Integrating Clinical Education into Ontario’s Changing Health Care System

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C O N S E I L  D E S
U N I V E R S I T É S  D E  L ’ O N T A R I O
# Background and Acknowledgements

The crisis in clinical education has been a significant challenge for health care systems and educational institutions. This document aims to provide an in-depth analysis of the crisis, its causes, and the experiences encountered across various disciplines. The Council of Ontario Universities (COU) has convened this study to address the issues and propose solutions to enhance clinical education opportunities and support the development of future health care professionals.

## Executive Summary

The executive summary provides an overview of the study's findings, highlighting the key issues and recommendations. It outlines the scope of the crisis and its impact on clinical education programs across Ontario.

## 1. The Crisis in Clinical Education

The crisis in clinical education is multifaceted, affecting various health care disciplines. The study examines the causes and experiences of the crisis to inform future strategies and policies.

### 2. Causes of the Crisis in Clinical Education

The causes of the crisis are rooted in structural and systemic issues within the health care system.

#### 2.1 Restructuring of the Health Care System

The restructuring of health care systems has led to changes in the delivery of services, which in turn impacts clinical education programs. This section explores the implications of these changes on clinical placements and the education of health care professionals.

#### 2.2 Growth in Size and Types of Health Professional Programs

The expansion of health professional programs has resulted in increased demand for clinical placements. This section delves into the specifics of enrolment in different programs and the challenges associated with this growth.

##### 2.2.1 Enrolment in Baccalaureate Nursing Programs

The rise in enrolment in baccalaureate nursing programs has strained clinical placement capacities. This increase in demand has led to difficulties in securing suitable placements for students.

##### 2.2.2 Enrolment in Practical Nurse Programs

The expansion of practical nurse programs has also contributed to the crisis, with the need for more placements creating additional challenges.

##### 2.2.3 Enrolment in Rehabilitation Sciences Programs

The growing enrolment in rehabilitation sciences programs, including audiology, occupational therapy, physiotherapy, and speech language pathology, has significantly increased the demand for clinical placements.

##### 2.2.4 Other Health Professional Programs

Other health professional programs have also faced increased enrolment, leading to shortages in clinical placements.

#### 2.3 Robust Clinical Education Requirements

The requirements for clinical education have become more robust, particularly in rehabilitation sciences and baccalaureate nursing programs.

##### 2.3.1 Rehabilitation Sciences

The increasing complexity of rehabilitation sciences programs has necessitated more clinical placements, further straining the system.

##### 2.3.2 Baccalaureate Nursing

The requirements for baccalaureate nursing programs have also escalated, with an emphasis on clinical placements.

## 3. Experiences of the Clinical Education Crisis

The experiences of the clinical education crisis are detailed across various disciplines, highlighting the challenges faced by each.

### 3.1 Nursing

The crisis in nursing has been particularly evident, with many students experiencing difficulties in securing placements.

##### 3.1.1 More Refusals of Placements

Increased refusals from clinical placements have impacted the ability of nursing students to complete their clinical education requirements.

##### 3.1.2 Increased Instructional Costs

The crisis has led to higher instructional costs for schools, as they struggle to accommodate increased enrolment without adequate placements.

##### 3.1.3 Shortage of Types of Hospital Placements

The limited availability of various hospital placements has been a significant challenge for nursing students.

##### 3.1.4 Reduced Availability and Burnout of Hospital-Based RN Preceptors

The shortage of preceptors has compounded the crisis, leading to burnout and reduced teaching capacity.

##### 3.1.5 Shortage of Home Care Placements

The scarcity of home care placements has been a major concern, affecting the ability of nursing students to gain essential experience.

##### 3.1.6 Shortage of CCAC Placements

The lack of Community Care Access Centre (CCAC) placements has further limited the opportunities for clinical learning.

##### 3.1.7 Shortage of Public Health Placements

The shortage of public health placements has made it difficult for students to gain experience in this vital area.

##### 3.1.8 Shortage of Primary Care Placements

The limited availability of primary care placements has also been a significant issue.

##### 3.1.9 Shortage of Appropriate Mentorship in Community Health Placements

The crisis has caused a shortage of appropriate mentorship in community health placements, impacting the quality of education.

##### 3.1.10 Challenges with Long-Term Care Placements

The difficulties in securing long-term care placements have added to the overall challenges faced by nursing students.

### 3.2 Rehabilitation Sciences

The crisis in rehabilitation sciences is characterized by shortages in various placements.

##### 3.2.1 Shortage of Hospital Placements

The limited availability of hospital placements has been a major issue for rehabilitation sciences students.

##### 3.2.2 Financial Costs to Students

The crisis has resulted in increased financial costs for students, as they struggle to secure adequate placements.

##### 3.2.3 Shortage of Placements in Community-Based Therapy

The lack of placements in community-based therapy has been a significant problem.

##### 3.2.4 Shortage of Placements in Private Practice Settings

The shortage of placements in private practice settings has also contributed to the crisis.

##### 3.2.5 Shortage of Placements with School Boards

The limited availability of placements with school boards has been another challenge.

### 3.3 Across Disciplines

The crisis across different disciplines is evident, with common themes emerging.

##### 3.3.1 Increased Administrative Costs

The crisis has led to increased administrative costs for educational institutions.

##### 3.3.2 Competition for Placements

The intense competition for placements has made it difficult for students to secure adequate clinical learning opportunities.
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Background and Acknowledgements

The Ontario government has been addressing the growing needs of the health care system in a climate of increasing demographic and fiscal challenges. At the same time, little attention has been paid to the severe challenges these health system changes are creating for the clinical education of the future generation of health care providers. The Council of Ontario Universities (COU) determined that a discussion paper was needed in order to draw attention to the crisis in clinical education and provide concrete recommendations.

The paper was developed with extensive consultations with resource groups from nursing and rehabilitation sciences programs, the Council of Ontario University Programs in Nursing (COUPN), the COUPN Undergraduate Coordinators (COUPN UG), the Ontario Council of University Programs in Rehabilitation Sciences (OCUPRS), the committee of the Academic Coordinators of Clinical Education/Directors of Clinical Education for university Rehabilitation Sciences educational programs (OCUPRS ACCEs/DCEs), and Executive members of the Provincial Heads of Nursing from the Colleges of Applied Arts and Technology (CAATs), as well as discussions with the nursing executive committee of Academic Hospitals of Ontario (AHO), rehabilitation regulatory colleges and associations, and staff at the Ministry of Health and Long-Term Care (MOHLTC) and the Ministry of Training, Colleges and Universities (MTCU). The clinical education resource groups from university rehabilitation sciences and nursing programs included the following individuals: Yolanda Babenko-Mould, Donna Barker, Sue Berry, Brock Chisholm, Catherine Donnelly, Janice Dusek, Kim English, Cathy Graham, Corinne Hart, Shirlene Hudyma, Jeannette LeGris, Anne MacPhail, Gina Marasco, J.B. Orange, Ruth Schofield, Susan Schurr, Rachel Stack, Kelley Tousignant, Sandra White, Sandra Wiens and Karen Williamson.

A review of published English language literature and other relevant documents on clinical education was also conducted.

Quantitative data was drawn from the following sources:

- 2012 survey of nursing schools on evening/weekend use of clinical placements;
- 2010 survey of Ontario rehabilitation clinical coordinators;
- Health Sciences Placement Network (HSPnet) 2013 data on decline rates in clinical placements;
- MTCU data on enrolments;
- COU 2007 clinical paper on costs of clinical education in universities;
- Colleges Ontario 2006 clinical paper on costs of clinical education in colleges; and
- College of Nurses of Ontario (CNO) 2005 study of clinical education hours.
Executive Summary

1. The Crisis in Clinical Education
   Ontario faces a crisis in the clinical education of health science professionals. Urgent action is needed by government to build recognition for clinical education into health system funding reform.

2. Causes of the Crisis in Clinical Education
   Health care system restructuring, growth in number and size of health science programs, and rigorous educational requirements to ensure safe care, have all contributed to what is now a crisis in clinical education of health science students. This paper focuses on baccalaureate nursing and university rehabilitation sciences programs in order to illustrate the crisis and required responses.

3. Experiences of the Crisis in Clinical Education
   The clinical education crisis is being experienced by nursing and rehabilitation sciences programs in multiple ways—shortages of placements across the continuum of care and within particular practice areas, burnout of preceptors, increased administrative and instructional costs for schools, greater financial costs to students who go further afield to placements, and increased competition for placements amongst schools and programs.

4. Current Approach to the Crisis in Clinical Education
   The dominant approach to the crisis in clinical education has been for postsecondary institutions to put more resources and initiative into creating additional placements, with targeted assistance from government, and using existing placements more efficiently. Efforts include intensification of placements, streamlining of curricula, clinical education databases (e.g., HSPnet), preceptor training, preceptor recognition, innovative placements, northern and rural placements, summer placements, interprofessional placements, clinical simulation, and distance technology. Many of these initiatives have been supported through the clinical education grants provided by Ministry of Training, Colleges and Universities (MTCU), and through Ministry of Health and Long-term Care (MOHLTC) project funds. Overall, this impressive array of initiatives has helped to sustain clinical education programs in the face of increasing pressures and stresses, but has been inadequate to overcome the crisis.

5. Limits of the Current Approach
   Too much burden has been placed on postsecondary institutions to adapt their clinical education programs to the changing health care system and rising enrolments. While these institutions continue to develop innovative approaches to clinical education in order to meet emerging health care needs, with targeted investments from government, they have reached the limit of what they can achieve under such an approach. MOHLTC must recognize clinical education as integral to the functioning and development of the health care system, and as an essential component in health system transformation initiatives. The shift away from the traditional acute care system to patient care across the continuum and to patient-based funding must integrate incentives for Local Health Integration Networks (LHINs), agencies and providers to take on the responsibility of helping to educate the next generation of providers.
6. **Approaches to the Crisis Beyond Ontario**
   A look beyond Ontario’s borders to see how other jurisdictions are dealing with the crisis offers some instruction. Much of the literature affirms the approach that Ontario has already undertaken in terms of measures that schools can take to expand capacity. Beyond this, Australia has recognized clinical education reform as “an important plank in national health care reform” and has undertaken multiple, coordinated measures to deal with the situation, some of which could be instructive for Ontario. The literature also points to the need for preceptors to be given reduced workloads, for dedicated clinical teachers in agency settings, and for the creation of clinical placement consortia. These measures are promising but would require recognition and support from MOHLTC in order to be implemented in Ontario.

