Understanding practice learning hours in pre-registration nursing programmes outside the EU

January 2022

Purpose of briefing

1 This briefing describes the findings of the work undertaken by the Research and Evidence team to understand practice learning hours in pre-registration programmes outside the EU.

Background

2 The NMC's programme standards set out how nursing programmes should be delivered to ensure that those leading to registration are fit for purpose. Programmes should enable students to achieve the nursing proficiencies in their intended field of practice.

3 Some of the content in our current programme standards is underpinned by EU law. But since the UK has left the EU, the NMC now has full flexibility for setting these standards.

4 In 2021, Harlow Consulting carried out a desk-based evidence review and benchmarking report[1] and Traverse carried out qualitative stakeholder engagement[2] to understand the impact of changing these standards across the four nations of the UK. This research allowed us to evaluate the advantages to changing our standards, and the degree of consensus about making any changes.

5 This report builds on the work done by Harlow Consulting. The Harlow review found significant variation in the minimum number of practice hours required in some countries outside the EU (see Table 1 below).

[1] Harlow Consulting (2021). Review of Minimum Education and Training Standards in Nursing and Midwifery – Desk based research.
[2] Qualitative research about current education programme standards (nmc.org.uk)

Table 1: Comparison of nursing pre-registration programme length, and theory/practice hours of comparator non-EU countries (taken from the Harlow Review)

Country	Pre-registration programme length		Minimum theory and practice hours	
	Years*	Hours	Theory	Practice**
UK	3	4,600	2,300	2,300
USA	4	Not specified	Not specified	Varies by state - average is typically 700-800
Canada	4	Not specified	Usually 50:50 but not specified	Usually 50:50 but not specified
Australia	3	Not specified	Not specified	800
New Zealand	3	Not specified	Not specified	1,100
Philippines	4	Not specified	Not specified	2,703***

** The programme length listed is for those starting a degree-level programme with no prior higher education qualifications or experience, which is the majority of learners. Some countries have programmes which allow a shorter period of time for learners with prior qualifications, such as Nursing Associate equivalents.*
*** Note that this gives the minimum mandated practice hours by country or state. In practice, there may be some variation between institutions within a country or state. For example, in Australia the minimum number is 800 hours, but this could vary between 800-1,000 hours in different institutions.*
**** The Harlow Consulting report[1] recorded this as 2,346 hours, but this was corrected following the information we received at the interview stage.*

6 We want to explore the rationale for the number of practice hours in each country and the circumstances in which they are delivered. This report focused on the five non-EU countries highlighted in the Harlow review: Canada, Australia, New Zealand, the USA and the Philippines. These countries had originally been selected to ensure that they were broadly comparable with the UK in the following ways:

6.1 Nursing and/or midwifery was a graduate profession

6.2 The health and care provided was at the level of an advanced economy

6.3 The Philippines was also included due to the high number of nurses from this country who have joined the UK register in recent years.

7 It should be noted that in the Philippines, the practice hours requirement is higher than the UK.

Summary

8 There are differences between the UK and the countries we looked at on some of the context factors we identified. However, the people we spoke to felt that these do not explain differences in practice hours.

9 Many of the considerations around the setting of practice hours and ensuring the quality of learning and outcomes highlighted by participants apply equally to UK programmes.

10 Numbers of practice hours are often the result of political factors or pragmatic decisions about the availability of practice placements, rather than based on evidence about the number of hours required for safe and effective practice.

11 All countries emphasised focusing on quality of learning and outcomes rather than inputs like numbers of practice hours. Participants felt that the number of practice hours they have are sufficient for students to achieve the required level of competency[3].

12 Several countries stated that there is a lack of empirical evidence of a link between number of practice hours and competency.

13 Quality of learning was facilitated by a number of methods. These included integrating theory and practice learning, a clinical instructors' certification programme and the use of specific teaching methods, such as problem-based learning or the SBAR tool.

