WE ARE ONE, BUT WE ARE MANY: HOW A REBOOT TO THE BACHELOR OF NURSING PROGRAM COULD BENEFIT US ALL

By Margaret McAllister and Sue Dean

In Australia, the process for becoming a qualified registered nurse has, more or less, stayed the same for 30 years. Our view is that it is time for a reboot and we give six good reasons why.

Clinical services are now extremely diverse, depending on nurses to understand and respond to their unique client needs and treatments. They are fast paced, highly technical and attract keen clinicians who may not intend to work there for a lifetime (Krahn and Galambos 2012). To stay efficient and effective, they require graduates who come fit for practice, and who do not need re-training and extra resources. New graduates should be ready for their chosen field upon leaving university, yet many specialty areas have identified that graduate nurses are ill equipped to work in specialty areas (Albutt et al. 2013, Cable et al. 2015, Happell and Gaskin 2013).

The highly-regulated bachelor of nursing program in Australia teaches a broad and basic set of skills to produce what is mythically known as 'the comprehensive nurse' able to practice in any area, from intensive care to mental health. Such an expectation is, we believe, excessive and unrealistic. No other health professional would have this burden placed upon them. This kind of generic training is more in tune with what monolithic hospitals from the 1970s and 80s may have needed, or provided, but it is anachronistic today (Keleher et al. 2010).

Furthermore, most universities today increasingly are accepting that they have a responsibility to the communities in which they are placed. The university as 'ivory tower' has been replaced by the concept of the university as a partner and collaborator in improvements for their local community. An important way for universities to collaborate with health services is to produce healthcare graduates, such as nurses, who are fit for specific community needs. Customised programs would satisfy local health service and community expectations, and lead to programs that are rich in diversity across the country. Perhaps the graduate could no longer lay claim to comprehensive training, but they could begin to proudly assert that their alma mater prepared them for a modern nursing specialty. They are an aged care nurse from UTAS, for example, or a Mental Health Nurse from UQ.

Thus, linked to this second reason, is this third argument: university students ought to be proud of their specialised learning and know that they are entering the workforce with a specific set of skills that are welcome and respected. Yet most nursing students leave without clear career goals, and frightened at the prospect of where they might be placed and in need of lengthy induction training and remedial education. This is a disempowered position for the new graduate and wasteful education dollars for the health service.

> AN IMPORTANT WAY FOR UNIVERSITIES TO COLLABORATE WITH HEALTH SERVICES IS TO PRODUCE HEALTHCARE GRADUATES, SUCH AS NURSES, WHO ARE FIT FOR SPECIFIC COMMUNITY NEEDS.

Despite the heavy investment that the student, the university and the health service has made in preparing graduates for work, nursing has the highest turnover rate of all the health professions (Duffield et al. 2014). Reasons cited are: unprepared for the work, role overload, unhappiness and a failure to care according to personal values (Fida et al. 2016; Boamah and Laschinger 2015; Leineweber et al. 2016). Any economist, or even job placement officer knows this makes no financial or social sense.

The few graduates who do stay long enough to be able to clarify which specialty they may want to focus on, are then hit with another hefty fee. To work in the area they have developed a passion for, where they are likely to make a positive difference in the care quality and the advancement of the knowledge in that field, they must return to university and pay to complete a graduate diploma or Masters program (Happell and Gaskin 2013). To the 90% of women who constitute nursing this is economically unfair, and burdensome if not impossible for their families (Snyder and Green 2008). Most of these graduate diplomas are actually entry to specialist practice. An example is Midwifery. It is now possible, in many parts of the country for students to identify midwifery as their career goal and to study it at undergraduate level. The same should be true for most other specialty contexts, such as mental health, aged care, disability and so on. This is not an argument for deskilling or diluting programs, but focusing learning so that it is relevant to context.

Our final argument, is that there is growing evidence healthcare consumers are dissatisfied with the care that they or their family members receive. Often these complaints are directed at nurses. Consumers believe that they are not receiving personalised care, and that nurses are not communicating clearly, compassionately or respectfully (Rahmati et al. 2015; Zamanzadeh et al. 2014; Drury et al. 2014; Dean et al. 2016). Given most students who enter nursing state they like talking to people and really want to make a positive difference (Sharp, McAllister and Broadbent 2015) then their failings with patients may be more to do with their own unmanaged anxiety and lack of role confidence. Anxiety and lack of confidence could both be assuaged with training that was focused, and where skills to be enacted were practised repeatedly with close guidance.

Margaret McAllister is Professor of Nursing in the School of Nursing, Midwifery and Social Science at CQ University in Qld

Sue Dean is Lecturer in the Faculty of Health at the University of Technology Sydney in NSW

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