7. **A Vision for Clinical Education in Ontario**
   Clinical education must be recognized as an integral part of the health care system and health system transformation. Where this is the case, hospitals, CCACs, community agencies, schools boards, public health units, primary care providers, and long-term care homes explicitly partner with postsecondary educational programs in training the next generation of health care providers, and are facilitated in doing so by government. Students, their professors and clinical instructors are not seen as a burden on health care agencies, but as an essential aspect of a dynamic environment involving researchers, learners, practitioners and patients, which develops the health human workforce and drives quality care.

8. **Recommendations**
   **8.1 Create incentives for clinical education in the community sector**
   Clinical education must become one of the activities in the community sector that is measured and reported to funders, as part of the formal accountability process. This will mean identifying performance outcomes for clinical education as part of Ministry-LHIN Performance Agreements, so that LHINs will build clinical education requirements into their accountability agreements with Community Care Access Centres (CCACs), long-term care homes, community health centres, and other LHIN-funded agencies. The government will also need to institute this in funding agreements with public health units, primary care agencies and school boards.

   **8.2 Build clinical education into hospital funding reform**
   The new funding formulas for hospitals need to integrate and bolster the teaching mandate in these institutions, so that they are recognized and rewarded for continuing this important activity in the face of more and more demands for performance in other areas.

   **8.3 Continue to develop long-term care homes as centres of learning, research and innovation**
   The piloting of three long-term care homes as centres of learning, research and innovation needs to be expanded across Ontario and made continuous, in order to help develop this sector in a way that can address the needs of the aging population.

   **8.4 Targeted funds for clinical education initiatives**
Targeted government funding for educational programs to develop clinical education initiatives and strategies can go a long way, as the evidence in Ontario has shown. Some examples for how additional funds could be used include:

- Travel and accommodation funds for programs to send students to rural and remote placements across Ontario;
- Distance-supervision methods (via skype, internet, etc.) for placement in rural and remote communities, to provide support for local clinicians in supervising students;
- Simulation scenarios for community-based and primary care;
- Rehabilitation-specific simulation equipment;
- Funds to maintain and repair high fidelity simulation equipment;
- Resources for further development of innovative clinical placement opportunities and models in community and primary care; and
- Funds to update and expand the centralized, online, Preceptor Education Program (PEP).

8.5 MOHLTC Oversight of HSPnet in Ontario
HSPnet provides a valuable service to Ontario hospitals, colleges and universities, as a web-based clinical placement communications and tracking system, and is becoming an increasingly significant source of data on clinical education as more agencies and postsecondary institutions adopt it. MOHLTC should consider taking over provincial oversight of HSPnet—including strategies for growth, cost recovery, use of data for provincial reporting and policy-making, and governance—in order to maximize the benefits of this system for clinical education and health care in the province, and align with HSPnet management practices in the rest of the country.

8.6 Extend needs-based forecasting to other health professions
The needs-based physician forecasting model developed by MOHTLC, now being extended to nursing, provides guidance as to the number and type of health care professionals that will be needed in the future. Such forecasting is essential in enrolment planning, and thus in optimizing clinical training resources for particular disciplines. MOHLTC needs to continue this important work for nursing and extend it to other health professions.

8.7 Recognize clinical education as part of preceptors’ continuing competency
Government and postsecondary institutions need to work together with regulatory bodies and professional associations to explore the possibilities of providing recognition for clinical education supervision as part of on-going licensure/registration or annual continuing clinical competency education.

9. The Costs of Doing Nothing
The lack of explicit incentives for clinical education of health science students in community, primary and long-term care will mean that students are not as well
prepared as they need to be to take up employment in these growing sectors, and may not be attracted to these sectors in terms of recruitment. The lack of a dynamic relationship between education, research and care will affect patient care. And the shortage of clinical placements means that many programs will not be able to grow to meet future health human resource demands.
1. The Crisis in Clinical Education
Like health care generally, clinical education of most health care professionals in Ontario has, until recently, taken place in acute care environments. Academic health science centres developed a formal mandate and received core government funding to support the teaching enterprise, and absorbed a large number of student placements. Clinical education in the community and long-term care sectors has taken place on a largely voluntary basis, with practitioners in the field supervising and mentoring students without a formal mandate or remuneration for this work.

Until the 1990s, this system of formal academic health science centres, combined with voluntary clinical mentoring in the community and long-term care sectors, worked well enough to produce the next generation of competent health care providers. This approach to clinical education is no longer working. As government and hospitals have sought to contain increasing costs of health care, as patient demographics have changed, with more elderly patients and patients with complex continuing conditions, as more care is shifted to the community, and as more health professionals are needed, the traditional model of clinical education has become stressed to the breaking point. In the rush to address changing patient needs and cost pressures, clinical education, particularly for nursing and rehabilitation sciences professions, has largely been left out of health system planning. ¹ As a result, the clinical education system is in a crisis, with a shortage of relevant, quality clinical education opportunities, inadequate capacity for schools to deal with the shortage, and more and more stress on schools, students and preceptors.²

2. Causes of the Crisis in Clinical Education
The crisis in clinical education can be understood in relation to three general factors: 1) restructuring of the health care system in a way that does not integrate clinical learning needs; 2) the growth in size and types of health professional educational programs to meet health system needs; and 3) robust regulatory and accreditation requirements for clinical education.

¹ This paper has a particular focus on nursing and rehabilitation sciences. Medical programs have grown significantly over the past decade, with accompanying clinical education challenges, but these challenges have been largely addressed through clinical education funding from the Ministry of Health and Long-Term Care (MOHLTC).

² The shortage of relevant, quality clinical education opportunities has become the chief policy issue facing university nursing and rehabilitation sciences programs in Ontario. No less than six policy papers have been written or commissioned by the Council of Ontario University Programs in Nursing (COUPN) and the Ontario Council of University Programs in Rehabilitation Sciences (OCUPRS) on the topic of clinical education since 2000. COUPN and the provincial heads of nursing at the community colleges in Ontario (CAATs) held two executive meetings in 2011 specifically on how to address this urgent issue. COUPN and OCUPRS submitted a research program Notice of Intent in 2012 for MOHLTC Health System Research Funds which proposed four projects, three of which were focused on adapting clinical education to new health system realities. COUPN and CAATs (the college programs heads of nursing) are working with the Canadian Association of Schools of Nursing on a national Task Force on Clinical Education. COUPN is working with the Joint Provincial Nursing Committee on a work group on education that has a major focus on clinical education. Clinical education has been the most prevalent topic of discussion at OCUPRS meetings.
2.1 Restructuring of the Health care System

For the past two decades, governments have been making efforts to contain increases in the costs of the health care system, while shifting the system to adapt to changing patient demographics and needs. Longer life expectancies, increase in chronic diseases, an aging population, increased understanding of factors contributing to health and disease, increasing technological capacities, citizen expectations for a robust public health care system, escalating costs, and other factors have driven health system restructuring. Aspects of this restructuring that have greatly impacted clinical education include the following:

- Since 1996, hospitals have been pushed to contain and reduce costs, resulting in patients being discharged earlier from hospital, closing of some hospitals, closing, privatization or outsourcing of rehabilitation services, greater overall acuity of care within hospitals, and changing staffing models.\(^3\)

- Greater emphasis on health care provision in the community, including homecare, community clinics, long-term care homes, and private rehabilitation therapy clinics;
  - In 1997, Community Care Access Centres (CCACs) were established as a one-stop centre for Ontarians to access home and community care and long-term care (LTC) homes. CCACs hold contracts with not-for-profit and for-profit agencies to provide nursing, personal support, and therapy services for their clients.

- The creation of 14 Local Health Integration Networks (LHI Ns) in 2006, which combine the functions of regional planning, integration and accountability for much of the health care system;

- A push towards greater interprofessional collaboration to better address the needs of the patient across the continuum of care, and to optimize practitioners’ existing scopes of practice;

- Expansion of newer primary care models, including Family Health Teams (FHTs) and Nurse Practitioner-led clinics;

- Greater emphasis on infectious diseases and pandemic planning;

- Health funding reform on initiatives, particularly Quality-Based Procedures (QBPs), which focus health funding on episodes of care according to clinical best practices, vs. the previous mechanism of providing global hospital funding and physician fee for service;

- An emerging “Senior’s Strategy” to address the issues facing this growing population.

These changes have generally had a positive effect on reshaping the health care system to respond to current and emerging challenges. However, changes have been implemented

\(^3\) For example, some hospitals are hiring greater proportions of diploma prepared Registered Practical Nurses (RPNs) relative to baccalaureate prepared Registered Nurses (RNs) as a way of reducing costs.
with little or no attention to their implications for the education of the next generation of
providers. As will be discussed in more detail below, the changes are having the following
implications for the clinical education enterprise:

- hospital cuts have reduced opportunities for clinical placements and put more strain
  on providers and schools in terms of fulfilling the clinical education enterprise;

- LHINs are almost entirely focused on Ministry of Health and Long-Term Care
  (MOHLTC) priorities, and have no mandate for clinical education;

- the nature of CCAC contracts with service providers inhibits those providers and
  agencies from offering placements for students and from reproducing the next
generation of providers;

- Interprofessional Collaboration (IPC), primary care, infectious disease, community,
  and seniors’ care emphases create greater education requirements for schools
  without the clinical teaching supports being put in place to address these
  requirements; and

- QBPs have meant that hospitals are redirecting their priorities away from teaching to
  fulfill their other obligations.4

2.2 Growth in Size and Types of Health Professional Programs
In response to provincial government initiatives and health care system needs and
demands, health professional programs in Ontario have grown tremendously in size and
type. This growth has greatly exacerbated the clinical education pressures caused by the
changes described above.

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4 The Council of Ontario Faculties of Medicine (COFM) recently raised this issue with the Deputy Minister of
Health.
2.2.1. Enrolment in Baccalaureate Nursing Programs

Source: Ministry of Training, Colleges and Universities (MTCU)
Note: Reflects total full-time enrolment in collaborative BScN programs; does not include part-time enrolments or Queen's University and University of Toronto stand-alone programs.