14 All countries incorporated simulated learning in their programmes. However, there was no sense that simulated learning was being used as a strategy to replace hours that would have been spent in practice, except in the USA. Only the USA permits a proportion of practice hours to be substituted with simulation. Investment in simulation has increased and takes many forms, including high- and low-fidelity manikins, use of actors or 'standardised patients', and virtual simulation. Uses of simulation are not restricted in these countries, as they are in the EU Directive.

15 Graduate programmes, while not mandatory, are increasingly strongly encouraged in the countries we looked at and are often the norm for newly qualified professionals. The format, length and structure of these programmes vary (with some funded by government) but the aims broadly align with the NMC's principles of preceptorship.

[3] In this research, we did not explore whether the learning outcomes required in these countries were comparable with those expected in the UK.

Research objectives

16 We want to understand the differences in practice hours in pre-registration programmes between the EU and some countries outside the EU. This ensures that we learn from the experiences of the global nursing sector when we consider whether to revise the standards.

17 The overarching research questions that this project aimed to answer were:

17.1 Why are practice learning hours in pre-registration programmes in some countries outside the EU different to those required by the NMC?

17.2 Do contextual factors adequately explain why practice learning hours are lower? If so, which ones are most important in ensuring that professionals are fit to practise on qualification?

17.3 Are there significant differences in programme outcomes, proficiencies or competencies between these programmes?

18 The original aim was to understand why practice hours are lower in some countries outside the EU. However, since practice hours in the Philippines are higher, we also refer in this report to hours being 'different'.

19 Please note that we have not sought to crosscheck information provided to us on these countries with UK requirements. Therefore the report does not note whether and to what extent programmes in these countries differ to those in the UK.

Methodology

20 We used a mixed methods approach to address the research objectives:

Phase 1: Desk-based research

21 We created a list of potential context factors (e.g. use of simulation), that could influence clinical practice hours in pre-registration courses (see Annexe 1). We used the Harlow Consulting report and advice from NMC nursing advisors and the project steering group to create this list. Please note that this report focuses on those factors which were found to impact on practice learning hours.

22 For each of our countries of interest, we searched the websites of professional regulators, educational institutions and available policy papers and academic articles. These were examined to understand the use of these context factors. Annexe 2 outlines some of the key differences in the context factors found between the UK and five countries from the desk-based research and qualitative depth interviews.

23 We noted where information wasn't available on a context factor.

Phase 2: Qualitative depth interviews with regulators and education authorities

24 We spoke to a total of nine people representing the five countries of interest. They were a mix of experts from regulators and academic institutions. The organisations are listed in the Acknowledgements section below.

25 We recruited people by pro-actively contacting relevant organisations. Some of these organisations had existing NMC relationships, and others had no prior engagement with us.

26 The interviews took place by video call, using Microsoft Teams. They were each about an hour in length.

Findings

Political, social and historical factors often influence decisions about practice hours, alongside issues within healthcare systems

27 There are differences between the UK and the countries we looked at on some of the context factors we identified. However, the people we spoke to felt that these do not explain differences in practice hours. Regulators and education authorities in the discussions highlighted those factors that had influenced decisions on practice hours. Many of these also apply to the UK also:

Political, social and historical factors

28 Political pressures, such as the worldwide nursing shortage, may prevent countries from increasing their practice hours, or compel them to reduce hours. In Australia and New Zealand, for example, there have been debates about whether hours should be increased or decreased. In New Zealand, there have been pressures to change the standards, including reducing practice hours. Some people see these standards as a barrier to nurse recruitment. The Nursing Council of New Zealand has recently consulted on changing practice hours[4], which is currently a minimum of 1,100. Options include reducing the minimum practice hours to 900 and allowing 200 of the 1,100 hours to be completed through simulation. Their website gives a number of reasons for considering changing their practice hours, including the fact that they are ‘aware of current pressures and competition for placement time.’

29 The current number of practice hours in Australia was decided based on a ‘common sense’ approach, drawing from previous experience. In the past, different states in Australia set their own practice hours. However, when the national body, the Nursing and Midwifery Board of Australia (NMBA) was formed in 2009, the state and territory nursing and midwifery boards agreed on an ‘average’ number of practice hours. This was based on the hours already mandated by states.

