff, who may experience stress and role confusion that may compromise their ability to support students [19, 20]. The limited number of registered nurses for mentorship in aged care homes combined with the lack of experienced gerontology nurse teachers, poses significant challenges to quality learning. Yet, despite an emerging body of research into how students learn in aged care home placements, there have been limited investigations into nursing faculty perceptions of aged care home placements. The aim of this study was to explore faculty staff perspectives on the challenges associated with providing clinical education in aged care homes to first-year student nurses.

Methods

Design

This study adopted an exploratory constructivist approach to qualitative interpretive inquiry. A constructivist approach assumes a relativistic ontology, acknowledging multiple realities, and a subjectivist epistemology, where understanding is co-created by the participant and the researcher [21]. In-depth interviews [22] were used to explore faculty staff perceptions on the challenges associated with providing clinical education in aged care homes. In-depth interviewing is a research technique comprising intensive individual interviews with a small number of respondents in order to explore new issues in depth [22]. Standards for reporting qualitative research (SRQR) guidelines were used (Supplementary File 1) [23].

Setting and participants

The study setting comprised six nursing programs across three universities in Norway. Recruitment was based on purposive criterion-based sampling [24]. Nurse program leaders, course leaders and practice coordinators were invited to participate. Nurse program leaders are responsible for the quality of bachelor’s programs in nursing. Course leaders are responsible for the content, administration, and quality of the course, including aged care home placements. Practice coordinators are educational administrators responsible for placing students and coordinating with the municipalities and placement sites.

Prior to data collection, approval was obtained from each of the three participating universities. Invitations to participate were emailed to eligible staff with information about the study.

Data Collection

A semi-structured interview guide was developed based on integration of literature and inputs from a user panel of student nurses (n = 3), nurse teachers (n = 2) and nurse mentors (n = 2) (see Supplementary File 2). The guide addressed themes such as collaboration between education and practice, learning environment, mentors, nurse teachers, quality assurance work, barriers, and improvement measures. It allowed flexibility in responses, depending on the participants’ interests and experiences. The first and last authors [KAL, IA], experienced qualitative researchers with backgrounds in nursing and education,
conducted the interviews. The interviews, conducted in the participant’s workplace, lasted an average of 60 minutes. Each interview began with an explanation of the study and confidentiality and informed consent procedures. The data were collected between November 2018 and February 2019.

**Data analysis**

All interviews were recorded using a digital recorder and were then transcribed verbatim by three of the co-authors [KAL, CF, IA]. The analytical approach followed Braun and Clarke’s [25] framework for thematic analyses, a flexible approach to analyzing qualitative data that searches for themes or patterns. A theme captures data that informs the research question and can assist with some response pattern or meaning within the data set [25]. Hence, the thematic analysis was guided by the research aim and followed the six phases described by Braun and Clarke [26]: (1) becoming familiar with the data; (2) generating initial codes; (3) searching for themes; (4) reviewing themes; (5) defining and naming themes; and (6) producing the report.

Four of the authors [KAL, CF, KA, IA] independently read the interviews to become familiar with the transcripts. They summarized and shared their impressions with the research team and explored different perspectives of the data. The transcripts were initially coded by the first and last authors who highlighted segments relevant to the research questions, to delineate patterns. The coded data were then sorted into potential recurring themes and patterns by looking for perceived challenges. Four of the co-authors [KAL, CF, KA, IA] discussed and achieved consensus by reviewing, modifying and make final refinements of the themes and potential sub-themes covering the pre-defined analytic concept (e.g., challenges to clinical education). Five themes were identified and presented under separate headings. Citations from the themes were compared across the data items (e.g., interviews) and the most illustrative were selected for each theme.

**Ethical considerations**

The study is approved by the Norwegian Centre for Research Data (2018/61309 and 489776) and exempted from ethical approval from the Norwegian Regional Committees for Medical and Health Research Ethics since no health information or patient data is registered. Participation was based on informed, voluntary, written consent. To protect the anonymity of the participants and the educational institutions, details on university demographics, institutional and participant characteristics are not included in the paper.

