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European Union directives and clinical practice in nursing education in the Nordic countries

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Abstract

Nursing education in countries belonging to the European Union (EU) must follow EU directive requirements. The aim of this opinion paper is to explore and discuss the challenges presented by EU requirements to clinical practice in nursing education. These requirements prescribe that clinical practice must be carried out in a variety of different and specialized areas that provide care in hospital units. This may offer students only a limited range of experience; thus, they may not be fully prepared to care for patients with common diseases, and only have a restricted knowledge about the ongoing development of caring for patients at home. EU directives require that half of a nursing education course be allocated to clinical practice. This is challenging, since the number of hours is laid down without considering such aspects as the need for pedagogical qualifications for preceptors, which in turn may affect the quality of the clinical practice.

Keywords

clinical practice, European Union directives, nursing, Nordic countries

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Introduction

The European Union directives 2005/36/EC and, later, 2013/55/EU aim to facilitate the free movement of EU citizens.[1,2] The Nordic countries (Denmark, Finland, Iceland, Norway and Sweden) are close neighbours, have close contacts in terms of healthcare and education, and have similar content and structure in their respective nursing education courses.[3] EU directive 2005/36/EC and EU directive 2013/55/EU (henceforth referred to as 'EU directives')[1,2] describe the requirements for the training of general nurses, in terms of content, placements and time spent in clinical practice. However, they do not clarify how these requirements may ensure quality. One of the cornerstones in developing clinical and professional competences in healthcare education is practice-based learning.[4] For this reason, clinical practice is an essential component of every nursing programme.[5,6]

The conditions for theoretical and clinical practice are stated as follows:

> The training of nurses responsible for general care shall comprise a total of at least three years of study which may, in addition, be expressed with the equivalent ECTS credits (180 ECTS), and shall consist of at least 4,600 hours of theoretical and clinical practice, with the theoretical training representing at least one third, and the clinical practice at least one half of the minimum duration of the training.[1(p.152)]

Clinical practice must therefore cover a minimum of 2,300 hours (90 ECTS).[1(p.152)] Furthermore, it is stated in Article 31 that: 'Clinical practice is that part of nurse training in which trainee nurses learn, as part of a team and in direct contact with a healthy or sick individual and/or community, to organize, dispense and evaluate the required comprehensive nursing care'.[1(p.152)] The time spent in clinical practice must be coordinated between schools of nursing, hospitals and community facilities respectively.

The revision presented in the EU directive of 2013[2] makes extended demands on the nursing profession and thereby on nursing education, e.g. being able to plan, organize, evaluate and communicate the nursing care given – which are all new elements in the EU directive of 2013 in relation to the requirements of EU directive 2005/36/EC.

Changes in healthcare systems comprising such aspects as accelerated patient processing, in which patients are discharged from hospitals earlier,[7] and reductions in the number of hospital beds on the wards where students

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mainly have their clinical practice, are issues in the Nordic countries as well as global issues. This has led to a shortage of clinical placements for nursing students to such an extent that currently there are difficulties in following the EU directives.[8] This is especially evident in specialized clinical wards such as paediatrics, critical care, operating room environments and maternity wards, which according to the directives are all compulsory elements.

EU directives have a major impact on nursing education, irrespective of national differences concerning healthcare needs, levels of development, and learning and teaching methods in theoretical and clinical environments.[9] Thus, the aim of this opinion paper – with a focus on the Nordic countries – was to explore and discuss the challenges presented by EU requirements to clinical practice in nursing education.

Discussion

This is an opinion paper, in which the discussion is based on a systematic and thorough review and evaluation of EU directives 2005/36/EC[1] and 2013/55/EU,[2] which regulate nursing education in the Nordic countries. The discussion is structured around two main points: 1) The consequences of the EU requirements in prescribed areas for clinical practice in nursing education, and 2) Challenges for the nursing degree programmes posed by the requirements in the EU directives concerning required time for clinical practice.