2.2.2. Enrolment in Practical Nurse Programs

Source: MTCU
Note: reflects total full-time enrolment; does not include part-time enrolment
2.2.3. Enrolment in Rehabilitation Sciences Programs (Audiology, Occupational Therapy, Physiotherapy, and Speech Language Pathology)

Source: MTCU
Note: reflects total full-time and part-time enrolment.

2.2.4. Other health professional programs

University programs for Medicine, Midwifery, Nurse Practitioners, Optometry, Pharmacy, Physician Assistants, and international bridging programs for various health science professions, have developed and/or expanded in Ontario. These, as well as other degree programs in community health science and public health, all have clinical education requirements that can overlap and create significant demands on health care teams.

Within colleges, the following health science programs have clinical education components (beyond the Personal Support Worker (PSW) and Practical Nursing programs discussed above):\(^5\)

- Communication Disorder Assistants
- Dental Assistant
- Dental Hygienist

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\(^5\) Colleges Ontario, “Improving Student Outcomes and Patient Care: Study of Clinical Education in Ontario’s Colleges of Applied Arts and Technology Health Sciences Programs: Final Report,” May 1, 2006.
• Denturist
• Diagnostic Cardiac Sonographer
• Medical Diagnostic Ultrasonographer
• Medical Imaging Technologist
• Medical Laboratory Technician
• Medical Laboratory Technologist
• Medical Radiation Technologist
• Nursing – Critical Care (Post-Graduate)
• Nursing – Operating Room (Post-Graduate)
• Occupational Therapy Assistant
• Paramedic
• Pharmacy Technician
• Physiotherapy Assistant
• Respiratory Therapy

All of the programs above have been developed and/or grown in close collaboration with MOHLTC in response to identified gaps in service provision, or to support more efficient provision of services. Overall, the growth in professional programs has created much greater pressure on the clinical education system, and has led to increased competition for placements, both intra and interprofessionally.

2.3 Robust clinical education requirements
Typically, approximately 50% of health professional education takes place outside of the classroom, in practice settings. Clinical education enables students to translate their knowledge of theories and principles into actual practice settings, and is fundamental to learning safe and effective practice. Standards set by professional regulatory colleges and educational accreditation bodies ensure that student clinical experiences are sufficiently robust and diverse for graduates to acquire the competencies they need to enter today’s health care system as safe providers. Educational programs must regularly adapt clinical requirements to changing health system realities and patient needs in order to ensure ongoing relevance and safety, and meet regulatory requirements.

2.3.1. Rehabilitation Sciences
Occupational Therapy (OT) and Physical Therapy (PT) programs have a standard of 1,000 to 1,025 clinical education hours. National PT guidelines list three specific

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areas of practice--cardiovascular and respiratory conditions, neurological conditions and musculoskeletal conditions--and three settings--acute, rehabilitation/long-term, and ambulatory care--in which the student must acquire “significant” clinical experience. Graduates of Ontario university programs in Audiology (AUD) and Speech-Language Pathology (SLP) require a minimum of 300 clock hours of direct, supervised clinical practice, at least 225 of which must be in the major professional area, with clients representing a wide range of problems. Graduates also require a minimum of 20 hours in the minor professional area (i.e., 20 hours of clinical work in SLP for AUD students).

Clinical education requirements are completed typically through three to six clinical placements varying in length from one to two-week intensive placements to those lasting two to three months. Community-based laboratories, simulated cases, and video-based teaching supplement these clinical education placements in the field.

In addition to the clinical practice requirements for professional education programs, AUD and SLP graduates must complete a mentorship period after graduation. These requirements create more demand on the mentorship system and exacerbate the shortages in clinical placements.

2.3.2. Baccalaureate Nursing

All graduates with a baccalaureate degree in nursing must meet the entry to practice competencies established by the College of Nurses of Ontario. To attain these competencies, schools require students to acquire robust clinical learning experiences in a breadth of settings, types of care, and types of client. Each provincial nursing regulatory body in Canada obliges baccalaureate nursing programs to provide students with direct practice experiences in “health promotion; the prevention of injury and illness; curative, supportive, rehabilitative and palliative care, including end-of-life care,” and “with clients of all ages and genders in a variety of settings.”

As well, because of the move to baccalaureate as entry to practice, there is a strong emphasis on community health in the curriculum, with accompanying placements that follow national guidelines.

In order to fulfill these requirements, nursing baccalaureate programs across Ontario typically require more than 1,000 hours of clinical education. Students have

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7 College of Audiologists and Speech-Language Pathologists of Ontario (CASLPO). “Guide for Initial Registration.”

8 Clock hours for Audiology and Speech-Language Pathology (SLP) degree requirements and registration will soon be moving to competency-based requirements, which will create some flexibility.

9 “National competencies in the context of entry level registered nurse practice,” (CNO 2008 updated).

10 Guidelines for Quality Community Health Nursing Clinical Placements for Baccalaureate Nursing Students http://www.casn.ca/vm/newvisual/attachments/856/Media/CPGuidelinesFinalMarch.pdf

11 In 2005, the Policy Department of the College of Nurses of Ontario (CNO) assessed all Ontario BScN and PN programs and averaged out the number of hours students spend in learning activities. BScN programs require 2367 hours, of which 50% are clinical, and 33% are theoretical.
placement experiences beginning usually with six hours per week in first year and intensifying until they are in placements 24-36 hours per week in their final year. Placements occur in a variety of settings throughout the years of the program and include long-term care facilities; rehabilitation and complex continuing care settings; small, medium and large acute care community and teaching hospitals; Public Health Departments; Community Health Centres; FHTs; Community Visiting Nursing agencies; and non-traditional community-based agencies. Simulated laboratories with high-fidelity mannequins as well as standardized patients (actors who pose as patients in lab based learning scenarios) supplement and prepare students for clinical placements in the field.

The above three factors combined—health care restructuring that does not consider or integrate clinical education needs, growth in size and types of health professional educational programs, and the robust nature of clinical education requirements—have created a crisis in the clinical education system. More and more education pressures are being placed on a health care system that is less and less prepared to absorb these pressures. At the same time, the province is extremely reliant on new health graduates to enter the workforce with the appropriate practical experience, in order to provide safe and competent care to patient populations.

3. Experiences of the Clinical Education Crisis

This section will illustrate how this crisis in clinical education is being experienced in baccalaureate nursing and rehabilitation sciences programs.

3.1 Nursing

3.1.1. More refusals of placements
One of the primary symptoms of the crisis in clinical education is that academic clinical coordinators experience more refusals in response to their requests for student placements with agencies. An analysis of the major database for clinical placements for nursing in Ontario, Health Sciences Placement Network (HSPnet), bears this experience out. The 2009-10 academic year data show that, for every 13 placement requests accepted by a receiving agency, there was one declined. By 2012-13, for every three placements accepted there was one decline. This is a four-fold increase in the number of declined placement requests in just three years. In response to these refusals, postsecondary clinical coordinators must seek elsewhere to place their students.

3.1.2. Increased instructional costs to schools for hospital placements
As hospital stays for patients become shorter and more procedures are conducted on a day-surgery or out-patient basis, patients staying in hospitals tend to have more serious conditions than in the past. As a result, there are fewer patients in hospitals, and fewer clinical practice opportunities. Furthermore, patients who are in hospitals require more complex care. Consequently, nursing students require more support and closer supervision in working with these patients. This means that clinical practice

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sites often accept smaller groups of nursing students than in the past, and that nursing faculty must spend additional time providing supervision. Since nursing faculty accompany students in groups to the hospital, the smaller the size of the groups, the more groups that must be formed, the more clinical faculty that must be hired, and the more expensive the enterprise becomes for the university.13

3.1.3. Shortage of types of hospital placements
The reduced lengths of stay in hospitals have also created shortages of certain types of placements. A good example of this is maternal-newborn care. In the past, new mothers would spend a week in hospital after the birth of their child, providing opportunities for students to interact with them. Currently, length of stay for new mothers and babies has been reduced to one to two days on average. Consequently, only a small percentage of nursing students have direct exposure to these types of patients. Shortages also exist for placements with children in acute care settings, and for mental health/illness placements.14

3.1.4. Reduced availability and burnout of hospital-based RN preceptors
Some hospitals in recent years have shifted the patient care model—with fewer Registered Nurses (RNs) being employed in favour of diploma-prepared Registered Practical Nurses (RPNs). This phenomenon has been a result of hospital efforts to reduce staffing costs, in response to government cuts to hospitals.15 The overall cuts to nursing positions and the resulting increase in patient-to-RN ratio (each registered nurse being responsible for more patients) have decreased the number of RNs in hospitals,16 and consequently the number of preceptors available to students. Moreover, as older nurses retire, the number of experienced preceptors available to provide student education and supervision decreases. The increasing pressures for preceptors due to educational program growth and year-round demands for preceptors can also lead to preceptor burnout.17

13 In nursing BScN programs, almost half of the time is spent in clinical courses in which small groups of six to eight students are supervised directly in a clinical agency by an instructor employed by the School of Nursing. The number of clinical instructors required far exceeds the number of faculty in the Schools of Nursing; hence schools tend to hire multiple clinical instructors on a contractual basis annually. This takes up most of their clinical education budgets, and leaves less opportunity for building up new learning opportunities for students or exploring innovative approaches to learning.


17 Ryan-Nicholls, Kimberley D. Preceptor recruitment and retention: The preceptor partnership is the most effective means of ensuring that students integrate professional theory with clinical practice, but a growing lack of nurse preceptors may threaten the process.. The Canadian Nurse 100(6), June 2004.
3.1.5. Shortage of home care placements
Ontario’s Action Plan for Health care has placed a priority on care at home over care in hospitals and long-term care settings, where this is possible. Although schools have sought to reflect this in their curricula, a number of challenges have been encountered. Publicly funded homecare is provided by agencies that hold contracts with CCACs. Neither these agencies nor CCACs have a mandate for clinical education. Home health care nurses are not compensated for taking students, and this is not recognized in the performance management system that CCACs have recently adopted in relationship to agencies. As a result of these barriers, some university schools of nursing report that less than 10% of their students have placements with homecare nurses. This inhibits recruitment to a field of practice that requires well-prepared and skilled, independent graduates.

3.1.6. Shortage of CCAC placements
RNs play an important role for CCACs in patient assessment and navigations. In spite of this, it is difficult for schools to acquire placements for students to be mentored into these roles. CCACs do not have adequate resources to facilitate RNs to take students on placement. At the same time, they increasingly need new graduates to have clinical experience in that setting in order to fill their health human resource needs. Hence the shortage is experienced by both the school, in not being able to place students in CCACs, and the agency, in not being able to recruit job-ready graduates.