**Results**

Of the 17 positions available to participate, 15 consented. The participants were nurse program leaders (n = 4), course leaders (n = 6) and practice coordinators (n = 5) across the three universities. The analyses identified five themes related to perceived challenges to clinical education in aged care home placements for first-year student nurses: (1) the aged care home staff model limits capacity to host students; (2) prevalence of part-time teachers can compromise the quality of student experience; (3) tension about
required qualifications and competence exist; (4) variation in learning assessments; and (5) lack of quality assurance. These themes are now presented and discussed.

**Theme 1: Aged care home staffing model limits capacity to host students**

All participants mentioned that aged care homes were generally welcoming of students on placement. However, placement capacity was limited by the low numbers of registered nurses (RNs) available as mentors:

The main challenge as I see it, is capacity for placement as the entire class is in aged care home placement simultaneously. There is also lower nurse coverage in aged care homes than in other placement sites (practice coordinator).

Participants from one educational institution tried to resolve this problem by dividing the class into two groups with different clinical placement periods. In another institution, students were placed in home healthcare, due to lack of capacity in aged care homes. Many participants emphasized that regulations governing students’ clinical placement within primary care and aged care homes were insufficient compared to placement regulations in specialized health care:

The municipalities are not obligated to take students on placements as the hospitals are by regulation. So, it is a bit unpredictable. Suddenly, just weeks before placement we get notice from an aged care home that cannot take students on placement after all, due to sick leaves, shortages of nurses and so forth. And, what do we do then? (program leader).

All the educational institutions reported having formalized agreements with the municipalities with stated capacity for students on aged care home placements. However, some participants indicated discrepancies between the number of placement positions offered and the number of students stipulated in the agreements. Participants described constant changes and unpredictability with the number of placement positions that complicated the placement planning process. Reasons for the reduction in placement positions offered by aged care homes included shortage of RNs, lack of supervisory competence, lack of time for mentoring, and understaffing. Moreover, the shortage of RNs could lead to suboptimal placements.

There is lower nursing coverage in aged care homes than in other placement sites. We want to have RNs to supervise the students. But due to the shortage of RNs, or sick leaves, students might be followed up by experienced auxiliary nurses for parts of their placement period. Students are not always happy about that (course leader).

A few participants wondered whether limited placement capacity would compromise placement quality:
Clinical education capacity in aged care home placements is a real challenge. It is difficult to talk about quality, because we are in a state of debt of gratitude towards the municipalities and the aged care home placement sites as they accept students for placements. So, we need to be constantly thankful towards the nursing home placement sites. It also is difficult to make demands and talk about quality. Talking about placement quality becomes a bit secondary (program leader).

Although most participants claimed they had to find alternative ways to maintain positive collaborations with the clinical setting, these solutions sometimes created new problems. For example, one practice coordinator emphasized that some aged care homes had the capacity and the willingness to accept students. However, these facilities were in rural and remote areas that were difficult for students and the nurse teacher to access:

A lot of rural municipalities that would be pleased to have and take students on placement in aged care homes. So, I do wish there was a way to supervise the students remotely. We are not using all the available placement sites in aged care homes because they are too far away for the nurse teachers to follow up with the students during placement (placement coordinator).

Each nurse teacher was responsible for four to 24 students, which placed a strain on the available pedagogical support and feedback provided to students:

It is challenging for the nurse teachers when they have a lot of students to follow up during the placement period. When a teacher is responsible for following up 24 students, it becomes challenging to keep track and provide individual supervision and feedback (course leader).

Participants did not identify an upper limit of students per nurse teacher. It was emphasized that a teacher’s availability, work plan and wishes determined the nurse teacher to student ratio. A course coordinator indicated that a nurse teacher could be responsible for students in several aged care homes, and travel should, therefore, be a factor in student allocations.