30 The Philippines have a slightly greater number of practice hours than the UK (2,703 hours compared with 2,300). The Philippines organisation suggested it may be because the UK has recruited many Filipino nurses since the 1950s. It makes

[4] Clinical Hours Consultation 2022 (nursingcouncil.org.nz)

sense for practice hours in the Philippines to not be lower than the UK, to prevent barriers to Filipino nurses practising in the UK.

31 In Canada, regulators do not mandate the number of practice hours. One of the Canadian organisations said that the average number of practice hours indicated by education institutions was around 1,000 to 1,200. They also gave the opinion that the culture in education and standards in Canada was not to be too prescriptive. Regulators specify the type of clinical experience students should have, but not the number of hours.

Healthcare system issues

32 Australia, Canada and the USA highlighted the challenge of getting access to clinical placements. Nursing students are often in 'competition' with other healthcare students, such as doctors and physiotherapists, for clinical placements. One of the Canadian organisations, the College of Nurses of Ontario, also noted that getting the range of clinical placements required for a generalist nurse could be a particular challenge in rural areas. They may be unable to access more specialist areas of nursing, such as paediatric cardiology.

All countries feel that the required quality and outcomes of learning can be achieved with the number of practice hours they have

33 All countries believe that the quality of learning is key. They stressed that their courses were based on outcomes, knowledge and competency, rather than focussing on the completion of hours. Several people pointed out that a smaller amount of high quality experience was more useful than a lot of poor quality experience.

34 The Australian and New Zealand regulators stated that there is a lack of empirical evidence of a link between number of hours and competency. The New Zealand regulator stated that looking at hours alone is quite 'reductionist'. The key thing is that the student is in a clinical learning environment. The Australian regulators felt that there is no evidence to suggest that 800 hours is not enough. The 'safety net' is that people must meet the Standards for Practice[5]. They noted, however, that extra hours might give some students more confidence. There is, in fact, some variation between institutions within countries in the number of practice hours they offer. For example, in Australia, while the minimum number is 800 hours, this could vary between 800-1,000 hours in different institutions.

35 Similarly, in the USA, regulators viewed 700-800 practice hours as optimal to pass the National Council Licensure Examination, the NCLEX[6]. The NCLEX was seen as the assurance that the graduate was safe to practise. The American Association of Colleges of Nursing (AACN) emphasise the quality of the learning experience. Nursing schools should not just 'tick off' competencies, but should be tying together theory and practice (see below).

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[5] Nursing and Midwifery Board of Australia - Registered nurse standards for practice (nursingmidwiferyboard.gov.au)

[6] Home | NCLEX

36 As noted above, Canada does not have a mandated number of practice hours. They use an outcome-based curriculum. Canada also focuses on the quality of their clinical instructors through a certification programme (see section 4 below).

37 In the Philippines, the practice hours are higher than in the UK. Nevertheless, the focus in the curriculum is still on outcomes, with students having to achieve competencies as well as their practice hours.

38 Both the Philippines and the USA emphasised the importance of integrating theory and practice learning.

39 In the Philippines, clinical instructors integrate classroom learning with learning on clinical placements (known as Related Learning Experiences). These instructors lecture on theory at the start of the week, and then go on clinical placements with students on Wednesday to Friday. There is therefore a clear correlation between theory and practice. The instructor also knows about the progress of the student, and any support that they need. The Policies and Standards for the Bachelor of Science in Nursing[7] in the Philippines states that:

39.1 'There shall be close correlation of theoretical knowledge to related learning experience. Classroom and RLE activities must be congruent.

39.2 Classroom and RLE is a continuous process. Faculty teaching in the classroom shall continue to teach the students in their RLE.'

40 In the USA, integrating theory elements of the course with the clinical placement is also seen as best practice. For example, theory can be integrated into care planning, by using best evidence on a particular condition. Another example of best practice in clinical learning in the USA was the use of the SBAR tool[8] (Situation – Background – Assessment – Recommendation). This is a framework for communicating about a patient's condition between members of a healthcare team, which is also used in the UK. Using the SBAR tool encourages assessment skills, and prompts staff to formulate information with the right level of detail.