3.1.7. Shortage of public health placements
Public health placements are important for baccalaureate nursing students to develop competencies related to health promotion, prevention, and population health. Yet university clinical coordinators encounter a similar problem with public health nursing placements as they do with home health and CCAC placements: agencies do not have a mandate to provide education and there is a shortage of such placements. New graduates may not be well-prepared in the practice of health promotion and disease prevention as a result of these deficiencies.

3.1.8. Shortage of primary care placements
RNs play an important role in primary care settings, including FHTs, Community Health Clinics and Nurse Practitioner-led clinics. Primary care placements thus represent potential opportunities for baccalaureate nursing students to develop a

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18 As reported by a November 2012 focus group with academic clinical educators in Ontario university nursing schools.

19 Community Care Access Centres (CCACs), who are seeking to hire considerable numbers of nurses with the growth in their mandate, are reluctant to hire new graduates who do not have enough experience in this setting. Yet they cannot find enough experienced nurses to fill the positions. (Interview with a CCAC leader fall 2012).


21 November 2012 focus group with academic clinical educators in Ontario university nursing schools.
range of entry-to-practice competencies. With limited resources, however, instead of a primary care setting taking a BScN student, they often prefer to accept a student from an educational program able to pay stipends, such as NPs, family physician residents and physician assistants.

3.1.9. Shortage of appropriate mentorship in community health placements

In face of the shortages described above, schools have turned to development of non-traditional community placements with agencies or groups that do not deliver health care as their primary mandate, for example in shelters, daycares, schools, and so on. Some university schools of nursing report 75-90% of their community placements as being non-traditional. These placements provide positive outcomes for students in terms of learning about community development, justice, equity, and program planning and evaluation. In many cases, however, there is no specific RN role in the setting, and the students may be non-nurse mentored. As a result, they are not exposed to the specific role and scope of an RN in these contexts.

3.1.10. Challenges with long-term care placements

As the complexity of patients has increased in long-term care settings, the role of the RN has become more complex. RNs now work at a supervisory level with RPNs and PSWs, who provide the supportive, hands-on care. Many schools now place students in these settings in senior years in order to reflect this reality. However, there tends to be only one RN per floor or unit per shift, the RN holds a wide degree of responsibility, and mentoring a student can be challenging for already overburdened staff. In addition, schools find it difficult to find the volume of placements needed to address the growing needs in this sector.

3.2 Rehabilitation Sciences

The restructuring of the health care system has also had a profound impact on professional rehabilitation sciences programs in terms of clinical education. In a 2010 survey of university academic clinical coordinators in the rehabilitation sciences, layoffs and

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23 As reported by members of a 2012 nursing focus group.


26 Interview with Gina Marasco, Manager, Central Placement Office, Daphne Cockwell School of Nursing at Ryerson University, Ryerson, Centennial, George Brown Collaborative Nursing Program, Ryerson Central Placement Office, March 2013.
Restructuring were most widely cited as a new barrier to finding clinical placements compared to the past, particularly for OT and PT. This manifests itself in various ways, as described below.

3.2.1 Shortage of hospital placements
In rehabilitation sciences, hospital cost-cutting measures have often meant reduction, elimination, or privatizing of hospital-based rehabilitation services, the last through contracting out or creating internal, for-profit subsidiary clinics. Subsequently, existing clinicians have a high caseload. Often, hospitals do not have any budget to replace therapists on maternity leave, and the caseload increases even further. In addition, more clinicians are working irregular hours, part-time hours and in multiple settings.

These working conditions make it much more difficult to incorporate a student, or for students to receive continuity of supervision. Therapists are overtaxed and more likely to refuse requests to take on a student. As a result of these factors, schools have found that fewer placements are available in hospitals compared to in the past, and that there are shortages of placements, particularly in cardio-respiratory and adult neurology.

3.2.2 Financial costs to students
Students face multiple challenges related to the reduction in clinical placements in larger, acute care hospitals. They may be sent farther afield, to community hospitals, in order to meet their requirements. This can require last minute moves with associated financial costs. It also may impact employment possibilities upon completion. Some coordinators report that students have had to delay placements due to the shortages, which also has significant financial costs.

3.2.3 Shortage of placements in community-based therapy
Rehabilitation therapists, while they might entail cost savings for the health care system in the long run, have been greatly reduced through the CCAC system in favour of PSWs who can assist with immediate homecare needs, as well as through the partial de-listing of community-based physiotherapy from OHIP in 2004.

In addition to there being few therapists in the publicly-funded, community-based system, those therapists that do practice in this sector are not recognized for taking

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students, and are subject to a performance management system that does not acknowledge or promote clinical education. Supervision of students, particularly junior students, requires additional time, slows down the provision of care, thereby taking longer to treat patients. Practitioners who agree to act as preceptor for a student often carry the same workload as that of non-preceptors. This negatively influences a clinician’s desire to be a preceptor or clinical educator. A 2012 survey of university clinical coordinators in Ontario rehabilitation professional programs showed that most relied on CCAC-funded practices for 10% or less of their total student placements.

3.2.4 Shortage of placements in private practice settings
A major response to the overall reduction in publicly funded rehabilitation services has been an increase in private practice in these fields. This has been facilitated by the fact that, in the 1990s, it became legal in Ontario for physiotherapists to see patients outside of hospital without a medical referral. In addition, gradual shifts in private insurance have allowed for PT, Audiology, massage and chiropractic services, among others, to be accessed without a medical referral. Hence these therapies have been able to thrive in private practice settings.

The effect on clinical education of the increase of private practice as the mode of delivery for rehabilitation therapy is similar to the situation for agencies that hold contracts for service provision through the CCACs. Agencies do not have a formal mandate for teaching, and operate on a tight cost margin. Consequently there are built-in disincentives for providers to take students. While physiotherapy in particular has had some success in building up student placement opportunities in private practice, it remains challenging for educational programs to provide enough such placements to meet student needs. As well, private practices cannot always predict how many patients or what kinds of patients they will be serving when the student placement is anticipated. This means that they cannot always guarantee the kind of placement or intensity of client contact that a student will need.

3.2.5 Shortage of placements with school boards
Parallel with the above have been the substantial program cutbacks by school boards throughout the province, which have significantly affected SLP, AUD and OT placements. Cutbacks have resulted in fewer non-teaching staff/ancillary support staff being retained on a salaried basis; many work in a consultative fashion only. At certain times these clinicians may have relatively little contact with children, interacting only with teachers, special educators and educational assistants. While having a placement with such a clinician can be excellent experience for students, it does not always allow the students to fulfill their ‘direct’ assessment and intervention hourly requirement for licensing and registration. Additionally, it is often difficult for beginning clinicians to contribute in these consultative placements when they have not yet had sufficient experience working directly with the children themselves.

The other related challenge is that clinicians are often moving to several schools throughout a single day. The coordination of the student’s availability in conjunction with the SLP or OT schedule might mean that the student would spend more time in transit than in actual clinical work. It also assumes that students have access to a car to visit rural schools.
3.3 Across Disciplines

3.3.1. Increased administrative costs
Increasing requirements have been placed on nursing and rehabilitation therapy schools for the administration surrounding clinical placements, for criminal record checks for students and, in some cases, for student training on electronic documentation systems used in hospitals. In addition, programs have invested in different clinical placement tracking and communication systems (discussed in Appendix A) in order to respond to the growth in the size of programs and the growing complexity of the clinical education enterprise. As well, the shortage of experienced preceptors requires universities to provide increased resources in terms of faculty time, support, and ongoing orientation for the professional development of junior nurses and rehabilitation therapists who are being called upon to take on preceptor roles across the continuum of care.

3.3.2. Competition for placements
An unfortunate symptom of the shortages in clinical education opportunities has been increasing competition amongst universities, colleges and disciplines for access to placements. Institutions sometimes seek to ‘lock-up’ sites for their students through affiliation agreements. This pits one institution against another and creates inequalities in student access to placements across the province. Within nursing, competition for placements exists between BScN and PN programs, even between some universities and colleges that offer the BScN program collaboratively. Within rehabilitation sciences, formal catchment area boundaries have been created in order to manage competition. However, these boundaries are historical, and schools are challenged to find agreement regarding how to adapt boundaries to shifting demands and inequities of access. While there are concerted efforts amongst placement coordinators and program leaders across the province to work together to accommodate student needs, the underlying problem of shortages continues to exacerbate competition.

3.3.3. Lack of opportunity for placements in emerging care models (tele-practice)
While many Ontario hospitals have received financial incentives to recruit and train tele-health nursing coordinators to deliver services and care via technology, there have been no incentives for these newly funded positions to integrate a teaching role. Consequently, academic clinical coordinators have been unable to secure placements with these providers. New graduates, particularly nurses and rehabilitation professionals, need to be adequately prepared for this emerging role in the health care system.30

4. Current Approach to the Crisis
In the past, MOHLTC played an active role in ensuring that hospitals and other health care delivery bodies were mandated and equipped to work in partnership with universities and colleges to train the next generation of health care providers. As a result of the restructuring of

30 http://otn.ca/en/programs/tm-lhin-nurse-program
the health care system, MOHLTC and hospitals have increasingly devolved responsibility for nursing and rehabilitation sciences clinical education onto the shoulders of the universities and colleges delivering the educational programs, who are asked to adapt education to the changing health care system, often with project-specific resources from government.

Schools have risen to the challenge, using multiple approaches to try and address the increased need for clinical education associated with rising enrolments and the changing health care system. Appendix A outlines in detail the initiatives to date that nursing and rehabilitation sciences programs have undertaken, in most cases with government supports. These initiatives include:

- intensification and streamlining of placements;
- preceptor recognition and capacity-building;
- rural and remote placements and technology to support this;
- faculty support to develop new clinical education sites;
- development of “innovative placements” outside of traditional agencies;
- interprofessional education placements;
- development of clinical education databases;
- clinical simulation;
- northern placements;
- summer placements; and
- long-term care homes as centres of learning, research and innovation.