**Theme 2: Prevalence of part-time teachers can compromise the quality of students’ learning experiences**

Most participants reported a large number of nurse teachers providing clinical education of first-year student nurses in aged care home placements were part-time staff. Participants reported that clinical RNs were hired to assume and educational role and act as nurse teachers. Based on figures from the previous year, the practice coordinators reported that between 15 and 50% of the nurse teachers overseeing clinical education in aged care homes were part-time, making continuity of supervision difficult. Aged care home placements for first-year student nurses emerged as the placement with the highest proportion of part-time nurse teachers:

One of the biggest challenges we have concerning first-year students’ placement in aged care homes is the lack of continuity among the nurse teachers. We agree that it is important to give students a good
placement experience in their first-year placement. However, at our institution, almost half of the teachers we use in aged care home placement are externally part-time staff (program leader).

None of the participants reported that the use of part-time nurse teachers was monitored by their institutions:

Management knows we need to hire nurse teachers externally to carry out students’ placements. It is the management that does not secure enough resources being prioritized to clinical education. Management tells us to call, call, call somebody you know that can be hired to oversee clinical education. Management is fully aware of the situation. But nothing happens or changes. It has been like this for years (course leader).

Moreover, several participants reported the part-time nurse teachers were often recruited based on faculty employee acquaintances. There appeared to be few formal competence requirements for the nurse teachers hired to provide clinical education aside from being a registered nurse. For example:

We ask our colleagues, if there is someone, they know that could act as teachers in clinical education in aged care home placements. So, it is a bit random. We sure want them [the hired teachers] to have a master’s degree. But a lot of them only have a bachelor’s degree. We do not have any specific educational requirements concerning the teachers we hire for overseeing clinical placements (program leader).

Most participants stated they preferred to use internal nurse teachers because first-year students often are more vulnerable and in need of support. However, several participants stated that because of shortages of nursing faculty it was difficult to avoid hiring part-time nurse teachers:

It is not to bypass that it is cheaper to hire a teacher to conduct clinical education than one with higher qualifications. However, we who are left with the responsibility – talking about quality – it is difficult when we have a large number of externally hired nurse teachers to carry out clinical practice education that is not part of our internal staff (program leader).

A few participants claimed that clinical education and placement follow-up were a lower priority and that nurses who held the doctorate were assigned mostly to advanced research and education. According to one practice coordinator, “clinical education is given a lower priority among staff than other responsibilities.”

In addition, participants noted the lack of formal preparation and orientation of the hired nurse teachers prior to the placement period. The educational institutions varied in their hiring practices. One educational institution mentored its externally hired nurse teachers; participants in other institutions claimed that this was an area in need of improvement. So, in conclusion, there are inherent problems across the educational institutions in terms of the competence and continuity of the staff entrusted with the supervision of students on placements.
Theme 3: Tension about required qualifications and competence exist

Participants disagreed on the competence of the nurse teachers. One participant considered clinical experience and expertise far more important than competence:

You do not need to be an associate professor to carry out clinical education. Nursing is a practical profession. People who have spent time building competence within academia have not been practicing nursing for a long time. I think students would benefit more from having clinical nurses with hands-on knowledge and expertise from the clinical field as nurse teachers. I think they can do a really good job (course leader).

However, most participants agreed that the nurse teachers’ pedagogical competence and the RN mentors’ competencies in supervision and assessment were most salient. Consequently, participants across educational institutions reported offering courses to strengthen RN mentors’ supervisory competencies free of charge. However, they also reported that it was difficult to get the RNs to participate in these courses as there were no formal competence requirements:

The aged care homes do not have the resources to send the RN mentors on courses that the university offers. The mentors don’t want to participate on their day off and if they don’t get compensation time for the course by their employee. So, I believe that it is more practical challenges than the mentors’ willingness to enhance their supervisory competencies (course leader).