41 One of the Canadian organisations also mentioned the use of 'problem-based learning'[9] (also known as inquiry-based learning) in some nursing schools, as an example of good practice. This is an approach that teaches student nurses to apply theory to clinical practice and develop their problem-solving skills, and is also in use in the UK.

Most countries emphasised that high quality simulation can help prepare students for clinical practice

42 All the countries of interest use simulation alongside theory learning. Simulation can be seen as one part of a high quality learning experience, which complements and supports practice learning.

[7] CHED MEMORANDUM ORDER (CMO)
[8] https://www.england.nhs.uk/wp-content/uploads/2021/03/qsir-sbar-communication-tool.pdf
[9] The effect of problem-based learning in nursing education: a meta-analysis - PubMed (nih.gov)

43 Simulation is mainly used to teach students skills and prepare them for clinical practice safely. Several countries emphasised the benefits of students learning skills safely in a simulation lab before practising them on a live human being. Students are also able to practise skills on their own in self-directed learning in simulation labs. In all five countries, simulation can be used to assess whether a student is proficient in a skill, such as intubation.

44 Australia and Canada noted that simulation is useful where students have not had the opportunity to practise a skill in a real life situation. This is particularly the case in very specialist areas. During the Covid-19 pandemic, nursing schools across the world also used simulation to deliver virtual teaching, when students were not allowed into hospitals. In Canada, a lot of virtual simulations were developed, such as ‘serious games’ to teach clinical skills. Serious games[10] are computer-based simulations that combine knowledge and skills development with video game-playing aspects to enable active, experiential learning.

45 All five countries appear to be developing the quality of simulation, both through financial investment in facilities, and efforts to optimise the simulation experience.

46 Both phases of research showed that these countries have put a lot of investment into simulation in recent years. Several nursing school websites[11] viewed in the desk research featured ‘state of the art’ simulation facilities. Simulation takes many forms, including high- and low-fidelity manikins, use of actors or ‘standardised patients’, and virtual simulation.

47 Several countries highlighted features of good quality simulation. One of the Canadian organisations noted that simulation should be a well-planned experience and involve good debriefing. The USA organisation noted that it was important for the nursing faculty to learn how to use simulation effectively to teach students. In Australia, universities bring actual clinicians into labs to teach, to ensure that simulated learning reflects current practice.

48 Most countries argue that they have not used simulation to compensate for a reduction in practice hours, explaining that it is used to supplement practice hours, rather than replace them.

49 In Australia and New Zealand, the regulators do not permit simulation hours to be included in total clinical practice hours[12]. Australian regulators and academics[13] think that there is not enough clear evidence to decide whether simulation can replace practice hours in direct patient care. Simulation hours in Australia may therefore vary from institution to institution, from around 300 – 600 hours.

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[10] Developing a Serious Game for Nurse Education - PubMed (nih.gov)

[11] Niagara University Nursing Simulation and Skills Labs: Next Level Learning | NU News
Clinical Facilities | Western Sydney University

[12] registerednurseaccreditationstandards2019_0.pdf (anmac.org.au)
NZ Handbook for pre-registration nursing programmes Apr22.pdf

[13] Emeritus Professor Steven Schwartz (2019). Educating the Nurse of the Future: Report of the Independent Review of Nursing Education (Department of Health, Australia)

50 In the USA, the National Council of State Boards of Nursing (NCSBN) allows up to 50% of practice hours to be through simulation[14]. This follows a study by Hayden et al (2014)[15], commissioned by the NCSBN. This showed that there were no significant differences in exam pass rates and clinical competency of three student cohorts, who had experienced different levels of simulation. However, the USA organisation in our interviews noted that the rules on simulation vary both by state and school of nursing. For example, some states use simulation to enhance students' learning, instead of replacing practice hours. Others might allow, say, 30% of practice hours as simulation. A 2018 review of all 50 Boards of Nursing in the USA[16] found that 24 states allowed simulation to replace some portion of practice hours. Only 15 states gave clear guidance on the amount of simulation that could account for practice hours in that state.