5. Limits of the Current Approach

5.1 The limit faced by postsecondary institutions

In spite of the tremendous work undertaken by postsecondary institutions, with targeted investments by government, to adapt clinical education to the changing health care system, the crisis in clinical education remains. Restructuring of the health care system has reduced and, in many cases, eliminated placement opportunities. Government has encouraged and sometimes mandated postsecondary institutions to increase the size and number of educational programs. Accreditation and regulatory bodies require ongoing, rigorous clinical education requirements across an expanding continuum of care in order to maintain patient safety. Postsecondary institutions have risen to the challenge, and put increasing resources and innovative practices into developing more and more diverse placements for an expanding population of students. But they have reached the limit of what they can reasonably accomplish within the existing approach.
5.2 MOHLTC must recognize clinical education as integral to the health care system

The responsibility to ensure that the health system appropriately accommodates clinical education in order to address the health human resource needs of the province has always rested with MOHLTC. MOHLTC fully recognized and accepted this responsibility when it built clinical education compensation into teaching hospital funding formula to ensure that placements are available. As well, it provided funds for various initiatives discussed above. Yet this has not been enough.

The major limit in current MOHLTC approaches to clinical education has been a lack of recognition of clinical education of all health professions as integral to the functioning and development of the health care system, and as an essential component in health system transformation initiatives. As MOHLTC moves towards patient-based funding for hospitals and community care, provider agencies are turning their attention to meeting these outcomes and providing these services as directed. To date, clinical education has not been integrated into the new funding approaches, even though it is central to health human resource planning and is highly measurable. It is rather an afterthought, or something that follows upon other, apparently more important, system reforms.

Unless clinical education is integrated into performance measurement, it will continue to be sidelined as agencies and LHINs struggle to respond to other pressures that are given higher priority.

5.3 The limit faced by MTCU

The Ministry of Training, Colleges and Universities (MTCU) Basic Income Unit (BIU) funding does not include any consideration for clinical placements. MTCU clinical education grants were developed in response to the Rae Report, Ontario: A Leader in Learning, which recognized, among other things, the significant and increasing costs associated with delivering clinical education for postsecondary educational institutions. The clinical education grants have been essential in helping schools to maintain the clinical education components of their programs. These MTCU funds were not intended to replace MOHLTC’s over-arching responsibility for clinical education. They were rather a stop-gap measure provided when Reaching Higher funding became available, in recognition of the huge deficit that schools were incurring in running clinical education programs. Furthermore, the amounts allocated address this deficit only partially, and the funds remain fixed, without being indexed to inflation or program growth. As a result, the funds are increasingly inadequate for schools to address the issue. They are essential for addressing some clinical education challenges. They cannot facilitate further adaptation, expansion or improvement.

6. Approaches to the Crisis beyond Ontario

The clinical education crisis is not unique to Ontario, and has been a topic of research and discussion across Canada and internationally, with examples from Australia, the UK, and the USA, as well as Canada more broadly. In many respects, the literature advocates similar approaches to those that have already been adopted in Ontario, including:

1. preparing students for placement prior to their going into the field, through standardized testing in a nursing lab environment, clinical preparation modules for rural environments, and appropriate course sequencing to ensure the academic subject matter has been taught prior to the student going into the placement in that area;
2. faculty from the nursing school providing preceptor support and education;
3. innovative clinical placements such as community support groups, schools, rural areas, inner city, corrections/forensics, role-emerging, university-based clinics, university-developed wellness programs, and international placements.

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32 This section was written with assistance from two literature reviews prepared respectively by the University of British Columbia Department of Nursing and the Canadian Association of Schools of Nursing (CASN) for its Task Force on Clinical Education.


38 Huddlestone, R. (1999). Clinical placements for the professions allied to medicine, part 2: placement shortages? Two models that can solve the problem. British Journal of Occupational Therapy, 62(7), 295-298; Occupational therapists refer to role emerging sites as those where an OT could be placed, as the OT could have a potentially important role with good learning opportunities in the setting, but where there is not an OT on staff to supervise. Nursing also makes use of such non-traditional sites in community settings, as noted above.

4. interprofessional collaboration placements;\textsuperscript{41}
5. greater use of simulation in the form of standardized patients,\textsuperscript{42} high fidelity mannequins,\textsuperscript{43} DVD and other e-based simulations;\textsuperscript{44}
6. greater flexibility in learning models, for example allowing students to work evening, night and weekend shifts, allowing BScN students to be precepted by diploma nurses, student placements in long-term care centres at an expanded scope,\textsuperscript{45} placing 2\textsuperscript{nd} and 3\textsuperscript{rd} year students in critical care and intensive care units,\textsuperscript{46} and patient pathway models where the student follows a patient throughout their trajectory of care;\textsuperscript{47} and
7. centralized faculty resource and clinical placement centers.\textsuperscript{48,49}

These practices and recommendations affirm the approaches that have been taken in Ontario, and show that Ontario schools are at the leading edge in terms of implementing recommended strategies to address clinical placement shortages.

Beyond these recommendations, other approaches outlined in the literature that are instructive for Ontario, but that would require government support, include the following:

1. Australia has implemented a national, coordinated, and multi-pronged approach to clinical education reform for all health professionals.\textsuperscript{50} Importantly here, in initiating


\textsuperscript{46} Ballard, P., & Trowbridge, C. (2004). Critical care clinical experience for novice students: Reinforcing basic nursing skills. Nurse Educator, 29, 103-106. Currently being done in Ontario, although many wait until the students are in 4\textsuperscript{th} year to place them in these settings (email survey with COUPN UG, Feb. 2013).


\textsuperscript{49} Ryerson has implemented a central clinical placement office that places all BScN students for its collaborative partnership with George Brown and Centennial, as well as its other nursing programs. The Preceptor Education Program (PEP) discussed earlier constitutes a centralized resource, as does HSPnet. Further work can be done in these areas, but limited resources are a barrier.

\textsuperscript{50} http://www.hwa.gov.au/work-programs/clinical-training-reform
this approach, the Council of Australian Governments identified clinical education reform as “an important plank in national health reform.” By linking clinical education to health care reform, they have thus overcome the central limitation of Ontario’s approach to clinical education.

2. financial and organizational collaboration that allows a preceptor to be given a reduced workload;  
3. various models, wherein a dedicated clinical teacher is located in the agency setting to attend to teaching and teaching-related issues—variously referred to as a “resident clinical teacher,” a “clinical teaching fellow,” and a “practice placement facilitator,” and
4. a clinical placement consortium, wherein faculty at several schools work together with major health care agencies to coordinate placements across multiple partnerships, in order to foster collaboration and cut down on the intense competition amongst schools and across programs for clinical placements.

7. A Vision for Clinical Education in Ontario

Clinical education must be recognized as an integral part of the health care system and health system transformation. Where this is the case, hospitals, CCACs, community agencies, schools boards, public health units, primary care providers, and long-term care homes explicitly partner with post secondary educational programs in educating the next generation of health care providers, and are facilitated in doing so by government. Students, their professors and clinical instructors are not seen as a burden on health care agencies, but as an essential aspect of a dynamic environment involving researchers, learners, practitioners and patients, which develops

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52 Ibid.


55 Clarke, C.L., Gibb, C.E., & Ramprogus, V. (2003). Clinical learning environments: an evaluation of an innovative role to support preregistration nursing placements. *Learning In Health & Social Care, 2*(2), 105-115. See Appendix A of this paper—one nursing school has an approximation of a clinical placement facilitator to manage the multiple groups that go on placement and ensure continuity of learning outcomes.

56 Kline, K., & Hodges, J. (2006). A rational approach to solving the problem of competition for undergraduate clinical site. *Nursing Education Perspectives, 27*(2), 80-82; Australia’s Integrated Regional Clinical Training Networks (IRCTNs) are another example of this approach. The IRCTNs are currently being implemented and are a key initiative in their clinical education reform http://www.hwa.gov.au/sites/uploads/mapping-clinical-placements-irctn-report-pwc-pkpa-hwa-20110308.pdf

57 The notion of a clinical placement consortium is a good one, and is currently being explored by dietetics programs in Ontario. However, it goes against the current model and incentive structures which rely on local school placement coordinators building relationships with agencies to place students from their own postsecondary institution.
the health human workforce and drives quality care. Students are acculturated into the new ways of thinking and practice through classroom and clinical experience. Practice environments integrate the teaching mission and forge dynamic relationships between research and practice. Stimulating, rewarding work environments assist in recruitment and retention of health care professionals. Better learning environments for students improve graduation rates and integration into the health workforce, reducing overall attrition and loss of investments. Patient care is improved.

8. Recommendations
In order to build on the strengths of Ontario’s approach to clinical education, address the limitations outlined in this paper, and move towards the vision articulated above, a number of measures need to be implemented.

8.1 Include clinical education in performance measurement across the continuum of care
Perhaps the most significant gap in Ontario’s approach to clinical education is the failure to recognize agencies and practitioners in community-based care who take on this vital task. Clinical education must become one of the activities in the community sector that is measured and reported to funders, as part of the formal accountability process. This will mean identifying performance outcomes for clinical education as part of Ministry-LHIN Performance Agreements, so that LHINs will build clinical education requirements into their accountability agreements with CCACs, long-term care homes, community health centres, and other LHIN-funded agencies. Government will also need to institute this recognition system for public health units, primary care agencies and school boards, in order that these agencies have the incentives to facilitate clinical education and build a culture of mentorship. Such an approach will not entail extra expenditures of funds by government, and will create a workable incentive structure.

8.2 Build clinical education into hospital funding reform
As has been noted above, hospital restructuring and the increasing complexity of the patients being cared for in the health care system have placed a much greater strain on the clinical education enterprise. The new funding formulas for hospitals need to integrate and bolster the teaching mandate in these institutions, so that hospitals are recognized and rewarded for continuing this important activity in the face of more and more clinical education demands. Such recognition can assist educational programs and hospitals to support student learning in the face of the growing complexity of care, and the need to create distinct clinical learning opportunities for full scope of practice. Such recognition can also be used to break down competitive territoriality in the clinical education of students by recognizing hospitals for taking students from multiple learning institutions and ensuring equity of access to placements.