Moreover, some participants proposed that students’ learning in clinical education had to be emphasized and that the RN mentors’ pedagogical competencies needed to be improved beyond their supervisory skills:

I wish we had a system where the RN mentors learned more about workplace learning, learning in general and supervision. There is insufficient focus on learning during the student’s placements in aged care homes (program leader).

When talking about the RN mentors’ competencies and supervisory skills, a program leader at one of the educational institutions noted:

It is a requirement that you as a teacher have university teaching and pedagogical basis of competence. But that is not the same as competencies in supervision. We talk about that RN mentors should be required to have supervisory competencies. However, no one is taking about the same requirements concerning the nurse teachers following up the students on placement. And that is interesting.

Theme 4: Variation in assessment of learning

There were inconsistencies across the educational institutions in the assessments of students’ performance and competence. One institution used a pass/fail assessment, another used a verbal scale
and the third used a numerical scale. The participants reported a range of satisfaction with these forms of assessment. Some justified the use of a numerical scale, while others preferred the freedom of writing a narrative. Several participants, especially course and program leaders, claimed that valid and reliable assessment of students’ competence was challenging, because of the differences in tasks and student readiness. The challenges reported were related to language difficulties, scoring/assessment of learning outcomes, assessment criteria, interaction among the student, RN mentor and the nurse teacher during the assessment process, and, finally, the RN mentor's competence in assessment.

Some participants claimed that assessment of students’ performance and competence was undertaken primarily by nurse teachers and requested more interaction and involvement from the mentor [the clinical nurse]. For example:

Much is up to the nurse teachers; they have the last word. The nurse teachers take control, lead, and make final decisions concerning whether the students have achieved their learning outcomes. So, we need to get the mentors more confident and provide them with assessment skills. The mentors are the ones that sees how the student performs in the care of patients and how they perform and behave in the clinical setting. It can be difficult for the nurse teachers to reveal if the student is weak or performs below expectations (program leader).

Difficulties with the language used in the competence assessment documents were proposed by some participants as a potential barrier for interaction and involvement from both the student and the RN mentors during the assessment discussions. The participants reported that students and mentors reported difficulty in understanding the concepts used to describe the student learning outcomes. Moreover, linguistic challenges potentially impeded both the assessment process and the learning experience. For example:

It is challenging when you have students with a foreign first language and Norwegian as a second language. The same goes for the mentors. Because some of the mentors can also be difficult to understand due to linguistics. If you have a student and a mentor that both has linguistic challenges paired together, than you can have a real challenge. Clearly, linguistic challenges can influence placement quality by affecting the quality of supervision, assessment, and follow-up. Thus, it ultimately affects the students’ learning outcome (course leader).

Another course leader at another institution shared the same opinion:

It is difficult with students with linguistic challenges who have not mastered communication with patients or staff. Then, there can be a lot of misunderstandings. This is something I find worrying.

Some participants reported linguistic challenges because multicultural workforces were more commonplace in aged care homes than in other clinical placement settings.

**Theme 5: Lack of quality assurance work**
Few participants were familiar with goal-oriented efforts directed towards ensuring quality in clinical education in aged care home placements. Goal orientation existed at a faculty level, but not in terms of clinical education or placement quality:

We do not have a specific strategy when it comes to improving or ensuring placement quality – we do not (program leader).

A course leader at another educational institution concurred:

When it comes to quality in clinical education and aged care home placements, we don’t do much except from providing supervisory courses to enhance the mentor’s competencies. Except for that we don’t do very much.