51 It should be pointed out here that these countries all have practice hours which are significantly lower than the UK (less than half of the 2,300 hours in the UK). Therefore, the decision to replace clinical hours with simulation may be more difficult in these countries.

Countries also focus on high quality practice placements for students

52 It should be noted that in all of these countries, as in the UK, students on placement have supernumerary status.

53 All countries identified a number of elements of a good quality placement, which enable students to achieve their competencies.

54 Firstly, the quality of the clinical teaching is key. There are a range of ways in which students are taught on clinical placements, which may vary between countries and nursing schools. Students may have clinical instructors, who teach them both in the classroom, and on the clinical placement. These typically teach a small group of 6-8 students in the clinical setting. Students may also have preceptors, who may be employed by the healthcare provider. They may also be shown how to do things by staff nurses in the healthcare provider.

55 The Philippines organisation felt that the UK could learn from its clinical instructor model. As noted above, in the Philippines, clinical instructors are university-based, but also teach students in placements. This gives the students a good clinical experience, and supports the integration of theory and practice. They noted that in the UK, a staff nurse might be looking after 6-8 patients, as well as one or two students, so they cannot maximise support to students.

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[14] National Simulation Guidelines for Prelicensure Nursing Programs | NCSBN

[15] Hayden, J et al (2014). 'The NCSBN National Simulation Study: A Longitudinal, Randomized, Controlled Study Replacing Clinical Hours with Simulation in Prelicensure Nursing Education', Journal of Nursing Regulation, Vol 5, Issue 2, July 2014 Supplement

[16] Bowling, A et al (2018). No evidence to support number of clinical hours necessary for nursing competency. Journal of Pediatric Nursing, 39 (2018) 27-36.

56 In Canada, there is also a focus on training good quality clinical instructors. The Canadian Association of Schools of Nursing (CASN) run an optional clinical instructors' certification programme[17], and have competencies for this programme.

57 Secondly, several organisations highlighted how a focused learning experience on clinical placement produces the best outcomes.

58 One of the Australian organisations stated that learning really does drive placement experiences in Australia. Placements are focused and have clear outcomes. Students are not simply treated as a 'pair of hands' by health facilities. This organisation felt that the relatively low practice hours in Australia could be explained by two things. Firstly, students are prepared for practice by focused simulation. Secondly, the clinical placement is focused on learning, with good, structured facilitation.

59 Likewise, in the USA, the integrated learning approach for clinical placements is seen as beneficial. After a clinical session, instructors have discussions with students to reinforce learning, such as asking how care could have been managed differently. This enhances the clinical learning experience and prepares the student better for practice.

60 In the Philippines, the integrated learning approach means that classroom learning is combined with simulation, and Related Learning Experiences (clinical placements). They also use graded demonstrations to test student competencies.

Graduate programmes support newly-qualified nurses to develop their competence

61 Graduate programmes, while not mandatory, are increasingly strongly encouraged in all countries of interest. These programmes may also be referred to as transition to practice programmes, residency programmes or internships. Several countries stressed that new graduates cannot be expected to be able to do everything that a nurse with several years' experience can do. While they view newly qualified nurses as being 'work safe', they see graduate programmes as a useful way of developing their competence further.

62 The length of graduate programmes varies between and within countries.

63 The Philippines recommend a transitionary period for new graduates, even though their pre-registration programmes have a higher number of practice hours than the UK. A structured transition period is the norm for newly qualified nurses, although it is not mandated. Once a nurse has passed the national licensure exam, and is registered, they often start as a volunteer in a hospital for 3-6 months. After this, they will become a probationary nurse for 6-12 months. They are then able to become a permanent employee.

64 In New Zealand, nurses have a supported year of practice, which is funded by the government. A national system, Nursing Advance Choice of Employment (ACE)[18],

[17] Clinical Instructor Certification Course - The Canadian Nurse Educator Institute (CNEI) (casn.ca)
[18] Graduate nurses | Ministry of Health NZ

is used by District Health Boards (DHBs) to recruit graduate nurses into supported first year of practice programmes. Many DHBs partner with local primary care and aged care providers to deliver these programmes.