8.3 Further develop and expand the number of long-term care homes as centres of learning, research and innovation
The piloting of three long-term care homes as centres of learning, research and innovation needs to be expanded across Ontario and made continuous, in order to help develop this sector in a way that can address the needs of the aging population.
8.4 Targeted funds for clinical education initiatives

The multi-faceted and innovative activities being undertaken by schools to expand relevant clinical placement opportunities across the province indicate what they can do when they have even small amounts of funding available to them. Targeted government funding for educational programs to develop clinical education initiatives and strategies can go a long way. Some examples for how schools could use such funds if they were available include:

- Travel and accommodation funds for programs to send students to rural and remote placements across Ontario, similar to what is already being done for rehabilitation sciences students through NOSM, would facilitate more placements of this kind, and serve as an important recruitment and retention tool for these areas;\(^{58}\)

- Further development of distance-supervision methods (via skype, internet, etc.) for placement in rural and remote communities, to provide support for local clinicians in supervising students;

- Pilot longitudinal integrated clerkships or practicum for rehabilitation sciences and nursing students, building on the success of this new model of distributed education in medicine. In this model, the student spends extended time--up to eight months--in a clinical setting or community away from the home university setting, with funds used to enable the student to stay connected to the home university for academic sessions through learning technologies and videoconferencing, and with innovative teaching tools like synchronous case studies and Virtual Academic Rounds.\(^{59}\)

- Further development of simulation scenarios for community-based and primary care. Much simulation has focused on acute care contexts; the potential for community-based and inter-professional scenarios has not been fully explored;\(^{60}\)

- Creation and evaluation of rehabilitation-specific simulation equipment. The current supply of nursing mannequins do not necessarily work for rehabilitation scenarios; consequently the potential for simulation in rehabilitation sciences has not been as fully realized as it has for nursing;

- Funds to maintain and repair high fidelity simulation equipment have been identified by the Council of Ontario University Programs in Nursing (COUPN) as important to sustain current investments;

- Resources for further development of innovative clinical placement opportunities and models in community and primary care, as well as non-traditional health care

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\(^{58}\) Recent research in physiotherapy clinical education shows that there are areas of the province that are not as highly used for placements. Norman, Kathleen, et. al. (2013). Physiotherapists and Physiotherapy Student Placements across Regions in Ontario: A Descriptive Comparison, Physiotherapy Canada, 65(1):64-73. These areas represent a potential area for expansion of clinical education, if sufficient travel funds were available for students and schools to access them.

\(^{59}\) This point is based on text and ideas provided by Sue Berry and Marion Briggs at the Northern Ontario School of Medicine (NOSM).

\(^{60}\) This gap was identified by a COUPN-CAATs simulation work group in 2012.
sites such as schools boards and “role-emerging” sites. Such placements expand the clinical placement field but tend to be resource-intensive to develop;

- Funds to update and expand the Preceptor Education Program will keep it current with emerging trends and evidence, and ensure an ongoing broad audience to help foster a culture of mentorship. It will also help avoid an inefficient, siloed approach to preceptor education across the province.

8.5 MOHLTC oversight of HSPnet in Ontario
HSPnet provides a valuable service to Ontario hospitals, colleges and universities, as a web-based clinical placement communications and tracking system, and is becoming an increasingly significant source of data as more and more agencies and postsecondary institutions adopt it. With the expansion of HSPnet, COU is at the limit of its capacity to manage this clinical placement system for all colleges, universities and receiving agencies in Ontario. MOHLTC should consider taking over provincial oversight of HSPnet from COU, in terms of strategies for growth, cost recovery, use of data for provincial reporting and policy-making, and governance. MOHLTC management would enable maximization of the potential benefits of HSPnet for clinical education and health care in the province. It would also align MOHLTC with HSPnet administrative practices in the rest of the country.

8.6 Extend needs-based forecasting to other health professions
Health education professional programs need guidance from a health systems planning perspective in terms of how many students to enroll and graduate. The needs-based physician forecasting model developed by MOHTLC, now being extended to nursing, provides guidance as to the number and type of health care professionals that will be needed in the future. Such forecasting is essential in enrolment planning, and thus in optimizing clinical education resources for particular disciplines. It also ensures that graduates will find employment in fields they have been trained for, and that patients and populations will have the care providers that they need. MOHLTC needs to continue this important work for nursing and extend it to other health professions.

8.7 Recognize clinical education as part of continuing competency for preceptors
Government and postsecondary institutions need to work together with regulatory bodies and professional associations to explore the possibilities of providing recognition for clinical education supervision as part of on-going licensure/registration or annual continuing clinical competency education. Further research on the relationship between mentoring students and maintenance of competency also needs to be conducted in support of such an approach.

9. The Costs of Doing Nothing

9.1 Limits on student preparedness
Current students in nursing and rehabilitation sciences are trained to be generalists, so that they are competent to take up employment across a wide range of sectors, practice areas, and service delivery where they may be needed. Clinical education requirements reflect this. In nursing, many schools have already had to compromise on clinical placements in some practice areas where it is impossible to find placements for all students, such as maternal
newborn care and children and youth. In rehabilitation sciences, not all students acquire placements that are synchronized with their classroom education, and so learning is not always optimally timed. The challenges of finding quality clinical learning opportunities in community care have already been reviewed above. Given the existing challenges, growth of the community and long-term care sectors *without* development of an educational mandate for these sectors creates a strong risk that graduates will not be adequately prepared to take on employment here.

### 9.2 Poorer patient care
At the same time as community, long-term, and primary care sectors grow, these sectors need to recruit more nurses, rehabilitation therapists, and other providers. Hence there will continue to be inadequate numbers of qualified care providers to meet patient needs, even though more resources are being put into the system. Furthermore, the innovations in care that are fostered by strong relationships between academia and practice will be less prevalent and have slower uptake.

### 9.3 Limits on program growth
The shortage of quality clinical placements is the single major barrier to further expansion of nursing, rehabilitation sciences, and other health professional programs. Without addressing the crisis in clinical education, further growth may be impossible. Given the aging population, the long-term implications of such limited growth in the professional programs may become a critical issue.
Appendix A: Initiatives to date in nursing and rehabilitation sciences in response to the clinical education crisis

1. Intensification and streamlining of placements
   Nursing schools continue to rely heavily on hospital placements to meet students’ clinical education needs. To do so, they have intensified these placements, working with hospitals to have placements in the evenings and in some cases on weekends, in order to accommodate the large numbers of students who require education in this setting.61

   Many educational programs have also streamlined placements through adapting curricular requirements, for example through changing the sequencing of courses, reducing the number of placements and extending the length of each one, focusing more on using simulation to prepare students for placements, and positioning placements within the program to optimize learning outcomes.62

2. Resources for developing clinical education in rehabilitation sciences programs
   In 1994, MOHLTC provided $1M for rehabilitation sciences programs to develop resources to assist in the development and enhance the quality of clinical placements. Over the next four years, 25 projects were completed with these funds. These included the development of resources for expanding clinical placement opportunities, for establishing new models of supervision, clinical education support materials, and a database for matching and tracking students on clinical placements (see Appendix B for a full list of these resources).

   Many of these resources continue to be used, or became the foundation for further development of resources and clinical placement opportunities described below.

3. School initiatives supported by MTCU clinical education grants
   One of the most significant steps forward for clinical education in health science programs came as a result of the Rae Report in 2005. The Rae Report, Ontario: A Leader in Learning, recognized, among other things, the significant and increasing costs associated with delivering clinical education for postsecondary educational institutions. In Reaching Higher,” the government response to the Rae Report, government acknowledged the important contribution that clinical education plays in the preparation of competent health professionals and the deficit that postsecondary institutions are incurring for these programs. Through Reaching Higher, the government announced funding for clinical education for the next five years. Approximately $56.3M over 5 years (from 2005 to 2010) was identified for health science programs other than medicine ($200,000 for 2005-06; $6.7M for 2006-07; $11M for 2007-08; $9.4M for 2008-09; and, $29M for 2009-10). A subsequent COU report calculated the deficit incurred by university health science programs

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61 In a 2012 survey of university nursing schools, all 14 reported using evening shifts for their undergraduate programs and three of the 14 reported using weekend shifts. Several others anticipate that they may use weekend shifts in future.

62 An excellent example of this latter is nursing BScN programs moving long-term care placements from first year to fourth year so that students can get exposure to a broader scope of RN practice and integrate their acute care and other knowledge to the long-term care environment, also making it more likely that the students would be interested in employment in this sector upon graduation.
for clinical education in 2005-06 to be nearly $67M,\[^{63}\] nearly $26M of which was for nursing and nearly $7M of which was for rehabilitation sciences.\[^{64}\] The MTCU funds have partially alleviated the deficit, and have been critical for maintaining the clinical education enterprise and helping schools to adapt to new health system realities and patient needs.\[^{65}\]

a. Initiatives in rehabilitation sciences programs

In rehabilitation sciences, some universities work with their clinical partners in the field to determine priorities for the use of the MTCU clinical education funds. Overall, funds are being used to: 1) offset some of the costs of preceptor education, support and recognition activities; 2) support some students in placements in underserved rural and remote areas; 3) enhance technology for remote supervision for students and support for students and preceptors in these placements; and 4) support faculty to develop innovative placements.

i. Preceptor recognition and capacity-building

Most of the MTCU funds have been allocated to preceptor support and capacity building. Preceptor support includes the payment of honoraria of $50/week/student to a preceptor’s employing agency. The sum of money received is not enough to reimburse clinicians’ time, but does provide funding to contribute to continuing education or professional development activities. The honoraria help prevent decline in the number of internships consequent to constraint in hospital budgets, and increase the awareness and profile of rehabilitation sciences in the institutions that are receiving the money.

Academic clinical coordinators have almost universally received positive feedback about the honoraria payments from their clinical partners.\[^{66}\] The payments represent an important mode of recognition for the work that is done.

