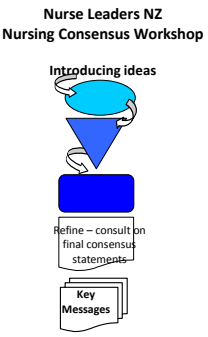


# Summary of discussion held at the NZNO-hosted Education Forum – February 11th 2011

## Introduction

A wide range of issues were discussed and the following pulls out the key themes that were identified during the day. The groups did appear to reach consensus on a number of issues as well as identifying some areas that still need work. Italics are used to distinguish quotes that are taken directly from the feedback sheets.

### *Undergraduate education*

In general, the feeling in the room was that undergraduate education structures are working relatively well and that there was no need for radical reform but rather progressive enhancement supported by robust research. There is space for *creative and innovative* development. Any long term change would need to be progressive and incremental.

### *University versus polytechnic provision*

There was consensus that provision by both polytechnics and universities should continue.

It was noted that there are strengths to each (e.g. universities have expertise in research; polytechnics have expertise in vocational education and teaching). It was noted that a model that draws on the strengths of both should be explored (see collaborative partnerships below).

### *Collaborative partnerships*

This was a significant theme and extended to partnerships between education providers and clinical providers and between education providers:

a. Partnerships between education and clinical providers

Collaborative partnerships between education providers and clinical providers are already occurring successfully in many locations. Examples include DEUs and joint appointments. It was felt that further work could be done to examine best practice in these models, develop centres of excellence and extend the benefits of such models across the sector so that all providers (clinical and education) can benefit from their successes – more sharing of ideas and innovations is required with

particular support required for smaller ITPs (see below). Where multiple education providers are using one site for clinical practice experience, issues were identified with differing evaluative criteria that were confusing for clinical staff.

> *Need an organisational culture whereby clinical staff share a commitment to 'our students', not 'their [education provider]' students. Clinical experience not ad hoc, and a true model of partnership. Also a sound knowledge of the expectations and competency assessment processes.*

b. Partnerships between education providers

Collaborative partnerships between education providers was also considered to be an area for further development. While some institutions are already developing good collaborative relationships, further development of similar relationships could be beneficial – possibly on a regional basis. In particular synergies could be developed that built on the particular strengths of the differing providers (see above). Such collaborative partnerships could:

> *...result in decreased administrative costs, increased consistency and quality, and provide a greater pool of teaching resource and expertise...*

Partnerships would draw on the respective strengths of the collaborating institutions to develop centres of excellence, innovation, teaching and research into nursing education.

> *New models of educational delivery are more likely to be a function of developing partnerships/relationships, shared resources and a shared vision of nursing essence and culture.*

> *Univ and/or polytech preparation – efficiencies could be made via a more collaborative approach. Increasing consistency and quality with a greater pool of teaching talent. Try to create more homogenous forms/frameworks*

Some groups indicated that a hierarchy did exist between institutions and that closer collaboration would mitigate this issue.

## *Curriculum*

The discussion suggested that a national curriculum was not supported. However, there was an indication from some groups that fewer curricula would be beneficial and that *collaboration for a fundamental framework for preparation of the new practitioner* could also be beneficial. There was clear consensus that undergraduate curricula should remain generalist although a number of groups noted the importance of increasing curricula focus on primary health care.

Further research into curricula and student outcomes was recommended by several groups.

> *Perhaps not just have one curricula but need to identify the core. Integrating these core, identified topics right from the start, stepping it up each year in complexity and level of skill.*

*Common concepts with regional variation within the curricula. There is some core knowledge that needs to be taught.*

*Are 17 curricula sustainable, and the resourcing that goes with that?*

### *National graduate profile*

There was support for development of a national graduate profile from several groups.

### *Faculty development*

Faculty development was identified as an issue. This included issues ranging from an ageing faculty, the need for pay parity with the clinical setting, the need for developing research partnerships across institutions, and the need to examine models of faculty practice. Further examination of these issues is required.

*For innovation to occur we need the visionary educators. It is context dependent. Strengths can be built on – the challenge is maintaining the quality along the way.*

### *Interdisciplinary education*

While there appeared to be general support for the concept of interdisciplinary education, many groups identified issues with implementing such a model suggesting further work is required across the sector to examine existing knowledge around interdisciplinary education and the feasibility of implementation within existing structures. There was consensus that interdisciplinary education involved more than shared lectures.

*Interprofessional education – the logistics with preparation and timetabling, etc requiring careful planning.*

*Interdisciplinary education – possibility of power issues, professional snobbery. Need to pick the 'right time' which could point to post-registration shared experiences*

*New i-p education models are mainly situated in the larger centres with mixed research findings about benefits*

*I-d modelling right from the top needs to happen.*

*It's difficult for some other organisations to see the merit in i-d education.*

*Must keep hold of our nursing identity within i-d education*

### *Student experience*

Groups identified a need to improve the quality of the student experience, examine the gap between what students would like and what educators perceive they need, and to undertake research into the realities of student nurse experiences and curriculum outcomes as noted above (NZNO undertakes an annual survey of all student nurse members which is available on request).

Bullying was noted as a persistent theme for students and further work needs to be done to address this issue.

### *First year of practice*

There was generally consensus that a three year bachelor's programme should continue but that further work needs to be done to ensure appropriate support for new graduate nurses in their first year of practice. Further work needs to be done to examine the feasibility of extending NEt-P to all new graduates (there was support from a large number of groups for this) and how this would then be construed (e.g. would this become a fourth year of education, a provisional year, an intern year, or simply a supported/supervised year etc). There was a suggestion that funding for the first year of practice should go with the nurse not the provider. This topic will be explored further in the 8 April meeting.

### *Smaller providers of nursing education programmes*

A number of groups noted that resourcing was a significant issue for smaller education providers – this included funding, staffing (faculty development), and cost of new models e.g. simulation. Greater support including collaborative partnerships was considered a useful approach to some of these issues. Problems identified with this approach included risks to institute income associated with collaboration and decisions being made at a management level rather than with nursing.

> *Resourcing is a big issue – the smaller polytechs do struggle with what is awarded as it varies between those ITOs*
>
> *The cost of simulation is costly – maybe a regional resource is a viable pathway.*

## Conclusion

Consensus based on the feedback received on the day:

- Undergraduate education is working well
- Both university and polytechnic provision should continue
- Collaborative partnerships between clinical and education providers and between education providers need to be strengthened and best practice shared
- A national curriculum is not supported
- Faculty development is a significant issue
- More cognisance of the student experience is required
- A three year generalist bachelor's programme should continue
- Smaller providers need significant support

Further work:

- Development and evaluation of models of collaborative partnerships is required.
- Further work on the idea of a fundamental framework for preparation of the new practitioner is required – what is this, what would it look like and would it be useful?

- Further consideration of consolidation and alignment of curricula is required.
- Exploration of the advantages and/or disadvantages of a national graduate profile is required.
- Research into faculty development needs is required (priority).
- Further examination of models of interdisciplinary education and the implications of this for nursing is required.
- Further examination of the perspective of student nurses is required.
- Examination of the structure of the first year of practice is required (priority).
- Exploration of how smaller providers can be supported is required.