65 In the USA, residency programmes are often shorter. The USA organisation said that they could vary between 6 and 18 weeks, depending on the provider. However, in some cases residency programmes could be up to a year.

66 Several countries described elements of their graduate programmes which are supportive. For example, in New Zealand, graduate jobs are 0.9 Whole Time Equivalents (WTE), and have supernumerary study days. Graduates are also provided with a nurse educator. Likewise, in Canada, CASN's six-month residency programme[19] includes both education sessions and the support of a preceptor. Graduates attend a total of six 7-hour workshops during the programme. They also have an initial three months of 1:1 preceptorship at a progressive workload. In the second three months, the preceptor acts more as a mentor, working the same shifts and supporting the graduate. They are evaluated against competencies at three and six months, and get a certification at the end.

67 The objectives of graduate programmes are similar across countries.

68 The USA organisation said that the aim of residency programmes is to ensure that graduate nurses could practise independently.

69 One of the Australian organisations stated that the aim of graduate programmes is to provide support, and build the confidence and capability of graduates. The programme can consolidate their knowledge and skills in a supported environment, and allow them to move from novice to practitioner.

70 One of the Canadian organisations felt that their six-month residency programme would give newly qualified nurses time to develop their competence further. Both Canada and the USA emphasised the benefits of residency programmes: higher rates of nurse retention; the reduction of stress; and increased clinical competence and safety. The Canadian organisation was taking an evidence-based approach to the development of the residency programme. They had run a pilot of the programme, to look at what was and wasn't working, and what they could fine-tune. They are currently trying to get government support to run research on the current programme. This would enable them to see whether the benefits of residency programmes highlighted above apply to their programme.

71 The objectives of graduate programmes in these countries do appear to have similarities with the NMC's Principles of Preceptorship[20]. The Principles do not go to the level of suggesting the structure or length of these programmes. However, views about best practice in graduate programmes in these countries appear to align with the NMC's Principles.

[19] Residency Program - The Canadian Nurse Educator Institute (CNEI) (casn.ca)
[20] Principles of preceptorship - The Nursing and Midwifery Council (nmc.org.uk)

Conclusion

72 Our research has suggested that:

72.1 Practice learning hours in pre-registration programmes in some countries outside the EU are different for a variety of reasons. These may be political, social or historical, such as the political pressures caused by the worldwide nursing shortage. They may also be related to other pressures in the healthcare system, such as the challenge of finding clinical placements for nursing students. However, all countries felt that their practice hours were sufficient to train nurses who were ready to enter the workforce.

72.2 There are other differences between the UK and the countries we looked at. These include pre-registration education which leads to qualification as a generalist nurse rather than split into specific fields of practice, a final, national assessment following graduation and the use of graduate programmes. However, there was a perception that these contextual factors have little or no influence on countries' practice hours.

72.3 Several countries pointed out that there was little evidence that increased practice hours would produce better graduates. However, all countries stressed the importance of the quality of the learning experience throughout the student journey and as a new graduate. A focused, quality learning experience is seen as key to producing a nurse who is safe to practise, rather than completing a set number of practice hours. The key elements of a quality learning experience which we have identified include:

- Integrating theory and practice learning
- High quality simulation which complements both theory and practice learning
- Good quality clinical teaching and learning, with well-trained instructors who are able to concentrate on providing students with a good clinical experience
- Focused learning experiences which optimise the number of hours spent in clinical placement
- Graduate programmes which further develop the newly qualified nurse

72.4 We can draw some broad conclusions about the differences in programme outcomes, proficiencies and competencies between these countries and the UK:

- All five countries run programmes which deliver generalist nurses, unlike the UK, where nurses train in one of four fields of practice.
- The programmes deliver nurses who are 'work safe', and ready to continue their learning in their first jobs.

- Four out of five of the countries have a national licensing exam after graduation, as an additional assurance of competence, unlike the UK.

- All countries strongly encourage graduate programmes to help newly qualified nurses develop their competence.