In addition to this modest financial recognition, schools also provide other forms of recognition, education, and support to strengthen the relationship between the university and clinicians in the field. A 2010 OCUPRS survey of academic clinical coordinators, along with MTCU reports on the use of the clinical funds, list various methods for such recognition:

- Preceptor newsletter
- Site visits by the academic clinical coordinator
- Annual recognition award to single preceptors and teams of clinicians

\[^{63}\] This figure does not include medicine.

\[^{64}\] COU, Clinical Education Project Report, prepared for the Ministry of Training Colleges and Universities, 2007.

\[^{65}\] Information for the following section is derived from the annual university reports to MTCU on the use of the clinical funds.

\[^{66}\] Survey of Academic Coordinators of Clinical Educators (ACCEs) at all professional rehabilitation programs in Ontario, 2010.
• Preceptor conference/workshops
• Certificate of appreciation/recognition
• Journal
• Dinner with motivational speaker
• Lunches at the clinical site, sometimes combined with lectures or workshops
• Preceptor annual letters
• Small token gifts
• Opportunities to provide guest lectures
• Opportunities to grade student evidence-based research projects
• Professional Associate/Adjunct status with library access, including electronic and remote literature resources, status appointment
• Thank-you letters to upper management in facilities where students are placed so that they are aware of the professional stewardship role actively assumed by their professionals

Generally, the recognition methods are well-received by preceptors.67

ii. Rural and remote placements
Many facilities in smaller rural areas offer student placements; however, students have often been unable to accept these placements in the past due to the prohibitive costs of travel and accommodation. MTCU clinical grants have been used to offset student travel and accommodations costs, and for student supervision, and thus have enabled students to gain valuable clinical experience at these sites. These placements also have the potential of facilitating recruitment of therapists to practice in more rural and remote settings, an ongoing issue for health care services in Ontario.

iii. Remote supervision and support
Some MTCU funding has been directed towards technological enhancements that enable connections between universities and students and preceptors further away. For example, one university used funds to expand pod casting capacity for clinical education workshops/conferences/symposia to remote facilities for all their rehabilitation sciences programs. Another is enhancing a classroom by installing a video conferencing system so that off-site clinicians can participate in seminars/conferences/meetings, etc. Videoconferencing and web conferencing also allow clinicians practicing remotely to participate in Rehabilitation Rounds, invited lectures, clinical education workshops, clinical education meetings and department meetings. They also enable clinicians to present patients to students from a distance. This interaction is thus achieved without added costs for travel to sites.

iv. Faculty support to develop new clinical education sites
A further use of clinical education funds in the rehabilitation sciences has been the hiring of part-time faculty to develop new sites, especially in the areas of community/home care, mental health and private practice placements. This part-time faculty support also enables student supervision within new practice settings or role emerging placements, such as FHTs. In the School of Communication Sciences and Disorders at Western University, education of Western clinical faculty have been undertaken to mount new clinical programs at the H.A. Leeper Speech and Hearing Clinic (vestibular and tinnitus programs, aphasia supported conversation, Lee Silverman Voice Treatment, stuttering therapy). These programs expand the clinical education experiences available to students.

b. Initiatives in nursing programs
In nursing in particular, the deficit for running clinical education programs has been so large (nearly $26M in 2005-06\textsuperscript{68}) that the majority of the MTCU clinical education funds has been almost entirely used to reduce the deficit--to defray the growing faculty costs associated with expansion of programs and changes to the hospital and community system.

The majority of nursing clinical placements until senior year take place in small groups of six to eight students who are taught by clinical faculty at acute care hospitals. Contract clinical faculty stipends are by far the biggest cost to nursing schools for clinical education. Nevertheless, reports to MTCU on the use of the grant money indicate the following examples of efforts to increase the availability, quality and efficient use of clinical placements:

- offsetting the costs of simulation labs and modules which are being used to a much greater extent to prepare students for clinical work; these costs include lab manager, lab technician, instructors to teach small groups of students in the simulation lab, equipment maintenance and repairs;
- salary for undergraduate program coordinators to do clinical instructor orientation, ongoing mentoring, and guidance;
- salary for a faculty member to coordinate the team of instructors in each clinical course in order to ensure consistency and quality in the delivery of the courses across clinical groups;
- some travel money for students to go to other small towns in the region for some community placements;
- faculty support for education and ongoing support to the preceptors for 4th year students;
- recognition certificate and gift for preceptors;
- orientation manuals prepared and given to preceptors;

\textsuperscript{68} COU, Clinical Education Project Report, prepared for the Ministry of Training Colleges and Universities, 2007.
• coordination/administration to build, maintain and strengthen relationships with hospital and community partners and agencies;
• evaluation of the quality of clinical placements and student experience at clinical sites;
• excellence in clinical teaching award.

4. Innovative placements

“Innovative placements” refer generally to placements that take place outside of the traditional hospital, large health care institutions or boards of education that have historically provided the placements for the many nursing and rehabilitation sciences students.

Nursing and rehabilitation sciences educational leaders have been looking to innovative placements more generally to respond to clinical placement shortages and new health system realities and needs. Many such placements have been developed in the community, as part of the more general attempt by educators to expose students to this sector where care is increasingly taking place.

a. Innovative placements in rehabilitation sciences programs

In a 2010 OCUPRS survey, university clinical coordinators identified the following innovative placements that are being implemented:

• one or two students placed with two part-time therapists at different sites/settings, e.g., private practice and rehab, community and hospital;
• creation of university clinics to facilitate placements, e.g., H.A. Leeper Speech and Hearing Clinic at Western University, university OT clinic in partnership with a private-practice agency, university IPE clinic;
• extended placements (fewer hours over more weeks to accommodate part-time preceptors);
• peer mentoring sessions using Ontario Telemedicine Network (OTN) videoconferencing during placement to connect distant students;
• involving students with weekend hospital coverage and on Alternate Level of Care (ALC) floors;
• continuum of care internships where the students follows a population across different facilities - i.e. acute care joint replacements for half, then half with the rehab facility with the same population;
• placements in residential programs for clients with developmental disabilities;
• specialized and/or integrated summer camps;
• school special education teams;
• employee services at universities and hospitals;

69 2011 discussions between COUPN and CAATs executives, 2010-11 discussions of OCUPRS.
• CCACs with OTs in Case Management roles;
• YM/YWCA;
• FHTs;
• homeless shelters;
• immigration services;
• mental health agencies;
• international placements; and
• placements in remote First Nations communities.

b. Innovative placements in nursing programs

- home care visits with a group of students and a clinical instructor;
- recruiting volunteer families at community agencies for individual student home visits;
- long-term care placements where the RN on the unit or in the facility is the official Preceptor, but the student spends time with RPN's and PSW's on a daily basis;
- child health placements in daycares, schools, elementary and high schools to study growth and development, communication and health activity;
- mental health placements using PhD psychologists and sociologists as preceptors;
- shelters;
- students researching information on influenza, immunization, adult teaching and learning principles, marketing, and population health to design and deliver an education campaign and flu shot clinics;
- international placements; and
- community public health placements where students work side by side with residents in high need communities and faculty researchers to identify the main issues affecting the health and happiness of residents and develop practical strategies to address these issues.

5. Interprofessional education placements

From 2006 through 2009, the MOHLTC sought to foster interprofessional collaboration (IPC) to help adapt the health care system to new needs and demands, and to promote sustainability. A collaborative, team-based approach to care was identified as being “an

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70 Many examples here were reported at annual province-wide nursing academic clinical coordinators’ meetings in 2010 and 2011, or come from reports to MTCU regarding the use of clinical education grant funds.

71 “Health in the Hubs Phase 1: Neighbours and Nursing Working Together,” McMaster University School of Nursing. [http://fhs.mcmaster.ca/nursing/documents/Phase1report.pdf](http://fhs.mcmaster.ca/nursing/documents/Phase1report.pdf)
enabler for improving patient care and meeting the demands that the system is facing” in light of the shift from acute to chronic care conditions.\textsuperscript{72}

Support from the MOHLTC and MTCU to educational institutions facilitated the development of infrastructure for interprofessional education projects, and for integrating interprofessional education in curricula. Each university received funds to implement these IPE projects. Many projects involved the development of clinical experiences in which students would have the opportunity to learn and enact these competencies within particular settings. Examples include:

- Development of student placements in an interprofessional clinic encompassing medical, nursing, rehabilitation, dietetic, and social work services for individuals living in low-income housing projects;
- IPE curriculum development in the simulation lab, with students enacting cases with particular patient groups and scenarios from an IPC perspective;
- Engagements with hospitals and other care institutions to develop clinical opportunities where interprofessional collaboration can be enacted, learned and evaluated.

6. Clinical education databases
The majority of all university and college nursing programs in Ontario are now using HSPnet, a web-based clinical placement communication and tracking system and database based in BC that has now been adopted in eight provinces.

HSPnet was initiated in Ontario between 2004 and 2006, when MOHLTC provided financial support to the Council of Ontario Universities (COU) to identify and pilot a clinical placement database for nursing programs. HSPnet was identified and piloted in three geographic areas with nursing schools and large receiving agencies, and was seen to have the following benefits:\textsuperscript{73}

1. streamlines the clinical education process;
2. reduces errors;
3. enables better coordination and use of available placements;
4. clinical partners can generate management reports that describe and acknowledge the huge contribution they make to clinical education;
5. capacity for interprofessional placements;
6. databank for statistical reporting and analysis; and
7. creates capacity to mobilize cohorts of students in an emergency at organizational, regional and provincial levels.


\textsuperscript{73} COU Report to MOHLTC: Nursing Clinical Placement System Project Summary July 2009.
Since 2006, HSPnet has grown in the following ways:

- All universities and colleges across the GTA, Hamilton, Kingston, London, Ottawa and Peterborough now use HSPnet to track their nursing student placements, and in many cases also PSW, massage therapy and paramedic students;
- HSPnet has been adopted by Nipissing University in North Bay for nursing students and is in the process of being adopted by Lakehead University and Confederation College in Thunder Bay;\(^{74}\)
- 35 major hospitals and other health care agencies across Ontario have adopted HSPnet to track their student placements;\(^{75}\) and
- Enhancements to the system that are being integrated by Ontario users include:
  - Call for offers;
  - Correspondence;
  - Prerequisites for students;
  - Student site pre-requisites;
  - Student site selector;
  - Automated student matching; and
  - Conflict checking (for schools to work out conflicts prior to submitting to receiving agencies).

In rehabilitation sciences, most programs continue to use the JUN database\(^{76}\) that was developed in the mid 1990s, and which has been evaluated as satisfactory for the time being.\(^{77}\)

For all other provinces using HSPnet, Ministries of Health provide ongoing funding and/or provincial oversight of the database, often through regional health authorities, in order to integrate it with health system development. Since 2007, COU has provided all provincial management, in terms of oversight and strategies for growth, cost recovery, development of data for provincial reporting and policy-making, and governance without any ongoing funding or involvement of government. Annual HSPnet costs for Ontario in 2013-14 are $163,000 plus COU labour costs.