Only one participant reported that their institution monitored its own performance in clinical education and placement quality through self-reports from students, teachers, or the practice field (e.g., the RN mentors or placement sites). Some educational institutions collected students’ course evaluations, which included clinical education based on standardized course evaluations. However, several participants emphasized that evaluations were only randomly followed up. The responsibility for monitoring placement quality was proposed by most participants as relying on the individual nurse teacher and his or her initiative to conduct evaluations after the placement period:

It is up to each individual teacher. Or, frankly it is written in the instruction contract that the teacher should conduct an evaluation meeting with the stakeholders in the aftermath of placement. However, I must admit that I do not have full control over it, if they [evaluation meetings] are conducted and if so who participates in these meetings, if it is with the RN mentors or with the management team at the aged care home. No, I strictly don’t know (program leader).

Moreover, several participants reported that if the nurse teachers conducted evaluations on their own initiative, these data were not followed up by the educational institutions and used for systematic quality improvements. For example:

If we gather information based on placement experiences from the various stakeholders – it will generate a huge amount of data. Evaluations commits. If we gather all these placement experiences and evaluations, we need to do something about them, follow them up in some way. We get struck with a lot off information without having a plan to proceed with it. A lot of times I feel that we gather a lot of information without knowing what to do with it and deal with it (course leader).

Most participants described the quality assurance work concerning clinical education as insufficient:

We do not conduct evaluation meetings with practice or with students in the aftermath of placement. We don’t. But it is something we probably should do and improve (program leader).

**Discussion**
The findings from this study suggest at least two key challenges in providing effective first-year student clinical placements in aged care homes: i) limited access for student placements; and ii) lack of qualified nurse teachers and available RN mentors. Other challenges pertain to the reliability and validity of assessment practices and lack of process for improving quality of nursing student education from within the educational institutions.

Because the clinical placement model in aged care homes requires students to work with qualified staff [12], the capacity to host students is limited by the low number of registered nurses, understaffing and reliance on agency staff. Some placements were canceled at short notice. Thus, findings suggest that limited capacity can make aged care homes less than optimal clinical placements.

Norway’s more than 950 aged care homes [7] should ensure an adequate number of placement opportunities. A case study of selected Norwegian nursing homes found variations in nurse competence and staffing [26], with subsequent consequences for students’ access to registered nurses. In the current regulatory environment, this variability complicates the formation of collaborative legal agreements between the higher education institution and each aged care home. These agreements may also differ when accounting for the unique capacities of each municipality and their geriatric facilities. Making, and monitoring, these arrangements is labor-intensive, often creating an impediment to aged care home placements for nursing students.

In Australia, guidelines for collaborative agreements have been developed [27]. Creating guidelines for collaborative agreements, as part of a broader policy program around quality clinical supervision for students in aged care homes and other health services, may enhance access to aged care homes for student placements. However, these agreements must specify minimum staffing levels to ensure adequate student learning. Further research into the minimum levels of staffing required to support student learning in the aged care home is required.

The lack of qualified teachers in aged care homes is manifested as a high proportion of part-time nurse teachers and often limited geriatric qualifications and competence. There was strong agreement among participants that part-time nurse teachers did not provide consistency for first-year students. Further, given the shortage of RNs available to mentor and support student nurses learning in aged care homes support from nurse teachers may be all the more important. Indeed, a study by Skaalvik et al. [28] found that students evaluated the role of the nurse teacher as more important in their first year than in their final year of study. Furthermore, the use of part-time nurse teachers in aged care homes required higher resource investment through preparing more teachers for their roles and often lacked a systematic approach leading to high variability in quality. Methods for preparing teachers to work in the aged care setting require further development, with online options possibly supported by a community of practice model for peer support and development of shared practices.

Other approaches to clinical education in aged care homes require further investigation. With budget cuts and constraint rising, educational leaders may commit to long-term partnerships with one or a small group of aged care homes [29]. Having nurse teachers consistently assigned to the same aged care
facility is essential for developing and strengthening their collaborative relationship [29]. In emerging models, nurse teachers can be jointly funded by the facility and the institution of higher education partners. These teachers could offer education and training in student supervision for registered nurses and collaborate with staff to identify and develop learning activities that are appropriate for students’ learning objectives, between student placements. This model has been used in the Student Nurse Led Ward model of clinical education in aged care homes with some success [30].