73 In summary, there is a lack of empirical evidence of a link between number of practice hours and competency of newly qualified nurses. There are some contextual differences in the way practice learning is implemented and supported in the countries we have looked at, compared with the UK. For example, they have a different approach to managing placements, and the immediate post-registration period, through graduate programmes. These differences enable programmes to deliver quality learning experiences which enable students to meet the required standards, on fewer practice hours than in the UK or EU.

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74 The NMC Research team would like to thank colleagues in the following organisations for generously giving their time to help with this research:

American Association of Colleges of Nursing (AACN)

Australian Nursing and Midwifery Accreditation Council (ANMAC)

Canadian Association of Schools of Nursing (CASN)

College of Nurses of Ontario (CNO)

Council of Deans of Nursing and Midwifery (Australia and New Zealand) (CDNM)
Filipino Nurses' Association UK (FNA-UK)

Nursing and Midwifery Board of Australia (NMBA)

Nursing Council of New Zealand (NCNZ)

Further information

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Annexe 1: Contextual factors list

Before the programme starts

Admission criteria:

- Are there different pathways into qualifying as a nurse (e.g. USA)?
- What are the entry criteria for admission to pre-registration programmes?
- Do these differ between programmes/institutions?
- Do admission criteria include age / years of education?
- Do admission criteria have requirements for experience of care / caring?
- Are there any other admission criteria which differ from the UK?

Preparation of students for the programme:

- Do some programmes offer a foundation or pre-nursing year for students without the necessary qualifications (e.g. universities in Canada)?
- Are there any other ways in which students are prepared for the pre-registration programme e.g. undertaking voluntary experience?

Recognition of prior learning (RPL)

- Are students offered recognition of prior learning for academic qualifications and / or experience of health care? If so, what is the maximum proportion of the programme that can be substituted by this recognition?

During the programme

Course content:

- Do courses prepare students to work in multiple fields of practice (adult, children, learning disability and mental health) (as in the US), or do they specialise in one field (as in the UK)?
- If students are prepared to be general nurses, which specialist / age-group areas does the curriculum cover? (e.g. adult, children, older adults; learning disability, mental health, rehabilitation….).
- Does course content differ significantly between countries, and between institutions within each country?
- Is the pre-registration curriculum time-based (e.g. based on number of hours or programme length) or outcomes-based (emphasis on knowledge, skills and competencies gained) or both?

- What proportion of time on pre-registration courses is spent on theory, clinical practice or integrated learning? Do curriculums distinguish between theory and practice hours?
- How do course curriculums enable students to pull together theoretical knowledge, practical skills and reasoning to enable them to become effective practitioners?
- How do course curriculums enable students to develop their problem-solving and critical reasoning skills?

Quality of clinical practice placements:

- How are placements planned across the curriculum? (for example, only in years 2 and 3; in blocks of 8 weeks three times a year, etc.)
- What variety of practice fields and age groups across the lifespan are included in placements?

Support given to students:

- What support do students get from:
    - Lecturers / personal tutors / Clinical instructors – Evidence shows the importance of clinical competence, interpersonal skills, student-centred focus
    - Other staff – Evidence shows they may have enabling or hindering effect on students' clinical learning experiences
    - Peer support?
- What measures are taken to:
    a) Recruit people from diverse backgrounds?
    b) Ensure that learning environments (both in the classroom and on placement) are inclusive and supportive of people from diverse backgrounds?

Format of learning:

- To what extent is learning delivered face-to-face, online and practice-based (e.g. blended learning in NZ), including hours / proportion of each? Has this changed since the Covid-19 pandemic?
- What alternative models of teaching clinical skills are used, e.g. Dedicated Education Units (DEU) in the US, peer assisted learning?

Use of simulation:

- Can simulation be used as a substitute for clinical practice (as in the US), or is it in addition to clinical practice (as in Australia and NZ)? In what proportion / how many hours?

- Can students be assessed as competent in a skill or proficiency through simulation?

Other learning in practice:

- Are other forms of learning and experience encouraged e.g. voluntary experience?

Assessment:

- What types of summative assessment take place as students progress through the programme?