The consequences of the EU requirements in prescribed areas for clinical practice in nursing education

Five or six of seven settings for clinical practice are hospital-based, while the seventh is home care. Today, and even more in the future, patients will be discharged much faster from hospitals and care will be given in the patient's own home. Therefore, we need to expand students' knowledge, skills and experience regarding home-based healthcare. We ask whether the focus on hospital-based clinical practice may be a drawback and a limitation for nursing students in the course of their education. Home care accounts for only a small part of their clinical practice; this will likely not give students the skills to meet the challenges posed by community-based healthcare. Dealing with patients in their own homes demands specific skills, e.g. concerning autonomy, communication etc.

Many of the compulsory areas for clinical practice are specialized units, e.g. paediatric and critical care units. These units can only accommodate a limited number of students at a time. The intention of the bachelor's nursing programme is to provide an education at a generalist level. This lack of balance between designated areas for clinical practice may limit students' experience and knowledge of the care of patients with common diseases that they will meet in their career as nurses.

Ministerial orders in the Nordic countries allow a portion of the total number of clinical hours to be replaced with time in the simulation centre. Simulation-based learning means training in a realistic environment utilizing simulation equipment. In order to create a realistic environment, the setting must include faculty members who have been formally trained in simulation pedagogy. The effectiveness of simulation learning has been shown in different nursing areas to be as good as, or better than, traditional learning.[10] However, some challenges arise when replacing some of the clinical hours with simulation: a) the students' ability to transfer the skills to clinical practice, and b) EU regulations describe clinical learning as involving being 'in direct contact with a healthy or sick individual'.[1(p.41)] It is difficult to fulfil the requirement for being 'in direct contact' in simulation training. The directives can be seen in this respect as a hindrance to pedagogical development. Simulation as a complement to clinical practice needs to be discussed and investigated further.

Challenges for the nursing degree programmes posed by the requirements in the EU directives concerning required time for clinical practice

Nursing education in the Nordic countries complies with the EU directive about the number of hours allocated to the clinical practice component.[11] There is no evidence regarding how many clinical hours are needed to produce a competent and capable nurse. There is no guarantee that the student has acquired the necessary skills just because they have been in clinical practice for a minimum of 2,300 hours. On the contrary, there will be students who, despite a large number of clinical hours, have not achieved a satisfactory level of competence.

The challenge is that the stipulated number of hours for clinical practice has no correlation with quality demands. Student competences are, for example, dependent on the quality and amount of supervision that the students are given during clinical practice,[12] and the quality of clinical learning is influenced by factors such as relationships between students and preceptors, and feelings of belonging.[13] Preceptors' qualifications are another aspect of quality. It is known that there must be a strong pedagogical focus on how the learning outcomes can be achieved, on feedback and assessment.[14] Despite this, the EU directives do not prescribe or state that preceptors must have certain minimum pedagogical qualifications or any minimum experience in nursing. We therefore question how the quality of nursing education in clinical practice can be ensured when such important elements as the pedagogical skills of preceptors are not compulsory.

Conclusion and implications

There are several consequences and challenges for nursing education in the Nordic countries when meeting the EU directives for clinical practice. We argue that when students follow a generalist course of education, the clinical practice element must give them experience of common health problems and diseases, and not be limited to specialized patient care. Equally important is the quality of

the preceptors' supervision, and opportunities to explore alternative learning situations, such as simulation-based learning. We suggest that clinical practice in nursing education calls for EU regulations that better suit the way in which the healthcare service is organized in different countries, which means giving students more experience of care in patients' homes. The viewpoints stated in this opinion paper may also have implications for other European countries, since the challenges and consequences of the directives affect nursing education in all EU countries.

Author contributions

Jette Henriksen has participated in designing the project, data collection, discussion and has written the manuscript and critical revised the manuscript with intellectual content. Anna Löfmark, Eivor Wallinvirta and Þóra Jenný Gunnarsdóttir have all participated in designing the project, data collection, discussion, and have critically revised the manuscript with intellectual content. Åshild Slettebø has participated in designing the project, data collection, discussion and has written the manuscript and critically revised the manuscript with intellectual content. All authors have approved the final version and accept the submission.

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The authors declare that there is no conflict of interest.

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