7. Clinical simulation

Clinical simulation has been widely implemented in nursing and rehabilitation sciences fields in Ontario to help address clinical education needs. Clinical simulation takes the form of high and low fidelity mannequins, standardized patients, video cases, and other innovative approaches. These novel learning contexts constitute a safe environment for students to

\(^{74}\) As of April 30, 2013

\(^{75}\) Valid as of April 2013

\(^{76}\) Jun Consulting Group, www.junconsulting.com

\(^{77}\) OCUPRS ACCEs/DCEs survey 2010.
develop their skills performing controlled acts that could potentially harm a patient if done improperly. This has become particularly important as the acuity level of patients in hospitals has risen. Clinical simulation also allows educators to shape the simulated environment to target particular learning outcomes, such as interprofessional competencies, and to compensate for difficult to find placements, such as maternal-newborn care, infectious disease outbreaks, and rare phenomena, and to prepare students for the real-life clinical environment so that they will be better received by sites and have a better learning experience.

In support of clinical simulation, MOHLTC provided nursing schools with funds in 2004-2005 to purchase high fidelity clinical simulation equipment, and subsequently for evaluation of simulation experiences. The evaluation concluded that the education students receive on mannequins and in other simulated settings cannot replace actual interaction with real patients, but can supplement and help students prepare for these real life learning experiences. In rehabilitation sciences in particular, simulation cannot currently be counted towards required hours for program accreditation and student qualification for registration.

While not a solution to clinical placement shortages, simulation has nevertheless become an integral part of clinical teaching in Ontario, and is being further developed for particular learning needs.

8. Preceptor Education Program (PEP)
The online Preceptor Education Program (PEP) for health professionals and students is an inter-professional web-based education program, based at Western University and Fanshawe College, which was initiated in 2007 with funding from MOHLTC. The site provides free, online, practical support to preceptors and their students through eight, 30-minute learning modules. The learning modules can be used by any health care discipline, as they are geared towards general topics in clinical education. For students, these topics include the following:

1. your role, what will be expected of you and important questions to ask your preceptor;
2. learning objectives for your placement that will really help you to focus your energy where it counts;
3. receiving and giving feedback to your preceptor that will ensure you gain as much as possible from the placement experience;
4. understanding and developing your clinical reasoning skills;
5. becoming a reflective practitioner;
6. how to manage conflict with your preceptor, clients and team members; and
7. making the most of the formal evaluation of your performance.

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78 Evaluation of the Use of Clinical Simulation in Ontario Nursing Programs, Final Report to MOHLTC, 2009. Research Project Grant # 06259
79 http://www.preceptor.ca/index.html
For preceptors, the site provides:

1. tips to help you prepare for and orient your student to your clinical setting;
2. ready-to-go learning activities and exercises that you and your student can do together that will ease the way to developing learning objectives, fostering clinical reasoning and reflective practice and dealing with conflict;
3. ways to give effective ongoing feedback (and fit it into your busy schedule) as well as how to prepare for and facilitate the formal evaluation of your student; and
4. useful documents and templates.

At last report (Oct. 15/12) there were 21,800 registered users of this site from a variety of different health care professions.

9. **Northern Placements in Rehabilitation Studies**

The Rehabilitation Studies (RS) and Northern Studies Stream (NSS) Programs at the Northern Ontario School of Medicine (NOSM) follow the distributed medical education model and have capitalized on the social accountability mandate of that institution to integrate clinical education for rehabilitation sciences students with rural and remote Northern Ontario health care settings, practice, and patient needs. The RS Program at NOSM acts as liaison to the various Schools of Rehabilitation Sciences, develops clinical educator expertise through the provision of resources and education, coordinates optimal clinical learning experiences in over 43 Northern communities, and is funded to provide clinical learners with travel and accommodation to the Northern Ontario placements. Facilitated by two part-time academic faculty members, the NSS, similar in nature to the RS, has the additional mandate of providing PT and OT learners from McMaster University with onsite small group academic learning of an entire unit of studies for up to eight weeks in a Northern Ontario community.

Fifty percent of McMaster rehabilitation sciences students do a clinical placement coordinated through NOSM. For other programs, the percentage of total student placements available through this program ranges from 1% to 10%. The impact of the RS and NSS programs on new graduate recruitment was recently determined to be very successful, with 19% of NSS/RS graduates returning to work in Northwestern Ontario and 37% cumulatively of participants over the past nine years returning to work in a rural or remote region.

10. **Summer externship for nursing students**

The summer externship program began as a successful pilot in the summer of 2004, with the aim of accelerating the degree program for senior baccalaureate nursing students so they could graduate and enter the workforce earlier. MOHLTC provided the funds to nursing programs to cover some of the costs of running a summer session, and also to test clinical education placements that promote recruitment to under-serviced areas, provide learning in population health needs, and more diverse clinical experiences to students who participate. A second, more expansive, version of the program was run in 2008, and it has continued on an annual basis since then. In 2012, MOHLTC committed $300,000 in annual funds to this program, so that schools can be assured of funding in offering this opportunity to students.

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81 Winn, Chisholm, Hummelbrunner, Kandler, Tryssenaar, unpublished data, 2010.
on an ongoing basis. Approximately 290 students benefited from these placement experiences in 2012.

While relatively small in size, the summer externship program creates greater efficiency in the use of clinical placements because it is conducted in the summer when clinical placements are not normally held and reduces demand at other times of the year.

11. Developing long-term care homes as centres of learning

Since 2006, the Ontario Promoting Productive Partnerships among Colleges, Universities and Long-Term Care Homes (PPP) Task Group has been researching and promoting the idea of formal partnerships between postsecondary institutions and long-term care institutions. PPP consists of representatives from non-governmental long-term care organizations, consumer groups, service organizations, colleges, universities and research institutes. Partnerships between long-term care homes and postsecondary institutions are seen by stakeholders to facilitate increased learning by students and staff, improved resident care in the homes, and increased recruitment of qualified caregivers in these settings. In terms of clinical education, developing long-term care homes as centres of learning, research and innovation will mean that these institutions can play a greater role in preparing students for practice in an aging society, and for developing the level of evidence-based care in homes.

In 2011, MOHLTC provided funding for three long-term care homes to be piloted as centres of learning, research and Innovation, thus constituting the first concrete implementation of this important policy direction.
Appendix B: List of resources developed by faculty in rehabilitation sciences programs between 1994 and 1998

1. Resources for expanding student placement opportunities:

   1.1. Marketing Fieldwork: A pamphlet outlining the steps for creating a new fieldwork site.

   1.2. Competency-Based Fieldwork Evaluation Instrument: An evaluation instrument to assess student performance in fieldwork placements.


   1.4. Community-based University Clinics: A report on the process of setting up four community-based university clinics in Ottawa (Voice, Aphasia, two for Stuttering).

   1.5. Site Development Protocol: A prototype for developing new community fieldwork sites with off-site supervision.

   1.6. The Potential Role of OT Within the Autism Program: A description of the role of OT within the autism program at Lakehead Regional Family Centre, Thunder Bay.

   1.7. Interdisciplinary Placements at a Palliative Care Centre: A report on the creation of interdisciplinary placements in Thunder Bay.


   1.9. Fieldwork for Rural and Northern Preceptors: A How-to brochure for clinicians with students in remote areas.

2. Resources for establishing new models of supervision

   2.1. Group Model: A video demonstrating the group model of student supervision that was piloted in Toronto.

   2.2. Interdisciplinary Model:

       2.2.1.1. Handbook on techniques to facilitate interdisciplinary fieldwork, accompanied by reports from five pilot sites.

       2.2.1.2. Interdisciplinary Team Functioning: A manual with several modules on team interactions, roles, etc. Developed for facilities considering an interdisciplinary model of fieldwork education.

   2.3. Student as Supervisor Model: A manual that outlines this model, which engages students in learning the process of fieldwork education.

   2.4. Part-Time/ Full-time Model: A manual that outlines this model of a part-time therapist providing fieldwork education for full-time placements.
2.5. **Role Emerging Community Placements in OT**: A resource guide outlining a strategy for educating students in community sites with off-site supervision.

2.6. **Role of the On-Site Supervisor**: A resource manual describing this model of supervision.

2.7. **Role of the Off-Site Supervisor**: A resource manual describing this model of supervision.

3. **Resources for creating educational support materials**

   3.1. **Clinical Education Self-Assessment Tool**: A device to self-assess clinical education performance.

   3.2. **Resource manual and brochures on:**
   
   3.2.1.1. Principles of Clinical Education and Leadership
   
   3.2.1.2. Student Orientation
   
   3.2.1.3. Developing Clinical Reasoning Skills
   
   3.2.1.4. Skills of Evaluation
   
   3.2.1.5. Coaching for Success
   
   3.2.1.6. Skills for effective Communication

   3.3. **Multimedia Courseware for Health Professionals**: A self-teaching CD with three modules: Ethical and Legal Issues in Rehab Professions; Questions and Answers about Private Practice; and a Database of the Guidelines and Regulations Pertaining to the Rehab Disciplines.

   3.4. **Rehabilitation in Small Communities**: Resource manuals and videos on three themes: Life in a Small Community, Health and Health Issues in Small Communities, and Personal and Professional Issues in Small Communities.

   3.5. **Site Profiles (London and Kingston)**: Binders for students on 19 new clinical sites in London and Kingston.

   3.6. **Consortium of Northern Practitioners**: A report on the process of building linkages among clinicians, the universities and each other in the north.

   3.7. **Caregivers of Individuals with Dementia**: A resource manual

4. **Resource for improving the methods of communication/streamlining**

   4.1. **Database for Clinical Education**: A computerized software package that will maintain information on facilities and students, and will also enable students to be matched to placements.
**Glossary**

AUD – Audiology

CAATs – Colleges of Applied Arts and Technology

CCAC – Community Care Access Centre

COU – Council of Ontario Universities

COUPN – Council of Ontario University Programs in Nursing

FHT – Family Health Team

HSPnet – Health Sciences Placement Network

IPC – Interprofessional Collaboration

IPE – Interprofessional Education

LHIN – Local Health Integration Network

LTC – Long-term care

MOHLTC – Ministry of Health and Long-term Care

MTCU – Ministry of Training, Colleges and Universities

OCUPRS – Ontario Council of University Programs in Rehabilitation Sciences

OT – Occupational Therapy

PSW – Personal Support Worker

PT – Physical Therapy/Physiotherapy

QBPs – Quality Based Procedures

SLP – Speech-language Pathology