After the programme

Entry level competencies:

- What are the core knowledge, skills and competencies which newly qualified nurses in each country are expected to have?

Registration/licensing:

- Do students have to pass an additional exam after graduation in order to be registered/licensed to practise as a nurse? (e.g. Canadian Registered Nurse Examination, NLE in the Philippines)

Preceptorship or other support:

- Do newly qualified nurses undertake a period of preceptorship?
- Is this mandated by the regulatory body, or is it at the discretion of employers?
- What other formal or informal support are NQNs offered? E.g. peer support/buddying; clinical supervision

Revalidation:

- How often do nurses have to revalidate / renew their license?
- What is required to revalidate? Practice hours / evidence of CPD / feedback / appraisal / reference / other

Annexe 2: Key differences in context factors between the UK and the five countries of interest

Context factor	UK	Canada	USA	Australia	New Zealand	Philippines
Is a University degree the main route to qualification?	Yes, 3 year Bachelor's Degree	Yes, 4 year Baccalaureate Degree (3 year Diploma still accepted in Quebec)	Yes, 4 year Bachelor of Science in Nursing (BSN)	Yes, 3 year Bachelor of Nursing (for Registered Nurses)	Yes, 3 year Bachelor of Nursing	Yes, 4 year Bachelor of Science in Nursing
Are there also condensed routes to qualification?	Yes, Recognition of Prior Learning (RPL) for those with previous relevant learning, including Nursing Associate qualification	Yes, 2 year with previous science degree, or practical nurse to Baccalaureate route	Yes, shortened BSN degree (around 2 years) for those with a previous Bachelor's degree, or a Registered Nurse Diploma (RND) or Associate Degree in Nursing (ADN)	Yes, decisions about RPL at the discretion of individual institutions	Yes, 2 year graduate-entry Master's degree	Commission on Higher Education (CHED) document[1] provides no details about provisions for the recognition of prior learning
Do courses prepare students to work in multiple fields of practice…?	No, trained in one of four fields of practice - adult, children, mental health or learning disability	Yes, trained as generalist nurses	Yes, trained as generalist nurses	Yes, trained as generalist nurses	Yes, trained as generalist nurses	Yes, trained as generalist nurses

Context factor	UK	Canada	USA	Australia	New Zealand	Philippines
Can simulation be used as a substitute for clinical practice in nursing degrees?	No, simulation currently restricted by the EU Directive with the exception of the recovery standards	Canadian guidelines[2] are not prescriptive	Yes, NCSBN guidelines[3] permit up to 50% of practice hours to be substituted by simulation. In practice, rules on simulation vary by state and school of nursing.	No	No	No
Do students on placement work with people across the lifespan and in different settings?	Yes, within the chosen field	Yes	Yes	Yes	Yes	Yes
What are some ways this country ensures a high quality placement experience?	• AEIs working in partnership with practice learning partners • Meeting the standards of student supervision and assessment • QA processes	• Focus on training good quality clinical instructors • Intensive preceptorship at end of programme	• Integrating theory and practice, e.g. through follow-up discussions • Support from clinical instructors from the nursing school	• Focus on quality of learning • Outcomes-focused standards • Support from preceptors	• Outcomes-focused approach • Placements adapted to local requirements	• Integrated approach combines classroom, simulation and placement learning • Clinical instructor model supports the integrated approach

Context factor	UK	Canada	USA	Australia	New Zealand	Philippines
Do students have to pass an additional national exam after graduation in order to be registered/licensed to practise as a nurse?	No	Yes	Yes	No	Yes	Yes
Are newly qualified nurses mandated to undertake a period of preceptorship?	No, informal arrangements by employers	No, but recommended	No, but recommended	No, but recommended	No, but recommended	No, but recommended

1. https://ched.gov.ph/wp-content/uploads/2017/10/CMO-No.05-s2008.pdf
2. Practice Domain for Baccalaureate Nursing Education: Guidelines for Clinical Placements and Education, CASN, 2015.
3. https://ncsbn.org/null/null/national-simulation-guidelines

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