The lack of teachers in aged care homes who possess geriatric qualifications and competence are limited. In the United States, a group of gerontology nurses has developed national competency standards for gerontological nurse educators, endorsed by the National Hartford Center of Gerontological Nursing Excellence [31]. Further research into the applicability of these competencies to the nurse teacher role is aged care homes is warranted. For sustainable and high-quality clinical education, future research should critically explore and extend our understanding of the relationship between the nurse teachers’ clinical expertise, competence, pedagogical skills set and students’ learning outcomes.

Lack of pedagogical competence and supervisory skills among the RN mentors (e.g. clinical nurse) who are supervising the students in age care homes reflects a frequently mentioned challenge related to supervision of students in aged care facilities [10]. Developing educational interventions such as web-based educational support and peer networks for RN mentors may also provide a method for improving their pedagogical knowledge and mentorship practices [32].

Another notable challenge in providing clinical education in aged care homes pertained to consistent, reliable, and valid assessment practices. This challenge is not unique to aged care homes or to Norway. Research into clinical nurse and academic perspectives on student clinical assessment in Singapore, suggests that the lack of a valid and reliable assessment tool, limited mentor competence in assessment, and limited academic-clinical collaboration were common issues [33]. A systematic review of assessment of student competence found the use of a valid and reliable assessment tool, with clear criteria identified and continued education and support for mentors is critical to quality learning [34]. Moreover, study findings indicate that the nurse teachers have a dominating role during the assessment process due to a lack of engagement from the RN mentors. Given the homogeneity in aged care home populations, there is an opportunity to develop an international collaborative into learning and assessment in aged care homes, possibly starting with establishing standards for first year nursing students.

A noteworthy finding from this study is that language difficulties may be more profound during students’ placements in the aged care home context because of their more multicultural workforce. Hence, findings suggest that educational institutions should address possible placement challenges that can emerge in aged care homes related to students and RNs with culturally and linguistically diverse backgrounds as the current knowledgebase seem to be inadequate especially within these settings.

The final challenge was the lack of a systematic process for improving quality of nursing student’s clinical education, especially in aged care homes. Some institutions did collect information from clinical placements, but the volume of data produced was difficult to review because the academic staff’s limited
resources. For those collecting student experience data, the great variation in placement experiences is consistent with other research conducted in Norway [35]. For a richer and more cohesive understanding of the aged care home as a clinical placement, evaluations and feedback from the RN mentors, the placement host, nurse teachers and student nurses are recommended. Again, an international collaborative is required to develop standards for the quality of educational experiences in the aged care home setting.

Clinical placements in aged care homes may not be sufficient preparation for graduate nurses who will be working with an older population. Lane and Hirst [4] recommend, at a minimum, a carefully constructed curriculum incorporating gerontological theories and placement experience in aged care homes. McSharry and colleagues [36] suggest that lecturers have a responsibility to bring student experiences from aged care homes into the classroom for analysis and direct further learning. As curricula are designed with more geriatric content, comprehensive studies are required to investigate those educational strategies that improve student competence in geriatric care [3].

In summary, while student placement in aged care homes is important for student learning, variability of aged care homes in terms of staffing combined with limited preparation of nurse teachers to work in this setting, renders high quality learning serendipitous. A regulatory approach to including geriatric content and experience in undergraduate nursing curricula is long overdue. While a first-year placement offers opportunities to learn about the essence of nursing, opportunities for second-year students to learn more about the clinical presentations of complex co-morbidities in this setting have yet to be explored. Further, research suggests that nurse graduates’ first post preferences depend on their third-year experience [37]. As the population over 80 years of age continues to grow, the need for nurses in aged care homes will continue to rise. To increase graduates in aged care homes, further research into the benefits of these third-year placements is required.

There is an urgent need for national, and possibly international, standards for gerontological nursing education in undergraduate nursing programs, inclusive of standards and guidelines to support students’ placements. As national governments examine and develop policy to address the burgeoning health issues associated with an ageing population, investment in geriatric nursing knowledge as a generalist competency through educational standards is recommended.

**Study limitations**

The study has several limitations that merit consideration when interpreting the findings. First, this study was based on a relatively small sample conducted within a Norwegian context, which restricts the transferability of the findings. Nevertheless, the findings and issues raised are relevant in a national and international context. Sample size and data saturation in qualitative research has been subject to enduring discussions due to a variety of conceptual understandings [38]. In this study, sample size was defined prior to data collection according to the purposeful criterion-based sampling strategy [24] and the study settings. The sample was highly specific for the aim of the study and the interview dialogue was
strong which enhances information power [39]. Furthermore, a high degree of consensus emerged during data analysis where themes were replicated across the data set and deemed sufficient to satisfy the exploratory nature of this in-depth study [40].

Furthermore, potential biases should be acknowledged since the data collection and analysis were conducted by researchers with a background in nurse education, which entails a prior understanding of the context. We tried to control for research biases by applying triangulation during data analysis. Four of the authors participated in data analysis and reflected upon the findings; this provided a basis for checking interpretations [42]. The analysis was not reviewed by the participants in terms of member checking transcripts and interpretations which could have been conducted to verify the findings [43].

**Conclusions**

The world population is ageing, and as people live longer, many will experience chronic multiple morbidities. A nursing workforce that is prepared to work with older people is critical. Aged care homes are a unique opportunity for first-year undergraduate nursing students to learn more about older people and chronic diseases, and to develop skills in communication and assisting them with the activities of daily living. However, the lack of maturity of the sector in providing educational experiences, particularly in relation to the quality of staff is a barrier to effective placements. While the health services have a history of hosting students and are widely accepted as suitable environments for student learning, these are not yet fully developed in aged care homes. It requires industry regulation around staffing for student supervision and collaboration between the aged care sector and universities to set standards for nurse teachers and training.

This research has investigated the challenges to clinical education in aged care homes as perceived and experienced by faculty staff. The research provides insight into the many impediments to students’ clinical education in aged care homes, limiting the quality of placement experiences and maximization of learning potential. Hence, we propose that targeted efforts are warranted to enhance student nurses’ clinical education in aged care homes.

In conclusion, we propose that nurse education institutions in partnership with aged care homes must invest in clinical education. Collaboratively, the academic-practice institutions must lead changes for improving the quality of students experience in aged care homes by evaluating their practices and contributions in clinical education and by engaging with bureaucrats in health and aging and national nursing bodies. Evaluations should be based on indicators appropriate for the aged care home setting that integrate a multiple stakeholder perspective. Moreover, the findings call attention to the need for national regulations and incentives and international research and development collaboratives that support quality of learning in aged care home placements. Taken together, these measures may enhance placements that stimulate and maintain students’ interest in the care of older people.

**Abbreviations**
Declarations

Ethics approval and consent to participate

The study is approved by the Norwegian Centre for Research Data (2018/61309 and 489776) and exempted from ethical approval from the Norwegian Regional Committees for Medical and Health Research Ethics since no health information or patient data is registered. The deans of the enrolled universities also approved the study prior to data collection. Participation was based on informed, voluntary, written consent. To protect the anonymity of the participants and the educational institutions, details on university demographics, institutional and participant characteristics are not included in the paper.

Consent for publication

Not applicable.

Availability of data and materials

The datasets used and analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

Contributions

KAL, CF, KA, IA conceptualized the study, developed the data collection tools, and participated in the analysis and interpretation of these data. KAL drafted the manuscript and revised it based on comments from all the authors. SB and LG have made substantial contribution to the drafting and revision of the manuscript. All authors have read and approved the manuscript.

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